THE LONDON SCHOOL OF ECONOMICS AND POLITICAL SCIENCE

DESIGNING, FIXING AND MUTILATING THE VULVA: EXPLORING THE MEANINGS OF VULVAL CUTTING

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DECLARATION

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ABSTRACT

This PhD thesis questions the gaps and mismatches between different understandings of modifications, cuts or surgeries on the vulva and the vagina. This doctorate brings to the surface the underpinnings behind classifying very similar, if not identical, cuts as vulval cosmetic surgery, intersex surgery and Female Genital Mutilation. It contests the boundaries that are taken for granted between these three 'sorts' of vulval and vaginal interventions, exploring the concepts (such as health, autonomy, or oppression) which are mobilised in order to justify their different classification. It examines how different discourses, articulated by different actors (feminist scholars, intersex advocates, medical professionals, and policy makers), converge in attaching meaning to these cuts on the vulva and vagina. This PhD argues that the idea of the gendered and racialised body constrains and shapes the conditions of possibility of the current tripartite discourses traversing vaginal and vulval interventions.

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INTRODUCTION

1 Three patients in the waiting room

Three patients are in the waiting room of a gynaecological clinic. A 21-year-old woman booked her appointment to ask for a referral to a cosmetic surgeon. For a while now, she has felt her labia minora are ugly and sees them as too big and long, which has made her feel increasingly self-conscious, to the point where she is now reluctant to engage sexually with her partner. After giving it some thought and looking for information online, she has decided she wants a labiaplasty. Next to her, there is an 18-year-old. She has been referred by her GP, who, after finding out she had recently travelled to Guinea-Bissau, and seeing that she had been presenting with recurring urinary tract infections, examined her and suspected she might have had her labia minora and clitoris excised. Her GP told her she needed closer examination by a specialist, who would clinically assess her symptoms, being warned that, in case the suspicions were confirmed, she would be recorded as having undergone Female Genital Mutilation (FGM).

On the other side of the room, a 19-year-old waits to be called by the nurse. She is used to these visits. Medical appointments have been an ordinary part of her life since she was born. When she was a child, she did not really understand why she needed to go to the hospital so often and why so much attention was paid to her genitals. It was not until she became older that she understood that the reason behind so many hospital visits was that she had an intersexual condition, which caused her to have, among other things, atypical

looking genitals. As a result, she underwent several surgeries during childhood, which, she was told, would enable her to look like a 'normal' girl.

These three patients seem to have little in common, except for the fact that they all fall under the remit of the same medical specialist. If asked about the motive of their appointment, not much of their stories would match. One would probably think that there are important differences between their bodies, the context that has led to their particular embodiment, and the reasons why they have had or will have their vulvas and vaginas modified. Aesthetic and sexual insecurities seem to be the main motivating factor of the first patient, while the second patient's need for medical attention seems to stem from her vulva having undergone harmful cuts. In contrast, the third patient's relationship with the medical profession is marked by her having been diagnosed with a medical condition requiring constant medical attention and surgical treatment.

Thus, the manner in which these three patients enter the medical sphere and the cuts they have or will undergo seem to belong to different worlds—of cosmetic surgery, intersex treatment and FGM. Cosmetic surgery is dominated by the language of self-perception, with our first patient's self-awareness triggering her actively seeking assistance from doctors. This dynamic is inverted for the third patient, who was diagnosed with an intersex condition and introduced to the medical world at birth, with her body having since been seen to be in constant need of medical assistance. The patient who is presumed to have undergone FGM is also perceived to require help from the medical profession, but in

order to mitigate and deal with the detrimental health consequences of having been unlawfully cut.

The juxtaposition of these three patients is reminiscent of the feeling one has after reading the famous passage in the introduction to *The Order of Things* where Michel Foucault recalls a 'certain Chinese encyclopaedia' which divides animals into:

> a) belonging to the Emperor b) embalmed c) tame d) sucking pigs e) sirens f) fabulous g) stray dogs h) included in the present classification i) frenzied j) innumerable k) drawn with a very fine camelhair brush l) et cetera m) having just broken the water pitcher n) that from a long way off looks like flies.[1]

This classification seems completely random, lacking a 'common ground', a proximity bringing it together.[2] Foucault uses this example to rethink what has been assumed to belong, and not belong, together, prompting reflection about the 'operating table' from which a 'grid of identities, similitudes, analogies' derive from and create a series of seeming self-evident classifications of reality.[3] He is determined to investigate the 'conditions of possibility' through which one assumes that 'things in themselves are capable of being ordered', teasing out the 'middle region' which is prior and key to how 'ideas could appear, sciences be established, experience be reflected in philosophies, rationalities be formed'.[4]

Similarly, this PhD thesis is an investigation of the 'deep strata' of the conditions that make it possible to 'reflect about relations of similarity or equivalence between

[1] Michel Foucault, *The Order of Things. An Archaeology of the Human Sciences.* (Routledge 1989) xvii.
[2] ibid xviii.
[3] ibid xiii–xxi.
[4] ibid xxii–xxiii.

things'.[5] Focusing on modifications, cuts or surgeries (the lexicon shifts depending on the context) on the vulva and the vagina, this project investigates the connections between so-called vulval cosmetic surgery, intersex surgery and FGM.[6] It uncovers the 'conceptual' glue that enables us to see these three patients in the waiting room as belonging to different worlds and having different problems that need to be tackled differently by the medical profession, even though they have all undergone or seek to undergo almost anatomically identical cuts on their genitalia. This PhD looks for what gives coherence to the current tripartite categories of vulval and vaginal modifications, teasing out the 'ground on which we are able to establish the validity of this classification'.[7]

Section 2 provides an overview of the academic discussion on body and genital modifications. Section 3 elaborates further on the precise aims and contributions of this PhD. Section 4 defines the boundaries of the project, Section 5 clarifies the use of some of its key terms and Section 6 summarises the contributions of each chapter.

2 Body modifications

The issue of whether and how we can have our bodies modified has been a fruitful area of research, especially since *R v Brown*.[8] In this case, the House of Lords dealt with the dilemma of whether the consent of the 'victims', who had sustained serious injuries as a result of their participating in sadomasochistic sex, shielded the defendants from criminal liability. When delivering their ruling, the Law Lords upheld the principle that previous

[5] ibid xvi.
[6] See Section 4 for further justification of why I chose these three interventions.
[7] Foucault, *The Order of Things. An Archaeology of the Human Sciences* (n 1) xxi.
[8] *R v Brown* [1994] 1 AC 212 (HL).

case law had already been establishing: 'it is not in the public interest that people should try to cause, or should cause, each other bodily harm for no good reason'.[9] However, they also acknowledged that there were exceptions to this general rule, explaining that there are some instances where inflicting serious harm might be in line with the public interest:

> [i]n some circumstances violence is not punishable under the criminal law … Surgery involves intentional violence resulting in actual or sometimes serious bodily harm but surgery is a lawful activity. Other activities carried on with consent by or on behalf of the injured person have been accepted as lawful notwithstanding that they involve actual bodily harm or may cause serious bodily harm. Ritual circumcision, tattooing, ear piercing and violent sports including boxing are lawful activities.[10]

Homosexual sadomasochistic sex was not found to be among these exceptions nor to warrant the creation of a new one.[11] The Law Lords' unease towards non-mainstream sexual practices and their stigmatising discourses towards homosexuality and sadomasochism gave rise to prolific academic commentary.[12] Likewise, the Law Commission was troubled by the 'unprincipled way in which these rules [of consent and offences against person] had developed',[13] publishing two consultation papers exploring how the criminal law deals with the lawfulness of activities such as medical and surgical

[9] *Attorney General's Reference* (No 6 of 1980) [1981] QB 715 719.
[10] *Brown* (n 8) 231.
[11] ibid 231 (Lord Templeman), 244-245 (Lord Jauncey), 262-267 (Lord Mustill), 277 (Lord Slynn).
[12] See eg Carl F Stychin, 'Unmanly Diversions: The Construction of the Homosexual Body (Politic) in English Law Unmanly Diversions' (1994) 32 Osgoode Hall Law Journal 503; Lois Bibbings and Peter Alldridge, 'Sexual Expression, Body Alteration, and the Defence of Consent' (1993) 20 Journal of Law and Society 356; Annette Houlihan, 'When No Means Yes and Yes Means Harm: HIV Risk, Consent and Sadomasochism Case Law' (2011) 20 Law and Sexuality 31.
[13] Law Commission, 'Criminal Law. Consent in the Criminal Law. A Consultation Paper (No 139)' (1995) para 1.1.

treatment, circumcision, tattooing, piercing, branding and scarification, sports, games or martial arts.[14]

More than twenty years after *Brown*, the recent case of *R v MB* has revived the discussion on body modifications.[15] The defendant, who was registered with the local authority for the purposes of tattooing and body piercing, carried out, upon request, the removal of a customer's ear, the removal of a customer's nipple and the division of a customer's tongue. He was charged with three counts of wounding with intent to do grievous bodily harm, contrary to section 18 of the Offences against the Person Act 1861. Although he contended that the procedures he performed were a 'natural extension of tattooing and piercing',[16] the Court of Appeal dismissed his argument. Instead, it considered that these interventions were medical acts performed without proper justification, preparation or safeguards.[17] The removal of an ear or a nipple constituted a 'series of medical procedures performed for no reason', where customers did not enjoy the protections they would have otherwise had if their requests had been made to a medical professional.[18] The Court argued that, in addition to securing a sterile environment and proper training to deal with the 'risks of infection, bungled or poor surgery', protecting the

[14] Law Commission, 'Criminal Law. Consent and Offences Against the Person. A Consultation Paper (No 134)' (1994); Law Commission (n 13).
[15] *R v MB* [2018] EWCA Crim 560 [2019] QB 1.
[16] ibid 34.
[17] ibid 42.
[18] ibid.

public also entails acknowledging that those who seek this sort of body modifications might need medical assistance and psychological help.[19]

At the time of writing, six defendants are currently on trial at the Old Bailey for being part of a 'body modification conspiracy'.[20] Two men face charges of grievous bodily harm for having partially removed the nipple and penis of Marius Gustavson, who is the alleged ringleader of a group of so-called 'nullos' (genitally nullified men).[21] Gustavson, who ran a subscription 'eunuch maker' website where video recordings of body modification procedures were uploaded, has been charged with 'acquiring or possessing criminal property, making an indecent image of a child and distributing an indecent image of a child'.[22] He also faces charges of grievous bodily harm, as he allegedly participated, together with three additional defendants, in the 'removal of a man's penis, the clamping of another's testicles, and the freezing of a leg which required amputation'.[23]

Brown and *MB* have been a catalyst for fruitful discussions concerned with the (un)lawfulness of body modifications. A first line of inquiry has been whether and how certain body modifications fall—and should fall—under the so-called 'medical exception',[24] and the regulatory problems derived from current regulation, such as who can

[19] ibid.
[20] Emine Sinmaz, 'Two Men Admit Removing Body Parts in "Eunuch Maker" Case ' *The Guardian* (19 April 2023).
[21] ibid.
[22] Jess Warren, 'Men Admit Removing Man's Body Parts Including Penis ' *BBC News* (19 April 2023).
[23] Sinmaz (n 20).
[24] Sally Sheldon and Stephen Wilkinson, 'Female Genital Mutilation and Cosmetic Surgery: Regulating Non-Therapeutic Body Modification' (1998) 12 Bioethics 263; Tracey Elliott, 'Body Dysmorphic Disorder, Radical Surgery and the Limits of Consent' (2009) 17 Medical Law Review 149; Andrew Beetham, 'Body Modification: A Case of Modern Maiming? R v BM [2018] EWCA Crim 560' (2018) 82 The Journal of Criminal Law 206; Rachel Clement, 'Consent to Body Modification in Criminal Law' (2018) 77 The Cambridge Law Journal 451; S Pegg, 'Not so Clear Cut: The Lawfulness of Body Modifications' (2019).

perform body modification procedures, where these procedures can be provided or what products are to be used.[25] This line of literature presents valuable and influential discussions around whether and how the general rule against harm (that is, that one's consent to grievous or serious bodily harm cannot shield from criminal liability, except under limited exceptions) should apply to body modifications and offers insights about whether and how these procedures should be undertaken. Nevertheless, much of it seems to leave unquestioned or underexamined the categories it discusses. For instance, Sally Sheldon and Stephen Wilkinson argue that, although some cosmetic procedures can be justifiable because of their benefit to the patient's mental health, others, 'such as repeated face lips and tucks for individuals who are in no way beyond the range of the normal but merely want to improve their appearance for aesthetic reasons' cannot.[26] Notwithstanding the fact that 'health', 'appearance' or 'normality' are crucial features of their argument, these are not subject to critical scrutiny, and what they mean and the potential problems or contradictions that using them in such a way may entail goes unexamined. Similarly, Penney Lewis's analysis of what types of 'public policy justifications' allow for a medical intervention not to be criminalised, depending on whether it is sanctioned by the profession and is considered to benefit the patient and/or society more generally, does not interrogate

[25] Melanie Latham, 'The Shape of Things to Come: Feminism, Regulation and Cosmetic Surgery' (2008) 16 Medical Law Review 437; Nuffield Council on Bioethics, 'Cosmetic Procedures: Ethical Issues' (2017).
[26] Sheldon and Wilkinson (n 24) 284.

the concepts of 'benefit' and 'harm'.[27] Rather, it takes them as a given and assumes they have a seemingly straightforward and stable meaning.

With a focus on decision-making and autonomy, a second stream of literature has tackled whether (and what) body modification practices can be validly consented to,[28] and whether the current framework of consent, including who should consent to these practices, is adequate.[29] For instance, the discussion with regards to elective amputations is particularly enlightening to exemplify how some of these debates about choice and decision-making also proceed from, rather than constitute an interrogation of, particular assumptions about 'benefit', 'health' or 'autonomy'. Indeed, some authors seem to operate on rather static framings of what an 'autonomous' decision may consist of, which can be seen from the fact that, quite often, a key concern in discussions about elective amputations is determining to what extent obsessive or delusional thoughts may fuel someone's desire to have their leg removed.[30] The common starting question in these discussions seems to be 'why would someone possibly want to get rid of their leg?', as if it were a bizarre, perhaps even crazy, request. Nevertheless, one might want to take a different starting point and ask: why is it so bizarre that someone might want to inhabit what has been deemed a disabled body? What perspectives about disability underpin and influence the discussion

[27] Penney Lewis, 'The Medical Exception' (2012) 65 Current Legal Problems 355.
[28] In relation to cosmetic surgery, see eg Kathryn Pauly Morgan, 'Women and the Knife: Cosmetic Surgery and the Colonization of Women's Bodies' (1991) 6 Hypatia 25; Latham (n 25).
[29] See eg Melanie Newbould, 'When Parents Choose Gender: Intersex, Children, and the Law' (2016) 24 Medical Law Review 474; Kai Moller, 'Male and Female Genital Cutting: Between the Best Interest of the Child and Genital Mutilation' (2019) Oxford Journal of Legal Studies.
[30] Thomas Schramme, 'Should We Prevent Non-Therapeutic Mutilation and Extreme Body Modification?' (2008) 22 Bioethics 8; Sabine Müller, 'Body Integrity Identity Disorder (BIID) Is the Amputation of Healthy Limbs Ethically Justified?' (2009) 9 American Journal of Bioethics 36, 42; David Patrone, 'Disfigured Anatomies and Imperfect Analogies: Body Integrity Identity Disorder and the Supposed Right to Self-Demanded Amputation of Healthy Body Parts' (2009) 35 Journal of Medical Ethics 541, 545.

about consent and elective amputations?[31] There is much to explore about (the terms in) which choices spark suspicion, as well as the assumptions lying behind mental health judgements in relation to these choices. This project argues for the need to open up to critical inquiry how presumptions about what constitutes a 'deficiency' or an 'enhancing' trait pervade narratives around decision-making, capacity and autonomy.

Modifications of the vulva and the vagina have also occupied a prominent place in academic discussion. Similar to the goal of this project, much of the debate has paid attention to the challenges involved in drawing lines between what seem to be very similar cuts. For instance, as upcoming chapters will unpack, medical regulatory bodies, such as the Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of Surgeons (RCS), show preoccupation about the 'legal uncertainty' in differentiating between what is described and marketed as cosmetic surgery, but is 'anatomically identical to the procedures explicitly prohibited by the Female Genital Mutilation Act 2003' (FGM Act 2003).[32] As well as giving rise to 'pragmatic problems' (eg when might surgeons be criminally liable if they excise their patient's labia or clitoris?),[33] the similarity between these interventions has sparked more 'principled' debates, since one of the core issues within the literature is the apparent contradiction in forbidding some women to have their

[31] Mireia Garcés de Marcilla Musté, 'Morality and Legality of Elective Amputations: Autonomy, Consent and Lawfulness of Healthy Limb Amputation' (King's College London 2018).
[32] Royal College of Obstetricians and Gynaecologists, 'Ethical Opinion Paper: Ethical Considerations in Relation to Female Genital Cosmetic Surgery (FGCS)' (2013) 7; Royal College of Surgeons, 'Cosmetic Surgery Standards FAQ ' <https://www.rcseng.ac.uk/standards-and-research/standards-and-guidance/service-standards/cosmetic-surgery/faq/> accessed 22 February 2021.
[33] Crown Prosecution Service, 'Female Genital Mutilation Prosecution Guidance' (2019). Chapter 5 examines in detail the overlap between vulval cosmetic surgery and FGM.

genitalia modified to comply with their cultural ideals and customs, whilst allowing others to undergo a very similar operation to conform to their ideals of beauty.[34]

Indeed, the contraposition of the image of non-Western women, who are held down against their will to have their vulvas excised in a way that is deeply painful and traumatic, versus that of Western women, who can make informed decisions about medical procedures performed by qualified medical professionals with their informed consent, is contested by many commentators.[35] Some make a similar criticism in relation to FGM and intersex surgeries, contending that both sorts of interventions are cultural practices encapsulating and reproducing norms about how genitalia should look and function.[36] Although these are 'analogous' operations, some argue, whilst intersex surgery has been legitimised through the Western medical discourse, FGM has been deemed a barbaric

[34] Moira Dustin, 'Female Genital Mutilation/Cutting in the UK: Challenging the Inconsistencies' (2010) 17 European Journal of Women's Studies 7; Lisa Avalos, 'Female Genital Mutilation and Designer Vaginas in Britain: Crafting an Effective Legal and Policy Framework' (2014) 48 Vanderbilt Journal of Transnational Law 621; Arianne Shahvisi, 'Female Genital Alteration in the UK: A Failure of Pluralism and Intersectionality' in Katja Kuehlmeyer, Corinna Klingler and Richard Huxtable (eds), *Legal and Social Aspects of Healthcare for Migrants: Perspectives from the UK and Germany* (Routledge 2018); Arianne Shahvisi, 'Why UK Doctors Should Be Troubled About UK Legislation' (2017) 12 Clinical Ethics 102; Arianne Shahvisi and Brian D. Earp, 'The Law and Ethics of Female Genital Cutting' in Sarah M. Creighton and Lih-Mei Liao (eds), *Female Genital Cosmetic Surgery. Solution to What Problem?* (Cambridge University Press 2019); Sheldon and Wilkinson (n 24); B Kelly and C Foster, 'Should Female Genital Cosmetic Surgery and Genital Piercing Be Regarded Ethically and Legally as Female Genital Mutilation?' (2012) 119 BJOG: An International Journal of Obstetrics and Gynaecology 389; Simone Weil Davis, 'Loose Lips Sink Ships' (2002) 28 Feminist Studies 7; Bronwyn Winter, Denise Thompson and Sheila Jeffreys, 'The UN Approach to Harmful Traditional Practices' (2002) 4 International Feminist Journal of Politics 72.

[35] See eg Janice Boddy, 'The Normal and the Aberrant in Female Genital Cutting: Shifting Paradigms' (2016) 6 HAU: Journal of Ethnographic Theory 41; Davis, 'Loose Lips Sink Ships' (n 34); Courtney Smith, 'Who Defines "Mutilation"? Challenging Imperialism in the Discourse of Female Genital Cutting' (2011) 23 Feminist Formations 25; Winter, Thompson and Jeffreys (n 34).

[36] J Steven Svoboda, 'Promoting Genital Autonomy by Exploring Commonalities between Male, Female, Intersex, and Cosmetic Female Genital Cutting' (2013) 3 Global Discourse 237, 251; Nancy Ehrenreich and Mark Barr, 'Intersex Surgery, Female Genital Cutting, and the Selective Condemnation of "Cultural Practices"' (2005) 40 Harvard Civil Rights-Civil Liberties Law Review 71, 138.

ritual.[37] A key feature of contention is the seeming lack of coherency in allowing (parental) choice for intersex surgery, whilst denying (parental or personal) choice for what is framed as FGM, when both interventions can be read to have the same purpose: cultural normalisation. In the words of Melinda Jones:

> [f]or victims of FGM, the act is authorised by parents, but the oppression can be understood as an expression of misogyny and patriarchy. For victims of [intersex surgery], the act is authorised by parents, but the oppression can be understood as an expression of patriarchy and the power of medicine. In both cases, it is the need for cultural normalisation that ultimately justifies the procedure.[38]

3 Aims and contribution

Drawing on these contributions, which are illuminating in sparking suspicion about the distinctions currently in place, my project seeks to 'dig deeper' and interrogate not only the different framing and regulation of FGM, intersex and cosmetic surgeries (in terms of their being considered lawful or unlawful, or proper versus improper medical practices), but also the underpinning terms on which these distinctions rely. Instead of asking 'why are intersex surgeries seen as beneficial whilst FGM is considered a mutilating practice?', this thesis asks: what does it mean to benefit? What does it mean to harm? What does it mean to have healthy genitalia? How are physical and mental well-being understood and deployed to justify or condemn each intervention? What do autonomy, freedom or oppression mean in each context? How is each of these recurrent concepts discussed and

[37] Cheryl Chase, '"Cultural Practice" or "Reconstructive Surgery"? US Genital Cutting, the Intersex Movement, and Medical Double Standards' in S James and C Robertson (eds), *Genital Cutting and Trasnational Sisterhood. Disputing US Polemics* (University of Illinois Press 2002) 143.
[38] Melinda Jones, 'Intersex Genital Mutilation - A Western Version of FGM' (2017) 25 International Journal of Children's Rights 396, 409.

how is it that, through their constant but distinct mobilisation, we can see these three interventions as different from one another?

This thesis emphasises the tensions and contradictions of how the body, and interventions on it, become, at times, a locus of oppression and suffering, an object of mistreatment and abuse and, at others, a vehicle for liberation, psychological relief and physical health. Through the juxtaposition of cuts that have been labelled vulval cosmetic surgery, intersex surgery or FGM, this thesis deconstructs the logic of how these three interventions are understood to be different from one another. It consists in a mapping exercise of unpacking how different meanings and deployments of physical health, mental well-being, oppression and autonomy are generated, seeing how these are 'circulated, internalised and/or resisted' in each case.[39] In doing so, this PhD contests the boundaries that are taken for granted between these three 'sorts' of vulval and vaginal modifications, as well as the concepts (health, autonomy, oppression) sustaining them. I analyse what is obscured and revealed through the specific discourses that are produced in relation to each intervention, showing how intersections of gendered and racialised ideals of embodiment are key in being the conceptual 'glue' holding these different framings together. The argument this thesis makes is that race and gender are key vectors in generating different

[39] Kevin Dunn and Iver Neumann, *Undertaking Discourse Analysis for Social Research* (University of Michigan Press 2016) 2.

meanings of having your vulva cut, constraining and shaping the conditions of possibility of the current tripartite discourses traversing vaginal and vulval interventions.

My interest is in studying, characterising and collating the medical, legal, activist and academic discourses around several common themes in cosmetic surgeries, intersex surgeries and FGM.[40] This PhD, therefore, does not seek to assess whether the legal status of these three interventions is sound or whether the medical protocols in place for each of these surgeries are adequate. It does not put forward new models of decision-making for intersex surgeries and it is not its aim to propose legal reform to solve the seeming overlap between vulval cosmetic surgery and the offence of FGM. Neither does it 'choose' among the different framings of cosmetic surgery within feminist debates, or argues in favour of a particular account of intersex embodiment within intersex advocacy. Adopting any of these positions would not contribute to contesting the concepts I aim to unpack, but it would rather 'assume the[ir] stability, taking [them] as a given'.[41] What this PhD does is critically assess what is revealed when a particular set of parallel discourses among these three sorts of vulval modifications are put next to each other, focusing on the similarities and differences between them in order to tease out 'where they coexist, reside and disappear'.[42]

In doing this exercise, I am not suggesting that these procedures are equivalent or that there are no actual or real differences between them. As a matter of fact, the upcoming

[40] Michel Foucault, 'Politics and the Study of Discourse' in Graham Burchell, Collin Gordon and Peter Miller (eds), *The Foucault Effect: Studies in Governmentality. With Two Lectures by and an Interview with Michel Foucault* (The Chicago University Press 2022) 55.
[41] Dunn and Neumann (n 39) 6.
[42] Foucault, 'Politics and the Study of Discourse' (n 40) 60.

chapters discuss these differences, exploring, for instance, the reluctance of the medical profession to perform vulval cosmetic surgery on children, in contrast with their willingness to operate on children diagnosed with intersexual conditions. I also examine the unequivocal position of the medico-legal world that FGM is unquestionably harmful, versus the ambivalent stance it adopts regarding the positive and negative effects of early intersex surgeries.

As I investigate the conditions that make it possible to conceive that cosmetic surgeries, intersex surgeries and FGM are different interventions that give rise to different issues, I also steer away from empirical judgements or claims relating to any of these procedures. My thesis does not suggest that those who undergo interventions labelled as FGM are more or less oppressed than those who have their vulvas modified through interventions deemed vulval cosmetic surgery. Likewise, it does not seek to belittle or dismiss the pain that might result from having your genitalia cut—as a result of an intersex diagnosis, a customary ritual or cosmetic pressure. Rather, my goal is directed towards interrogating how understandings of pain and oppression are produced and deployed in each case, acknowledging that these processes of knowledge production create and shape the empirical bodily realities they purport to describe. Indeed, not only do cosmetic surgery, intersex surgery or FGM literally shape bodies by cutting them, but I see these interventions as also taking part in the process of 'materialisation and signification' through

which those who are cut become subjects—'the cosmetic surgery patient', 'the mutilated woman' or 'the intersex child'.[43]

My PhD hence analyses these processes of knowledge production and subject construction, seeing how 'facts' about having a vulva cut are established. In doing so, I argue that the universe of taxonomizing discourses dividing these three interventions constitutes an instance through which gendered and racialised ideals about embodiment are established and reinforced.

4 Boundaries

4.1 Cuts on the vulva and vagina

Vulval modifications are the focus of this thesis, not only because of the loaded meaning(s) the genital area has been accorded, but also because of the array of interventions to which it has been subjected for—allegedly—different motivations and rationales, both inside and outside the medical sphere. Specifically, this PhD deals with anatomically very similar cuts on the area of the vulva and the vagina. It investigates how the medical profession justifies the performance of, at times therapeutic, others enhancing, cuts on them, with so-called labiaplasties, vaginoplasties and clitoroplasties, as well as how the legal framework criminalises these exact same cuts when it considers they are not justified on the grounds of 'physical or mental health'.[44] This thesis interrogates the continuities and discontinuities that are perceived to exist between these interventions when being performed and labelled

[43] Judith Butler, *Bodies That Matter: On the Discursive Limits of Sex* (Routledge 1993) xix.
[44] Female Genital Mutilation Act 2003 s 1(2)(a).

as cosmetic, intersex or mutilating operations, analysing how the medical and legal worlds, together with feminist scholarship and intersex activism, have generated particular sets of truths about healthy, normal or oppressed bodies under their gaze.

One of the three 'types' of cuts under examination are intersex surgeries. As an initial note, intersexuality is an umbrella term covering a wide variety of 'differences' in 'sex' development (see below and Chapter 3 for further discussion on the controversial meaning of these terms). Ranging from Congenital Adrenal Hyperplasia to Klinefelter Syndrome, the management of intersex conditions encompasses a wide range of surgical interventions. Some of these, such as hypospadias repair, orchiopexy (repair of undescended testes), phalloplasty, prostatectomy or testicular prosthesis, do not deal with the vulva and the vagina, but the penis, testicles or prostate. Because the focus of this project is on the vulva and the vagina, this array of operations involved in intersex medical management are not examined in this thesis. Rather, I focus on surgeries tackling vaginal and vulval structures, which include labiaplasty, clitoroplasty, clitoral reduction, clitoral recession or vaginoplasty.

4.2 Penile circumcision

Academic commentary examining genital practices beyond the vulva and the vagina has bloomed in the last few years. For example, increasing scrutiny has been paid to the routine removal of the foreskin of the penis.[45] Prophylactic circumcision is no longer considered

[45] See eg Brian D Earp, 'In Defense of Genital Autonomy for Children' (2016) 42 Journal of Medical Ethics; Marie Fox and Michael Thomson, 'Short Changed? The Law and Ethics of Male Circumcision' (2005) 13 International Journal of Children 161; Marie Fox and Michael Thomson, 'Bodily Integrity, Embodiment, and the Regulation of Parental Choice' (2017) 44 Journal of Law and Society 501; Brian D Earp, Jennifer Hendry

proper medical practice in the UK as it was in the early 20th century, when the foreskin was seen as a site of dirt and infection that had to be removed to avoid infection and disease.[46] However, it can still be routinely performed for religious reasons if it is believed to be in the child's best interests and is performed with their consent or, if they lack competence, that of their parents (it can also be performed for medical reasons in cases of phimosis).[47] Sharing a similar ethos to this thesis, several scholars have deconstructed the social embeddedness of this practice, shedding light on the role it plays in sculpting a stereotypical ideal of the male body, unpacking significant junctures between masculinity, sexual performance and penile anatomy.[48] Albeit fruitful connections might be drawn between penile circumcision and the interventions studied in this thesis, which can also serve to interrogate the distinctions currently drawn between body modification practices,[49] I leave this sort of genital modification unconsidered. My main interest is in exploring the

and Michael Thomson, 'Reason and Paradox in Medical and Family Law: Shaping Children's Bodies' (2017) 25 Medical Law Review 604; Moller (n 29).

[46] For a full historical account, see Robert Darby, *A Surgical Temptation. The Demonization of the Foreskin & the Rise of Circumcision in Britain* (The University of Chicago Press 2005).

[47] British Medical Association, 'Non-Therapeutic Male Circumcision (NTMC) of Children – Practical Guidance for Doctors' (2016).

[48] Marie Fox and Michael Thomson, 'Cutting It: Surgical Interventions and the Sexing of Children' (2005) 1 Cardozo Journal of Law & Gender 81; Juliet Richters, 'Circumcision and the Socially Imagined Sexual Body' (2006) 15 Health Sociology Review 248, 251; Joseph Zoske, 'Male Circumcision: A Gender Perspective' (1998) 6 The Journal of Men's Studies 189, 203; Daniel M Harrison, 'Rethinking Circumcision and Sexuality in the United States' (2002) 5 Sexualities 300, 301.

[49] For discussions exploring connections between intersex surgeries and penile circumcision, see Fox and Thomson, 'Cutting It: Surgical Interventions and the Sexing of Children' (n 48); Francesca Romana Ammaturo, 'Intersexuality and the "Right to Bodily Integrity": Critical Reflections on Female Genital Cutting, Circumcision, and Intersex "Normalizing Surgeries" in Europe' (2016) 25 Social and Legal Studies 591; For discussions investigating links between penile and vulval 'ritual' or 'custom' practices, see Kristen Bell, 'Genital Cutting and Western Discourses on Sexuality' (2005) 19 Medical Anthropology Quarterly 125; Marie Fox and Michael Thomson, 'Foreskin Is a Feminist Issue' (2009) 24 Australian Feminist Studies 195.

similarities and differences arising from interventions modifying the clitoris, labia minora, labia majora and vagina.

4.3 Gender reassignment surgery

For the same reason, gender reassignment surgery (GRS) is also excluded from my analysis. The lawfulness of GRS in the UK has been undisputed for more than fifty years.[50] However, there has been a recent attack on the propriety of hormonal treatments that may precede the surgery, especially when involving children and adolescents. The recent *Bell v Tavistock* saga exemplifies how heated the debate has become, although the heart of the litigation concerned *Gillick* competence and whether children and young adults can give consent to the administration of puberty blockers.[51] At first instance, the Divisional Court judgement issued guidance where it 'generalise[d] about the capability of persons of different ages to understand what is necessary for them to be competent to consent to the administration of puberty blockers'.[52] Such undermining of the principle of *Gillick* competence (according to which those aged 16 or under can consent to medical treatment if they have sufficient understanding of what it involves and its implications) was a cause of concern,[53] especially given its particular negative implications for adolescents seeking to access gender-affirming treatment.[54] In September 2021, the Court of Appeal overturned

[50] *Corbett v Corbett* [1971] P 83 (CA) 99; Law Commission (n 13) para 8.29.
[51] *Quincy Bell & Mrs A v The Tavistock and Portman NHS Foundation Trust and* Others [2020] EWHC 3274 (Admin); *Bell & Anor v The Tavistock and Portman NHS Foundation Trust* [2021] EWCA Civ 1363.
[52] *Bell & Anor v The Tavistock and Portman NHS Foundation Trust* (n 51) para 85.
[53] Kirsty L Moreton, 'A Backwards-Step for Gillick: Trans Children's Inability to Consent to Treatment for Gender Dysphoria— Quincy Bell & Mrs A v The Tavistock and Portman NHS Foundation Trust and Ors [2020] EWHC 3274 (Admin)' (2021) 00 Medical Law Review 1.
[54] Sandra Duffy, 'Puberty Blockers Ruling Will Have Chilling Effect' (*Scottish Legal News*, 2020) <https://www.scottishlegal.com/articles/dr-sandra-duffy-puberty-blockers-ruling-will-have-chilling-effect> accessed 30 June 2022.

the Divisional Court. Reinstating *Gillick*, it considered it was 'inappropriate to give the guidance concerning when a court application would be appropriate and to reach general age-related conclusions about the likelihood or probability of different cohort of children being able of giving consent'.[55]

In addition to puberty-suppressing hormones, the key issue in *Bell*, which are designed to 'give adolescents more time to explore their gender nonconformity', gender transition may involve other courses of treatment.[56] So-called 'feminising/masculinising hormone therapy' is prescribed to set in motion 'physical changes that are more congruent with a patient's gender identity', such as inducing breast growth or decreasing erectile function in those who take 'feminising' hormones; or growth in facial hair or clitoral enlargement for those under the course of 'masculinising' hormones.[57] Surgery, which can include several procedures within and beyond the genital area, such as breast or chest surgery, pectoral implants, voice surgery, thyroid cartilage reduction or lipofilling, may also be performed.[58] In terms of genital surgeries, those aimed at creating a neophallus may involve phalloplasty and scrotoplasty (that is, the reconstruction of the labia majora into a scrotus and of the vagina, labia minora and clitoris into a penile structure), together with hysterectomy (removal of uterus) and salpingo-oophorectomy (removal of fallopian tubes and ovaries).[59] Vaginoplasties, clitoroplasties, labiaplasties and orchiectomies (removal of

[55] *Bell & Anor v The Tavistock and Portman NHS Foundation Trust* (n 51) para 89.
[56] World Professional Association for Transgender Health, 'Standards of Care for the Health of Transsexual, Transgender, and Gender- Nonconforming People' (2012) 19.
[57] ibid 36.
[58] ibid 57.
[59] ibid 63; Anna Zurada and others, 'The Evolution of Transgender Surgery' (2018) 31 Clinical Anatomy 878, 20.

testicles) are to be performed if the goal is to transition to the female gender, surgically shaping the penis and testicles into a vagina, labia and clitoris.[60]

Even if some of these GRS surgical procedures, including the construction of a neovagina, the shaping of the labia or the removal of testicles, may also be performed following some intersex diagnoses, this project does not deal with interventions with gender transitioning purposes. The actual surgical procedure might be very similar in both intersex surgeries and GRS, but the latter are ascribed with a 'transformational' nature or intention that is not invoked when performed upon bodies that are considered intersex. In GRS, vaginoplasty and clitoroplasty are designed to turn a penis into a vagina, shifting the original 'status' of the organ to a different one. Nevertheless, intersex surgeries, as upcoming chapters show, do not necessarily share such transformational endeavour. They are not framed as being aimed at substituting a penis for a vagina but, rather, as 'securing' that what might be deemed a doubtful vagina becomes an undoubtful one. In fact, John Money, the creator of the protocols that ruled the medical management of intersexuality for more than fifty years until relatively recently, defined these interventions as having a 'finishing' effect on genitals which, because of a problem during gestation, had yet not been fully developed.[61] This distinct framing of very similar surgical procedures is also worthy of examination, and there are numerous parallels and differences between the medical management of intersex and transgender bodies that raise important questions about (pathologisation of) gender identity, medical authority or autonomy. However, GRS remains beyond the scope of this PhD, which is circumscribed to procedures which modify,

[60] Zurada and others (n 59) 12.
[61] Joan G Hampson, John Money and John L Hampson, 'Hermaphroditism: Recommendations Concerning Case Management' (1956) 16 Journal of Clinical Endocrinology & Metabolism 554.

even if seen as ambiguous, vaginal and vulval structures as such, leaving aside interventions that are framed as 'transforming' penises to vaginas, or vice versa.

4.4 Geography

Finally, a note on geographical boundaries. For the purposes of this PhD, these are confined to the United Kingdom, and, specifically, to England and Wales. Yet, as every boundary examined in this project, this is also a blurred one, since the performance of and debates about the genital modifications I investigate extend beyond the UK border. Interventions labelled as FGM, albeit now also taking place on British soil, have their origins in some regions in the African and Asian continents, and their status as mutilations within the British and international medico-legal framework cannot be understood, as we shall see in upcoming chapters, without their being perceived as 'foreign' practices. Likewise, cosmetic surgery—in almost any part of the body, not only the vulva and vagina—is an international phenomenon, with so-called cosmetic surgery tourism becoming increasingly popular,[62] and influential scholars from all over the globe having theorised about this form of body transformation.[63] Something similar happens with intersex surgeries, whose former ruling protocols were elaborated and popularised by a team of doctors based in the US, which is where the movement of intersex activism also began to take form in the late 1990s, later spreading to Europe. Now, the medical management of intersexuality takes its key principles from guidelines gathering consensus among international experts, although these

[62] Michael Krumholtz and Noelis Ciriaco, 'Dying for a New Body: Why so Many Deaths from Plastic Surgery Tourism? The Guardian' (London, 23 August 2019).
[63] For instance, Kathryn Paul Morgan elaborates her account of cosmetic surgery from the US, whilst Kathy Davis locates her discussion in The Netherlands. See Morgan (n 28); Kathy Davis, *Reshaping the Female Body: The Dilemma of Cosmetic Surgery* (Routledge 1995).

remain controversial, with an increasing number of international organisations and institutions having taken issue with these surgeries, especially if performed at an early age.[64] Without attempting to isolate or ignore the transnational nature of these practices, the perspective this PhD takes is through a UK lens. It adopts the UK legal framework and medical protocols as its skeleton, whilst also drawing on international instruments and looking at discussions beyond the UK which contribute to the taxonomisation of vulval and vaginal modifications as different practices.

5 Controversies

5.1 Surgeries, mutilations and pathologies

Terminology is one of the main challenges of this thesis, given the debates surrounding how to name the three interventions under study. As Chapter 3 discusses, whether one should use the labels 'intersexuality' or, rather, 'disorders' or 'differences' of sex development is contentious. In fact, how to define 'intersexuality' and what variations fall under the 'intersex' category is already a controversial matter.[65] For example, Turner and Klinefelter Syndromes were not associated with intersexuality when they first became established as medical categories in the mid 20th century.[66] Even though these syndromes might affect the development of sexual characteristics (for example, Klinefelter Syndrome

[64] See, for instance Amnesty International, 'First, Do No Harm. Ensuring the Rights of Children With Variations of Sex Characteristics' (2017).
[65] Fae Garland and Mitchell Travis, *Intersex Embodiment: Legal Frameworks beyond Identity and Disorder* (Bristol University Press 2023) 8.
[66] David Andrew Griffiths, 'Shifting Syndromes: Sex Chromosome Variations and Intersex Classifications' (2018) 48 Social Studies of Science 125, 132.

patients may have reduced facial hair, smaller testes and enlarged breasts),[67] they were not originally thought to put in 'doubt' one's belonging to the male or female category.[68] David Griffiths tells the story of how it was through the development of genetics as a science that these conditions came to be associated with intersexuality, and are now included in the current Disorders of Development classification system.[69] (Chapter 1 provides a detailed historical account of the medical management of intersexuality). Currently, hypospadias (where the urethral opening is not at the top of the penis) give rise to a similar dilemma, since they constitute a body variation that is not always considered to amount to or be connected with an intersex condition.[70] Diagnostic assessments for intersexuality are only triggered when they are severe (that is, when the urethral meatus is located at the penoscrotal junction and testes remain undescended), with the rest of the cases usually falling outside of the medical label of intersexuality.[71]

Dilemmas about which bodily variations are included in the category of intersexuality also bring the problem of quantifying its incidence.[72] Overall, intersex traits affect 1 in 4,500-5,500 births, although the numbers do vary considerably depending on the specific diagnosis: Congenital Adrenal Hyperplasia approximately occurs in 1 every 14,000-15,000 births, whilst the estimate for Klinefelter Syndrome is 1 in 500 births and, in contrast, for Turner Syndrome, 1 in 2,500 births.[73] According to the 2016 update of the

[67] Kristian A Groth and others, 'Klinefelter Syndrome—A Clinical Update' (2013) 98 Journal of Clinical Endocrinology and Metabolism 20.
[68] Griffiths (n 66) 132.
[69] ibid 140.
[70] Garland and Travis (n 65) 8.
[71] Peter A Lee and others, 'Global Disorders of Sex Development Update since 2006: Perceptions, Approach and Care' (2016) 85 Hormone Research in Paediatrics 158, 159.
[72] ibid.
[73] ibid.

Chicago Consensus Statement (the cornerstone guideline in the management of intersexuality, see Chapter 2 for further discussion), if 'all congenital genital anomalies are considered, including cryptorchidism and hypospadias, the rate may be as high as 1:200 and 1:300'.[74]

Issues about nomenclature also arise when one talks about female genital 'mutilation', 'circumcision' or 'cutting'. Chapter 1 explains how the expression 'female genital mutilation' became established in the international human rights discourse in the 1990s.[75] Currently, the United Nations and UNICEF use what they call a 'hybrid' term of 'female genital mutilation/cutting', explaining that they want to 'highlight that the practice is a violation of the rights of girls and women' whilst also 'recognis[ing] the importance of employing respectful terminology when working with practicing communities'.[76] England and Wales, as Chapter 2 chronicles, have also caught up with the new mainstream nomenclature: whilst the first piece of legislation introduced in 1985 to criminalise this sort of vulval cutting was named the Prohibition of Female Circumcision Bill, the current statute —the Female Genital Mutilation Act 2003—adopts the new terminology.

Throughout the thesis, in order to ensure consistency, I use the terms 'vulval cosmetic surgery', 'intersex surgery' and 'female genital mutilation' to refer to each sort of intervention. However, I also explore the dilemmas surrounding the use of these labels,

[74] Lee and others (n 71) 159.
[75] UNICEF, 'Female Genital Mutilation: A Statistical Overview and Exploration of the Dynamics of Change' (2013) 7.
[76] ibid.

as they are key catalysts to examine discursive intersections between idea(l)s of identity, race, pathology and health.

5.2 Sex and gender

The meaning and use of 'woman', 'female', 'gender' and 'sex', all of which are key concepts in this thesis, is also far from settled. In fact, some of these terms, as we understand (and discuss) them today, are relatively new to everyday vocabulary. For instance, the use of 'gender' was circumscribed to grammar, being deployed in relation to words rather than to human beings, until only seventy years ago, when John Money incorporated it into his studies on intersexuality.[77] As Chapter 5 discusses in detail, Money was concerned about the 'terminological overload' of 'sex', since, as a concept, he did not think it worked when it came to describing those who identified and behaved as men or women but whose anatomy was considered to fall short of what he deemed normal standards of maleness or femaleness.[78] Money thus decided to borrow 'gender' from the linguistics world to refer to 'all those things that a person says or does to disclose himself or herself as having the status of boy or man, girl or woman, respectively'.[79]

Money's work constituted a foundational basis for feminist theory.[80] His position that 'gender' could be separated from anatomical attributes ('sex') provided feminist scholars with a scientific account to defend the claim that the subordination of women was

[77] John Money, 'The Conceptual Neutering of Gender and the Criminalization of Sex' (1985) 14 Archives of Sexual Behavior 279, 280.
[78] John Money, 'Gender: History, Theory and Usage of the Term in Sexology and Its Relationship to Nature/Nurture' (1985) 11 Journal of Sex and Marital Therapy 71, 72.
[79] Money 'The Conceptual Neutering of Gender' (n 77) 282.
[80] Jennifer Germon, *Gender: A Genealogy of an Idea* (Palgrave Macmillan 2009) 86–87.

'neither natural nor inevitable', but rather the result of cultural stereotypes.[81] Encapsulated by the De Beauvoirian dictum that 'one is not born, but rather becomes, a woman',[82] the so-called sex/gender distinction became a cornerstone principle of second wave feminism. Seeking to contest biological determinism, this distinction was helpful to claim that, although maleness or femaleness are natural features (sex), biology is still interpreted by the culture of each given moment, producing norms of masculinity and femininity about what it means to have a male or female body (gender). Despite its popularity, this dichotomy has come under increasing attack. In *Gender Trouble*, Judith Butler calls for rethinking the naturalness of 'sex', claiming that it is not a 'politically neutral surface on *which* culture acts', but rather it is 'as culturally constructed as gender':[83]

> Can we refer to a 'given' sex or a 'given' gender without first inquiring into how sex and/or gender is given, through what means? And what is 'sex' anyway? … Are there ostensibly natural facts of sex discursively produced by various scientific discourses in the service of other political and social interests?[84]

Rather than something people *are* or *have*, according to Butler, both sex and gender should be conceived as discursive formations and performative processes through which individuals are classified as, and become, men or women.[85] Given the instability of 'sex' and 'gender', Butler claims that 'women' as a static identity category around which feminism articulates its claims needs to be rethought.[86] The 'uncritical appeal' to 'women'

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[81] ibid 87.
[82] Simone De Beauvoir, *The Second Sex* (Lowe and Brydone (Printers) 1956) 273.
[83] Judith Butler, *Gender Trouble: Feminism and the Subversion of Identity* (Routledge 1990) 10 (emphasis in original).
[84] ibid 10.
[85] ibid 4.
[86] ibid 3–5.

may be 'self-defeating',[87] she argues, as it might 'serve to reinforce and naturalise differences that are the social and historical result of oppression'.[88]

This theoretical move has triggered a spirited debate, with so-called 'culture wars' making headlines almost every week in UK newspapers.[89] At the forefront of this discussion, there are those who adopt a 'gender critical' position and are keen on preserving and defending the notion of womanhood. For example, Sheila Jeffreys insists that sex is a biological fact, and not a cultural construction, claiming that the goal of feminism should be to abolish gender norms imposed on our 'female' and 'male' bodies, with the aim of getting rid of 'masculinity and femininity as the behaviours of the oppressors and of the oppressed'.[90] In order to do that, one must acknowledge that gender is tied to biology, since femininity and masculinity 'aren't free floating, imposed from nowhere and without ultimate purpose', but they 'are motivated and have something to do with the sex-based oppression of women'.[91] Contrary to Butler, Jeffreys believes that questioning the biological basis of gender and sex undercuts the feminist fight, as it ignores 'the material

[87] ibid 4.
[88] Margaret A McLaren, *Feminism, Foucault, and Embodied Subjectivity* (State University of New York Press 2002) 124.
[89] 'Kathleen Stock: University of Sussex Free Speech Row Professor Quits' *BBC News* (Sussex, 29 October 2021); Luke Tryl, 'Forget Toxic Twitter Debates: The UK Isn't as Divided on Trans Rights as You Think' *The Guardian* (London, 16 June 2022).
[90] Sheila Jeffreys, 'Transgender Activism: A Lesbian Feminist Perspective' (1997) 1 Journal of Lesbian Studies 55, 63–67.
[91] Heather Brunskell-Evans, *Transgender Body Politics* (Pinifex Press 2020) 9.

reality of women's bodies',[92] and 'the way in which the actual or potential activities of this body, menstruation, child-bearing are constructed in male supremacist society'.[93]

Among the several implications that might result from this position, it is perhaps those around trans women that have become the most contentious.[94] For example, Jeffreys or Janice Raymond contend that someone born with testicles and a penis, even if they undergo surgery and hormonal treatment and identify as a woman, cannot ever share the material struggles and experiences of women-born-females.[95] In fact, trans women are sometimes even read as dangerous, being accused of wanting to take advantage of and posing a threat to 'safe' women-only spaces.[96] Within that understanding, Heather Brunskell-Evans contends that children and adolescents should be 'protected' from accessing gender affirming or transitioning treatment and should instead receive 'support … in feeling comfortable in their own bodies and to express themselves in whoever way they choose without reference to gender identity'.[97]

Nevertheless, so-called 'gender critical' arguments carry several problems. As Sarah Franklin argues, they feed reactionary politics, since they create 'a sense of gender terror' by claiming that acknowledging trans people's rights to self-identify as women

[92] Jeffreys, 'Transgender Activism: A Lesbian Feminist Perspective' (n 90) 65.
[93] ibid 64–67; see also Janice G Raymond, *The Transsexual Empire: The Making of the She-Male* (Teachers College Press 1979) xx.
[94] Ruth Pearce and Sonja Erikainen, 'TERF Wars: An Introduction' (2020) 68 The Sociological Review Monographs 677.
[95] Raymond (n 93) xxvviii; Jeffreys, 'Transgender Activism: A Lesbian Feminist Perspective' (n 90) 66.
[96] Sheila Jeffreys, 'The Politics of the Toilet: A Feminist Response to the Campaign to "degender" a Women's Space' (2014) 45 Women's Studies International Forum 42.
[97] Heather Brunskell-Evans, 'The Medico-Legal "Making" of 'the Transgender Child' (2019) 27 Medical Law Review 640, 656.

threatens the existence of 'true' women.[98] By contending that only 'true' females can be 'true' women, trans women are positioned as posing a danger to women (by, for instance, accessing their toilets) and as undermining biological 'facts' (such as menstruation and capacity to bear children as defining aspects of femaleness and womanhood).[99] Furthermore, the claim that real women are only those with certain biological features assumes the binary sexed system as a natural fact, rather than challenging it as being the product of given assumptions about embodiment, sex and gender.[100] Consequently, the existence of trans women becomes 'evidence to be rebutted' and the main focus of attention is 'the policing of the boundaries of woman', as if feminism could (and should) come up with a set of criteria for exclusion and inclusion on who belongs to the collective.[101]

Within feminist theory, 'gender' thus remains a site for conflict.[102] Whilst some see it as a self-determined identity or as a device to contest, others frame it as a 'relational' concept that serves to describe the 'ordering system of male domination' whereby 'stereotypical appearance and behaviour' are required by persons of each sex, which must be challenged in order to achieve women's liberation.[103]

However, the meaning and use of gender extends beyond being a (contested) identity or catalyst for discussing the marginalisation of certain subjects, as it is a legal and

[98] Sarah Franklin, 'Gender as a Proxy: Diagnosing and Resisting Carceral Genderisms' (2022) 29 European Journal of Women's Studies 132S, 136s.
[99] ibid.
[100] Sara Ahmed, 'An Affinity of Hammers' (2016) 3 TSQ: Transgender Studies Quarterly 22, 30.
[101] ibid 31.
[102] Davina Cooper, 'A Very Binary Drama: The Conceptual Struggle for Gender's Future' (2019) 9 Feminists@Law 1, 16.
[103] Jeffreys, 'The Politics of the Toilet: A Feminist Response to the Campaign to "degender" a Women's Space' (n 96) 43.

institutional concept as well. In the UK, everyone is registered as male or female on their birth certificate. This status was unmodifiable until the Gender Recognition Act 2004 (GRA 2004), which was passed with the purpose to 'provide transsexual people with legal recognition in their acquired gender'.[104] Under the GRA 2004, trans people can amend the gender on their birth certificate if they meet certain criteria: they must have or have had gender dysphoria, they must have 'lived in the acquired gender' for two years and they must 'intend to continue to live in the acquired gender until death'.[105] Although the Act was initially celebrated for enabling gender legal change without making it dependent on undergoing surgical or hormonal treatment, even being a model for other European countries, several of its provisions have been found to be problematic.[106] The GRA 2004 medicalises and pathologizes trans identities, making legal recognition contingent on providing evidence of gender dysphoria, a mental disorder under the Diagnostic Statistical Manual.[107] Besides, the fact that the Act requires applicants to have lived in their 'acquired gender' for two years also poses problems. It imagines gender in a binary way, which in practice means that those who do not identify as only or completely male or female are not able to obtain their gender recognition certificate.[108] Acknowledging some of these problems, the UK Government issued a consultation in 2018 with the purpose of 'mak[ing]

[104] 'Gender Recognition Act 2004 - Explanatory Notes' para 3.
[105] Gender Recognition Act 2004 s 2(1).
[106] Peter Dunne, 'Ten Years of Gender Recognition in the United Kingdom: Still a" Model for Reform"?' (2015) 4 Public Law 530.
[107] ibid 5; Andrew N Sharpe, 'A Critique of the Gender Recognition Act 2004' (2007) 4 Journal of Bioethical Inquiry 33, 38.
[108] Flora Renz, 'Genders That Don't Matter: Non-Binary People and the Gender Recognition Act 2004' in Peter Dunne and Senthorun Raj (eds), *The Queer Outside in Law: Recognising LGBTIQ People in the United Kingdom* (Palgrave Socio-Legal Studies 2021) 147; For further criticism of the GRA 2004, see eg Andrew N Sharpe, 'Endless Sex: The Gender Recognition Act 2004 and the Persistence of a Legal Category' (2007) 15 Feminist Legal Studies 57.

it easier for transgender people to achieve legal recognition'.[109] Despite concluding that reform was needed to make the process for applying for a gender recognition certificate 'kinder and more straightforward',[110] the Government, perhaps because of the vocal campaign of 'gender critical' circles against self-declaration,[111] decided against changing its eligibility criteria.

Meanwhile, the Scottish Parliament passed in December 2022 the Gender Recognition Reform (Scotland) Bill, which seeks to 'improve and simplify the application process [of legal gender recognition] by making it less lengthy and intrusive'.[112] Among other changes, the Bill removes the requirement of a medical diagnosis of gender dysphoria, and lowers the minimum age of applicants to 16.[113] It also introduces some procedural changes: applicants must declare to have lived in the acquired gender for three months (rather than two years) and applications are made to the Registrar General for Scotland, rather than to the Gender Recognition Panel, which is a UK tribunal.[114] Some academics and politicians have raised concerns that the Bill may have 'unintended harms', particularly for the mental health of young people wanting to transition, who will no longer require to undergo diagnostic assessments to obtain legal recognition,[115] and for women's

[109] C Fairbairn, D Pyper and B Balogun, 'Gender Recognition Act Reform: Consultation and Outcome' (2022) 5.
[110] ibid 31.
[111] Pearce and Erikainen (n 94) 679–680.
[112] Scottish Government, 'Gender Recognition Reform (Scotland) Bill: More Information' (2022) <https://www.gov.scot/publications/gender-recognition-reform-scotland-bill-more-information/#Current> accessed 26 April 2023.
[113] ibid.
[114] ibid.
[115] Margaret McCarthey, 'Scottish Gender Recognition Reform May Have Unintended Harms for Health and Healthcare' (2022) BMJ 0333.

safety and rights.[116] The Bill has also prompted a constitutional debate, since the UK government used its veto power under Section 35 of the Scotland Act to prevent the Bill from receiving the Royal Assent because it allegedly affects reserved matters, including 'equal opportunities' as set out in the Equality Act 2010.[117] The Scottish Government recently announced that it will challenge the veto, lodging a petition for judicial review.[118]

There have also been discussions about whether the law should recognise gender beyond current binary categories or even do away with gender altogether. The Future of Legal Gender Project has recently explored the implications of gender decertification.[119] Abolishing gender as a legal status could reduce stigma and the formal burdens that come attached with living with an identity outside the currently recognised binary legal categories, as well as 'undermine the assumption that gender divisions in roles, dress, behaviour, and treatment are natural, lawful or desirable'.[120] Notwithstanding that decertification would 'just' consist in not '*legally* fixing one's gender at birth', one of the

[116] 'Scotland Passes Controversial Legislation That Makes It Easier to Legally Change Gender ' *Sky News* (22 December 2022)
[117] Equality Hub, Office of the Secretary of State for Scotland and Government Equalities Office, 'Policy Statement of Reasons on the Decision to Use Section 35 Powers with Respect to the Gender Recognition Reform (Scotland) Bill' (2023) paras 7–9.
[118] Scottish Government, 'Section 35 Order Challenge ' (2023) <https://www.gov.scot/news/section-35-order-challenge/> accessed 26 April 2023.
[119] D Cooper and others, 'Abolishing Legal Sex Status: The Challenge and Consequences of Gender-Related Law Reform, Future of Legal Gender Project. Final Report' (2022).
[120] ibid 16–17.

main criticisms posed against getting rid of gender as a legal category is that it might lead to the 'erasure of women' and the neglect of biological 'male' or 'female' differences.[121]

5.3 Intersections of race and gender

'Gender' is a key term in this thesis, yet its meaning is not static, as it shifts depending on the discourse under examination. For example, Chapter 3 sees gender through the lens of feminist debates, putting in dialogue several feminist and intersex scholars on their views regarding the embodied implications of modifying your vulva and vagina. Meanwhile, Chapter 5 unpacks how medical accounts of intersexuality conceive gender as a bodily inscribed feature that science should be able to decipher and police.

However, throughout the thesis, I see gender as a social and cultural phenomenon which is, to a certain extent, independent from, but also permanently connected to, the body, deploying it to scrutinise the links drawn between identities (man, woman, boy, girl), bodily activities (pregnancy, menstruation, sexual intercourse) and attributes (chromosomes, gonads, hormones, genital morphology).[122] Thus, this thesis investigates the conflation of possessing certain anatomical attributes with womanhood, and how this association is incorporated in and nurtured by the framing of the body modifications under study. That is why I refer to the three interventions under investigation as vulval and vaginal cuts, and not the overarching term of 'female' genital operations (when the terms 'female' or 'male' are used in this thesis, it is because I am either quoting directly from, or

[121] 'Q&A on Sex, Gender, Decertification and Equality' <https://futureoflegalgender.kcl.ac.uk/cookie-lists/resources/qa-on-sex-gender-decertification-and-equality-2022/> accessed 6 July 2022.
[122] Cooper and others (n 119) 11.

referring to, medical guidance[123] or statute[124]). Rather than ascribing femaleness to certain bodily structures, my aim is to analyse the nexus between particular anatomical features and maleness and femaleness, manhood and womanhood, seeking to ultimately answer questions such as: what does it mean to have a vagina? What is a vagina for? When is a vagina considered 'abnormal' and what does it entail for how one is conceptualised as a woman? What role do law and medicine play in answering these questions?

Moreover, this thesis reads together discourses of gender and sexuality with those of race, rethinking, to put it in the words of Ann Laura Stoler, the 'connections between European and colonial historiography, between a European bourgeois order and the colonial management of sexuality, as well as how those tensions might bear upon how we go about writing about genealogies of race today'.[125] This thesis unearths how racial ideals of the body, especially around the vulva, and expectations of womanhood and sexuality shape current medico-legal taxonomies of vulval cutting. As upcoming chapters show, current medical understandings of vulval anatomy and criminalisation of so-called FGM cannot be detached from their colonial history.

In other words, this thesis deconstructs the productive dynamics of race and gender in relation to vulval cutting. It unpacks how current taxonomies and ways of thinking about cosmetic surgery, intersex surgeries and FGM are encoded in racial and gendered discourses about embodiment, and the ways in which they tell a particular story about what

[123] See, for instance, Royal College of Obstetricians and Gynaecologists, 'Ethical Opinion Paper: Ethical Considerations in Relation to Female Genital Cosmetic Surgery (FGCS)' (n 32).
[124] For example, Female Genital Mutilation Act 2003.
[125] Ann Laura Stoler, *Race and the Education of Desire. Foucault's History of Sexuality and the Colonial Order of Things* (Duke University Press 1995) viii.

it means to have a normal vulva, experience pleasure, live one's sexuality and have a healthy psychosexual development.

5.4 The body

Traditionally untheorized or neglected, the humanities and social sciences have become more and more interested in the body.[126] Feminist scholarship has been key for this move, exposing the somatophobia that has underpinned Western thought's traditional reading of the body as the 'site of unruly passions and appetites that might disrupt the pursuit of truth and knowledge'.[127] Especially given the influence of Foucault, fruitful analyses of bodily practices, such as undergoing cosmetic surgery, putting on make-up or exercising, have proliferated within feminist academic circles.[128] Likewise, socio-legal scholarship has also been increasingly paying more attention to the body.[129] Together with deconstructing the gendered characteristics of the legal subject,[130] the issue of how the law imagines, represents and regulates the body has occupied a prominent place within the work of feminist legal theorists.[131] Particular attention has been directed towards bodies that seem

[126] Margrit Shildrick and Janet Price, 'Openings on the Body: A Critical Introduction' in Margrit Shildrick and Janet Price (eds), *Feminist Theory and the Body: A Reader* (Routledge 1999) 1; Brian S Turner, 'Introduction: The Turn to the Body' in Brian S Turner (ed), *Routledge Handbook of Body Studies* (Routledge, Taylor and Francis 2012) 1.
[127] Shildrick and Price (n 126) 29; For further discussion, see, for example Margrit Shildrick, *Leaky Bodies and Boundaries: Feminism, Postmodernism and (Bio)Ethics* (Routledge 1997).
[128] For instance, Sandra Bartky, 'Foucault, Feminity and the Modernization of Patriarchal Power' in Katie Conboy, Nadia Medina and Sarah Stanbury (eds), *Writing on the Body: Female Embodiment and Feminist Theory* (1997); Cressida J Heyes, 'Foucault Goes to Weight Watchers' (2006) 21 Hypatia: A Journal of Feminist Philosophy 126; McLaren (n 88) 91–99.
[129] For a recent example, see Chris Dietz, Mitchell Travis and Michael Thomson (eds), *A Jurisprudence of the Body* (Palgrave Socio-Legal Studies 2020).
[130] Ngaire Naffine, 'Who Are Law's Persons? From Cheshire Cats to Responsible Subjects' (2003) 66 Modern Law Review 346; Ngaire Naffine, 'Women as the Cast of Legal Persons' in Jackie M Jones and others (eds), *Gender, Sexualities and Law* (Routledge 2011).
[131] Roxanne Mykitiuk, 'Fragmenting The Body' (1994) 2 Australian Feminist Law Journal 63; Anna Grear, '"Sexing the Matrix": Embodiment, Disembodiment and the Law—Towards the Re-Gendering of Legal Personality' in Jackie M Jones and others (eds), *Gender, Sexualities and Law* (Routledge 2011); Ruth

to pose a challenge to the paradigmatic 'liberal legal subject [as] disembodied and simultaneously male',[132] including, among others, 'female' bodies,[133] disabled bodies,[134] anorexic bodies,[135] or pregnant bodies.[136]

My project is part of the shift within feminist scholarship moving from 'exploring women's right *over* their bodies, to analysing how social regulation has gendered the body and embodied experiences'.[137] Taking the medico-legal framework as not merely regulatory, but also constitutive of the bodies it regulates,[138] this PhD conceives the body as a material reality that acquires meaning through its interaction with the medical and legal context. It sees the medical world and legal framework as 'shap[ing] corporeality at the most profound level'.[139]

In order to reflect this perspective, during the thesis, I use the term 'embodiment' to refer to this idea of the 'institutionally constituted, culturally located and material body'.[140] This theoretical move enables us to question how law and medicine 'conceive of,

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Fletcher, Marie Fox and Julie McCandless, 'Legal Embodiment: Analysing the Body of Healthcare Law' (2008) 16 Medical Law Review 321.

[132] Grear (n 131) 42.

[133] Kirsty Keywood, 'More than a Woman? Embodiment and Sexual Difference in Medical Law' (2000) 8 Feminist Legal Studies 319.

[134] Mitchell Travis, 'Non-Normative Bodies, Rationality, and Legal Personhood' (2014) 22 Medical Law Review 526; Isabel Karpin and Roxanne Mykitiuk, 'Going out on a Limb: Prosthetics, Normalcy and Disputing the Therapy/ Enhancement Distinction' (2008) 16 Medical Law Review 413.

[135] Kirsty Keywood, 'My Body and Other Stories: Anorexia Nervosa and the Legal Politics of Embodiment' (2000) 9 Social & Legal Studies 495.

[136] Naffine, 'Women as the Cast of Legal Persons' (n 130); Lara Karaian, 'Pregnant Men: Repronormativity, Critical Trans Theory and the Re(Conceive)Ing of Sex and Pregnancy in Law' (2013) 22 Social and Legal Studies 211.

[137] Fletcher, Fox and McCandless (n 131) 335.

[138] ibid.

[139] N Sullivan, 'The Somatechnics of Intersexuality' (2009) 15 GLQ: A Journal of Lesbian and Gay Studies 313, 314.

[140] Chris Dietz, Mitchell Travis and Michael Thomson, 'Nobody, Anybody, Somebody, Everybody: A Jurisprudence of the Body' in Chris Dietz, Mitchell Travis and Michael Thomson (eds), *A Jurisprudence of the Body* (Palgrave Macmillan 2020) 7.

construct and create our bodies',[141] acknowledging that the ways in which we inhabit and understand our bodies cannot be decoupled from, but rather acquires meaning through, the legal and medical institutions, which are also porous and nurtured by cultural and social practices.

6 Chapter outline

By conceptualising law and medicine as regulatory frameworks that (re)produce codes of intelligibility about vulvas and vaginas, this thesis teases out how different iterations of discourses of health, autonomy, freedom and sexuality influence the classification of very similar cuts as 'beneficial, 'mutilating' or 'enhancing'.[142] Through this exercise of deconstruction, I argue that these discourses mutate and adapt in accordance to the extent to which the cut on the vulva conforms to or challenges the pervasive notion that normal bodies are dichotomously gendered and coded as white.

Chapter 1 prefaces the thesis by historically tracing the evolution of how vulval modifications have been grounded as proper or improper, lawful or unlawful, interventions in the UK. Chapter 2 maps out the current medico-legal taxonomies of vulval cutting and

[141] Garland and Travis (n 65) 11.
[142] Anne Fausto-Sterling, *Sexing the Body. Gender Politics and the Construction of Sexuality* (Basic Books 2000) 5.

the main ethical and legal challenges that are perceived to exist in relation to each of the three interventions.

After these two introductory chapters, each chapter is devoted to a common theme underlying the three cuts, looking at how particular notions of mental health, oppression, harm, need and benefit play out in each case. Chapter 3 investigates how feminist literature discusses, and how feminist critics differ in their conceptualisation of, the issues of oppression and choice across these three cuts. Chapter 4 focuses on psychological well-being, unpacking the connections between mind, body and decision-making in each case; and Chapter 5 examines the rationale that each type of cut has been ascribed to have.

CHAPTER 1. HISTORICISING VULVAL CUTTING

This chapter consists in a historical analysis of the evolution of vulval modifications. Whilst the rest of this thesis is devoted to studying present distinctions between vulval cuts, this chapter historically situates the evolving perceptions of these interventions. A historical inquiry is valuable as it excavates and sheds light on how medical science and legal norms have generated shifting truths about vulval cutting. By paying attention to how vulval surgery, intersex surgeries and Female Genital Mutilation (FGM) have been justified or condemned since late 19th century Britain, this chapter contends that the understanding of these three sorts of interventions as proper or improper must be read to have evolved by being ingrained within dominant cultural conceptions of each given moment.

Although these interventions have been performed since earlier times, the 19th century is the starting point of the analysis as it is a period when major developments and changes in medical practice occurred. Medicine underwent professionalisation and, by the end of the century, licencing standards, educational institutions and medical societies regulated, controlled and policed the conduct of doctors.[1] Parallel with the institutionalisation of medical practice, it was also then when the concept of 'normal functioning' re-shaped the understanding of illness, leaving humoral theory behind. Until then, as Michel Foucault explains, medicine had been 'much more related to health than to normality', re-establishing 'vigour, suppleness and fluidity' lost in illness, rather than

[1] SED Shortt, 'Physicians, Science, and Status: Issues in the Professionalization of Anglo-American Medicine in the Nineteenth Century' (1983) 27 Medical History 51, 54.

ensuring that bodies conformed to a 'standard functioning and organic structure'.[2] Indeed, Section 1 shows how medical accounts of 'normal' vulvas started to be developed and disseminated in the 19th century. Furthermore, it was also then when British colonial forces 'discovered' modifications of the vulva and the vagina also taking place outside of Britain. This chapter does not have the space to capture all the nuances in tracking how different communities outside of the UK have performed the practice now deemed FGM. Rather, it tells the story of the ways in which British colonial and postcolonial governments, followed by international bodies, have perceived these instances of clitoral removal and labial cutting as problematic.

The argument this chapter makes is that the status of vulval cosmetic surgeries, intersex interventions and FGM as proper or improper treatment, or lawful and unlawful cuts, is not simply a matter of whether they have proven to be beneficial or harmful. Rather, this chapter suggests that concepts of 'health' and 'benefit' have to be contextualised in relation to what have been understood as healthy and normal expressions of womanhood and gender difference, and that these vary substantially through time.

1 Vulval cosmetic surgery

1.1 Victorian medicine and excessive sexual desire

In order to understand how vulval surgeries were performed during the second half of the 19th century, one must look at how medicine conceptualised genital anatomy and sexuality

[2] Michel Foucault, *The Birth of the Clinic: An Archeology of Medical Perception* (Routledge 1963) 35.

more widely. In essence, the quintessential 'normal' woman was seen to engage in 'wifely and maternal' behaviour and, with low libido, was only sexually aroused by her husband's stimulation.[3] Women who deviated from this standard raised concerns for the medical profession, and were pathologised as 'hysterical' or 'nymphomaniac'. The diagnostic label of nymphomania grouped together a myriad of behaviours, ranging from compulsively masturbating or spontaneously orgasming in public,[4] to being seen as having too much sexual desire, being more passionate than their husbands, wanting to divorce their husbands, flirting with men who were not their husbands, cheating on their husbands, or being attracted to women.[5]

Clitoral irritation was what most often invoked to explain these transgressions of proper womanhood.[6] In accordance with reflex neurosis theory, women would touch themselves to calm their irritated clitoris, overstimulating the 'pudic nerve' and sending signals to the brain that could trigger the wide range of symptoms listed above.[7] Masturbation was hence seen as a two-fold problematic behaviour, as not only did it 'distract' women from their main reproductive function—as Sarah Rodriguez puts it, it was 'sexual energy spent recklessly'[8]—but it was also the physiological cause of many health problems. For instance, some medical accounts considered masturbation to be the source of vulval malformations, such as hypertrophy of the labia, since stimulating the vulva

[3] Carol Groneman, 'Nymphomania: The Historical Construction of Female Sexuality' (1994) 19 Signs: Journal of Women in Culture and Society 337, 345.
[4] ibid 341.
[5] ibid 340–341.
[6] ibid 355; Sarah B Rodriguez, *Female Circumcision and Clitoridectomy in the United States* (University of Rochester Press 2014) 69.
[7] Groneman (n 3) 349; Rodriguez (n 6) 20.
[8] Rodriguez (n 6) 18.

would make its labia 'grow larger, thicker and darker' (the next section unpacks the racial undertones of these vulval attributes).[9] Isaac Baker Brown, a prominent and, as I explain below, perhaps one of the most infamous 19th century gynaecologists, believed that women who masturbated were more likely to display the pathologies of:

> desiring to escape from home, being fond of becoming a nurse in hospitals … distaste for marital intercourse, and very frequently, either sterility or a tendency to abort in early months of pregnancy. If left unchecked [it could lead to] epilepsy, idiocy, or insanity.[10]

Lack of hygiene and dirt in the genital area were considered the main sources of clitoral irritation, for which gynaecologists recommended pouring acid to clean the area and eliminate 'smegma', as well as removing the clitoral hood, where dirt would accumulate.[11] For Baker Brown, however, these remedies were not sufficient, claiming that the removal of the full clitoris was necessary to adequately end any possible irritations.[12] Despite his firm belief that clitoridectomy was the most appropriate cure for all the disturbances listed above, the medical profession in the UK never accepted it as a proper intervention.[13] The published letters and articles in the British Medical Journal at the time bear witness to this. For instance, a review of Baker Brown's book contended that his theories were not 'well-founded in physiology or pathology' and doubted the effectiveness of clitoridectomy as a cure for nervous diseases, 'suspecting that Mr Brown ha[d] considerably exaggerated its

[9] Camille Nurka, *Female Genital Cosmetic Surgery. Deviance, Desire and the Pursuit of Perfection* (Palgrave Macmillan 2019) 162.
[10] Isaac Baker Brown, *On the Curability of Certain Forms of Insanity, Epilepsy, Catalepsy, and Hysteria in Females* (Robert Hardwicke 1866) 15.
[11] Rodriguez (n 6) 23.
[12] Ornella Moscucci, 'Clitoridectomy, Circumcision, and the Politics of Sexual Pleasure in Mid-Victorian Britain' in Andrew H Miller and James Eli Adams (eds), *Sexualities in Victorian Britain* (Indiana University Press 1996) 66.
[13] ibid 68.

value'.[14] Not only did medical professionals question the basis and therapeutic effects of clitoridectomy, but they had ethical concerns about it as well.[15] While constantly seeking public attention and advertising his procedure in the lay press, Baker Brown seemed to have operated on women without the consent of their husbands (or, if unmarried, without the consent of their friends or the patients themselves), and also to have violated the Lunacy Laws—in accordance to which insane patients could only be treated in a licenced asylum—boasting about having cured insanity by extirpating his patients' clitoris.[16] His fall was fast: in 1867, only a year after of having published his book on clitoridectomy, he was expelled from the Obstetrical Society of London and died six years later with the reputation of having been a 'quack'.[17]

In short, it seems that clitoridectomies never had the status of proper treatment by anyone other than Baker Brown. Nevertheless, it is an anecdote in the history of medicine that—together with other interventions that were accepted practice, like pouring acid, breaking clitoral adhesions or removing the clitoral hood—show that genital operations were a Victorian technique to re-establish 'normal' womanhood.[18] That is why some feminist theorists, like Adrianne Rich, have argued that these medical interventions were technologies of 'compulsory heterosexuality', as they were designed to reinforce marital

[14] 'Rewiews and Notices' [1866] British Medical Journal 438, 438; For a summary and discussion of the medical debate around Baker Brown's postulates see Ann G Dally, *Women Under the Knife: A History of Surgery* (Castle Books 1991) 168–179.
[15] Moscucci (n 12) 68.
[16] Andrew Scull and Diane Favreau, 'The Clitoridectomy Craze' (1986) 53 Social Research 243, 256.
[17] Moscucci (n 12) 69.
[18] Scull and Favreau (n 16) 258.

vaginal sexual relationships as the normal and healthy paradigm, keeping sexuality contained and only aroused by and enjoyed with men.[19] In the words of Ornella Moscucci:

> [clitoral surgeries] are part of the history of the enforcement of heterosexuality and the maintenance of gender boundaries … redirecting [female pleasure] toward an acceptable social end: heterosexual vaginal intercourse. Within 'normal' female sexuality, there could be no place for the clitoris, with its propensity for sexual unorthodoxy and forbidden pleasures.[20]

1.2 Colonial medicine and the vulva

Running parallel to the development of vulval surgeries in the UK, there is a story that extends beyond Britain of how medical understandings of the vulva began to be established in the 19th century. Indeed, as Ann Laura Stoler argues, European discourses on sexuality cannot be isolated to Europe, but must be 'traced along a more circuitous imperial route'.[21] Specifically, colonial encounters of European 'scientific' men with African women were pivotal in the construction of the medical imaginary surrounding the vulva.[22]

Perhaps the most famous of these encounters was the one with Saartje Baartman, a South African woman who was brought to Europe to be toured as a circus attraction.[23] She was exhibited in London in 1810 and died in Paris in 1816. Her skeleton and a cast of her body, together with a wax mould of her genitals, were on display in the Musée de l'Homme

[19] Adrienne Rich, 'Compulsory Heterosexuality and Lesbian Existence' (1980) 5 Signs 631, 352.
[20] Moscucci (n 12) 71–72.
[21] Ann Laura Stoler, *Race and the Education of Desire. Foucault's History of Sexuality and the Colonial Order of Things* (Duke University Press 1995) 7.
[22] Nurka (n 9) 83.
[23] ibid 89.

in Paris until 1980.[24] The reason behind the long fascination for Baartman's body must be found in her elongated labia and protruding buttocks, which became dubbed as the 'Hottentot Apron'.[25]

Although Dutch explorers in South Africa back in 1600 had already documented their interest in 'Hottentot women',[26] it was the French biologist Georges Cuvier who developed the foundational medical account of the 'Hottentot Apron'.[27] Cuvier, who published a study of Baartman's anatomy in 1827 after performing a post-mortem examination on her, used her labia as a key feature to draw differences between the human races.[28] Whilst there could be great variation among labial sizes and degrees of protrusion among White women, Cuvier insisted that African women's labia were naturally bigger.[29] Elongated labia, for Cuvier, were a sign of animality, an anatomical trait demonstrating that Black women were closer to moneys and orangutans than to humans, using labial size to reify racial hierarchies.[30] As a caveat, Cuvier was not alone in his insistence on classifying anatomical traits by linking them to racial purity, as he was part of the eugenic shift that dominated 19th century medicine.[31] The emergence of statistics as a science played a major role in medicine's increasing tendency to quantify and standardise bodily

[24] Anne Fausto-Sterling, 'Gender, Race and Nation. The Comparative Anatomy of "Hottentot" Women in Europe, 1815- 1817' in Jennifer Terry (ed), *Deviant Bodies: Critical Perspectives on Difference in Science and Popular Culture* (Indiana University Press 1995) 20.
[25] ibid 50.
[26] ibid.
[27] Nurka (n 9) 89.
[28] ibid.
[29] ibid.
[30] Fausto-Sterling (n 24) 38.
[31] David Andrew Griffiths, 'Shifting Syndromes: Sex Chromosome Variations and Intersex Classifications' (2018) 48 Social Studies of Science 125, 131.

features, which in turn resulted in the othering of particular attributes, such as labial hypertrophy, as abnormal.[32]

Cuvier's study of Baartman paved the way for further research on vulval anatomy, which was always entrenched with racial imaginaries, with perhaps one of the most comprehensive accounts having been provided by Heinrich Ploss, Max Bartels and Paul Bartels, three German anthropologists, in *Woman: An Historical, Gynaecological and Anthropological Compendium.* First published in Germany in 1885 and translated into English in 1935, this book examined in detail differences in vulval anatomy in Black, White and Asian women. It had embedded two recurring discourses about racial differences. First, labial hypertrophy was presented as a natural black feature and, at the same time, a medical problem for European women which could and should be solved through labial excision.[33] Second, labial size also became a proxy for moral excess and mental deviancy.[34] As we saw in the previous section, elongated labia came to be perceived

[32] Lennard J Davis, *Enforcing Normalcy: Disability, Deafness and the Body* (Verso 1995) 30–33.
[33] Nurka (n 9) 113.
[34] Camille Nurka and Bethany Jones, 'Labiaplasty, Race and the Colonial Imagination' (2013) 28 Australian Feminist Studies 417, 435.

as a threat to proper femininity, associated with the morally degrading activities of 'lesbianism [and] masturbation', which were not 'directed towards a reproductive end'.[35]

Chapter 5 examines how these racial imaginaries continue to be embedded in current discourses of vulval cosmetic surgery. For now, however, the next section goes back to Britain, where it continues to trace the history of vulval surgeries.

1.3 Frigidity and the vaginal orgasm

At the turn of the 20th century, the Victorian platonic, ideal notion of marriage was left behind and sex became a critical element for a successful and happy relationship.[36] Because of this shift, women were no longer assumed to be sexually restrained, but the preoccupation became that they would not be sexual *enough* for their husbands (ie frigid).[37] Although frigidity was not a 20th century medical 'invention', it was at this time when it became an object of clinical knowledge and was conceptualised as a female disorder that impaired women's sexual capacities.[38] Nevertheless, the medical profession did not have a uniform conceptualisation of this condition. While gynaecologists usually thought it was due to a biological malfunction, like 'ovarian inefficiency, amenorrhoea, prolapse of the womb or constipation';[39] psychoanalysts suggested that it should be attributed to arrested development or having experienced traumatic events, like a bad wedding night.[40] Likewise,

[35] ibid.
[36] Sheila Jeffreys, *The Spinster and Her Enemies: Feminism and Sexuality 1880-1930* (Spinifex Press 1985) 172; Rodriguez (n 6) 78–80.
[37] Jeffreys (n 36) 169.
[38] Peter Cryle and Alison Moore, *Frigidity: An Intellectual History* (Palgrave Macmillan 2011) 161.
[39] Jeffreys (n 36) 171.
[40] Rodriguez (n 6) 104.

the concrete symptoms of the condition were also disputed, as it could include lacking sexual desire or interest altogether, being unable to attain any type of orgasm or being unable to attain certain orgasms in particular.[41]

Sigmund Freud's vaginal orgasm theory, which established a long lasting dichotomy between clitoral and vaginal orgasms, hugely shaped the understanding of frigidity.[42] By deeming clitoral excitability 'masculine' and 'immature' and claiming that sexual maturity entails the transfer of women's centre of pleasure from the clitoris to the vagina, he argued that women were frigid (in his words, 'anaesthetic') when they were not able to enjoy vaginal penetration.[43] Given the particular reception of psychoanalysis at the time, vaginal orgasm became the expression of proper womanhood, making inseparable the concepts of coital intercourse, orgasm and frigidity.[44]

There were several proposed cures for this condition. For instance, psychotherapy or relaxant drugs were indicated if the woman was thought to be frigid as a result of first wedding night trauma and/or a problem in her psychosexual development.[45] Clitoral surgeries, previously designed to prevent masturbation, were designed as solutions for frigidity as well.[46] For instance, the psychoanalyst Marie Bonaparte claimed that surgically relocating the clitoris so it would be more easily stimulated during coitus could help

[41] ibid 101.
[42] Katherine Angel, 'The History of "Female Sexual Dysfunction" as a Mental Disorder in the 20th Century' (2010) 23 Current Opinion in Psychiatry 536, 2.
[43] Sigmund Freud, *Three Essays on the Theory of Sexuality: The 1905 Edition* (Philippe Van Haute, Herman Westerink and Ulrike (trans. Kistner eds, Verso 2017) 260–262.
[44] For further discussion on Freudian accounts of frigidity see eg Cryle and Moore (n 38) 222–253.
[45] Rodriguez (n 6) 104.
[46] ibid 120.

women, like herself, who failed in transferring their pleasure to the vagina to attain 'mature' orgasms.[47]

Regardless of the concrete prescribed treatments, what seems clear is that women's sexuality was—or, rather, remained—problematic for the medical profession when it did not conform to phallocentric and heterosexual standards. In fact, 20th century medical accounts of women's sexuality are arguably not that different from the ones that dominated in the Victorian era. While the anatomical centre of sexual pleasure (and preoccupation) migrated from the clitoris to the vagina and the specific forms of expected normal female behaviour also changed (from being passionless to being—vaginally—sexual), the notion of normal sexuality kept orbiting around coitus and heterosexual relationships: normal women were to enjoy sex with *men* through *vaginal* penetration, deeming abnormal—ie nymphomaniac in 19th century and frigid in the 20th century—those who found sexual pleasure in other non-coital experiences. Thus, frigidity, even if it can be seen as opposed to nymphomania, can be argued to constitute a different way of pathologising inappropriate sexuality and a justification for restoring proper womanhood. As Elizabeth Grosz puts it: '[f]rigidity is not the refusal of sexual pleasure per se. It is the refusal of specifically genital and orgasmic sexual pleasure. The so-called "frigid" woman is precisely the woman whose pleasure does not fit neatly into the male-defined structure of sexual pleasure'.[48]

Some feminist writers adopt a similar perspective to argue that frigidity was used as a weapon of male dominance. Sheila Jeffreys posits that the interest of the medical

[47] Cryle and Moore (n 38) 235.
[48] Elizabeth Grosz, *Sexual Subversions: Three French Feminists* (Allen&Unwin 1989) 133.

profession in female pleasure was to ensure women's 'total surrender to men's power and dominance'.[49] Similarly, Rich suggests that the 'psychoanalytic doctrines of frigidity and vaginal orgasm are methods of male power to force their sexuality upon women'.[50] Both of these accounts seem to suggest that the medical profession is part of a patriarchal 'strategy' or 'plot' to dominate women. However, perhaps a more productive framing of the pathologisation of particular behaviours, and the mobilisation of vulval surgery as the solution, is not through the view of women as victims of sexist doctors. Rather, the way in which the medical profession targeted and 'cured' certain behaviours during the late 19th and early 20th century should be seen as a translation or consequence of broader understandings of womanhood dominating at the time. Frigidity—just like nymphomania—can be conceived as a medical 'device' based on, and also nurturing, evolving framings of 'normal' sexuality in which coital penetration (and pleasure) remained a central element.

1.4 The sexual and cosmetic revolutions

The second half of the 20th century was marked by the so-called 'sexual revolution', with a shift towards allegedly more open attitudes regarding sex. In the UK, the partial legalisation of abortion with the Abortion Act 1967, the introduction of no-fault divorce with the Divorce Reform Act 1969 and the pill being made available to all women in 1966 were some of the measures, among others, that contributed to transforming the mores of

[49] Jeffreys (n 36) 185.
[50] Rich (n 19) 639.

the time.[51] Medical research was a central driver for change as well. In 1953, Alfred Kinsey's research deemed the clitoris 'the portion of genitalia best supplied with end organs of touch', in contrast with the vagina, whose walls 'were practically without nerves'.[52] William Masters and Virginia Johnson also valued the clitoris as a 'unique organ in the total of human anatomy',[53] encouraging sexual positions that increased the (direct or indirect) stimulation of the clitoris.[54] Crucially, they put to rest the Freudian division between clitoral and vaginal orgasms, explaining that, although every woman's orgasmic experience is different, there are not any anatomical differences between those who achieve orgasm by stimulating their vagina, their clitoris, or any other erogenous part of their body.[55]

These scientific accounts were celebrated and used by some feminist thinkers during the late 1960s and 70s to reclaim the clitoris as the organ for sexual liberation. Anne Koedt, in perhaps the most famous criticism delivered against vaginal orgasm theory, used Masters and Johnson's work as 'anatomical evidence' to criticise Freud, questioning 'normal concepts of sex' for only being defined in terms that 'please men'.[56] She called for a new understanding of sex that would adequately acknowledge vulval and vaginal anatomy and prioritise 'mutual enjoyment'.[57] Despite being deployed as a legitimising basis to build a new sexuality framework because of the importance they gave to the

[51] Matt Cook, 'Sexual Revolution(s) in Britain' in Gert Hekma and Alain Giami (eds), *Sexual Revolutions* (Palgrave Macmillan 2014) 127; However, some scholars stress that these years were not as liberating as it might first appear. See eg Sheila Jeffreys, *Anticlimax: A Feminist Perspective on the Sexual Revolution* (NYU Press Year 1991) 168–170.
[52] Alfred C Kinsey and others, *Sexual Behaviour in the Human Female* (WB Saunders Company 1953) 158.
[53] William H Masters and Virginia E Johnson, *Human Sexual Response* (J & A Churchill 1966) 45.
[54] ibid 59–60.
[55] ibid 66.
[56] Anne Koedt, *The Myth of the Vaginal Orgasm* (Pittsburgh, Pa: Know Inc 1970) paras 8–14.
[57] ibid 7.

clitoris, it is nevertheless disputable whether Masters and Johnson did actually challenge how 'normal' sex and vulval anatomy had so far been conceptualised. They only studied heterosexual women who confirmed they climaxed during coital intercourse,[58] which remained the standard reference to understand women's sexual response.[59] These (not so new) understandings of women's sexuality shaped the practice of vulval and vaginal interventions, whose performance and management was crucially influenced, in turn, by the rise of cosmetic surgery.

A controversial practice often deemed 'quackery' until the beginning of the 20th century, cosmetic surgery started to gain legitimacy after World War I, given the success of reconstructive surgery in helping returning wounded soldiers, and became popular after World War II, with the rise of consumer culture and the establishment of surgical 'fixes' as available 'solutions' for maintaining youth and beauty.[60] (Chapter 4 provides a detailed account of cosmetic surgery and its connections with (self)perceptions of beauty and mental health.)

Cosmetic surgery reconfigured the discourse around genital surgeries, substituting the previously dominant language of pathology and cure (eg, with the discourse of nymphomania, frigidity) for that of *choice,* with cosmetic interventions being *elective* surgeries people *choose* to undergo to *enhance* (rather than cure) their bodies (although, as

[58] For an extensive criticism of Masters and Johnson's methodology, see Paul A Robinson, *The Modernization of Sex: Havelock Ellis, Alfred Kinsey, William Masters, and Virginia Johnson* (Cornell University Press 1989) 120–190.
[59] Mary Boyle, 'Sexual Dysfunction or Heterosexual Dysfunction?' (1993) 3 Feminism and Psychology 73, 80.
[60] Elizabeth Haiken, *Venus Envy: A History of Cosmetic Surgery* (Johns Hopkins University Press 1997) 95–108; See also Sander L Gilman, *Making the Body Beautiful. A Cultural History of Aesthetic Surgery* (Princeton University Press 1999).

Chapter 5 explores in depth, the line between therapy and enhancement is in practice blurred). Moreover, while, until then, it was the role of doctors to 'spot' deviant and problematic features, cosmetic surgery placed the responsibility on individuals themselves to self-scrutinise and take the relevant steps to make sure their bodies are 'normal'.[61] Some surgeons and beauty magazines took advantage of this new framework and, using the rhetoric of the sexual liberation and women's movements, portrayed cosmetic procedures as liberating practices that would enable women to take full advantage of the opportunities that their bodies could offer—as choices women could (and should) make to improve their genitals, both from a cosmetic and functional perspective.[62] Still today, as Camille Nurka shows by gathering accounts of how cosmetic surgery is presented to patients, it is not unusual for cosmetic surgeons to speak about these interventions as vehicles to increase one's feelings of body satisfaction in order to feel more at ease in one's body.[63] For instance, a cosmetic surgery clinic based in the UK advertises labiaplasty on its website as a procedure that will 'give yourself a boost of self-confidence by removing excess skin around your intimate area'.[64]

Notwithstanding their increasing popularity, it was not until the late 1980s and early 1990s that research and academic discussion about vulval cosmetic surgeries started to blossom.[65] Since then, a wide range of vulval cosmetic procedures have become

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[61] Rosemarie Garland-Thomson, 'Integrating Disability, Transforming Feminist Theory' (2002) 14 NWSA Journal 1, 10–11.
[62] Rodriguez (n 6) 140–142.
[63] Nurka (n 9) 204.
[64] 'Labia Reduction Surgery (Labiaplasty) ' <https://signatureclinic.co.uk/labia-reduction-labiaplasty/?gclid=Cj0KCQjwvZCZBhCiARIsAPXbajutl8MKtaF0LJKoR6S-AL_S4PENhttMngvNFvRa0mwn8yRsOfdf9O8aAlluEALw_wcB> accessed 16 September 2022.
[65] Michael Goodman, 'Genital Plastics: The History of Development' in Michael P Goodman (ed), *Female Genintal Plastic and Cosmetic Surgery* (Wiley-Blackwell 2016) 3.

increasingly available, such as labiaplasty, clitoroplasty, vaginal tightening, labia majora augmentation, wrinkle removal of the labia or pubic liposuction, among others.[66] These procedures seem to obey very similar principles to the ones which guided surgical interventions for frigidity or nymphomania in earlier times, as many of them are set to ensure that genitalia are 'fit' and attractive enough for penis-vagina intercourse.[67] For instance, vaginal tightening, usually performed on women who have lost 'elasticity' and 'tightness' as a result of aging and/or childbirth, is designed to make the vagina apt to endure—and give and feel pleasure within—vaginal intercourse.[68] Similarly, trimming of the clitoral hood and repositioning of the clitoris now also fall under the umbrella of cosmetic practices, ensuring a greater stimulation of the organ during coitus,[69] and labiaplasties shape the labia so they are symmetric and without protrusions, making the vulva attractive and providing psychological reassurance in order to help women enjoy sexual intercourse (See Chapter 5 for a discussion of what these procedures entail, as well as their risks and potential benefits).[70]

By substituting the discourse of pathology and therapy for that of choice and enhancement, cosmetic surgery constitutes the last chapter of the historical saga of the first sort of surgical interventions on the vulva that this thesis investigates. With heterosexual expectations and coital intercourse, together with racialised assumptions about vulval

[66] Fiona J Green, 'From Clitoridectomies to "Designer Vaginas": The Medical Construction of Heteronormative Female Bodies and Sexuality through Female Genital Cutting' (2005) 7 Sexualities, Evolution and Gender 153, 175.
[67] Virginia Braun, 'In Search of (Better) Sexual Pleasure: Female Genital "Cosmetic" Surgery' (2005) 8 Sexualities 407, 418.
[68] ibid.
[69] Lesley A Hall, 'Clitoris' in Colin Blakemore and Sheila Jennett (eds), *The Oxford Companion to the Body* (Oxford University Press 2003) 3.
[70] Lindy Joan McDougall, 'Towards a Clean Slit: How Medicine and Notions of Normality Are Shaping Female Genital Aesthetics' (2013) 15 Culture, Health and Sexuality 774, 777.

anatomy, occupying a central position, justifications and framings of these interventions have shifted and adapted to dominating expectations and discourses through time. They have evolved from being a resource to manage nymphomania and cure for frigidity to an expression of choice, enhancement and self-care. Despite this changing framework, current vulval cosmetic practices constitute an iteration of very similar cultural narratives that, for more than two hundred years, have framed women's bodies as defective and as needing surgical help to adapt to the given standard of womanhood.[71]

2 Intersex surgery

2.1 A challenge to 'true' sex

Historical accounts of the hermaphroditic[72] body can be traced back to Ancient times. In fact, the term 'hermaphroditism' comes from a Greek myth where the body of Hermaphroditus, the son of Hermes and Aphrodite, was united with that of the nymph Salmacis, thus acquiring both deemed male and female sexual organs.[73] Despite its long history, it was not until the 19th century that hermaphroditism started to fall under the purview of the medical profession as a phenomenon to be studied and corrected. According to Michel Foucault, for whom the figure of the hermaphrodite was key in his genealogy of what he called 'the problem of the abnormal', hermaphroditism was, until the 19th century, seen as a form of monstrosity.[74] Creatures of monster status were those which 'transgressed

[71] Nurka (n 9) 187–188.
[72] I shall be using the term 'hermaphroditism', 'intersex' or 'disorders of sex development' interchangeably but in chronological order depending on the dominant 'label' of each era.
[73] George Androutsos, 'Hermaphroditism in Greek and Roman Antiquity.' (2006) 5 Hormones 214, 125.
[74] Michel Foucault, *Abnormal. Lectures at the Collège de France 1974-1975* (Valerio Marchetti and Antonella Salomoni eds, Verso 2003) 55.

the natural limit', as their bodies entailed a 'mixture of two realms', such that of the human and animal ('the man with the head of an ox'), of two individuals (conjoined twins) or of two sexes: 'the person who is both male and female is a monster'.[75] However, at the beginning of the 19th century, this vision changed, as hermaphrodites ceased to be seen as violations of the natural order and started to be conceptualised as 'eccentricities, kinds of imperfection, errors of nature'.[76] Instead of a mixture of two sexes, the hermaphrodite became an individual with one sex but a 'defective structure', starting to fall under the jurisdiction of the 'fixing' endeavour of modern medicine.[77]

The change in medical science from a 'one-sex' to a 'two-sex' model was critical in this conceptual shift. Thomas Laqueur explains that, until the mid 18th century, women's bodies were understood to be a 'deformed' or 'inverted' version of men's bodies, because of lack of heat:[78] the ovaries were 'interior' male testes (and, were, in fact, frequently called 'female testicles') and the uterus was the 'colder' version of the scrotum.[79] When the 'two-sex model' took over, the female body was no longer perceived as a distorted vision of its male counterpart, but it was conceived as 'radically and incommensurably different'.[80] With this new paradigm, medicine started to analyse and map the human body with the assumption that maleness and femaleness were complete opposites, which entailed that

[75] ibid 63; it seems that English law did not consider hermaphrodites within the monster category, constructing legal monstrosity with an increasing focus on the idea of the animal/human mixture. See Andrew N Sharpe, 'England's Legal Monsters' (2009) 5 Law, Culture and Humanities 100, 130.
[76] Foucault, *Abnormal. Lectures at the Collège de France 1974-1975* (n 74) 72.
[77] ibid.
[78] Thomas Laqueur, *Making Sex: Body and Gender from the Greeks to Freud* (Harvard University Press 1990) 70.
[79] Thomas Laqueur, 'Orgasm, Generation, and the Politics of Reproductive Biology' (1986) 14 Representations 1, 5.
[80] ibid 7–9.

bodies could only be male or female. This meant that, regardless of how ambiguous one's anatomy was, a person could only have *one* real sex.[81]

The gonads were the bodily features used as 'tellers' of sex, with doctors having the role of discovering ovaries or testicles that had been concealed behind deceptive and confusing bodily anatomy.[82] 'True' hermaphrodites (ie individuals with both testicles and ovaries) were rarely diagnosed as such at the time. Given the conviction that femaleness and maleness were completely opposite anatomical features, it seems that there was an inclination to see the presence of both ovaries and testicles as only 'apparent', since a thorough and meticulous examination would reveal that the individual had in fact only one veritable sex.[83] Moreover, it was not always easy to discern whether an organ was a testicle or an ovary.[84] Several diagnostic techniques were employed, like rectal or vaginal exams and even sometimes exploratory surgery, but an undescended testicle could be easily confused with an ovary, and an ectopic ovary could be mistaken for a testicle.[85] Given this difficulty, many physicians focused on other traits, with the belief that the gonads would manifest themselves through them, like the voice, menstruation (or lack thereof), breasts,

[81] Laqueur (n 78) 136; Alice Domurat Dreger, *Hermaphrodites and the Medical Invention of Sex*, vol 53 (Harvard University Press 1998) 109.
[82] Dreger (n 81) 150.
[83] Michel Foucault, *Herculine Barbin: Being the Recently Discovered Memoirs of French Hermaphrodite* (Vintage Books 1980) viii.
[84] Dreger (n 81) 85.
[85] ibid 85–92.

bodily hair, the shape of the pelvis or the bodily structure and shape more generally, as the assumption was that women were 'smaller' and had 'lighter' bones than men.[86]

Behaviour and sexual orientation were also pivotal aspects in diagnosing hermaphroditism. Sex, gender and sexuality were conflated into one feature, to the point where exhibiting behaviour that was not considered coherent with one's sex and feeling sexual attraction to same-sex individuals was a reason to suspect hermaphroditism.[87] Given the association (and even conflation) between hermaphroditism and homosexuality and the potential 'confusions' in sexual encounters that hermaphroditism could cause (one could be engaging in homosexual intercourse without knowing that their partner had, in reality, the gonads of their same sex), some contemporary commentators suggest that the history of the medical management of 'doubtful' genitalia and homosexuality go hand-in-hand.[88] According to Alice Dreger, physicians had 'the duty to police the "natural" law of heterosexuality', ensuring the correspondence between sex-gender-sexuality by spotting and correcting those who might pose a challenge to it.[89] Rather than 'medical' reasons, as usually no physical discomfort or pain derived from having 'doubtful' genitalia, the 'social' justification of making bodies apt for married heterosexual life is what encouraged corrective surgery.[90] Heterosexual marriage was the norm, for which women were expected to have a penetrable vagina and men a penis capable of penetration.[91] From this

[86] Frank Huisman and John Harley Warner (eds), *Locating Medical History: The Stories and Their Meanings* (The John Hopkins University Press 2004) 87–102.
[87] Dreger (n 81) 135; Elisabeth Reis, *Bodies in Doubt: An American History of Intersex* (The John Hopkins Press 2009) 66.
[88] Reis (n 87) 57–63; Dreger (n 81) 126; Christina Matta, 'Ambiguous Bodies and Deviant Sexualities: Hermaphrodites, Homosexuality, and Surgery in the United States, 1850-1904' (2005) 48 Perspectives in Biology and Medicine 74, 75.
[89] Dreger (n 81) 126.
[90] Reis (n 87) 85.
[91] ibid 70.

perspective, moulding bodies to these standards, upholding the 'one body, one sex' rule and preventing homosexual intercourse appeared to be core rationales of 19th century intersex surgeries.

Like in vulval surgeries, colonial visions of embodiment played a significant role in shaping medical discourses of intersexuality as well.[92] In fact, Hottentot Women, already mentioned in Section 1, were also a key actor for the medical study of intersexuality, since their protruding labia were perceived as complicating the classification of African women along the male/female binary.[93] 19th century medical literature saw African women's bodies as more masculine, since their vulvas were 'situated more forward and higher up than in European women, whilst the outer lips … were puffed up as if swollen', with their enlarged labia minora being invoked to resemble an 'erectile' organ.[94]

The perceived ambiguity of African women's genitals constituted another trope to reify racial hierarchies, being used to (further) prove that Black people were more primitive and the 'missing link' in the evolutionary chain.[95] According to Amanda Lock Swarr, the 19th century shift towards the one sex model introduced above, according to which humans only have one real sex and gonads are its 'true' teller, was central in the conflation of intersexuality with blackness.[96] Under the new 'one sex' theory, whilst true

[92] Zine Magubane, 'Spectacles and Scholarship: Caster Semenya, Intersex Studies, and the Problem of Race in Feminist Theory' (2014) 39 Signs: Journal of Women in Culture and Society 761, 761.
[93] Amanda Lock Swarr, *Envisioning African Intersex. Challenging Colonial and Racist Legacies in South African Medicine* (Duke University Press 2023) 32.
[94] ibid 33; For further discussion, see Magubane (n 92).
[95] Swarr (n 93) 31.
[96] ibid 39.

hermaphroditism became a rarity in Europe, Africa became the target place to search for this 'impossible' phenomenon of human nature.[97] In the words of Swarr:

> scientists at this time held the believe that the higher beings were in the evolutionary hierarchy, the stronger the differentiation between "males" and "females" and they asserted a rigid differentiation evidenced colonialists' biological superiority.[98]

As Chapter 3 discusses, the idea of intersexuality as a black trait carried on during the 20th century and has been revitalised over the controversy surrounding South African sprinter Caster Semenya, who has been banned from competing because of her (alleged) intersex condition.[99]

2.2 From the gonads to psychology

Back in Europe, from the 1920s and culminating in the 1940s, the gonads ceased to be regarded as the sole and core marker of sex. How people with 'doubtful' genitalia *lived* their lives and *felt* in relation to their bodies became the main signal of whether someone was a man or a woman.[100] This tendency is exemplified in a medical case study, where the decision to perform surgery was seen as dependent upon the patient exhibiting 'female qualities of neatness, orderliness and compliance' and her desire to be a woman, rather than on whether she had testicles or ovaries.[101] This rise of interest in how people felt about

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[97] Hilary Malatino, 'Situating Bio-Logic, Refiguring Sex: Intersexuality and Coloniality', in Critical Intersex' in Morgan Holmes (ed), *Critical Intersex* (Asghate 2009) 91.
[98] Swarr (n 93) 38.
[99] For the most recent development in this long controversy, see Lane Higgins, 'There Will Be a New 800-Meter Champion in Tokyo. Thank the Testosterone Rules' (*The Wall Street Journal*) <https://www.wsj.com/articles/800-meters-tokyo-olympics-testosterone-rules-semenya-11627959617> accessed 14 September 2021.
[100] Reis (n 87) 100.
[101] Francis M Ingersoll and Jacob E Finesinger, 'A Case of Male Pseudohermaphroditism. The Importance of Psychiatry in the Surgery of This Condition' (1947) 27 The Surgical clinics of North America 1218, 1218.

their bodies ran in parallel to the rise of psychoanalysis and the incorporation of the study of the mind into the realm of medicine.[102] By stressing sex difference and stereotyping certain behaviours, including sexual orientation, as female or male, psychological tests became popular instruments for mapping the features of 'normal' male and female sexual identity, and for determining to which sex someone with confusing anatomy belonged.[103]

The study of the mind and human behaviour occupied a more prominent position in comparison to 'the gonadal age', but the essentialization of behaviour with sex and the perpetuation of 'male' and 'female' roles strongly resembled how 'sex' was studied and understood. In other words, although the standard through which 'true' sex was established shifted (from anatomy to psychology), the ruling principles of sex difference, binarism and stereotyping remained stable. However, this shift of attention towards psychological characteristics did entail changes regarding consent practices, as doctors were listening to what their patients had to say. During the 19th century, since the gonads were the tellers of true sex, it was not relevant to know (and act in accordance with) how patients felt in relation to their bodies.[104] Their anatomy, as opposed to their feelings, revealed their sex. This new psychological paradigm, historian Elizabeth Reis argues, reshuffled attitudes towards consent, together with the influence of the Nuremberg Code and the Declaration of Geneva.[105] These two documents were created in light of the atrocities committed by physicians in Nazi Germany and enshrined informed consent as the cornerstone principle

[102] Reis (n 87) 117.
[103] ibid 133.
[104] See eg Fred J Taussig, 'Shall a Pseudo-Hermaphrodite Be Allowed to Decide to Which Sex He or She Shall Belong?' (1904) 49 The American Journal of Obstetrics and Diseases of Women and Children 162.
[105] Elizabeth Reis, 'Did Bioethics Matter? A History of Autonomy, Consent, and Intersex Genital Surgery' (2019) 0 Medical Law Review 1, 5.

of medical research and practice.[106] Nevertheless, patients' voices did not remain prominent in the medical management of intersexuality for too long, as the 1950s inaugurated a new era where surgical intervention during early childhood became the norm.

2.3 A psychological emergency

The main reason why the medical profession started to focus on operating on very young intersex patients was owing to the spectacular influence of the publications and guidelines produced by John Money, a professor of paediatrics and psychology at Johns Hopkins University, and his research team (hereafter 'Money's protocols'), who were particularly concerned about how to provide young intersex patients with a healthy upbringing.[107] For Money's team, the biggest challenge intersex patients encountered was the lack of harmony between their physical sexual variables (gonads, hormones, internal and external genital morphology), because these anatomical 'contradictions' were considered to hinder the development of a stable 'gender identity/role' as a man or a woman.[108] Although Money rejected the idea that gender was (only) biologically determined, as he believed that it was also 'created' through 'social' and 'environmental' aspects like 'nouns, pronouns … hair-cut, dress, and personal adornment', he thought that anatomical elements, like genital appearance, played a crucial role in its establishment:[109]

> On the one hand it is evident that gender role and orientation is not determined in some automatic, innate, or instinctive fashion by physical,

[106] ibid.
[107] Reis (n 87) 40.
[108] John Money, Joan G Hampson and John L Hampson, 'Imprinting and the Establishment of Gender Role' (1957) 77 MA Arch NeurPsych 333, 333. See Chapter 5 for a discussion of the concept of 'gender/identity role'.
[109] ibid 335.

> bodily agents, like chromosomes, gonadal structures, or hormones. On the other hand, it is also evident that the sex of assignment and rearing does not automatically and mechanistically determine the gender role and orientation … Rather, it appears that a person's gender role and orientation becomes established, beginning at a very early age, as that person becomes acquainted with and deciphers a continuous multiplicity of signs that point in the direction of his being a boy, or her being a girl.[110]

As one acquired one's gender identity through interacting with the rest of the world, being born with 'ambiguous' anatomy challenged the process of 'normal' gender rearing, since the baby's 'confusing' genitals prevented the most basic announcement ('it's a boy!' or 'it's a girl!') from triggering the chain of communications, responses and actions that would shape the child's gender.[111] In order to ensure that those born with 'doubtful' genitalia could experience healthy psychological development and not find themselves 'swing[ing] on a boy girl-pendulum',[112] Money recommended gender assignment and surgery to 'correct' 'confusing' anatomy as soon as possible, and by eighteen months at the latest, removing early on in life the major obstacles for 'psychological healthiness', hence securing the 'successful establishment of a thoroughgoing conviction of gender'.[113]

Money's criterion for assigning and 'correcting' the genitals was, in contrast with previous eras, not the gonads nor the psychological make-up (understandably so, as they were treating new-borns), but 'the morphology of the external genitals and the ease with which these organs can be surgically reconstructed to be consistent with the assigned sex'.[114] One of the most illuminating examples of how the process of gender assignment,

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[110] ibid.
[111] John Money and Anke A Ehrhardt, *Man & Woman: Boy & Girl* (The John Hopkins University Press 1972) 12.
[112] ibid 15.
[113] Joan G Hampson, John Money and John L Hampson, 'Hermaphroditism: Recommendations Concerning Case Management' (1956) 16 Journal of Clinical Endocrinology & Metabolism 559.
[114] Money, Hampson and Hampson (n 108) 334.

subsequent surgery and gender-rearing worked is the John/Joan case, highly publicised by Money's team as evidence of success of their protocols and understanding of gender.[115] As a result of a botched circumcision, a boy had had his penis ablated at seven months old. Given that his phallus would never achieve the expectations of a 'normal' penis (that is, urinating standing up and penetrating a vagina),[116] but had the potential to be surgically fixed to resemble a vulva, Money and his team advised the family to raise him as a girl. The baby underwent the necessary operations, and her parents were reassured that she would 'differentiate a female gender identity', provided they followed their guidelines on policing her 'girlness'.[117] The team explained to them the importance of 'gender rearing practices', like having her wear dresses, growing her hair long, teaching her to urinate sitting down and preparing her to be a proper housewife.[118] For a healthy upbringing, unconfused anatomy therefore had to be accompanied with the (self)conviction and messaging from parents that the child is a boy or a girl, with Money noting that 'no person in our society could be other than crippled without a sturdy conviction of belonging either to one sex, or the other—of being a man or being a woman'.[119] Nevertheless, this approach

[115] Money and Ehrhardt (n 111) 118–122.
[116] Anne Fausto-Sterling, *Sexing the Body. Gender Politics and the Construction of Sexuality* (Basic Books 2000) 57.
[117] Money and Ehrhardt (n 111) 119.
[118] ibid 119–121.
[119] Hampson, Money and Hampson (n 113) 549.

had tragic consequences for 'Joan', who never adapted to being a girl and, at age 14, decided to live as a boy,[120] an identity he maintained until he committed suicide at age 38.

In order to imprint a stable and clear gender identity on their children, parents had to be convinced of their child's gender in the first place, as otherwise their uncertainty would be 'covertly transmitted to the child, as contagiously as though it were rubella'.[121] In practice, this meant that they were given dubious and partial information about their child's diagnosis and treatment, with the medical team using terms like 'genital unfinishedness', suggesting that their child only needed a 'final' surgical touch to secure their maleness or femaleness.[122] Besides, parents were advised to be careful when disclosing medical information to their children, and to family and friends, even being recommended to move away and start a new life somewhere where nobody would suspect that their child had been born 'genitally unfinished' (See Chapter 4 for further analysis of the psychological implications of Money's protocols).[123]

2.4 A multidisciplinary challenge

It was precisely secrecy and children's lack of knowledge that raised most concerns about Money's protocols and which eventually led to their falling out of proper medical practice.[124] As Chapter 5 discusses, Money's postulates, even during their heyday, did not

[120] Milton Diamond and Keith Sigmundson, 'Sex Reassignment at Birth' (1997) 151 Archives of Pediatrics & Adolescent Medicine 298.
[121] Money and Ehrhardt (n 111) 15.
[122] Money, Hampson and Hampson (n 108) 553.
[123] Cheryl Chase, '"Cultural Practice" or "Reconstructive Surgery"? US Genital Cutting, the Intersex Movement, and Medical Double Standards' in S James and C Robertson (eds), *Genital Cutting and Trasnational Sisterhood. Disputing US Polemics* (University of Illinois Press 2002) 133.
[124] Reis (n 87) 146.

go unquestioned within the medical profession, as not everyone agreed with his theory that individuals could be moulded into being boys or girls if they were 'adequately' raised as such, and operated accordingly early on.[125] However, the almost fifty year rule of Money's protocols came to an end mainly due to the work of intersex activists.[126] Cheryl Chase, an intersex patient who had had her clitoris removed as a child without her knowledge, created the first intersex activist group, Intersex Society of North America (ISNA), in 1993.[127] With the goal of changing how the medical profession dealt with intersexuality, ISNA initially had a confrontational attitude, organising protests outside of paediatric meetings and conventions.[128] In the early 2000s, they changed their strategy as they decided it would be more productive to work with, rather than against, doctors, and ISNA started to collaborate with clinicians (this shift was not welcome by all sectors of intersex activism, as Chapter 3 examines).[129] Their degree of involvement with medical professionals was such that Chase became a key actor in the elaboration of the so-called Chicago Consensus Statement, a document elaborated by leading experts in the field which aimed to change the principles underpinning the medical management of intersexuality.[130]

The Chicago Consensus Statement was published in 2006.[131] In addition to introducing a new nomenclature for intersexuality, with the term 'Disorder of Sex

[125] Bernard Zuger, 'Gender Role Determination: A Critical Review of the Evidence from Hermaphroditism' (1970) 32 Psychosomatic Medicine 449.
[126] Sarah Creighton and Catherine Minto, 'Managing Intersex: Most Vaginal Surgery in Childhood Should Be Deferred' (2001) 323 BMJ 1264.
[127] Georgiann Davis, *Contesting Intersex: The Dubious Diagnosis* (New York University Press 2015) 29.
[128] ibid 39–40.
[129] ibid 47–48.
[130] ibid 44.
[131] IA Hughes and others, 'Consensus Statement on Management of Intersex Disorders' (2006) 91 Archives of Diseases of Childhood 554.

Development' (Chapter 3 discusses the controversy surrounding this new term),[132] it established that gender reassignment 'should be avoided before expert evaluation', which should only be performed by an experienced multidisciplinary team in constant open communication with the family.[133] It stressed the importance of the child's understanding and involvement in treatment decisions, abandoning the pressure and anxiety for 'fixing' genitals and anatomy as soon as possible.[134] Moreover, if/when performing surgery, the statement also made clear that preserving the orgasmic function of the genitals should take precedence over cosmetic appearance.[135]

Notwithstanding these changes, the idea of gender as natural and dichotomous continues to be central in current guidelines. For instance, the 2016 update of the Consensus Statement calls for further research, noting that 'a biomarker of gender identity is not yet available'.[136] Similarly, the 2016 Society for Endocrinology UK guidance explains that it is 'paramount' that a child with 'suspected DSD' undergoes clinical assessment in order to determine the 'sex of rearing'.[137] The implication that medicine should enable the determination of gender, and that children should be raised with a clear gender identity is not that far away from former understandings of intersexuality. The difference is how 'refined' scientific research has become, with current technology not

[132] ibid; however, the change of terminology has not been uncontroversial, see eg Ellen K. Feder and Katrina Karkazis, 'What's in a Name?: The Controversy over "Disorders of Sex Development"' (2008) 38 Hastings Center Report 33; Sarah S Topp, 'Against the Quiet Revolution: The Rhetorical Construction of Intersex Individuals as Disordered' (2013) 16 Sexualities 180.
[133] Peter A Lee and others, 'Consensus Statement on Management of Intersex Disorders' (2006) 118 Pediatrics e491.
[134] Hughes and others (n 131) e491.
[135] ibid.
[136] Peter A Lee and others, 'Global Disorders of Sex Development Update since 2006: Perceptions, Approach and Care' (2016) 85 Hormone Research in Paediatrics 158, 168.
[137] S Faisal Ahmed and others, 'Society for Endocrinology UK Guidance on the Initial Evaluation of an Infant or an Adolescent with a Suspected Disorder of Sex Development' (2016) 84 Clinical Endocrinology 771, 15.

paying attention only to the gonads (19th century physicians), psychology (early 20th century doctors), or considering the body to be a malleable entity which can become whichever sex the genitals resemble most closely (as in Money's protocols). Currently, a more 'holistic' examination of a wide range of characteristics (hormonal, chromosomal, anatomical) will take place. However, the idea that gender is a dichotomous biological inscription of bodies that science should ideally be able to 'unfold' in order to assign one sex and gender to anomalous bodies continues to be ingrained in current medical thought.[138]

In parallel with vulval and vaginal cosmetic surgeries, medical discourses regarding intersexuality have also shifted through time. Yet, intersexual bodies remain to be subject to medical surveillance and treatment, and standing outside of the gender binary is perceived to be a health issue that requires medical intervention and cure (Chapter 5 unpacks the idea of 'health' that underpins current medical protocols).

3 Female Genital Mutilation

3.1 A colonial problem

In contrast with the two interventions examined so far, there have been some cuts to the vulva which have not been performed as solutions or remedies for medical problems. So-called Female Genital Mutilation (FGM) is a traditional practice originating in some

[138] I have argued that something similar has also occurred in relation to the policing of intersexuality in the sporting world, see Mireia Garcés de Marcilla Musté, 'You Ain't Woman Enough: Tracing the Policing of Intersexuality in Sports and the Clinic' (2022) 31 Social and Legal Studies 857.

regions of Africa and Asia,[139] and this section particularly focuses on its history in Sudan and Kenya. These two countries were under British rule from the late 19th century until the second half of the 20th century, and they are used here as examples to show how particular discourses against this intervention arrived there through British settlers and were negotiated with local communities in each case.

Sudan fell under British rule in 1898. Little attention was paid to vulval cutting until after World War I, when concerns about the country's underpopulation became prevalent and excision (cutting of the vulva and clitoris) and infibulation (stitching the labia together)—known in Sudan as pharaonic circumcision—were considered to be one of the main causes of the country's low birth rates.[140] In order to remedy this problem, a maternity centre was established, and joined by two British midwifes, Mabel and her sister Gertrude Wolff in 1920.[141] The Wolff sisters, albeit that their goal was to spread British medical standards, did not unilaterally impose a rigid view of what they considered to be proper medical practice, but engaged in a negotiation with local postures.[142] For example, instead of directly eliminating Dayas (local women in charge of vulval cutting and childbirth), they decided to keep them in check by training and introducing them to a regime of licensing and periodical inspection.[143] Among other things, they taught them about the importance of cleanliness and the use of sterile equipment, as well as how to deliver children in the

[139] UNICEF, 'Female Genital Mutilation: A Statistical Overview and Exploration of the Dynamics of Change' (2013) 26.
[140] Janice Boddy, 'Legislating Against Culture: Efforts to End Pharaonic Circumcision in the Anglo-Egyptian Sudan' (2008) 33 Suomen Antropologi: Journal of the Finnish Anthropological Society 17, 17–18.
[141] Heather Bell, *Frontiers of Medicine in the Anglo-Egyptian Sudan, 1899-1940* (Clarendon Press 1999) 204.
[142] ibid 211.
[143] ibid 11. However, Bell notes that the extent to which this regime was enforced is doubtful.

semi-reclining position, in contrast with the traditional Sudanese position of 'squatting'.[144] Fearing that their trained local midwifes would probably not comply with a prohibition on performing pharaonic circumcision, they opted for teaching them a less invasive version of the intervention.[145] With a smaller cut and less stitching, together with hygienic safeguards and follow-up care, the Wolffs' harm-minimisation strategy sought to reduce the sequalae and complications from these procedures.[146]

This climate of relative condemnation and tolerance towards pharaonic circumcision shifted at the end of the 1930s. The nurse Elaine Hills-Young replaced the Wolff sisters as Principal of the Midwifery Training School in 1937 and adopted a more radical stance with regards to this practice, forbidding her trainees from performing it and ceasing to teach them any sort of 'mild' version.[147] Important political changes occurred during this period as well. After the Anglo-Egyptian Treaty was signed in 1936, British colonial officials, who had so far been careful when interfering with local customs, out of fear that it could hinder diplomatic negotiations, began to adopt a more assertive stance towards pharaonic circumcision.[148] In 1946, the penal code was amended to include (some forms of) the procedure.[149] As it was thought that it was mainly the stitching of the vulva which entailed problems for reproduction, only infibulation was criminalised, and it remained lawful to 'remove the free and protruding part of the clitoris'.[150] Along with this new legal provision, the Civil Secretary's Standing Committee on Female Circumcision,

[144] ibid 210.
[145] ibid 221.
[146] ibid.
[147] Boddy (n 140) 18.
[148] ibid 20.
[149] ibid 24.
[150] ibid 25.

created in 1939, circulated pamphlets aimed at convincing the Sudanese that they should discontinue procedures that were 'holding [them] back', explaining that '[Sudanese] daughters can never be as successful as the daughters of other nations while this practice continues'.[151]

In the years that followed, pharaonic circumcision became one of the catalysts of the nationalist fight against the British colonial government, and its criminalisation became perceived as an attack to Sudanese 'sovereignty and identity'.[152] The conviction in September 1946 of a midwife under the reformed penal code sparked substantial demonstrations, led by pro-independence leader Mohammad Mahmud Taha, calling for her release.[153] During the politically turbulent years preceding independence in 1956, pharaonic circumcision remained common practice,[154] and the criminal prohibition was never fully enforced, given the considerable reluctance of provincial governors, midwifes and mothers to stop the practice.[155]

Meanwhile, what became known as the 'female circumcision controversy' unfolded in Kenya during the late 1920s.[156] If in Sudan it was midwives who became key agents of policing vulval cutting, Christian missionaries, who were first established in the country at the turn of the century, seem to have assumed a similar role in Kenya after seeing

[151] Poster 'To the Women of Sudan', quoted in ibid.
[152] Rogia Mustafa Abusharaf, 'Virtuous Cuts: Female Genital Circumcision in an African Ontology' (2001) 12 Differences: A Journal of Feminist Cultural Studies 112, 119.
[153] Boddy (n 140) 27.
[154] ibid 28.
[155] ibid 27.
[156] Katherine Angela Luongo, 'The Clitoridectomy Controversy in Kenya: The "Woman's Affair" That Wasn't' (2000) 28 Ufahamu: A Journal of African Studies 105.

the adverse effects of clitoral removal and labial excision.[157] For example, Jocelyn Murray explains that one mission decided to 'Christianise' the operation and encouraged families to only have their daughters cut by a baptised Christian 'operator' at a 'private ceremony'.[158] In contrast, their neighbouring missionary leaders adopted a more radical position, excommunicating and suspending from school all those who underwent the procedure.[159] This latter policy, far from being the intended goal, alienated most of the population, as churches and schools emptied, and most of the community started to pray and organise teaching activities independently.[160]

Like in Sudan, vulval cutting became an issue for the British colonial government when it came to be seen as one of the main factors responsible for the country's low birth rate.[161] However, after witnessing how locals reacted to missionary 'bans' and seeing how some prominent pro-independence movements embraced vulval cutting as a marker of national identity, the government was afraid of antagonising the population.[162] Thus, in 1926, it adopted a 'subtle' strategy of passing a circular which condemned the most invasive forms of cutting (excision) but allowed what they considered minor versions of it

[157] Jocelyn Murray, 'The Church Missionary Society and the "Female Circumcision" Issue in Kenya 1929-1932' (1976) 8 Journal of Religion in Africa 92, 93.
[158] ibid 101.
[159] ibid.
[160] ibid 99.
[161] Luongo (n 156) 119.
[162] ibid 111–122.

(clitoridectomy),[163] delegating to Local Native Councils, a colonial-appointed local government institution formed by 'tribal elders and chiefs', the main task of enforcing it.[164]

This 'controversy' even reached Westminster. During a colonial policy debate in the House of Commons in 1929, two MPs, the Duchess of Atholl and Eleanor Rathbone, gave speeches condemning vulval interventions in Kenya.[165] This had already been a central topic for the Committee for the Protection of Coloured Women in the Crown Colonies, and these two MPs shared with the House their concern that these practices were 'nothing short of a mutilation' and were embedded in bride-selling practices that were no different from slavery.[166] Their goal was to criminalise these interventions, but their efforts were unsuccessful. The colonial government had proposed a criminal prohibition which, like the approach taken in 1926, only concerned 'full' vulval excision, leaving what was seen as the 'minor' procedure of clitoridectomy outside of the scope of the criminal law.[167] Nevertheless, by 1930, it had already become apparent that 'mere' clitoridectomy was not at all common, but the full form was the customary intervention.[168] Since the government was afraid that outlawing full excision altogether would cause social unrest and be a dangerous trigger for (further) anti-colonial protests, the preferred solution was to set up a campaign of 'education and propaganda' through government circulars and missionary

[163] Susan Pedersen, 'National Bodies , Unspeakable Acts : The Sexual Politics of Colonial Policy-Making' (1991) 63 The Journal of Modern History 647, 666.
[164] Luongo (n 156) 123.
[165] Pedersen (n 163) 656.
[166] ibid.
[167] ibid 675.
[168] ibid.

societies, seeking to convince locals to, if not abandon the practice altogether, at least perform its 'milder forms'.[169]

In contrast with vulval interventions, other body modification practices, such as tattooing, piercing or the removal of the penile foreskin,[170] went comparatively unnoticed by colonial governments.[171] Perhaps this is because of the demographic implications of vulval interventions, or the key importance that these appeared to have for the communities' social order. As vulval cutting was a central element structuring marriage, power and social status, controlling this custom was seen as a strategy that could potentially enable to rule over the population's social order.[172]

3.2 A health problem and a feminist issue

As more colonialised countries gained independence during the late 1950s and 1960s, vulval modifications began to fall under the purview of international organisations. However, in 1959, the World Health Organization (WHO), when asked by the UN Economic and Social Council, refused to take issue with these interventions. It saw them as a cultural, not a medical, problem, which called for political solutions, rather than public health-based strategies, via negotiations with local leaders.[173] It was not until the 1970s that the discourse of vulval cutting as a public health issue and a manifestation of

[169] ibid 675–677.
[170] For a parallel discussion of penile circumcision with other 'traditional' body modification practices around the world, see Peter Charles Remondino, *History of Circumcision From the Earliest Times to the Present: Moral and Physical Reasons for Its Performance* (Philadephia: FA Davis 1900) Chapter 6.
[171] Michela Fusaschi, 'Gendered Genital Modifications in Critical Anthropology: From Discourses on FGM/C to New Technologies in the Sex/Gender System' (2022) International Journal of Impotence Research 4.
[172] Luongo (n 156) 123.
[173] Fusaschi (n 171) 3.

patriarchal violence took off.[174] The Seminar on Harmful Traditional Practices Affecting the Health of Women and Children, organised by the WHO in 1979, kickstarted this 'global campaign' strategy,[175] where Fran Hosken, an American journalist who travelled around Africa and documented several instances of vulval modifications, presented her findings.[176] She called for a coordinated campaign to 'wipe out' FGM, which she defined as a 'social burden of sexual violence imposed by the patriarchal system on those least able to protect themselves to keep them in servitude to men'.[177] In fact, it was Hosken who popularised the term 'female genital mutilation' which, given the influence of her work, gradually substituted 'circumcision' as the dominant label for these interventions in the 1990s.[178] As Chapter 3 discusses in depth, during the late 1970s and 1980s, FGM became a symbol of patriarchal violence, especially for some streams of Western feminism, which claimed that global sisterhood was required to 'eradicate' it, a perspective that, as we shall see, has been criticised for reifying racialised and imperialist perspectives.[179]

Debates within the 1980 United Nations Mid-Decade Conference on Women bore testament to the conflict between African and Western approaches to vulval cutting.[180] Some Western feminists seemed to have had 'confrontational and condescending' attitudes towards African women attending the event, suggesting that they needed foreign help to

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[174] ibid.
[175] Ylva Hernlund and Bettina Shell-Duncan, 'Transcultural Positions, Negotiating Rights and Culture' in Ylva Hernlund and Bettina Shell-Duncan (eds), *Transcultural Bodies. Female Genital Cutting i the Global Context* (Rutgers University Press 2007) 13.
[176] Fusaschi (n 171) 4.
[177] Fran P Hosken, *The Hosken Report: Genital and Sexual Mutilation of Females* (Fourth revision, Women's International Network News 1994) 11, 31.
[178] Fusaschi (n 171) 4.
[179] For further discussion, see Lisa Wade, 'Learning from "Female Genital Mutilation": Lessons from 30 Years of Academic Discourse' (2012) 12 Ethnicities 26.
[180] Anika Rahman and Nahid Toubia (eds), *Female Genital Mutilation: A Guide to Laws and Policies Worldwide* (Zed Books 2000) 10.

guide them if they wanted to succeed in eliminating the practice.[181] As a result, some of the attendees founded what later became the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC).[182] The IAC had a primarily health-focused approach, lobbying governments and starting educational campaigns which raised awareness about the negative health consequences of vulval interventions, working under the assumption that people would cease to perform them if they were informed about their risks.[183]

However, there were several problems involved in framing vulval cutting as a health problem. First, this approach wrongly assumed that one of the key reasons why these procedures were so popular was because of the widespread confusion or ignorance about their potential complications.[184] Bettina Shell-Duncan explains that those undergoing these procedures are probably already aware of their potential complications, and yet they continue to believe that it is best for them and their daughters to undergo them, mainly given the detrimental social consequences of refusing to do so.[185] Second, the 'catastrophisation' discourse underpinning the health-based approach, framing vulval modifications as inevitably having terrible health repercussions, posed credibility issues, since this 'dramatic' view did not always match the lived experience of those being cut, since many of them did not necessarily experience agonising pain or faced life-long

[181] Stephen Hopgood, 'Modernity at the Cutting Edge: Human Rights Meets FGM' in Michael N Barnett (ed), *Paternalism Beyond Borders* (Cambridge University Press 2016) 271.
[182] Rahman and Toubia (n 180) 10.
[183] Hernlund and Shell-Duncan (n 175) 13.
[184] Hosken (n 177) 11.
[185] Bettina Shell-Duncan, 'From Health to Human Rights: Female Genital Cutting and the Politics of Intervention' (2008) 110 American Anthropologist 225, 226.

sequalae (See Chapter 5 for further discussion on the effects of FGM).[186] Third, focusing on health complications implied that medicalisation was a legitimate and sound harm reduction strategy, which the WHO and other international organisations, wanting to eliminate all forms of FGM, did not support.[187]

3.3 A human rights violation

Given these challenges, the health-based strategy did not prove successful in reducing the prevalence of FGM, and it was substituted by a human rights approach, through which FGM was conceived of as a breach of women's rights.[188] In 1990, the Committee on the Elimination of All Forms of Discrimination Against Women (CEDAW) recommended States take 'appropriate and effective measures with a view to eradicating the practice', including data collection, 'support of women's organisations at the national and local levels', 'encouragement of politicians, professionals, religious and community leads' and 'introduction of appropriate educational and training programmes'.[189] This was also the year when the Committee on Traditional Practices Affecting the Health of Women and

[186] ibid.
[187] UNICEF (n 139) 8.
[188] ibid.
[189] United Nations Committee on the Elimination of Discrimination Against Women (CEDAW), 'CEDAW General Recommendation No. 14: Female Circumcision' (1990) 1.

Children decided to adopt the term Female Genital Mutilation, followed by the WHO in 1991.[190]

The 1995 International Conference on Women celebrated in Beijing made explicit that FGM was a form of 'violence against women',[191] and called for governments to 'prohibit female genital mutilation wherever it exists and give vigorous support to efforts among non-governmental and community organisations and religious institutions to eliminate such practices'.[192] In addition to being acknowledged as a form of gender-based violence, FGM is now also considered to breach a wide number of human rights provisions, as the 2008 UN Interagency Statement makes clear:

> Female genital mutilation violates a series of well-established human rights principles, norms and standards, including the principles of equality and non-discrimination on the basis of sex, the right to life when the procedure results in death, and the right to freedom from torture or cruel, inhuman or degrading treatment or punishment … As it interferes with healthy genital tissue in the absence of medical necessity and can lead to severe consequences for a woman's physical and mental health, female genital mutilation is a violation of a person's right to the highest attainable standard of health.[193]

In order to effectively stop FGM, UN agencies recognise that a 'multidisciplinary approach' is necessary, since passing laws criminalising the practice is not effective provided it does not come with a package of measures which promote 'social change' to ensure the practice is not driven underground.[194] At the institutional level, the UN urges,

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[190] UNICEF (n 139) 7.
[191] Fourth World Conference on Women, 'Beijing Declaration and Platform for Action' (1995) para 113.
[192] ibid para 232 (h).
[193] World Health Organization, 'Eliminating Female Genital Mutilation. An Interagency Statement' (2008) 9.
[194] ibid 17; See also World Health Organization, 'Female Genital Mutilation. A Joint WHO/UNFPA/UNICEF Statement' (1997) 13; UNICEF (n 139) 113.

on the one hand, national governments and parliaments to enact legal measures prohibiting FGM, and, on the other hand, it suggests that the medical profession should not allow it under any circumstances and should subject to 'disciplinary proceedings' those who perform it.[195] At community level, several UN agencies, including the WHO and UNICEF, seek to set up 'empowering education' and 'public dialogue' programmes, so 'people examine their own beliefs and values … in a dynamic and open way that is not experienced or seen as threatening'.[196] The goal is to attain 'coordinated choice to abandon the practice', so nobody is disadvantaged by opting out of it.[197] The UN also wants to achieve local 'public pledges' against FGM, and potentially work with local leaders to establish 'alternative rituals' which echo the coming of age meaning that vulval cutting has for many communities whilst leaving vulvas untouched.[198]

Within Europe, the Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence recognises FGM as a form of violence against women, imposing a duty of criminalisation to states.[199] The European Union has also taken issue with this practice, with the European Institute for Gender Equality having produced a report in 2013 recommending steps be taken towards the prevention of, protection from, and prosecution for FGM.[200] The European Parliament has also issued

[195] World Health Organization (n 193) 17.
[196] ibid 14.
[197] ibid 13.
[198] ibid 16.
[199] Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence (2011) article 28.
[200] European Institute for Gender Equality, 'Female Genital Mutilation in the European Union and Croatia' (2013).

several resolutions calling for the need to raise awareness and build cooperation networks to end this practice.[201]

In England and Wales, this intervention has been considered a criminal offence since 1985, with the Prohibition of Female Circumcision Act, now replaced by the Female Genital Mutilation Act 2003. There are also non-criminal measures, like FGM Protection Orders and reporting and recording duties for medical professionals, in place (see Chapter 2 for further discussion).[202]

The current human rights approach has not gone unchallenged, with one of its main criticisms having been that it imposes Western views of 'violence' and 'dignity' on non-Western cultures.[203] Implemented through negotiations with local structures, rather through only criminal bans which demonize local customs, Stephen Hopgood suggests that current human rights-based strategies to eliminate FGM constitute a form of 'soft paternalism' which seek to 'change behaviours' that have been deemed a terrible breach of human rights in accordance to Western standards.[204] Embedded in this perspective is the assumption that those who have vulvas constitute a 'coherent group identity within different cultures', and hence share similar conceptions of what it means and what is challenging about being a woman.[205] Therefore, what are considered to be problems or

[201] EU Parliament, 'Resolution on Female Genital Mutilation 2001/2035 (INI)' (2001); EU Parliament, 'Resolution on Combating Female Genital Mutilation in the EU 2008/2071 (INI)' (2008); EU Parliament, 'Resolution on Ending Female Genital Mutilation 2012/2684 (RSP)' (2012).
[202] Department of Health and Social Care, 'Safeguarding Women and Girls at Risk of FGM ' <https://www.gov.uk/government/publications/safeguarding-women-and-girls-at-risk-of-fgm> accessed 29 December 2021.
[203] Shell-Duncan (n 185) 230.
[204] Hopgood (n 181) 276.
[205] Ratna Kapur, 'The Tragedy of Victimisation Rhetoric: Resurrecting the "Native" Subject in International/Postcolonial Feminist Legal Politics' (2002) 15 Harvard Human Rights Journal 6.

attacks on autonomy, well-being and sexuality by Western women are also taken to be issues that women outside of the West must also take issue with.[206] Not only does this perpetuate the framing of African women as victims in need of foreign rescue, as Ratna Kapur argues, but it also falls short of acknowledging that ideas of womanhood and sexuality are not monolithic, but vary across different cultures.[207]

As Section 1 has shown, the clitoris has been enshrined in the West as the ultimate symbol of female pleasure and the organ of sexual liberation. It might make sense from this perspective, therefore, to interpret trimming or removing the clitoris and the labia as, in the words of Hosken, 'depriv[ing] women of sexual pleasure and keep[ing] women under male control'.[208] Nevertheless, even though reduction or loss of sensitivity are the by-product of clitoridectomy or excision, these do not seem to be their main rationales.[209] Drawing on the Sudanese experience, anthropologist Janice Boddy explains that excision and infibulation are performed in order to shape someone into a full woman, as until then she is considered not completely developed and incapable of bearing children:[210]

> Genital surgery accomplishes the social definition of a child's sex; it completes and purifies a child's natural sexual identity by removing physical traits deemed appropriate to his or her opposite … the operations implicitly identify neophytes with their gender-appropriate spheres of

[206] ibid.
[207] ibid.
[208] Hosken (n 177) 32.
[209] Janice Boddy, *Wombs and Alien Spirits. Women, Men and The Zar Cult in Northern Sudan* (The University of Wisconsin Press 1989) 55.
[210] ibid 56.

> interaction as adults: the interiors of house yards enclosed by high mud walls in the case of females.[211]

Vulval cutting hence constitutes, in some contexts, an act whereby 'women actively and ongoingly construct other women'.[212] Rather than possessing a full clitoris and labia, for some Sudanese women, their 'natural' form is having them excised, given that being uncut is seen as remaining incomplete and underdeveloped.[213] However, even if read from the 'inside', these cuts can still be criticised for reinforcing particular ideals of beauty and function, and for being imposed upon women who have no real choice to refuse to undergo them.[214] Chapter 3 further explores the challenges of reading FGM through different viewpoints, examining indigenous accounts in favour and against this intervention.

4 Conclusion

This chapter has traced the evolution of vaginal and vulval cosmetic surgeries, intersex interventions and FGM by showing how the performance of these operations has been ingrained within dominant and shifting discourses of health, womanhood, and sexuality. First, it has shown how cultural narratives about proper femininity and gender difference have underpinned the performance of what are now defined as vulval cosmetic and intersex surgeries. The former, now embedded in a narrative of choice, enhancement and sexual pleasure, can be traced back to interventions designed to cure illnesses concerning what the mores and medical knowledge of 19th and 20th century deemed inappropriate sexual

[211] ibid 58.
[212] ibid.
[213] Ellen Gruenbaum, *The Female Circumcision Controversy: An Anthropological Perspective* (University of Pennsylvania Press 2001) 68.
[214] Nawal El Saadawi, *The Hidden Face of Eve* (Zed Books 1980) 33.

behaviour. Meanwhile, the medical management of intersexuality tells a story about anxiety and concern for bodies which do not seem to clearly align with either side of the gender binary, resulting in their having been regarded as in need of fixing since the late 19th century.

Second, this chapter has uncovered some of the colonial and postcolonial intricacies in relation to vulval cutting. It has shed light on the colonial vestiges of vulval measurements and acknowledged the racialised underpinnings of (early) medical accounts of intersexuality. It has also provided historical context to the current perception of FGM as an unequivocal harmful practice which requires transnational and local coordinated action to secure its abolishment. Already seen by colonial forces as a 'backwards' intervention which had to be discontinued because it posed problems for population growth, it is now considered a form of discrimination reinforcing gendered power structures and a violation of the most basic human rights which international and national efforts must end.

Exposing the evolution of these three operations is the first step in order to complicate the foundations and classifications currently in place, opening up questions about the conceptualisation of vulval modifications. What defines and constitutes a legitimate body modification needs critical interrogation through which 'health', 'disease' or 'harm' cease to be regarded as universal and neutral concepts, but are seen instead as value-laden and socially constructed.

CHAPTER 2. CONTINUITIES AND DISCONTINUITIES IN VULVAL CUTTING

This chapter surveys the current medical, ethical and legal discussion within the literature in relation to vulval cosmetic surgery, intersex surgery and Female Genital Mutilation (FGM). It provides a snapshot of the common, but distinctly discussed, themes that arise in relation to these three interventions by drawing on medical journals, medical guidance and recommendations, legislation, prosecution guidelines, parliamentary reviews and reports from international organisations. The aims of this chapter are two-fold. First, it introduces the main challenges that are perceived to exist in relation to each type of vulval cutting. Second, it maps the commonalities and differences in how vulval cosmetic surgeries, intersex surgeries and FGM are discussed, laying the ground for the analysis in Chapters 3, 4 and 5.

1 Vulval cosmetic surgery

1.1 The medical and business gaze

The starting point for analysing how medico-legal discourse talks about decision-making with regards to vulval cosmetic surgery is the doctor-patient encounter and the context in which these procedures are performed. The manner in which the cosmetic surgery patient enters the medical world differs from the 'standard' doctor-patient relationship. Usually, patients seek medical assistance to cure or relieve a medical problem. The role of the doctor is therefore to examine them, decipher their symptoms and offer them a diagnosis and a

course of treatment.[1] In vulval cosmetic surgery, however, it is usually the patient who presents the surgeon with an account of her genitalia and how she wants it modified.[2] She has a pre-conceived idea of what her problem is (the appearance of her vulva), of the course of treatment she wants (surgery) and usually of the outcomes she expects from the procedure.[3] The doctor does eventually decide whether to cut or not, but the patient's desire to have her vulva modified is what puts in motion the medical process and is the centre of all interactions with her doctor.[4]

Such inversion of the medical gaze, where procedures are 'user-led rather than practitioner-led',[5] is also accompanied by the 'consumeristic' drive of cosmetic surgery. This type of surgery is not typically available on the NHS, being offered only in circumstances where it is considered medically necessary or as a result of an underlying condition or accident (eg to remove cancerous tissue or to repair tearing or scars after childbirth).[6] Clinical Commissioning Groups, now replaced by Integrated Care Systems, issued statements where they made clear that they do not 'routinely' commission 'refashioning of the vagina' unless there is a medical indication for doing so, such as

[1] Michel Foucault, *The Birth of the Clinic: An Archeology of Medical Perception* (Routledge 1963) 90.
[2] ibid.
[3] Nuffield Council on Bioethics, 'Cosmetic Procedures: Ethical Issues' (2017) para 7.48.
[4] The issue of whether the need or desire to have surgery is genuine or the result of an oppressive framework is discussed in Chapter 3.
[5] Nuffield Council on Bioethics (n 3) para 7.45.
[6] NHS, 'Cosmetic Procedures - Labiaplasty (Vulval Surgery)' <https://www.nhs.uk/conditions/cosmetic-procedures/labiaplasty/> accessed 3 January 2021.

cancer, congenital malformation or repair after trauma.[7] (See Chapter 5 for further discussion.)

If patients do not qualify for treatment under the NHS,[8] they may seek medical attention privately and pay for the surgery themselves. The cost of these procedures is usually between £2000 and £4000, plus fees, consultation and follow-up costs.[9] In these instances, medical considerations might also merge with business interests, since surgeons seek to sell their services with marketing and advertising strategies, whilst remaining ethically bound to have the well-being of their patients at the centre of their practice.[10] The Nuffield Council on Bioethics summarises this tension as follows:

> This strong association with the trust-based nature of clinical practice, where patient welfare is assumed to be at the heart of all interactions … comes into conflict with the way in which cosmetic procedures are advertised and promoted as a desirable consumer good, to be purchased on demand by customers, rather than undertaken, with the advice and support, and after careful consideration of the risks, by patients.[11]

Such 'conflict' between medical and consumer interests has underpinned the main regulatory challenges of the cosmetic surgery sector. Following the Poly Implant Prothèse (PIP) scandal, which affected more than 300,000 women worldwide, who had had faulty and leaky breast implants inserted, the Department of Health commissioned an independent report reviewing the regulation of cosmetic surgery in 2013. The so-called 'Keogh Report'

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[7] NHS Hull CCG, 'General Commisssioning Policy - Labiaplasty and Vaginaplasty' (2016); North Somerset and South Gloucestershire CCG Bristol, 'Commissioning Policy: Female Genitalia' (2017); Swindon and Wiltshire Bath and North East Somerset CCG, 'Female Genital Cosmetic Surgery'; NHS Leeds CCG, 'Gynaecology and Urology Commissioning Policy' (2019).
[8] Chapter 5 elaborates further on the 'physical' or 'functional' justifications of these interventions.
[9] NHS, 'Cosmetic Procedures - Labiaplasty (Vulval Surgery)' (n 6).
[10] Leonore Tiefer, 'Female Genital Cosmetic Surgery: Freakish or Inevitable? Analysis from Medical Marketing, Bioethics, and Feminist Theory' (2008) 18 Feminism and Psychology 466, 467–470.
[11] Nuffield Council on Bioethics (n 3) para 2.17.

identified ‘woeful lapses in product quality, after care and record keeping’, as well as ‘widespread use of misleading advertising, inappropriate marketing and unsafe practices right across the sector’.[12] It concluded that reform was needed to ensure that ‘practitioners have the right skills, the products used are safe, providers are responsible, people get accurate information and support is available when things go wrong’.[13]

In light of this review, the General Medical Council (GMC) and the Royal College of Surgeons (RCS) issued new guidance for doctors who perform cosmetic interventions.[14] Implying or pretending to be a doctor when one does not have the required qualifications does amount to an offence,[15] but there are no statutory limits on what a qualified doctor can do within the remits of medicine. This means that any qualified medical practitioner can call themselves an ‘aesthetic’ or ‘cosmetic’ ‘surgeon’, regardless of whether they have had post-graduate surgical training as such.[16] This is why the RCS has launched the Cosmetic Surgery Certification Scheme, which is a voluntary accreditation for surgeons on the GMC specialist register who perform cosmetic surgery, recognising that they have the ‘appropriate training and experience in the area of cosmetic surgery’.[17] The newly issued GMC guidance also stresses that doctors must ‘recognise and work within the limits of

[12] Bruce Keogh, ‘Review of the Regulation of Cosmetic Interventions Final Report’ (2013) 5.
[13] ibid; for a detailed account of the regulatory ‘gaps’ and reform of cosmetic surgery in the UK see Melanie Latham, ‘The Shape of Things to Come: Feminism, Regulation and Cosmetic Surgery’ (2008) 16 Medical Law Review 437; Melanie Latham, ‘“If It Ain’t Broke, Don’t Fix It?”: Scandals, “Risk”, and Cosmetic Surgery Regulation in the UK and France’ (2014) 22 Medical Law Review 384.
[14] General Medical Council, ‘Guidance for Doctors Who Offer Cosmetic Interventions’ (2016); Royal College of Surgeons, ‘Professional Standards for Cosmetic Surgery’ (2016).
[15] Medical Act 1983 s 49.
[16] British Association of Aesthetic Plastic Surgeons, ‘A Surgeon by Any Other Name Would (Not) Cut as Sweet’ <https://baaps.org.uk/media/press_releases/1373/a_surgeon_by_any_other_name_would_not_cut_as_sweet/> accessed 2 May 2023.
[17] Royal College of Surgeons, ‘Cosmetic Surgery Certification’ <https://www.rcseng.ac.uk/standards-and-research/standards-and-guidance/service-standards/cosmetic-surgery/certification/> accessed 5 February 2021.

their competence'.[18] Besides this, the British Association of Aesthetic Surgeons has its own register of cosmetic surgeons, who must go through a background check and peer review process in order to become members.[19]

The Competition and Markets Authority, whose role is to keep activity in the private market competitive, mediates the private provision of cosmetic surgery. It issued the Private Healthcare Order 2014, setting limits and prohibitions on referral and incentive practices (such as discounts or loans), and establishing an obligation to supply information about performance measures and fees to the Private Healthcare Information Network.[20] Cosmetic surgery providers must also be registered with the Care Quality Commission (CQC), an independent body which monitors the provision of health and social services in England.[21] In its recent inspection of independent cosmetic surgery services in October 2019, the CQC warned that there were some areas of 'inadequate practice', including 'staff without the appropriate training, unsafe practices in the use of sedation and anaesthetics, poor monitoring and management of patients whose condition might deteriorate, a lack of

[18] General Medical Council (n 14) para 1.
[19] British Association of Aesthetic Plastic Surgeons, 'Why Use a BAAPS Member' <https://baaps.org.uk/patients/safety_in_surgery/why_use_a_baaps_member.aspx> accessed 23 February 2021.
[20] Private Healthcare Market Investigation Order 2014, pts 3, 4.
[21] The CQC only regulates procedures which involve surgery, with very popular treatments, such as Botox, chemical peels, dermal fillers or laser hair removal falling outside of its purview. The lack of proper regulation and oversight of these procedures has given rise to many problems regarding informed consent, risks and poor follow-up care. See Alexandra Topping, 'Cosmetic Procedure Industry Is like the "Wild West", Say Campaigners' *The Guardian* (24 September 2021).

attention to fundamental safety process, and variable standards of governance and risk management', among others.[22]

Like anyone who uses a private healthcare provider, the woman who seeks to cosmetically alter her vulva has therefore one foot in the world of medicine, driven by selfless Hippocratic duties, and the other in the world of business and profit-making. The way professional bodies, medical practitioners and regulators discuss decision-making in this context thus echoes such 'double nature', showing special concern about the challenges the intersection between business and medical interests might pose to reaching an informed and non-pressured decision about surgery.

1.2 Poor consent practices

One of the main concerns the medical profession has with regards to vulval and vaginal cosmetic surgery is the lack of robust evidence about its potential risks and outcomes.[23] Despite being regularly performed since the 1960s, these interventions did not begin to be discussed in the medical literature until the 1970s,[24] and current studies have been criticised for being 'extremely rudimentary'.[25] The published research is accused of lacking

[22] Care Quality Commission, 'Independent Cosmetic Surgery Services – Emerging Concerns' (2019) <https://www.cqc.org.uk/news/stories/independent-cosmetic-surgery-services-emerging-concerns> accessed 5 February 2021.

[23] Rufus Cartwright and Linda Cardozo, 'Cosmetic Vulvovaginal Surgery' (2008) 18 Obstetrics, Gynaecology and Reproductive Medicine 285; LM Liao, L Michala and SM Creighton, 'Labial Surgery for Well Women: A Review of the Literature' (2010) 117 BJOG: An International Journal of Obstetrics and Gynaecology 20, 23; Lina Michala, Lih-Mei Liao and Sarah M Creighton, 'Female Genital Cosmetic Surgery: How Can Clinicians Act in Women's Best Interests?' (2012) 14 The Obstetrician & Gynaecologist 203, 204; Giussy Barbara and others, 'Vaginal Rejuvenation: Current Perspectives' (2017) 9 International Journal of Women's Health 513, 517.

[24] LH Honoré and KE O'Hara, 'Benign Enlargement of the Labia Minora: Report of Two Cases' (1978) 8 European Journal of Obstetrics and Gynecology and Reproductive Biology 61; Darryl J Hodgkinson and Glen Hait, 'Aesthetic Vaginal Labioplasty' (1984) 74 Plastic and Reconstructive Surgery 414.

[25] Liao, Michala and Creighton (n 23) 22.

independence, drawing on limited data about the (positive) effects of the procedures, and not considering the particular needs and characteristics of patients when reporting high satisfaction outcomes.[26] The Royal College of Obstetricians and Gynaecologists (RCOG) acknowledged this problem in 2013, criticising the 'lack of high-quality literature on this subject',[27] and warning that 'there is a definite need for more data to inform women about short- and long-term outcomes to allow true informed consent for these procedures'.[28]

In addition to the lack of available data, there is also concern about poor consent practices. The Keogh Report stressed that cosmetic surgeons should pay special attention to communicating the risks involved, making sure that patients understand what is at stake, especially because those seeking this sort of procedures 'have a natural tendency to focus on outcome … and may not pay enough attention to limitations and risks':[29]

> patients should be aware of the implications of surgery, the limitations of the procedure and the potential complications. When the risks of surgery are discussed patients should be alerted to the risks of medical complications and also the possibility of an unsatisfactory aesthetic outcome'.[30]

In other words, cosmetic surgery providers should take off their 'business' hat, 'acting first and foremost in the best interests of their users/patients, and not taking the role of a salesperson'.[31] The Nuffield Council on Bioethics stresses that they should be 'prepared to

[26] ibid; Virginia Braun, 'Female Genital Cosmetic Surgery: A Critical Review of Current Knowledge and Contemporary Debates' (2010) 19 Journal of Women's Health 1393, 1398.
[27] Royal College of Obstetricians and Gynaecologists, 'Ethical Opinion Paper: Ethical Considerations in Relation to Female Genital Cosmetic Surgery (FGCS)' (2013) 3.
[28] ibid 4.
[29] Keogh (n 12) paras 5.5-5.6.
[30] ibid para 5.19.
[31] Nuffield Council on Bioethics (n 3) xxv.

say "no"' when approached by patients',[32] 'ensur[e] that potential users have access to the information and support they need to make a decision that is right for them',[33] and avoid dubious advertising practices such as 'time-limited deals, financial inducements or "buy one get one free" deals'.[34] The newly issued GMC guidance for cosmetic surgeons highlights the importance of managing expectations from patients,[35] discussing side effects and complications with them,[36] allowing enough time for reflection,[37] and being transparent about fees and charges.[38] When setting their professional standards, the RCS stressed that consent is a 'process' and 'not merely the signing of a form', which requires not only adequately informing and being transparent about the risks and outcomes of surgery, but also allowing for a 'cooling-off period of at least two weeks' so patients can reflect on their decision.[39]

Moreover, the Committee of Advertising Practice and the Advertising Standards Authority monitor the marketing of cosmetic interventions,[40] providing guidance on how these should be advertised in a socially responsible manner.[41] For example, adverts should not mislead or trivialise the complexity, invasiveness or pain involved in the procedure, imply unrealistic changes or play on consumers' insecurities.[42] The NHS, RCS and GMC

[32] ibid.
[33] ibid xxvi.
[34] Keogh (n 12) para 6.10.
[35] General Medical Council (n 14) paras 17–19.
[36] ibid paras 22–23.
[37] ibid paras 24–26.
[38] ibid paras 28–29.
[39] Royal College of Surgeons, 'Professional Standards for Cosmetic Surgery' (n 14) para 11.
[40] Committee of Advertising, 'Cosmetic Interventions. Advertising Guidance' (2016).
[41] Committee of Advertising, 'Cosmetic Surgery' <https://www.asa.org.uk/advice-online/cosmetic-surgery.html> accessed 8 February 2021; Whether advertising cosmetic surgery should be allowed has been object of debate, see eg Fazel Fatah, 'Should All Advertising of Cosmetic Surgery Be Banned? Yes' (2012) 345 British Medical Journal 1.
[42] Committee of Advertising (n 40) 14–34.

websites offer advice to patients on how to choose a surgeon that will respect their right to make an informed decision.[43] They warn about scam and dangerous surgeries, offering a list of questions patients should ask, about the experience, qualifications and membership of professional associations of the surgeon, the price and possible complications of the surgery; along with 'red flags' to avoid, like clinics that are only advertised on social media or those who offer group discounts or vouchers.

1.3 Wanting the perfect vagina

There is a vast amount of empirical research investigating why women seek to cosmetically alter their vulvas.[44] Whilst there is no consensus on what their main motivation is, the literature presents three main hypotheses on why women are driven to vulval cosmetic surgery: (i) physical discomfort (eg felt whilst exercising, having intercourse or wearing tight clothes), (ii) appearance concerns and (iii) sexual dissatisfaction.[45] The line between these motivations is difficult to draw and sustain, since in many cases insecurities about appearance might impact sexual satisfaction, and physical discomfort might also arise from excessive fixations with a (perceived) abnormality of one's genitalia.[46] Whilst some

[43] NHS, 'Cosmetic Procedures - Choosing Who Will Do Your Cosmetic Procedure' <https://www.nhs.uk/conditions/cosmetic-procedures/choosing-who-will-do-your-procedure/> accessed 3 January 2021; 'Choosing a Surgeon and Hospital — Royal College of Surgeons' <https://www.rcseng.ac.uk/patient-care/cosmetic-surgery/choosing-a-surgeon-and-hospital/> accessed 3 January 2021; General Medical Council, 'Cosmetic Procedures: What Do I Need to Consider?' (2016).

[44] David Veale and others, 'Psychosexual Outcome after Labiaplasty: A Prospective Case-Comparison Study' (2014) 25 International Urogynecology Journal and Pelvic Floor Dysfunction 831; D Veale and others, 'Psychological Characteristics and Motivation of Women Seeking Labiaplasty' (2013) 44 Psychological Medicine 555; Michael P Goodman and others, 'A Large Multicenter Outcome Study of Female Genital Plastic Surgery' (2010) 7 Journal of Sexual Medicine 1565; John R Miklos and Robert D Moore, 'Labiaplasty of the Labia Minora: Patients' Indications for Pursuing Surgery' (2008) 5 Journal of Sexual Medicine 1492.

[45] Goodman and others (n 44) 1558; Braun (n 26) 1399; Rebecca Deans and others, 'Why Are Women Referred for Female Genital Cosmetic Surgery?' (2011) 195 Medical Journal of Australia 99.

[46] Braun (n 26) 1338. See Chapter 5 for further discussion on the rationales of vulval cosmetic surgery.

surgeons dismiss the importance of appearance concerns, adopting instead a discourse that sees these procedures as 'empowering', breaking the "last taboo" of sexual health'[47] and allowing women to 'have the best of both worlds; improvement in presenting symptoms as well as an aesthetically pleasing look';[48] many medical professionals and regulatory bodies express preoccupation about cosmetic pressure being the main driver for seeking 'designer vaginas'.[49]

Altering one's genitalia is a decision that does not sit in a vacuum, but is embedded in the wider social world.[50] The idea(l) of the normal vagina of having no labial protrusions, being 'clean', hairless, with a 'petite "stilt like" opening' is pervasive in our culture,[51] being reinforced not only by pornography,[52] but also by films, literature, social media and even medical understandings of 'healthy' genitalia.[53] For example, a study showed that GPs are

[47] Michael P Goodman, 'Philosophy, Rationale, and Patient Selection' in Michael P Goodman (ed), *Female Genital Plastic and Cosmetic Surgery* (Wiley-Blackwell 2016) 35.
[48] David L Matlock and Alex F Simopoulos, 'FOR: Cosmetic Vulvar Surgery Is a Safe and Effective Option for Our Patients' 2014 BJOG Debate: Labiaplasty as a Cosmetic Procedure 767.
[49] Cheryl B Iglesia, 'Cosmetic Gynecology and the Elusive Quest for the Perfect Vagina' (2012) 119 Obstetrics and Gynecology 1083; Lih-Mei Liao and Sarah M Creighton, 'Requests for Cosmetic Genitoplasty: How Should Healthcare Providers Respond?' (2007) 334 British Medical Journal 1090; Lih Mei Liao and Sarah M Creighton, 'Female Genital Cosmetic Surgery: A New Dilemma for GPs' (2011) 61 British Journal of General Practice 7; Barbara and others (n 23) 917; Keogh (n 12) paras 5.10-5.11; Nuffield Council on Bioethics (n 3) chs 1, 2, 6, 7, 8.
[50] Nuffield Council on Bioethics (n 3) ix.
[51] Goodman (n 47) 31.
[52] C Moran and C Lee, 'What's Normal? Influencing Women's Perceptions of Normal Genitalia: An Experiment Involving Exposure to Modified and Nonmodified Images' (2014) 121 BJOG: An International Journal of Obstetrics and Gynaecology 761; Bethany Jones and Camille Nurka, 'Labiaplasty and Pornography: A Preliminary Investigation' (2015) 2 Porn Studies 62.
[53] Virginia Braun and S Wilkinson, 'Socio-Cultural Representations of the Vagina' (2001) 19 Journal of Reproductive and Infant Psychology 17; Julian Lloyd and others, 'Female Genital Appearance: "Normality" Unfolds' (2005) 112 BJOG: An International Journal of Obstetrics and Gynaecology 643; Welmoed Reitsma and others, 'No (Wo)Man Is an Island-the Influence of Physicians' Personal Predisposition to Labia Minora Appearance on Their Clinical Decision Making: A Cross-Sectional Survey' (2011) 8 Journal of Sexual Medicine 2377; Liao and Creighton, 'Female Genital Cosmetic Surgery: A New Dilemma for GPs' (n 49) 8; Hayley Mowat and others, 'The Contribution of Online Content to the Promotion and Normalisation of Female Genital Cosmetic Surgery: A Systematic Review of the Literature' (2015) 15 BMC Women's Health 1.

more likely to refer for surgery, and plastic surgeons are more likely to operate on, genitalia whose appearance does not conform to societal expectations of a 'normal' vulva.[54] This is why the Nuffield Council on Bioethics calls for an ambitious macro-approach to 'change public attitudes' about 'unrealistic and sometimes discriminatory appearance ideals',[55] with measures like the prohibition of advertising that 'create[s] body confidence issues'[56] and further research on the role of social media in contributing to 'appearance anxiety'.[57]

At the micro-level of the doctor-patient relationship, the literature insists on the role of both GPs and specialised surgeons to make women aware of the many ways a 'normal' vulva can look, reassuring them that theirs has an appropriate appearance and does not need a surgical fix.[58] The RCOG recommends training medical practitioners on 'genital variation' so they can provide women with 'accurate information about the normal variations in female genitalia'.[59] This recommendation is echoed by the GMC,[60] the RCS[61] and the British Association of Plastic Reconstructive and Aesthetic Surgeons, who call for the need to acknowledge the cultural and social context in which women make the decision to alter their genitalia:

> The reasons women choose this type of surgery are complex and it is critical to unpick these before any procedure is performed to ensure that informed choice is made … Female genital surgery is often trivialised and there is a certain amount of subtle coercion in the media to suggest this surgery may

[54] Reitsma and others (n 53).
[55] Nuffield Council on Bioethics (n 3) para 8.6.
[56] ibid para 8.13.
[57] ibid para 8.16.
[58] Michala, Liao and Creighton (n 23); Liao and Creighton, 'Requests for Cosmetic Genitoplasty: How Should Healthcare Providers Respond?' (n 49) 1091; Liao and Creighton, 'Female Genital Cosmetic Surgery: A New Dilemma for GPs' (n 49) 8; Moran and Lee (n 52) 705; Nuffield Council on Bioethics (n 3) para 7.46.
[59] Royal College of Obstetricians and Gynaecologists, 'Ethical Opinion Paper: Ethical Considerations in Relation to Female Genital Cosmetic Surgery (FGCS)' (n 27) 7.
[60] General Medical Council (n 14) paras 17–19.
[61] Royal College of Surgeons, 'Professional Standards for Cosmetic Surgery' (n 14) 9.

> be desirable for women. We can't deny that there is an element within the wider cosmetic surgery industry that may be seeking to benefit from women's apprehensions in this area.[62]

Such need for educating and 'relieving' women from cosmetic pressure is a matter of special concern when it comes to underage girls seeking vulval cosmetic surgery.[63] The RCOG and the British Society for Paediatric and Adolescent Gynaecology (BritSPAG) suggest that these interventions should not be performed before patients are at least 18 years old because of the potential negative consequences of early surgery.[64] Not only is full genital development usually not completed before the age of 18,[65] but surgical interventions 'do not tackle the cultural and economic factors that are giving rise to vulval appearance distress'.[66] Instead, the BritPSAG insists that clinicians should 'improve their skills and confidence in educating and supporting girls'.[67]

1.4 Being obsessed with the (im)perfect vagina

The medical literature seems relatively settled on the fact that at least a small percentage of those who seek vulval cosmetic surgery tick the diagnostic boxes of Body Dysmorphic

[62] British Association of Plastic Reconstructive and Aesthetic Surgeons, 'BAPRAS Responds to Research Published on Female Genital Cosmetic Surgery' <https://www.bapras.org.uk/media-government/news-and-views/view/bapras-responds-to-research-published-on-female-genital-cosmetic-surgery> accessed 8 February 2021.
[63] Paul L Wood, 'Cosmetic Genital Surgery in Children and Adolescents' (2018) 48 Best Practice and Research: Clinical Obstetrics and Gynaecology 137, 138.
[64] Royal College of Obstetricians and Gynaecologists, 'Ethical Opinion Paper: Ethical Considerations in Relation to Female Genital Cosmetic Surgery (FGCS)' (n 27) 8; British Society for Paediatric & Adolescent Gynaecology, 'Labial Reduction Surgery (Labiaplasty) on Adolescents' 9, 8.
[65] Royal College of Obstetricians and Gynaecologists, 'Ethical Opinion Paper: Ethical Considerations in Relation to Female Genital Cosmetic Surgery (FGCS)' (n 27) 8.
[66] British Society for Paediatric & Adolescent Gynaecology (n 64) 6.
[67] ibid 2; in 2018, the British Society for Paediatric and Adolescent Gynaecology issued a booklet to familiarise children and teenagers with vulvar anatomy: British Society for Paediatric and Adolescent, 'So What Is a Vulva Anyway?' (2018).

Disorder (BDD).[68] In accordance with the 11th Revision of the International Classification of Diseases (ICD-11), the international standard for psychiatric disorders elaborated by the World Health Organization (WHO), BDD is an obsessive-compulsive disorder 'characterised by persistent preoccupation with one or more perceived defects or flaws in appearance that are either unnoticeable or only slightly noticeable to others'.[69] Such preoccupations are 'persistent' and lead to 'repetitive and excessive behaviours', like repeated self-examination or numerous 'attempts to camouflage or alter the perceived defect', including 'specific forms of dress or undergoing ill-advised cosmetic surgical procedures'.[70]

The medical literature expresses concerns about patients seeking cosmetic interventions as a 'surgical' fix for BDD and other anxieties or life problems, such as fear of isolation or the thought that surgery will save a relationship,[71] as well as about the negative impact cosmetic surgery might have on the individual's mental health when the (unrealistic) expected outcomes are not achieved.[72] Surgery is usually counter-indicated for those with a diagnosis of BDD or other mental health problems.[73] The preferred treatment option for individuals with BDD, according to NICE, is cognitive behavioural

[68] S Higgins and A Wysong, 'Cosmetic Surgery and Body Dysmorphic Disorder - An Update' (2018) 4 International Journal of Women's Dermatology 43, 44; Veale and others, 'Psychological Characteristics and Motivation of Women Seeking Labiaplasty' (n 44) 561; Barbara and others (n 23) 517; Giussy Barbara and others, '"The First Cut Is the Deepest": A Psychological, Sexological and Gynecological Perspective on Female Genital Cosmetic Surgery' (2015) 94 Acta Obstetricia et Gynecologica Scandinavica 915, 916.
[69] World Health Organization, 'International Classification of Diseases, Eleventh Revision (ICD-11)' <https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/731724655> accessed 25 October 2022.
[70] ibid.
[71] Roberta J Honigman, Katharine A Phillips and David J Castle, 'A Review of Psychosocial Outcomes for Patients Seeking Cosmetic Surgery' (2004) 113 Plastic and Reconstructive Surgery 1229, 7.
[72] Ginny Brunton and others, 'Psychosocial Predictors, Assessment, and Outcomes of Cosmetic Procedures: A Systematic Rapid Evidence Assessment' (2014) 38 Aesthetic Plastic Surgery 1030, 1034.
[73] Laura Bowyer and others, 'A Critical Review of Cosmetic Treatment Outcomes in Body Dysmorphic Disorder' (2016) 19 Body Image 1; Higgins and Wysong (n 68).

treatment.[74] Depending on the source of the anxious or body-distorted thoughts, other courses of psychological treatment, such as behaviour therapy, mindfulness-based therapy or sex therapy might be indicated as well.[75]

Chapter 4 discusses mental well-being in detail. For now, it suffices to say that medical guidance urges cosmetic surgeons to pay special attention to the 'vulnerabilities and psychological needs' of patients who seek their help in order to ensure that their request is 'voluntary',[76] rather than a 'symptom' of an underlying mental disorder or displaced anxiety,[77] and that the surgical intervention 'will be of benefit' to them.[78] The RCS recommends the referral of patients who raise mental health concerns to mental health experts, and 'avoid[ing] or deferr[ing] the operation' for those who have unrealistic expectations, a history of 'repeated cosmetic procedures' and 'psychological disturbances'.[79] The RCOG goes further, recommending that 'the offer of counselling should be part of the process of obtaining informed consent'.[80]

[74] National Institute for Health and Care Excellence, 'Obsessive-Compulsive Disorder and Body Dysmorphic Disorder: Treatment' (2005) para 1.5.
[75] Lori A Brotto, Maggie Bryce and Nicole Todd, 'Female Genital Cosmetic Surgery: Psychological Aspects and Approaches' in Sarah M Creighton and Lih-Mei Liao (eds), *Female Genital Cosmetic Surgery: Solution to What Problem?* (Cambridge University Press 2019) 123.
[76] General Medical Council (n 14) para 19.
[77] Andrew T Goldstein and Sarah L Jutrzonka, 'Ethical Considerations of Female Genital Plastic/Cosmetic Surgery' in Michael P Goodman (ed), *Female Genital Plastic and Cosmetic Surgery* (Wiley-Blackwell 2016) 40; Barbara and others (n 23) 914.
[78] General Medical Council (n 14) paras 18–19.
[79] Royal College of Surgeons, 'Cosmetic Surgery Certification' (n 17) 9.
[80] Royal College of Obstetricians and Gynaecologists, 'Ethical Opinion Paper: Ethical Considerations in Relation to Female Genital Cosmetic Surgery (FGCS)' (n 27) 7.

2 Intersex surgery

2.1 Being born in the medical gaze

If the 'patient-led' doctor-patient encounter is the starting point for studying how the medical world frames the decision to undergo vulval cosmetic surgery, birth is often the defining moment with regards to intersex surgery.[81] Birth is usually now a medicalised event, with most children being born in hospital and therefore falling under medical scrutiny as soon as they arrive in the world.[82] It is at this moment, with the first sight of the baby, that the first signs of intersex embodiment are usually spotted.[83] 'Unexpected' anatomical features, like an enlarged clitoris, a micropenis or hypospadias, puzzle both parents and medical professionals, who do not know whether to classify the new born as a 'boy' or a 'girl'.[84] This initial moment of confusion sets in motion a whole set of 'expert evaluations' to carry out an 'expedited and thorough assessment' of the baby so that it can be assigned a gender sooner rather than later.[85] This 'diagnostic evaluation' consists in a

[81] Some cases of intersexuality may also be detected prenatally. For further disussion, see Lyn S Chitty and others, 'Prenatal Management of Disorders of Sex Development' (2012) 8 Journal of Pediatric Urology 576; Robert Sparrow, 'Gender Eugenics? The Ethics of PGD for Intersex Conditions' (2013) 13 American Journal of Bioethics 29.

[82] Richard Johanson, Mary Newborn and Alison Macfarlane, 'Has Medicalisation of Childbirth Gone Too Far?' (2002) 324 British Medical Journal 892, 894.

[83] Most cases are diagnosed at birth, although it might also happen antenatally or as late as adolescence. See eg Elena Bennecke and others, 'Subjective Need for Psychological Support (PsySupp) in Parents of Children and Adolescents with Disorders of Sex Development (Dsd)' (2015) 174 European Journal of Pediatrics 1287; Peter A Lee and Christopher P Houk, 'Disorders of Sexual Differentiation in the Adolescent' (2008) 1135 Annals of the New York Academy of Sciences 67.

[84] Katrina Karzakis, *Fixing Sex. Intersex, Medical Authority and Lived Experience* (Duke University Press 2008) 183–184.

[85] IA Hughes and others, 'Consensus Statement on Management of Intersex Disorders' (2006) 91 Archives of Diseases of Childhood 554, 556; Peter A Lee and others, 'Global Disorders of Sex Development Update since 2006: Perceptions, Approach and Care' (2016) 85 Hormone Research in Paediatrics 158, 164–167; S Faisal Ahmed and others, 'Society for Endocrinology UK Guidance on the Initial Evaluation of an Infant or an Adolescent with a Suspected Disorder of Sex Development' (2016) 84 Clinical Endocrinology 771, 5; British Society for Paediatric Endocrinology and Diabetis, 'Clinical Standards And Principals Of

battery of tests and examinations, including a meticulous observation of the genital area,[86] a biochemical evaluation of hormone levels,[87] and a genetic search to identify potential mutations and phenotype variations[88] that might explain the genital anomalies and guide doctors and parents in deciding about gender assignment.[89] A 'multidisciplinary team' of paediatricians, endocrinologists, psychologists, gynaecologists, and neonatologists will assist the family in this process,[90] balancing, together with diagnostic information, aspects like 'surgical options, need for life long replacement therapy, the potential for fertility, views of the family, and sometimes the circumstances relating to cultural practices' to make a choice about the baby's gender.[91]

'All individuals should receive gender assignment', and no gender evaluation should be made before such expert and multidisciplinary evaluation.[92] Leaving behind genital morphology as the sole indicator for gender assignment, as Chapter 1 shows, post-2006 medical practice is based on a holistic assessment with the aim of determining which gender identity will lead to the best quality of life for the child. This cannot be reduced to having 'normal looking' genitalia, as Money's protocols, discussed in Chapter 1, intended, but it encompasses other aspects such as 'falling in love, dating, attraction, ability to

Management for DSD Clinical Standards for Management of an Infant or Adolescent Presenting with a Suspected Disorder of Sex Development (DSD)' (2017).

[86] Lee and others (n 85) 164.

[87] ibid 166.

[88] ibid.

[89] For a detailed accounnt of how these examinations take place, see Olaf Hiort and others, 'Management of Disorders of Sex Development' (2014) 10 Nature Reviews Endocrinology 520, 522–524.

[90] Hughes and others (n 85) 556.

[91] ibid; for a detailed account of how a multidisciplinary team of this sort works in practice see Caroline E Brain and others, 'Holistic Management of DSD' (2010) 24 Best Practice and Research: Clinical Endocrinology and Metabolism 335.

[92] Hughes and others (n 85) 554.

develop intimate relationships, sexual functioning, and the opportunity to marry and to raise children'.[93]

Such medical scrutiny and the gender assignment process happens whilst parents are usually still in an initial state of shock and disorientation. Many of them report not knowing about intersexuality before the birth of their child,[94] and recall this event as a 'profoundly alienating clinical experience'.[95] Acknowledging how stressful this situation might be for them, current medical guidance rejects secrecy and dubious diagnostic explanations that were the norm in the Money era, considering transparency, communication and psychological support the core aspects of the clinical management of intersex conditions.[96] Families should be offered early psychological input to help process all the new information, act as liaison with other members of the clinical multidisciplinary team, and manage their expectations and questions regarding the sexual development of their child.[97] Peer support groups should also be made available so parents feel less isolated and can talk to families who are or have been in a similar situation.[98] The relationship with

[93] ibid 558.
[94] Halley P Crissman and others, 'Children with Disorders of Sex Development: A Qualitative Study of Early Parental Experience' (2011) 10 International Journal of Pediatric Endocrinology 8.
[95] Karzakis (n 84) 184.
[96] Hughes and others (n 85) 557; Lee and others (n 85) 160; Brain and others (n 91) 339.
[97] Ahmed and others (n 85) 3, 4; British Society for Paediatric Endocrinology and Diabetis (n 85) 4; Brain and others (n 91) 342.
[98] Lee and others (n 85) 160; Ahmed and others (n 85); British Society for Paediatric Endocrinology and Diabetis (n 85) 4.

the multidisciplinary team should rest on trust and transparency, building an open, supportive and patient-centred approach.[99]

2.2 Parental consent and best interests

Once the baby is assigned a gender, the dilemma that opens up is whether and how to treat them. Given the extremely young age of the child (a new-born), these medical decisions will be taken by parents with the assistance of the multidisciplinary team. Whilst there is consensus among the medical community that hormonal and surgical treatments that are life-saving or critical for the health of the child (eg cortisol to prevent an adrenal crisis in some cases of Congenital Adrenal Hyperplasia (CAH) or the reparation of a blocked urinary tract) should not be delayed,[100] interventions that are primarily aimed at 'fixing' the appearance of the baby's genitalia are more controversial.[101]

Money's protocols, as Chapter 1 discussed, insisted on early intervention (18 months after birth at the latest) to allow for a non-confused and clear upbringing of the baby as a boy or a girl, but new medical guidelines are more nuanced. There is a general concern about the lack of evidence regarding the positive or negative effects of early surgical treatment.[102] As Chapter 5 explores, surgical approaches and techniques have been

[99] Lee and others (n 85) 170.
[100] Hughes and others (n 85) 557; Hiort and others (n 89) 525.
[101] Lee and others (n 85) 173; Hiort and others (n 89) 525.
[102] Milton Diamond and Keith Sigmundson, 'Sex Reassignment at Birth' (1997) 151 Archives of Pediatrics & Adolescent Medicine 298, 303; Sarah M Creighton and others, 'Childhood Surgery for Ambiguous Genitalia: Glimpses of Practice Changes or More of the Same?' (2014) 5 Psychology and Sexuality 34, 41; Lee and others (n 85) 176; Pierre DE Mouriquand and others, 'Surgery in Disorders of Sex Development (DSD) with a Gender Issue: If (Why), When, and How?' (2016) 12 Journal of Pediatric Urology 139, 146; Lih-Mei Liao and others, 'Clitoral Surgery on Minors: An Interview Study with Clinical Experts of Differences of Sex Development' (2019) 9 BMJ Open 25821, 2.

constantly changing since Money introduced his protocols in the 1960s: clitoridectomy is no longer deemed an acceptable routine practice, and clitoral and vaginal procedures are now usually performed together, rather than in two stages, which has reported better results in preventing vaginal stenosis and urethral incontinence.[103] It is thus difficult to compare surgical outcomes and obtain 'standardised' long-term data about positive or negative results when the surgical approach has not remained consistent.[104]

Lack of robust data notwithstanding, the 2006 Chicago Consensus statement did not clearly rule out surgery, emphasising 'functional outcome rather than strictly cosmetic appearance' and circumscribing it only to 'cases of severe virilisation'.[105] This is likely to be the case for girls with CAH, who have XX chromosomes and ovaries, but whose external genitalia might present different degrees of 'virilisation', ranging from 'an enlarged clitoris' to a 'penile urethra' and including features like labial fusion. In cases where severe 'virilisation' is persistent after several months of hormonal treatment, it is common for parents to opt for 'feminising' surgery, after having extensively discussed its risks, benefits, long-term care and potential follow-up surgeries with the multidisciplinary clinical team.[106] This surgery can involve several interventions on the clitoris (clitoral reduction, clitoroplasty, reconstruction of clitoral hood) and the vagina (construction of a vaginal cavity, dilatation of the vaginal cupule, reconstruction of labia, separation of the

[103] Maria F Roll and others, 'Feminising Genitoplasty: One-Stage Genital Reconstruction in Congenital Adrenal Hyperplasia: 30 Years' Experience' (2006) 16 European Journal of Pediatric Surgery 329, 332.
[104] Naomi S Crouch and others, 'Sexual Function and Genital Sensitivity Following Feminizing Genitoplasty for Congenital Adrenal Hyperplasia' (2008) 179 Journal of Urology 634, 637.
[105] Hughes and others (n 85) 557.
[106] Creighton and others (n 102) 39; Katja P Wolffenbuttel and Naomi S Crouch, 'Timing of Feminising Surgery in Disorders of Sex Development' (2014) 27 Endocr Dev 210, 217; Francisca Yankovic and others, 'Current Practice in Feminizing Surgery for Congenital Adrenal Hyperplasia; A Specialist Survey' (2013) 9 Journal of Pediatric Urology 1103, 1106; Brain and others (n 91) 341.

vagina from the urethra), depending on the degree of 'virilisation' that is to be 'feminised'.[107]

Chapter 5 looks in depth at the rationales for performing intersex surgeries and doing so early on. As a summary, some of the reasons offered for performing these interventions early (between 2 and 6 months of age) are that the quality of genital tissue is better, healing is faster, the experience is less traumatic for parents and children, who will not remember the surgery and will grow up with a 'consistent' anatomy with their assigned gender, which will potentially prevent difficulties with body image and bullying.[108] However, there are also opponents of early surgery within the medical community, who argue it has detrimental effects on sexual function, as it usually entails loss of sensitivity of the clitoris.[109] These surgeries also require check-ups and sometimes follow-up procedures during childhood and early adolescence, which have been reported to be traumatising for and experienced as shameful by patients,[110] and are not the 'quick fix' and 'one time' solution they might seem to be.[111] 'Virilisation' might decrease as the child grows older or the child might develop a gender identity 'consistent' with another anatomy;

[107] Isabelle Vidal and others, 'Surgical Options in Disorders of Sex Development (DSD) with Ambiguous Genitalia' (2010) 24 Best Practice and Research: Clinical Endocrinology and Metabolism 311, 314; Lee and others (n 85) 174; Creighton and others (n 102) 40.
[108] Yankovic and others (n 106) 1106; Vidal and others (n 107) 311; Creighton and others (n 102) 40; A Binet and others, 'Should We Question Early Feminizing Genitoplasty for Patients with Congenital Adrenal Hyperplasia and XX Karyotype?' (2016) 51 Journal of Pediatric Surgery 465.
[109] Sarah Creighton and Catherine Minto, 'Managing Intersex: Most Vaginal Surgery in Childhood Should Be Deferred' (2001) 323 BMJ 1264, 1265; Crouch and others (n 104); Catherine L Minto and others, 'The Effect of Clitoral Surgery on Sexual Outcome in Individuals Who Have Intersex Conditions with Ambiguous Genitalia: A Cross-Sectional Study' (2003) 361 Lancet 1252, 1256.
[110] Katrina Roen, 'Intersex or Diverse Sex Development: Critical Review of Psychosocial Health Care Research and Indications for Practice' (2019) 56 Journal of Sex Research 511.
[111] Nina Callens and others, 'Long-Term Psychosexual and Anatomical Outcome after Vaginal Dilation or Vaginoplasty: A Comparative Study' (2012) 9 Journal of Sexual Medicine 1842, 8.

so a conservative approach that prevents irreversible effects is considered by some to be a better alternative.[112]

All in all, surgical management and timing of intersex conditions remains controversial and further evidence is needed, but what post-2006 medical practice seems to be settled on is the importance of a supportive and trust-based relationship between the multidisciplinary clinical team and parents so the latter can make the decision as to their child's best interests. Even opponents of surgery within the medical profession admit that 'it is important to adopt a respectful and non-blaming stance' with regards to parental decisions in such 'uniquely difficult circumstances', as parents decide what they think is best for their child.[113]

2.3 Future autonomy and bodily integrity

Besides a lack of clear scientific consensus with regards to (positive or negative) outcomes of surgery, there has been an increasing awareness in the medical world of how early surgery might deprive children from making (future) decisions about their own bodies. As we saw in Chapter 1, intersex activism, through organisations like the Intersex Society of North America (ISNA), pioneered the fight against Money's secrecy and rapid surgical intervention, contesting the idea that intersexuality is a 'psychosocial emergency' that must 'fixed' as soon as possible in order to ensure a 'healthy' upbringing.[114] These claims had

[112] David A Diamond and others, 'Management of Pediatric Patients with DSD and Ambiguous Genitalia: Balancing the Child's Moral Claims to Self-Determination with Parental Values and Preferences' (2018) 14 Journal of Pediatric Urology 416.e1, 416.e5.
[113] Creighton and others (n 102) 41; Diamond and others (n 112) 416.e5.
[114] Cheryl Chase, 'Hermaphrodites with Attitude: Mapping the Emergence of Intersex Political Activism' (1998) 4 GLQ: A Journal of Lesbian and Gay Studies 191; See also Consortium on the Management of

an impact on some members of the medical community, who admitted that 'infants and young children are powerless to oppose any procedures, so genital surgery for them is not just a medical issue but also a moral one,'[115] and started to be consolidated in the 2006 Chicago Consensus statement. It discouraged surgery except for cases of severe 'virilisation' and considered open communication and transparency with the child and parents an essential element of medical care. Ten years later, the 2016 update acknowledged the importance of 'uphold[ing] the individual's rights to participate in decisions that will affect them now or later; leaving options open for the future by avoiding irreversible treatments that are not medically necessary until the individual has the capacity to consent'.[116] It also recognised that early surgery has come 'under intense scrutiny, with a number of agencies condemning or calling for a complete moratorium on elective genital surgery or gonadectomy without the individual's informed consent'.[117]

Indeed, the management of intersex conditions is increasingly regarded as a pressing human rights issue. In 2007, the Yogyakarta Principles recognised the problems of early surgery in intersex medical management, requiring states to:

> take all necessary legislative, administrative and other measures to ensure that no child's body is irreversibly altered by medical procedures in an attempt to impose a gender identity without the full, free and informed consent of the child in accordance with the age and maturity of the child

Disorders of Sex Development and Intersex Society of North America (ISNA), 'Clinical Guidelines for the Management of Disorders of Sex Development in Childhood' (2006).
[115] Minto and others (n 109) 1256.
[116] Lee and others (n 85) 176.
[117] ibid.

> and guided by the principle that in all actions concerning children, the best interests of the child shall be a primary consideration.[118]

The UN Rapporteur for Torture acknowledged in 2016 the 'severe mental suffering' and 'stigmatization' that 'children born with atypical sex characteristics' often suffer as a result of having been subject to 'irreversible sex assignment, involuntary sterilisation and genital normalising surgery' without their consent.[119] According to the UN Human Rights Office of the High Commissioner, intersex people face several human rights abuses, including 'infanticide, forced and coercive medical interventions, discrimination in education, sport, employment and other services and lack of access to justice and remedies'.[120] Likewise, the Council of Europe issued a report in 2015 where it called on member states to 'end medically unnecessary "normalising" treatment of intersex persons when it is enforced or administered without the free and fully informed consent of the person concerned',[121] a stance that was reaffirmed by a speech of the Council of Europe Commissioner of Human Rights in June 2020.[122] The EU Agency for Fundamental Rights has also warned member

[118] International Commission of Jurists, 'Yogyakarta Principles - Principles on the Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity' (2007) Principle 18.
[119] United Nations Human Rights Council, 'Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment A/HR/31/57' (2016) para 50.
[120] UN Human Rights Office of the High Commissioner, 'Intersex People: OHCHR and the Human Rights of LGBTI People' <https://www.ohchr.org/en/sexual-orientation-and-gender-identity/intersex-people> accessed 25 October 2022.
[121] Council of Europe Commissioner for Human Rights, 'Human Rights and Intersex People' (2015) 8.
[122] Council of Europe Commissioner for Human Rights, 'How to Advance the Human Rights of Intersex People: Lessons Learned from Finland' (2020).

states that they 'should avoid "sex-normalising" medical treatments on intersex people without their free and informed consent'.[123]

Malta is the first country to have enacted legislation specifically protecting the bodily integrity and physical autonomy of intersex individuals.[124] In addition to recognising gender self-determination without the need to provide any sort of medical proof,[125] the 2015 Gender Identity, Gender Expression and Sex Characteristics Act prohibits early unnecessary interventions on intersex people.[126] Although it seems to have important loopholes and implementation problems,[127] the Act was initially celebrated for putting children's autonomy at the centre of decision-making, protecting them from irreversible interventions and acknowledging their evolving capacity and rights to be involved in their medical care.[128] Germany, Portugal, Greece and Spain have followed in Malta's footsteps, and have recently passed legislation forbidding surgery on intersex children until they are old enough to consent to these interventions.[129]

The UK has not followed this trend, although the Government did issue a call for evidence in 2019 investigating 'the experiences and needs of people in the UK who have

[123] European Union Agency for Fundamental Rights, 'The Fundamental Rights Situation of Intersex People' (2015) 7; See also Human Rights Watch, 'Medically Unnecessary Surgeries on Intersex Children in the US' (2017) <https://www.hrw.org/report/2017/07/25/i-want-be-nature-made-me/medically-unnecessary-surgeries-intersex-children-us#_ftn49> accessed 12 February 2021; Amnesty International, 'First, Do No Harm. Ensuring the Rights of Children With Variations of Sex Characteristics' (2017).
[124] Tanya Ni Mhuirthile, 'The Legal Status of Intersex Persons in Malta' in Jens M Scherpe, Anatol Dutta and Tobias Helms (eds), *The Legal Status of Intersex Persons* (Intersentia 2019) 360.
[125] Gender Identity, Gender Expression and Sex Characteristics Act 2015 Article 3(4).
[126] ibid Article 14(1); for further discussion on the Act, see Ni Mhuirthile (n 124).
[127] Fae Garland and Mitchell Travis, *Intersex Embodiment: Legal Frameworks beyond Identity and Disorder* (Bristol University Press 2023) 131.
[128] Ni Mhuirthile (n 124) 365–266; Fae Garland and Mitchell Travis, 'Legislating Intersex Equality: Building the Resilience of Intersex People through Law' (2018) 38 Legal Studies 587, 592.
[129] 'Greece Bans "sex-Normalising" Surgeries on Intersex Babies' *Reuters* (2022); 'Portugal Votes to Respect the Rights of Trans and Intersex People' *ILGA Europe* (2018); Cristian González Cabrera, 'Victory in Fight for Gender Recognition in Spain' <https://www.hrw.org/news/2023/02/16/victory-fight-gender-recognition-

variations in sex characteristics.[130] It looked at 'terminology, healthcare and medical intervention, experiences in education, support services, workplace, benefits, sport and leisure services and sex assignment and birth registration'.[131] With regards to medical treatment, the call was particularly interested in whether people have 'undergone medical procedures', what their experiences and perspectives on healthcare services were and how they thought their medical care could be improved.[132] At the time of writing, the responses from the call for evidence have not been made available, and the Government is yet to publish the report on what steps, if any, will be taken.[133]

Current UK medical guidance does not reflect a clear change either. If one reads closely the 2016 and 2021 UK Society of Endocrinology guidance, although there have been some modest changes, the exact implications for the early performance of surgery are unclear. The 2016 guidance explicitly mentions surgery as a form of medical care, and foresees that the multidisciplinary team 'will develop a plan for clinical management with respect to diagnosis, sex assignment and management options',[134] making clear that parents must be 'fully informed of the controversies around undertaking or withholding early genital surgery'.[135]

The 2021 revision omits explicitly talking about surgery. It adopts a less concrete explanation of the treatment plan that the team must discuss with the parents, talking about

spain-0> accessed 11 April 2023; For a comparative perspective, see Part IV in Jens M Scherpe, Anatol Dutta and Tobias Helms (eds), *The Legal Status of Intersex Persons* (Intersentia 2018).
[130] Government Equalities Office, 'Variations in Sex Characteristics. A Call for Evidence' (2019) 10.
[131] ibid.
[132] ibid.
[133] ibid 3.
[134] Ahmed and others (n 85) 2.
[135] ibid 3.

'diagnosis, sex assignment, management choices and psychosocial care',[136] so that 'parents are fully informed and can understand the care plan to which they are asked to consent'.[137] However, the paediatric endocrinologist, who tends to be more inclined to surgical interventions, shaping the parents' views in favour of early surgery,[138] continues to take the leading role in communicating with families,[139] deciding upon the 'timely involvement of other members of the team'.[140] Therefore, even though UK guidelines do not mention (early) surgery as a treatment option, they do not adopt a clear stance on deferring it either, keeping the endocrinologist at the centre of the model of care.[141]

This ambivalence has been the object of criticism by lawyers and ethicists. Several ethicists have argued that surgery should be delayed until the child is old enough to understand and decide whether they want to go ahead with it.[142] As Brian D Earp puts it: '[c]hildren of whatever gender should not have healthy parts of their most intimate sexual

[136] S Faisal Ahmed and others, 'Society for Endocrinology UK Guidance on the Initial Evaluation of a Suspected Difference or Disorder of Sex Development' (2021) 95 Clinical Endocrinology 818, 5.
[137] ibid 6.
[138] Jürg C Streuli and others, 'Shaping Parents: Impact of Contrasting Professional Counseling on Parents' Decision Making for Children with Disorders of Sex Development' (2013) 10 Journal of Sexual Medicine 1953, 5.
[139] Ahmed and others (n 85) 2; Ahmed and others (n 136) 5.
[140] Ahmed and others (n 136) 5.
[141] Fae Garland and others, 'Management of "Disorders of Sex Development"/Intersex Variations in Children: Results from a Freedom of Information Exercise' (2021) 21 Medical Law International 116, 136.
[142] Karzakis (n 84) 161; Brian D Earp, 'In Defense of Genital Autonomy for Children' (2016) 42 Journal of Medical Ethics; J Steven Svoboda, 'Promoting Genital Autonomy by Exploring Commonalities between Male, Female, Intersex, and Cosmetic Female Genital Cutting' (2013) 3 Global Discourse 237.

organs removed, before such a time where they can understand what is at stake in such a surgery and agree to it themselves.'[143]

Following similar reasoning, some legal commentators have been critical of the English proxy decision-making regime whereby parents can consent to medical treatment on behalf of their infant children.[144] In most cases, if medical professionals and those with parental responsibility agree on a specific treatment, the child will undergo the course of treatment without the need for court involvement. Some exceptions, where the treatment is deemed controversial, like sterilisation to prevent pregnancy,[145] will require court approval. Melanie Newbould argues GMC and NICE should issue specific and clear guidelines with regards to the treatment of children with intersex traits, as well as suggesting that judicial guidance might also be helpful, since currently there is no legal test case on the 'precise requirements for the consent procedure' of surgeries involving intersex children.[146]

Other scholars believe that more significant change is needed in order to adequately protect the rights of intersex individuals. For example, they propose statutory reform to acknowledge a 'third unassigned sex', which it is argued would help to discourage early surgery, as it would provide a legal 'standby' to at least delay assigning gender and upholding male or female gendered characteristics on intersex children.[147] Germany moved

[143] Earp (n 142) 162.
[144] Melanie Newbould, 'When Parents Choose Gender: Intersex, Children, and the Law' (2016) 24 Medical Law Review 474; Edmund M Horowicz, 'Intersex Children: Who Are We Really Treating?' (2017) 17 Medical Law International 183.
[145] *Re B (A Minor) (Wardship: Sterilisation)* [1988] AC 199.
[146] Newbould (n 144) 494.
[147] Horowicz (n 144) 218.

in that direction in 2013, amending its legislation to allow the register of births without having to specify the baby's gender in cases where 'the child can be assigned to neither the female nor the male sex'.[148] Although this change was introduced to protect intersex patients from early surgeries, it seems to have had the opposite effect, since parents seem to be (more) prone to surgery in order to prevent their child from being assigned a 'third' legal gender category.[149]

3 Female Genital Mutilation

3.1 A forbidden practice

In contrast with the other two interventions studied in this chapter, FGM is not lawful, with Chapter 1 having traced the history of the current international crusade in place against this practice. According to the World Health Organization (WHO), FGM 'comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons'.[150] The WHO recognises four types of FGM:

> Type I: partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
> Type II: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).
> Type III: narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
> Type IV: all other harmful procedures to the female genitalia for non-

[148] Garland and Travis (n 127) 68.
[149] ibid.
[150] World Health Organization, 'Eliminating Female Genital Mutilation. An Interagency Statement' (2008) 4.

> medical purposes, for example: pricking, piercing, incising, scraping and cauterization.[151]

The Crown Prosecution Service (CPS) notes that the WHO classification 'has not been adopted or incorporated into domestic legislation so as to define FGM for the purpose of any offence', although 'prosecutors should be aware of the WHO classifications because they may be used or referred to in FGM resources, or by investigators or experts'.[152]

FGM has been explicitly considered a criminal offence in the UK since 1985, when the Prohibition of Female Circumcision Act was passed. Prior to this piece of legislation, there was no specific criminalisation of FGM, although the cutting and mutilation of a vulva could have been prosecuted under Section 47 (assault occasioning actual bodily harm), 20 (wounding or grievous bodily harm) or 18 (wounding or grievous bodily harm with intent to cause grievous bodily harm) of the Offences Against the Person Act (OAPA).[153] With the campaigning of FORWARD, a charity devoted to FGM advocacy work based in the UK and founded in 1981, Parliament decided to explicitly criminalise the practice. To put it in the words of Baroness Trumpington, the goal of the 1985 Act was 'to make the law crystal clear', leaving no doubt that England would not tolerate this 'horrific custom' which would appal 'most people in Britain when they realized it was practiced here'.[154] Indeed, as Charlotte Proudman suggests, Parliamentary interventions like this one reflect a narrative of us versus them, nurturing assumptions of migrant

[151] ibid.
[152] Crown Prosecution Service, 'Female Genital Mutilation Prosecution Guidance' (2019).
[153] Ruth Gaffney-Rhys, 'From the Offences Against the Person Act 1861 to the Serious Crime Act 2015 - the Development of the Law Relating to Female Genital Mutilation in England and Wales' (2017) 39 Journal of Social Welfare and Family Law 417, 420.
[154] Prohibition of Female Circumcision Bill HL Deb vol 465 col 213 (18 June 1985).

communities engaging in 'primitive and ignorant cruelties' as opposed to Britain, where this abhorrent act will not be tolerated.[155]

In the early 2000s, FORWARD carried on with their lobbying efforts, seeking to close some loopholes of the 1985 Act by pushing to criminalise the act of taking a girl abroad to undergo FGM.[156] The Female Genital Mutilation 2003 (FGM Act 2003) was introduced as a Private Members Bill by Ann Clwyd and replaced the 1985 Act.[157] According to Section 1(1) of the FGM Act 2003, 'a person is guilty of an offence if he excises, infibulates or otherwise mutilates the whole or any part of a girl's labia majora, minora or clitoris'. The act of 'assisting a girl to mutilate her own genitalia' is also a criminal offence,[158] and so is 'aid[ing], abet[ing], counsel[ling] or procur[ing] a person who is not a UK national or UK resident to do a relevant act of female genital mutilation outside the UK'.[159] Section 3A also criminalises those who are responsible for (ie have parental responsibility or have assumed 'responsibility for caring for the girl in the manner of parent'[160]) but fail to protect a girl under the age of 16 of FGM.[161]

The FGMA 2003 therefore comprises four offences: mutilating a girl's genitalia, assisting a girl to mutilate her genitalia, assisting a non-UK person to mutilate overseas a girl's genitalia, and failing to protect a girl under the age of 16 from having her genitalia

[155] Charlotte Proudman, *Female Genital Mutilation. When Culture and Law Clash* (Oxford University Press 2022) 63.
[156] FORWARD, 'Our Herstory, 35+ Years On' <https://www.forwarduk.org.uk/about-us/our-herstory/> accessed 15 March 2023.
[157] In Scotland, the 1985 Act was replaced by the Prohibition of Female Genital Mutilation (Scotland) Act 2005.
[158] Female Genital Mutilation Act 2003 s 2.
[159] ibid s 3(1).
[160] ibid s 3A(4).
[161] ibid s 3A(1).

mutilated. It also has extra-territorial effect, extending to FGM offences committed outside of the UK 'by or against those who at the time are habitually resident in the UK'.[162] As explored in later chapters, no offence will have been committed if the intervention is 'necessary for [the girl's] physical or mental health'[163] *and* is performed by a registered medical practitioner,[164] or is performed 'for purposes connected with labour or birth' during or just after giving birth by a registered medical practitioner or a (soon to be) midwife.[165]

Intense campaigns have accompanied these criminal provisions. The Home Office and Border Control started Operation Limelight in 2014, 'a proactive airside operation looking at inbound and outbound flights to countries of prevalence for FGM' at Heathrow and six other airports in the UK.[166] Its aim is to provide 'safeguarding' and 'raise awareness of harmful practices', 'identify[ing] those at risk and to help prevent these practices from happening'.[167] In practice, officers are to observe passengers' behaviour and ask them questions about their trip (where they are flying to, what the purpose and length of their travel is), and about their knowledge and engagement with FGM (such as whether members of their family practise it or whether they know if it is an illegal intervention).[168] Officers

[162] Ministry of Justice/Home Office, 'Serious Crime Act 2015 Factsheet – Female Genital Mutilation' (2015) para 10. The Serious Crime Act 2015 amended Sections 3 and 4 of the FGM Act 2003 and extended its extra-territorial jurisdiction.
[163] Female Genital Mutilation Act 2003 s 2(a).
[164] ibid s 3(a).
[165] ibid s 2(b), s 3(b).
[166] Border Force, 'FGM: Border Force Targets "High Risk" Flights at Heathrow to Stop Female Genital Mutilation' <https://www.gov.uk/government/news/fgm-border-force-targets-high-risk-flights-at-heathrow-to-stop-female-genital-mutilation> accessed 25 October 2022.
[167] Home Office and Border Force, 'Operation Limelight: A Multi-Agency Safeguarding Operation at the UK Border Responding to Female Genital Mutilation (FGM)' (2020) 2.
[168] ibid 3.

should also consider the need for a baggage search.[169] Furthermore, the Metropolitan Police set up in 2003 a coordinated initiative under the name of Project Azure.[170] The police has since partnered with NHS England, the Home Office and Children's Social Care, and 'work[s] closely with faith and community leaders' in order to 'protect' and 'empower people to come forward' if they have information or are themselves victims of FGM.[171]

Despite these campaigns, the first case of FGM was not brought to trial until 2015. Dr Dhanuson Dharmasena was prosecuted for suturing a patient's vulva to stop her bleeding as a result of an incision made to allow her to give birth, as she had been previously infibulated. The patient did not support the prosecution (but instead gave evidence for the defence),[172] and several members of the medical profession came forward to publicly defend Dr Dharmasena, explaining that 'there is the world of difference between FGM and repairing cuts necessary to allow a baby's delivery'.[173] The jury acquitted him.[174]

Months prior to this case, the House of Commons Affairs Committee had launched an inquiry to address the 'national scandal' of 'fail[ing] to respond adequately to the

[169] ibid.
[170] Metropolitan Police, 'Female Genital Mutilation ' <https://www.met.police.uk/advice/advice-and-information/caa/child-abuse/female-genital-mutilation-fgm/> accessed 25 October 2022.
[171] ibid.
[172] Proudman (n 155) 86.
[173] Haroon Siddique, 'FGM Charges against Doctor Criticised by Obstetricians and Gynaecologists' *The Guardian* (27 March 2014); The president of thr RCOG also issued a statement of support after the acquittal, condemning the prosecution of Dr Dharmasena Royal College of Obstetricians and Gynaecologists, 'FGM Trial – the Wrong Prosecution' <https://www.rcog.org.uk/en/blog/FGM-trial-the-wrong-prosecution> accessed 16 February 2021.
[174] Sandra Laville, 'Doctor Found Not Guilty of FGM on Patient at London Hospital' *The Guardian* (4 February 2015).

growing prevalence of FGM in the UK'.[175] In its report, the Committee highlighted the need to 'work with professionals in health, education, social care … to ensure the safeguarding of girls' and to 'improve working with communities to abandon FGM'.[176] That is why it recommended changes aimed at raising awareness around FGM, such as mandatory training for practitioners,[177] introducing FGM in the teaching curriculum,[178] and increasing the funding to work with grass-roots groups, which should be accompanied by a national public health campaign.[179] Nevertheless, none of these recommendations ended up being adopted, with the Government opting to only pay attention to the Committee's proposals focused on legislative change towards more punitive measures.[180] What followed was the Serious Crime Act 2015, which amended the FGM Act 2003 in five aspects: it removed the requirement of perpetrators and victims to be nationals or permanent residents in the UK, as now the Act also covers those who are 'habitually resident'; it provided the right to anonymity for victims of FGM to protect them from the press; it introduced the offence of failing to protect a girl from FGM, the duty of certain regulated professionals to report FGM, and granted courts the power to issue Female Genital Mutilation Protection Orders (FGMPOs) (see Chapter 4 for further discussion).[181]

After these reforms were introduced, the second prosecution against FGM was brought in 2018, this time against a father for allowing his daughter to undergo FGM.

[175] House of Commons Home Affairs Committee, 'Female Genital Mutilation: The Case for a National Action Plan' (2014) 47.
[176] ibid.
[177] ibid 49.
[178] ibid 51.
[179] ibid.
[180] Proudman (n 155) 70.
[181] ibid 74–75.

Although the first medical professional who examined the six-year-old girl reported injuries consistent with FGM, when she was re-examined nine weeks later by another doctor, there were no signs of the intervention having been performed.[182] One month after this case, another father was prosecuted for organising the mutilation of his daughter on two occasions.[183] The daughter testified that her father had invited an unidentified man to their family home, who cut her as she was lying down in the hallway, as a form of punishment after she had stolen some money.[184] The defendant denied the charges and his defence team argued that, as a result of divorce, the children had been 'susceptible to their mother's influence' and had, as a result, 'rewritten their history' about what had happened.[185] He was also acquitted.

The first and only conviction so far was not until 2019, when a woman was sentenced to 11 years in prison for cutting the genitalia of her three-year old daughter.[186] She denied the accusations, explaining that she was not familiar with FGM at all, and that her daughter's injuries resulted from her falling down onto a kitchen cupboard, although her daughter explained that she had been cut by a 'witch'.[187] The experts agreed that the

[182] Steven Morris, 'Police Promise to Learn Lessons after Collapse of FGM Trial in Bristol' *The Guardian* (22 February 2018).
[183] Alexandra Topping, 'UK Solicitor Cleared of Forcing Daughter to Undergo FGM' *The Guardian* (22 March 2018).
[184] ibid.
[185] ibid.
[186] Sarah Marsh, 'Mother Jailed for 11 Years in First British FGM Conviction' *The Guardian* (8 March 2019).
[187] ibid.

cuts of the girl were consistent with type II FGM, and were the result of using a sharp instrument, rather than a fall on a cupboard door.[188]

A particularly interesting aspect about this case is that the father was not convicted for failing to protect his daughter from FGM, even though he seems to have been present when she was cut.[189] Proudman contends that the leniency towards the father, in contrast with the harshness with regards to the mother (who was not from an FGM practicing background and had not been cut herself), could be due to the pervasive narrative that women are the *only* ones in charge of FGM, and men (fathers, grandfathers, brothers) are not at all involved in reinforcing this practice.[190] The simplistic view of FGM as falling under the exclusive purview of women might also have been embedded in the two failed prosecutions of fathers for FGM-related offences outlined above. These two cases, both featuring the father as the defendant with motivations (such as cutting as punishment) that do not fall under the 'classic' narrative of mothers carrying on the tradition, challenge 'preconceived views of FGM', perhaps having contributed to doubting as to whether FGM had even been performed.[191] (Chapter 4 explores the social embeddedness of the decision to have FGM, and to have one's daughter undergo FGM.)

With only one conviction, one could say that the criminalisation of FGM is far from successful. This could be due to several factors. First, there seems to be a lack of awareness of the unlawful status of FGM among those who engage with the practice. According to a 2018 study which interviewed women accessing two specialist FGM clinics in England,

[188] *R v N (Female Genital Mutilation)* Sentencing Remarks (2019) 2.
[189] Proudman (n 155) 84.
[190] ibid 85.
[191] ibid 93.

72% of them did not know that FGM was a criminal offence, and the ones who knew reported that they had learned it from the media or friends and family, rather than in healthcare or teaching settings.[192] Second, the criminalisation of FGM, especially it being regarded as child abuse, as Proudman contends, alienates those from practicing communities, who are framed as 'mutilators', which might nurture 'hostility and resistance', rather than collaboration, towards reporting and engaging in anti-FGM campaigns.[193]

3.2 Protecting 'girls' beyond criminal law

Criminalisation is not the only mechanism in place against FGM. As introduced above, Section 5A and Schedule 2 of the FGMA 2003 give powers to the courts of England and Wales to make FGM Protection Orders (FGMPO) to protect girls who are at risk of genital mutilation or have been mutilated.[194] Chapter 4 explores FGMPOs in depth but, in a nutshell, an FGMPO may relate to a conduct within or outside of England and Wales and contain prohibitions, restrictions or requirements such as the surrender of passports or the prohibition of entering the country.[195] Breaking the provisions of the FGMPO is a criminal offence.[196] Furthermore, as Chapter 5 discusses, the FGMA 2003 imposes a duty on healthcare professionals, teachers and social care workers in England and Wales to notify

[192] Martina Larsson and others, 'An Exploration of Attitudes towards Female Genital Mutilation (FGM) in Men and Women Accessing FGM Clinical Services in London: A Pilot Study' (2018) 38 Journal of Obstetrics and Gynaecology 1005, 1007–1008.
[193] Proudman (n 155) 112.
[194] Female Genital Mutilation Act 2003 Schedule 2, para 1.
[195] Crown Prosecution Service (n 152).
[196] Female Genital Mutilation Act 2003 Schedule 2, para 4.

the police if, in the course of their work, they 'discover that an act of female genital mutilation appears to have been carried out on a girl who is aged under 18'.[197]

Aside from the specific provisions of the FGM Act 2003, care proceedings could also be initiated. The first case of this sort involving FGM was *Re B and G.* Two children of African-born Muslim parents, a boy and a girl, were placed in foster care after they had been seemingly abandoned in the street by their mother.[198] Whilst in foster care, suspicions that that the girl had been cut arose when it was reported that she had 'irregular genitalia'.[199] The main challenge was to ascertain whether she had been cut or not, as the evidence was not clear. Not all experts had the same degree of expertise with regards to FGM and paediatric patients, and the only one who had expertise in both FGM and infant girls did not examine G in person, but only saw a DVD.[200] Eventually, the court was not persuaded that there was, in fact, a scar on G's genitalia, and concluded that the local authority had not established its case that G had undergone or was at risk of undergoing FGM.[201]

Even if G was not found to have undergone FGM, Sir James Munby P clarified that, if she had, that would have triggered the application of Section 31(2) of the Children Act 1989, according to which 'the state can intervene [provided] the local authority [has] proved two things: "significant harm" attributable to parental care which is not what it would be "reasonable to expect" of a parent'.[202] Regarding the first limb of the test, the

[197] ibid s 5B. For further discussion on medical professionals' duties to report and record, see Chapter 5.
[198] *Re B and G (Children) No 2* [2015] EWFC 3 [1].
[199] ibid [13].
[200] ibid [13–37].
[201] ibid [53].
[202] ibid [66].

Court agreed with the local authority that any and all forms of FGM (however 'mild') would amount to 'significant harm':

> [n]o form of FGM can … be characterised as trivial or unimportant, having regard not merely to its purely physical characteristics but also to its associated trauma and potential emotional or psychological consequences … Unless FGM in all its forms is treated as constituting significant harm, local authorities and other agencies, and indeed family courts, may be very significantly hampered in their ability to protect vulnerable children.[203]

As for the second limb of the statutory test, the court also concurred with the local authority that, even if FGM constituted a 'cultural' practice for some parents, that did not make it 'reasonable'.[204] Nevertheless, it also clarified that meeting the statutory requirements would not necessarily lead to adoption, since welfare evaluations in these cases are extremely complex, having to balance whether the child's welfare would have been better served by 'separating her from her family' or 'preserving the family unit', especially taking into account the relationship with her sibling.[205] In this judgment, Sir James Munby P also called for more medical experts in FGM concerning young children,[206] and he also drew an analogy with penile circumcision which, as I explain below, has proved to be controversial.

The second case involving care proceedings in the context of FGM was reported in 2016. Two girls, aged 13 and 5, had been placed in foster care after they had been found to be at risk of FGM due to a planned family trip to Guinea where their father had the intention

[203] ibid [67].
[204] ibid [71].
[205] ibid [75–77].
[206] ibid [79].

of having them cut.[207] The court ruled that the girls were to return with their parents' care, who were put under the obligation to arrange medical examinations for their daughters at the request of the Local Authority not more than once a year.[208] This measure was designed as a form of deterrence, with the court being clear that the risk that triggered the care proceedings had not 'vanished', requesting parents to periodically demonstrate that their children remained uncut.[209]

3.3 Consent as impossible

In *R v Brown*, the Law Lords made clear that consent alone is not enough to justify the lawfulness of an activity causing actual or serious bodily harm, as such activity must also be judged to be in the public interest.[210] FGM is a practice whose compatibility with the public interest is explicitly rejected by the FGMA 2003, which specifically criminalises it. It is therefore immaterial whether women choose to have their vulva cut, since their consent is irrelevant in the eyes of the law to whether an offence has been committed or not. This is so regardless of the age of the woman (although the Act uses the term 'girl', it clarifies that 'girl includes woman'[211]), and of her 'belief' that 'the operation is required as a matter of custom or ritual', when assessing if the intervention can be justified as being necessary for her mental health (see Chapter 4 for further discussion).[212] Thus, the defence of consent cannot be used in FGM. As the statutory guidance puts it, 'it is an extremely harmful

[207] *A London Borough v B and others (Female Genital Mutilation: FGM)* [2016] EWFC B111 [5–8].
[208] ibid [8].
[209] ibid [9].
[210] *R v Brown* [1994] 1 AC 212 (HL) 337.
[211] Female Genital Mutilation Act 2003 s 6(1).
[212] ibid s 1(5).

practice—responding to it cannot be left to personal choice'.[213] (Chapter 5 explores the harmful effects FGM is invoked to have).

Not only is consent irrelevant to the lawfulness of these interventions, but it is also regarded as either absent (ie women are being forced to undergo these interventions against their will), or invalid (ie women are willing to have these operations but their consent is not freely given). FGM is framed as a barbaric and oppressive practice that has been brought to the West as a result of migration, with the RCOG explaining that the UK has seen an increase in these operations, originally practised in Africa, Asia and the Middle East.[214] 'British values' are seen too be at odds with this sort of practice, as Baroness Gaitskell made clear during the parliamentary debate of the Female Circumcision Act 1985:

> It is, after all, enough that women from other countries come and live in ours. We are doing very well by them in allowing them to live in this country. It is nice for them and it is nice of us to do it. But we do not have to import their kind of rules. The point is that such people are not in a position to teach us anything about sexual behaviour.[215]

When the Law Commission produced its consultation paper reflecting on the state of the law regarding offences against the person in 1995, it skimmed over the issue of FGM, as there was no doubt that this practice would remain a criminal offence.[216] Current multi-agency statutory guidance on the FGMA 2003 makes clear that although it is a 'complex

[213] HM Government, 'Multi-Agency Statutory Guidance on Female Genital Mutilation' (2020) 4.
[214] Royal College of Obstetricians and Gynaecologists, 'Female Genital Mutilation and Its Management' (2015) 26.
[215] Prohibition of Female Circumcision Bill HL Deb (n 154), vol 465, cols 207– 24.
[216] Law Commission, 'Criminal Law. Consent in the Criminal Law. A Consultation Paper (No 139)' (1995) para 9.3.

issue … FGM is a crime and child abuse, and no explanation or motive can justify it'.[217] It acknowledges several motivations for FGM among different communities, such as to 'bring status and respect to the girl, preserve a girl's virginity/chastity, a rite of passage, give a girl social acceptance, especially for marriage, uphold the family "honour", cleanse and purify a girl, give a girl and her family a sense of belonging to the community', among others.[218] However, these rationales are deemed to be embedded in gender inequality and violence against women, with FGM being the ultimate manifestation of such beliefs: '[FGM] maintains power structures based on gender in a society where women and their "honour" are valued as the objects and properties of men'.[219]

4 Double standards

Despite this clear opposition to FGM, its differentiation from other vulval modification practices is problematic. As explained above, if the excision or the infibulation of the vulva is performed by a qualified medical practitioner and considered necessary for the girl's mental or physical health, or is performed in connection with childbirth, no offence will have been committed. Nevertheless, as Chapter 5 analyses in depth, this exception is not as clear in practice, with the Nuffield Council on Bioethics, the RCOG and the RCS having complained about the legal ambiguity that surrounds vulval cosmetic surgery.[220] For

[217] Government (n 213) 40.
[218] ibid.
[219] European Institute for Gender Equality, 'Female Genital Mutilation in the European Union and Croatia' (2013) 23.
[220] Royal College of Obstetricians and Gynaecologists, 'Ethical Opinion Paper: Ethical Considerations in Relation to Female Genital Cosmetic Surgery (FGCS)' (n 27) 2; Royal College of Surgeons, 'Cosmetic Surgery Standards FAQ ' <https://www.rcseng.ac.uk/standards-and-research/standards-and-guidance/service-standards/cosmetic-surgery/faq/> accessed 22 February 2021; Nuffield Council on Bioethics (n 3) xx.

example, the Nuffield Council on Bioethics highlights the 'legal uncertainty' in relation to procedures that are described and marketed as vulval cosmetic surgery, but are 'anatomically identical to the procedures explicitly prohibited by the FGMA 2003'.[221]

The fact that the legal framework reacts differently to what in practice are very similar interventions was already a matter of discussion during Parliamentary debates of both the 1985 and 2003 Acts. Marion Roe MP, who brought forward the 1985 Prohibition of Female Circumcision Bill, clarified that, even though there might not be an anatomical difference between the two interventions, the purpose of the proposed new piece of legislation was 'to prevent the custom of female circumcision, not legitimate ethical and surgical procedures'.[222] This distinction between legitimate and illegitimate forms of vulval cutting was supported by the Minister of Health, who thought it was necessary to distinguish FGM (or, as it was referred to at the time, 'female circumcision') from 'desirable medical practices'.[223]

In 2003, Sandra Gidley MP challenged such a stark distinction between these two practices, arguing that perhaps both interventions should be criminalised.[224] She made the point that, if one of the main reasons why FGM is so abhorrent is because it is a form of patriarchal oppression, one should wonder whether vulval cosmetic surgery also conveys the same message, being designed to 'keep women in their place'.[225] She argued that the law should not 'make any exceptions for white women expressing a choice for fashion

[221] Nuffield Council on Bioethics (n 3) xx.
[222] Prohibition Of Female Circumcision Bill Deb vol 77 col 584 (19 April 1985).
[223] ibid col 587.
[224] Female Genital Mutilation Bill Deb vol 401 col 1200 (21 March 2003).
[225] ibid.

reasons', but rather 'ensure that no distinction is drawn between these two practices' in order to signal that 'women are okay as they are … and do not need to mess about with themselves in that way'.[226] In 2016, the House of Commons Home Affairs Committee also acknowledged the double standard in 'tell[ing] communities in Sierra Leone and Somalia to stop a practice which is freely permitted in Harley Street', recommending an amendment to the FGM Act 2003 to 'make it very clear that female genital cosmetic surgery would be a criminal offence'.[227] Chapter 4 and 5 explore in detail the potential overlap between FGM and vulval cosmetic surgeries, unpacking the circumstances in which a woman may have her vulva lawfully modified.

The apparent contradiction in forbidding some women from having their vulvas modified to comply with their cultural ideals and customs, whilst allowing others to undergo a very similar operation to conform to their ideals of beauty, has been one of the core issues of contention within the literature.[228] Some critics of current legislation call for a stronger and more coherent protection of autonomy and bodily integrity for all girls and

[226] ibid.
[227] House of Commons Home Affairs Committee, 'Female Genital Mutilation: Abuse Unchecked' (2016) 26.
[228] Moira Dustin, 'Female Genital Mutilation/Cutting in the UK: Challenging the Inconsistencies' (2010) 17 European Journal of Women's Studies 7; Lisa Avalos, 'Female Genital Mutilation and Designer Vaginas in Britain: Crafting an Effective Legal and Policy Framework' (2014) 48 Vanderbilt Journal of Transnational Law 621; Arianne Shahvisi, 'Female Genital Alteration in the UK: A Failure of Pluralism and Intersectionality' in Katja Kuehlmeyer, Corinna Klingler and Richard Huxtable (eds), *Legal and Social Aspects of Healthcare for Migrants: Perspectives from the UK and Germany* (Routledge 2018); Arianne Shahvisi, 'Why UK Doctors Should Be Troubled About UK Legislation' (2017) 12 Clinical Ethics 102; Arianne Shahvisi and Brian D. Earp, 'The Law and Ethics of Female Genital Cutting' in Sarah M. Creighton and Lih-Mei Liao (eds), *Female Genital Cosmetic Surgery. Solution to What Problem?* (Cambridge University Press 2019); Sally Sheldon and Stephen Wilkinson, 'Female Genital Mutilation and Cosmetic Surgery: Regulating Non-Therapeutic Body Modification' (1998) 12 Bioethics 263; B Kelly and C Foster, 'Should Female Genital Cosmetic Surgery and Genital Piercing Be Regarded Ethically and Legally as Female Genital Mutilation?' (2012) 119 BJOG: An International Journal of Obstetrics and Gynaecology 389; Simone Weil Davis, 'Loose Lips Sink Ships' (2002) 28 Feminist Studies 7; Bronwyn Winter, Denise Thompson and Sheila Jeffreys, 'The UN Approach to Harmful Traditional Practices' (2002) 4 International Feminist Journal of Politics 72.

women. For instance, Adrienne Shahvisi argues that all non-therapeutic forms of genital cutting for all children should be prohibited, and more caution should be exercised when restricting the choices of adult women.[229] Instead, she contends that it would be more fruitful to tackle the cultural and social structures that make cosmetic surgery and FGM possible.[230]

A similar criticism is made in relation to FGM and intersex surgery. J Steven Svoboda, Nancy Ehrenreich and Mark Barr separately argue that both intersex surgeries and FGM are cultural practices that encapsulate and reproduce norms about what genitalia should look like and how they should function.[231] Likewise, Cheryl Chase contends that they are 'analogous' operations, but intersex surgery has been legitimised through Western medical discourse, whereas FGM has been deemed a barbaric ritual.[232] There seems to be a lack of coherency in allowing (parental) choice for intersex surgery, whilst denying (parental or personal) choice for FGM, when, as Melinda Jones argues, both interventions have the same purpose: cultural normalisation. As she puts it:

> [f]or victims of FGM, the act is authorised by parents, but the oppression can be understood as an expression of misogyny and patriarchy. For victims of [intersex surgery], the act is authorised by parents, but the oppression can be understood as an expression of patriarchy and the power of medicine. In

[229] Shahvisi, 'Why UK Doctors Should Be Troubled About UK Legislation' (n 228) 106.
[230] ibid.
[231] Svoboda (n 142) 251; Nancy Ehrenreich and Mark Barr, 'Intersex Surgery, Female Genital Cutting, and the Selective Condemnation of "Cultural Practices"' (2005) 40 Harvard Civil Rights-Civil Liberties Law Review 71, 138.
[232] Cheryl Chase, '"Cultural Practice" or "Reconstructive Surgery"? US Genital Cutting, the Intersex Movement, and Medical Double Standards' in S James and C Robertson (eds), *Genital Cutting and Trasnational Sisterhood. Disputing US Polemics* (University of Illinois Press 2002) 143.

> both cases, it is the need for cultural normalisation that ultimately justifies the procedure.[233]

The distinctions between therapy and non-therapy, and culture and religion, were an important element for the court in the *Re B and G* judgment, discussed above, in order to distinguish between FGM and penile circumcision.[234] In his reasoning, Sir James Munby P argued that penile circumcision amounted to 'significant harm', suggesting that, if even the less invasive forms of FGM involved significant harm, penile circumcision, which is seemingly more invasive than type IV FGM, should also be considered to qualify as significant harm.[235] The difference between FGM and penile circumcision is, therefore, not the actual harm the procedure involves for the children subjected to them, but rather that the latter, in contrast with the former, is considered 'reasonable parenting', hence failing to meet the second limb of the statutory test in Section 31 of the Children Act 1989:

> Whereas it can never be reasonable parenting to inflict *any* form of FGM on a child, the position is quite different with male circumcision. Society and the law, including family law, are prepared to tolerate non-therapeutic male circumcision performed for religious or for purely cultural or conventional reasons, while no longer being willing to tolerate FGM in any of its forms.[236]

Sir James Munby P gave two reasons to justify this distinction. First, he argued that penile circumcision is a religious ritual, while 'FGM has no basis in any religion'.[237] Second, he contended that, whilst FGM has no medical benefits, but, on the contrary, brings about

[233] Melinda Jones, 'Intersex Genital Mutilation - A Western Version of FGM' (2017) 25 International Journal of Children's Rights 396, 409.
[234] Brian D Earp, Jennifer Hendry and Michael Thomson, 'Reason and Paradox in Medical and Family Law: Shaping Children's Bodies' (2017) 25 Medical Law Review 604, 620–621.
[235] *Re B and G (Children)* (n 198) [69].
[236] ibid [72] (emphasis in original).
[237] ibid.

terrible sequalae, penile circumcision, although 'opinions are divided', may provide 'hygienic or prophylactic benefits'.[238]

For Ruari D McAlister, this comparison between FGM and penile circumcision is completely inadequate, since these practices cannot 'be placed on equal footing'.[239] She argues that penile circumcision cannot be said to amount to 'significant harm', since 'though the medical benefits are not accepted by all, the religious and cultural benefits clearly exist'.[240] Although, as I explain below, this is not a widely accepted position, she argues that it would be more harmful to prevent children from undergoing an intervention that is such a crucial part of their identity and social and religious upbringing.[241] However, it is her contention that the same cannot be said for FGM, where 'medical disadvantages alone far outweigh any perceived benefit'.[242]

Whether the intervention is harmful or not, and whether that harm can be accepted as 'reasonable', is therefore critical for the law to accept or condemn genital practices. Nevertheless, as Sir James Munby P and much of the literature acknowledge, the health benefits or harms of penile circumcision are controversial.[243] That is why Kai Möller opts for a line of argument that steers away from empirical assessments of benefit or harm.[244] Rather than relying 'on the extent of the physical and emotional harm' caused by these interventions, he contends that genital cutting is 'inherently wrong' because it violates 'the

[238] ibid.
[239] Ruari D Mcalister, 'A Dangerous Muddying of the Waters?' (2016) 24 Medical Law Review 259, 264.
[240] ibid 266.
[241] ibid.
[242] ibid.
[243] See eg Task Force on Circumcision, 'Circumcision Policy Statement' (2012) 130 Pediatrics 585.
[244] Kai Moller, 'Male and Female Genital Cutting: Between the Best Interest of the Child and Genital Mutilation' (2019) Oxford Journal of Legal Studies 2.

child's right to have his or her physical integrity respected and protected'.[245] His position against genital modifications on children thus results from his commitment to protect the child's bodily integrity.

Chapter 5 will further explore distinctions between vulval cosmetic surgery, intersex surgeries and FGM (as science vs rituals, and benefits vs harms), alongside how the effects of these operations are framed.

5 Juxtaposing discourses

The main purpose of this chapter has been to unpack how medical and legal debates differently frame some of the key issues regarding vulval cosmetic surgery, intersex surgery and FGM. The first sort of interventions are performed in a context where the doctor-patient relationship is highly influenced by business interests, in which the decision to undergo cosmetic surgery is considered to be challenged in three main ways: lack of sufficient and/or appropriate information, cosmetic pressure and mental health concerns. Meanwhile, medical examinations, diagnoses and prognoses are crucial factors in designing a treatment plan for intersex patients, who are usually initially new-borns, with a multidisciplinary medical team helping parents choose what course of action is in the best interests of their child. In recent years, however, early intervention has been under

[245] ibid 33.

attack, with increasingly more voices calling for the need to protect intersex children from irreversible early surgeries.

In the case of FGM, deemed a criminal offence in England and Wales, even if women consent to this intervention, the law sees their choice not only as insufficient to justify the lawfulness of the operation, but also as invalid. FGM is regarded as a patriarchal oppressive practice to which one cannot opt in freely. Nevertheless, distinctions between these three practices are not so clear-cut in practice, with sectors within the medical profession and ethical and legal scholars having questioned their potential incoherencies and ambiguities.

Rather than looking for and exposing the inconsistencies embedded in the different framing of these interventions, this chapter is the first step in the lookout for the 'glue' that allows these operations to be framed and discussed in different terms. Each intervention brings up similar, but distinctly deployed, challenges and questions. For example, (un)certainty features as a factor in all three interventions. In both cosmetic and intersex surgeries, the medical community seems to agree that there is a lack of sufficient robust evidence of their safety, consequences and risks for patients. In contrast, FGM is considered an unquestionably harmful practice, physically and psychologically. Similarly, patriarchal oppression, which seems to disable the choice of adult women with regards to FGM, also raises challenges for decision-making regarding vulval cosmetic surgery. Nevertheless, although it invalidates the choice in the case of the former, it is seen as insufficient to do so in the case of the latter, at least in the eyes of the law. Parents of intersex children, and intersex patients themselves, are also immersed in a universe of

norms and societal expectations, and it is precisely the shock linked to their 'atypical' anatomy what is perceived to underpin the need for psychological support and is, eventually, a key factor in deciding in favour of surgery (eg in order to avoid bullying and enable their child to have a 'normal' and 'consistent' anatomy).

The age at which the intervention is performed is also a pivotal issue across the three vulval cuts, with more reluctance to modify children's vulvas in some contexts than in others. FGM legislation contains enhanced protections for underage girls (like compulsory reporting or the criminalisation of the failure to protect a girl under 16 from undergoing FGM), and the medical profession agrees that, if there is no pressing physical need, vulval cosmetic surgery should not be performed on those who are under 18. In contrast, even though it is increasingly controversial, surgery is, at least, part of the discussion about the management of intersex conditions when patients are still very young.

Finally, concerns about mental health are also a common theme featuring differently across the three cuts. Whilst in vulval cosmetic surgery, the main issue seems to be ensuring that only mentally 'fit' patients undergo these interventions, the mental health discourse in intersex surgeries is framed as a strategy designed to assist parents (and eventually children) deal with the unexpected and complex reality of intersex embodiment.

One might argue that the different framing of each intervention is because the factual realities of each cut are different: FGM is a ritual practice but vulval cosmetic and intersex surgery are deemed proper medical interventions. Adult women undergo cosmetic surgery whereas children are the focus of the dilemma in intersex surgeries. Nevertheless, the 'origin' of these 'factual differences' is precisely what this thesis seeks to interrogate.

Why is vulval cosmetic surgery not a legitimate treatment for underage women whereas surgery is a given option for parents of intersex children? Why are those undergoing FGM assumed to be so oppressed that they are incapable of choice, but having vulval cosmetic and intersex surgeries, despite also being embedded in social norms, stems from free choice? Why does having and/or being an intersex child require psychological support whilst wanting to 'refashion' your vulva is in itself a trigger for concerns about mental anxiety?

With these questions, this chapter has provided a springboard to start to interrogate the tripartite conceptualisation of vulval cutting. Chapters 3, 4 and 5 explore in detail what 'orders' such different understandings of similar issues. The next chapter focuses on debates about oppression and choice presented by feminist literature.

CHAPTER 3. THE OPPRESSION OF VULVAL CUTTING

The previous chapter provided a snapshot of how the medical and legal worlds frame choice in relation to vulval cosmetic surgery, intersex surgery and Female Genital Mutilation (FGM), identifying several themes that interwove across all three interventions. One of them is the concern that patriarchal and/or gender oppression might underpin, complicate or prevent decision-making when undergoing these operations. As we have seen in Chapter 2, medical bodies are worried about the 'subtle coercion' that might drive women to vulval cosmetic surgery,[1] acknowledging the need to change 'public attitudes' about 'unrealistic and sometimes discriminatory appearance ideals' and 'educate' women on the many variations that a 'normal' and 'healthy' genital anatomy might have.[2] Likewise, in the context of intersex surgery, more voices within the medical and legal community have increasingly recognised and worked to readdress the lack of choice and position of vulnerability of many intersex individuals, who have had their bodies operated on when they were too young to provide their consent.[3] Finally, the current UK legal framework does not see undergoing FGM as the result of free choice, considering FGM

[1] British Association of Plastic Reconstructive and Aesthetic Surgeons, 'BAPRAS Responds to Research Published on Female Genital Cosmetic Surgery' <https://www.bapras.org.uk/media-government/news-and-views/view/bapras-responds-to-research-published-on-female-genital-cosmetic-surgery> accessed 8 February 2021.

[2] See eg Lina Michala, Lih-Mei Liao and Sarah M Creighton, 'Female Genital Cosmetic Surgery: How Can Clinicians Act in Women's Best Interests?' (2012) 14 The Obstetrician & Gynaecologist 203; Nuffield Council on Bioethics, 'Cosmetic Procedures: Ethical Issues' (2017) para 7.46.

[3] See eg Peter A Lee and others, 'Global Disorders of Sex Development Update since 2006: Perceptions, Approach and Care' (2016) 85 Hormone Research in Paediatrics 158; Amnesty International, 'First, Do No Harm. Ensuring the Rights of Children With Variations of Sex Characteristics' (2017); Human Rights Watch, 'Medically Unnecessary Surgeries on Intersex Children in the US' (2017) <https://www.hrw.org/report/2017/07/25/i-want-be-nature-made-me/medically-unnecessary-surgeries-intersex-children-us#_ftn49> accessed 12 February 2021; Brian D Earp, 'In Defense of Genital Autonomy for Children' (2016) 42 Journal of Medical Ethics.

'victims' not capable of freely saying 'yes' to this procedure and dismissing their consent as insufficient to accept the lawfulness of this intervention.[4]

The present chapter explores the differences between various feminist approaches to the issue of oppression in each of these cuts. Feminist debates have played an important role in the categorisation of these forms of vulval cutting as different interventions, so this chapter examines them not only for the 'problems' they find or open up in relation to these body modification practices, but also for how they are implicated in the construction and taxonomisation of these operations.[5] By tracing how various feminist perspectives have framed oppression in each context, this chapter argues that different conceptions of the vulva play a role in accounting for diverse deployments of oppression across the three cuts. Specifically, it contends that underlying conceptions of the vulva as normal and healthy underpin and influence the ways in which feminist scholarship considers that patriarchal or gender oppression hinders decision-making in each context.

1 Vulval cosmetic surgery

1.1 The vulva

The question of (free) choice in cosmetic surgery has been subject to intense scrutiny. Thousands of pages are dedicated to the so-called 'structure-agency' debate, mainly

[4] European Institute for Gender Equality, 'Female Genital Mutilation in the European Union and Croatia' (2013) 23; Law Commission, 'Criminal Law. Consent in the Criminal Law. A Consultation Paper (No 139)' (1995) para 9.3; World Health Organization, 'Eliminating Female Genital Mutilation. An Interagency Statement' (2008) 5.
[5] Victoria Pitts-Taylor, *Surgery Junkies: Wellness and Pathology in Cosmetic Culture* (Rutgers University Press 2007) 73.

focused on ascertaining whether it is possible for women to freely undergo cosmetic surgery or whether they are manipulated into wanting to aesthetically enhance their bodies. Such debate has not been framed in relation to vulval interventions specifically; liposuctions,[6] rhinoplasties,[7] face-lifts[8] or breast augmentations[9] are the mostly common examples, together with beauty practices which do not involve surgical procedures. For instance, Sandra Lee Bartky talks about a wide range of 'disciplinary practices' on 'female identity and subjectivity',[10] such as bodily posture, movement, facial expressions, skin and hair care.[11] The distinction between 'routine' (putting on make-up, 'doing' one's hair) and 'extreme' (surgery) beauty practices is increasingly blurry, given the growing demands and higher 'minimal standards' of 'proper femininity'.[12] That is why some scholars argue that all beauty practices, from lipstick to cosmetic surgery, are on a continuum, since cosmetic pressure pervades every inch of our body and forces women to engage in a wider range of practices to remain beautiful.[13] As Andrea Dworkin puts it:

> In our culture, not one part of a woman's body is left untouched, unaltered. No feature or extremity is spared the art, or pain, of improvement. Hair is dyed, lacquered, straightened, permanented, eyebrows are plucked, pencilled, dyed; eyes are lined, mascaraed, shadowed, lashes are curled, or

[6] Kathryn Pauly Morgan, 'Women and the Knife: Cosmetic Surgery and the Colonization of Women's Bodies' (1991) 6 Hypatia 25, 29.
[7] Sander L Gilman, *Creating Beauty to Cure the Soul. Race and Psychology in the Shaping of Aesthetic Surgery* (Duke University Press 1998) 31; Pitts-Taylor (n 5) 164.
[8] Elizabeth Haiken, *Venus Envy: A History of Cosmetic Surgery* (Johns Hopkins University Press 1997) 155–158; Kathy Davis, *Reshaping the Female Body: The Dilemma of Cosmetic Surgery* (Routledge 1995) 7.
[9] Sheila Jeffreys, *Beauty and Misogyny. Harmful Cultural Practices in the West* (Routledge 2005) 149; Morgan (n 6) 28; Davis, *Reshaping the Female Body: The Dilemma of Cosmetic Surgery* (n 8) 8.
[10] Sandra Bartky, 'Foucault, Feminity and the Modernization of Patriarchal Power' in Katie Conboy, Nadia Medina and Sarah Stanbury (eds), *Writing on the Body: Female Embodiment and Feminist Theory* (1997) 132.
[11] ibid 134–139.
[12] Heather Widdows, *Perfect Me: Beauty as an Ethical Ideal* (Princeton University Press 2018) 97.
[13] Jeffreys (n 9) 28.

> false—from head to toe, every feature of a woman's face, every section of her body, is subject to modification, alteration.[14]

Although surgical and non-surgical beauty practices may share the same goal (achieving a better or normal appearance) and may be underpinned by similar problematic principles (patriarchal or cosmetic oppression), there might be important differences between wearing high heels, plucking one's eyebrows, waxing one's (pubic) hair and undergoing surgery. As explained in the previous chapter, cosmetic surgery may involve risks to health, during and after the procedure, as well as short- and long-term side effects, which can be irreversible. Moreover, if sought privately, it is much more expensive (in relation to vulval surgeries specifically, the prices are in the range of £2000 and £4000 per procedure in the UK[15]) than other 'routine' beauty practices.

Vulval cosmetic surgery also raises specific controversies because, as discussed in Chapter 2, the act of cutting the vulva falls under the scope of the Female Genital Mutilation Act 2003 (FGM Act 2003). Unless the intervention is necessary for the physical or mental health of the patient, it may be considered a criminal offence.[16] In contrast, the *actus reus* involved in other cosmetic procedures will seldom amount to a criminal offence, although the surgeon could be criminally liable, under Sections 18 and 20 of the Offences Against the Person Act, if they perform the operation without consent, or for gross negligence manslaughter if the patient dies as a result of their gross negligence. Notwithstanding the fact that vulval cosmetic surgeries give rise to the question of whether

[14] Andrea Dworkin, 'Gynocide: Chinese Footbinding' in Alison M Jaggar (ed), *Living with contradictions: Controversies in Feminist Social Ethics* (Westview Press 1994) 219.
[15] NHS, 'Cosmetic Procedures - Labiaplasty (Vulval Surgery)' <https://www.nhs.uk/conditions/cosmetic-procedures/labiaplasty/> accessed 3 January 2021.
[16] Female Genital Mutilation Act 2003 s 1(2).

a surgeon is committing an offence or whether their actions can be saved by Section 1(2) of the FGM Act 2003, these interventions are a *type* of cosmetic surgery that is equally embedded within the social and cultural context potentially pressuring women into having their vulva refashioned.[17] Its 'unique' potentially criminal status does not remove vulval surgeries from the critique around choice that has been the heart of feminist debates regarding cosmetic surgery.

1.2 Victims

As introduced above, the discussion about cosmetic surgery and choice has focused on the so-called structure-agency debate. In a nutshell, the 'structure' side of this discussion has as its main claim that the decision to undergo (vulval) cosmetic surgery is not genuine, but the result of patriarchal pressure. Early formulations of this position were put forward by some radical feminist thinkers who saw cosmetic surgery as a form of violence against and a mechanism of controlling women. Cosmetic surgery is 'self-mutilation by proxy', with women being 'maimed' so their bodies conform to the 'regulatory comments, whistles and stares of men'.[18] In order to liberate themselves from being put at the service of men's sexual interests, women must gather collective strength and help each other raise consciousness in order to abandon these practices.[19] Although it is not an easy endeavour, as there is a risk of being desexualised, seen as ugly and ostracised socially, the 'radical redefining of the relationship between women and their bodies' is the only way through

[17] Clare Chambers, 'Medicalised Genital Cutting and the Limits of Choice' in Sarah M Creighton and Lih-Mei Lao (eds), *Female Genital Cosmetic Surgery: Solution to What Problem?* (Cambridge University Press 2019) 79.
[18] Jeffreys (n 9) 178.
[19] ibid 175.

which liberation will be achieved, recognising beauty in all types of bodies without the need for altering them in the service of male interests.[20]

Not being entirely convinced by the 'oppressor (men) - oppressed (women)' dynamic through which radical feminism understood cosmetic practices, some feminist thinkers in the 1990s started to draw on Foucauldian conceptions of power to study cosmetic interventions.[21] For Michel Foucault, power is not (only) centralised in a static figure, person or institution, but it is a 'multiplicity of force relations'.[22] Power is relational, non-subjective and pervasive, emanating from and permanently circulating among everyone and everything in every direction possible: 'from the top downwards … with each other, with oneself'.[23] Power operates through different disciplinary practices, 'small acts of cunning endowed with great power of diffusion, subtle arrangements, apparently innocent, but profoundly suspicious',[24] producing individuals (and also populations) that are 'useful, docile and integrated into systems of efficient and economic controls'.[25]

Although Foucault has been criticised by feminist theorists for neglecting the feminine body,[26] his account of power has been appropriated by many feminist thinkers, letting go of the 'good guys/bad guys' conception of oppression and instead focusing on the 'subtle' dynamics by which women find themselves engaging with cosmetic

[20] Dworkin (n 14) 220.
[21] Margaret A McLaren, *Feminism, Foucault, and Embodied Subjectivity* (State University of New York Press 2002) 92.
[22] Michel Foucault, *The History of Sexuality. Volume 1: An Introduction* (Penguin Books 1978) 92–93.
[23] Michel Foucault, *Power/Knowledge: Selected Interviews & Other Writings 1972-1977* (Colin Gordon ed, Pantheon Books, New York) 199.
[24] Michel Foucault, *Discipline and Punish: The Birth of the Prison* (Vintage Books 1977) 139.
[25] Foucault, *The History of Sexuality. Volume 1: An Introduction* (n 22) 139.
[26] Bartky (n 10) 132.

practices.[27] Susan Bordo, one of the most prominent early exponents of so-called 'Foucauldian feminism', explains that 'traditional' understandings of power fall short of accurately acknowledging 'the degree to which women may "collude" in sustaining sexism'.[28] Ceasing to conceive power 'as something that people "have" and instead as a dynamic or network of non-centralised forces' enables us, she contends, to study how women participate in their own 'subordination' by willingly undergoing procedures like cosmetic surgery without having to frame them as 'passive "victims" of sexism'.[29] Despite not dealing with cosmetic surgery directly, Sandra Lee Bartky presents a clear picture of how Foucauldian notions of power can be useful to conceptualise patriarchal oppression, explaining how diffused, extremely detailed and pervasive the imposition of 'femininity' on women is:

> [t]he woman who checks her make-up half a dozen times a day to see if her foundation has caked or her mascara run, who worries that the wind or rain may spoil her hairdo, who looks frequently to see if her stockings have bagged at her ankle, or who, feeling fat, monitors everything she eats, has become, just as surely as the inmate of Panopticon, a self-policing subject, self-committed to a relentless self-surveillance. This self-surveillance is a form of obedience to patriarchy.[30]

Kathryn Paul Morgan offers one of the first Foucauldian accounts tailored to cosmetic surgery in particular, seeking to understand why women would choose to participate in 'anatomizing and fetishizing their bodies'.[31] Her main argument is that, although women are using the rhetoric of choice when talking about cosmetic surgery, this is a 'paradox'

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[27] Susan Bordo, 'Feminism, Foucault and the Politics of the Body' in Janet Price and Margrit Shildrick (eds), *Feminist Theory and The Body: A Reader* (Routledge 1999) 254.
[28] ibid 252.
[29] ibid 255.
[30] Bartky (n 10) 149.
[31] Morgan (n 6) 28.

since they are not *really* choosing, but they are: (1) 'conform[ing] to norms of beauty',[32] (2) 'exploited' (rather than liberated) into making their bodies apt to the dominant culture,[33] and (3) coerced by increasing more strict notions of 'beauty' and 'ugliness'.[34] Bordo makes a similar argument, explaining that, while it is wrong to regard women as '"cultural dupes", blindly submitting to oppressive regimes of beauty', their having their bodies aesthetically modified must be understood within the current framework of values in which not looking a certain way—and in the case of vulval surgeries, not having a symmetric, hair-free and small vulva—entails being 'nothing'.[35] Women undergoing cosmetic surgery are neither mere victims of nor outsiders to patriarchal oppression—they are 'players in the game', being immersed in and contributing to a system where they can only 'matter' if their bodies conform to mainstream notions of femininity and beauty.[36]

The 'game' is not articulated merely through patriarchal oppression, but also through consumer culture.[37] As shown in Chapter 2, cosmetic surgery is embedded in a complex structure in which medical and business interests interact. Sometimes patients seeking surgery also become 'entrepreneurial actors who are rational, calculating and self-regulating',[38] boosting their confidence and sexual pleasure by investing in their body transformation.[39] This rhetoric of consumer choice has been criticised for concealing the fact that decisions regarding surgery are made in a context where constant exposure to

[32] ibid 26.
[33] ibid 38.
[34] ibid 41.
[35] Susan Bordo, *Unbearable Weight. Feminism, Western Culture, and the Body* (University of California Press 1993) 31.
[36] ibid 29.
[37] ibid 25.
[38] Rosalind C Gill, 'Critical Respect: The Difficulties and Dilemmas of Agency and "Choice" for Feminism: A Reply to Duits and Nan Zoonen' (2007) 14 European Journal of Women's Studies 69, 74.
[39] Bordo (n 35) 245.

social media creates new anxieties about 'normal' and 'desirable' bodies, triggering new self-doubts and needs.[40] Thus, not only is cosmetic surgery a commodifiable good to be purchased to 'cure' or 'deal' with a problem created by consumer culture, but, by having surgery, patients also become objects of consumption, increasing the 'value' of their bodies by becoming more beautiful and desirable.[41]

Through these Foucauldian lenses, the vulva and vagina appear to be new sites of docility owing to their increasing visibility, as a result of pornography, sex becoming part of the popular discourse and new fashion movements in which intimate parts are more exposed.[42] With the co-option of the sex-positivity discourse and sexual liberation,[43] vulval surgeries are now deployed as a tool to live up to one's sexual potential, 'fixing' the body so it is an adequate vehicle to experience pleasure.[44] Under the disguise of sex-positivity, with surgery getting rid of the physical and psychological obstacles preventing women from enjoying sex, particular notions of 'desirable' and 'normal' vulvas are disseminated, thus othering vaginal diversity.[45] Large and protruding labia are 'tucked' so cunnilingus can be better enjoyed and 'loose' vaginas are tightened to 'fix' the 'disasters'

[40] Simone Weil Davis, 'Loose Lips Sink Ships' (2002) 28 Feminist Studies 7, 8–11; Virginia Braun, 'In Search of (Better) Sexual Pleasure: Female Genital "Cosmetic" Surgery' (2005) 8 Sexualities 407, 419.
[41] Sara Rodrigues, 'From Vaginal Exception to Exceptional Vagina: The Biopolitics of Female Genital Cosmetic Surgery' (2012) 15 Sexualities 778, 789; Virginia Braun, 'Selling a Perfect Vulva? Selling a "Normal" Vulva!' in Sarah M Creighton and Lih-Mei Liao (eds), *Female Genital Cosmetic Surgery Solution to What Problem?* (Cambridge University Press 2019) 141.
[42] Lindy Joan McDougall, 'Towards a Clean Slit: How Medicine and Notions of Normality Are Shaping Female Genital Aesthetics' (2013) 15 Culture, Health and Sexuality 774, 784; Virginia Braun, '"The Women Are Doing It for Themselves": The Rhetoric of Choice and Agency around Female Genital "Cosmetic Surgery"' (2009) 24 Australian Feminist Studies 233, 24; Virginia Braun and Celia Kitzinger, 'The Perfectible Vagina: Size Matters' (2001) 3 Culture, Health & Sexuality 263, 263; Davis, 'Loose Lips Sink Ships' (n 40) 10.
[43] Michael P Goodman, 'Philosophy, Rationale, and Patient Selection' in Michael P Goodman (ed), *Female Genital Plastic and Cosmetic Surgery* (Wiley-Blackwell 2016) 35.
[44] Sarah B Rodriguez, *Female Circumcision and Clitoridectomy in the United States* (University of Rochester Press 2014) 140–142.
[45] Braun, 'In Search of (Better) Sexual Pleasure: Female Genital "Cosmetic" Surgery' (n 40) 417.

of childbirth, all of which can be represented as contributing to women feeling more relaxed and in a psychological mindset more conducive to sexual enjoyment.[46]

If the decision to undergo cosmetic surgery is, at some level, always already embedded in patriarchal power, and disseminated or amplified through consumer culture, the question that arises is whether there are any modifications which stand free of oppression and rebel against patriarchal and neoliberal market logics. Radical feminists seem to think that this is not possible. For them, the 'only' emancipatory strategy is accepting and remaining in one's given body, as any sort of body modification or adornment constitutes a patriarchal mutilation.[47] Reclaiming women's bodies must be based, as Sheila Jeffreys puts it, 'on a tender recognition that our bodies are not the problem … it is the hatred and discrimination that needs to be attacked and not our bodies/ourselves'.[48] From this perspective, even 'non-mainstream' forms of body alteration, such as piercing, tattooing or scarring, are harmful forms of male violence.[49] Instead of transforming bodies in ways that might be transgressive, radical feminism sees these actions as manifestations of false-consciousness, internalising and reproducing abuse.[50]

In contrast, some Foucauldian or postmodern feminists suggest that there are forms of bodily transformation that, because they challenge beauty norms, can be considered

[46] ibid 413–417.
[47] Jeffreys (n 9) 148.
[48] Sheila Jeffreys, '"Body Art" and Social Status: Cutting, Tattooing and Piercing from a Feminist Perspective' (2000) 10 Feminism and Psychology 409, 427.
[49] ibid 410.
[50] Victoria Pitts-Taylor, *In the Flesh. The Cultural Politics of Body Modification* (Palgrave Macmillan 2003) 54.

instances where women take 'control' and exercise 'choice' over their own bodies.[51] For instance, Morgan proposes the appropriation of cosmetic surgery techniques 'in name of its feminist potential for parody and protest'.[52] This would entail using technology to produce 'ugly' bodies—carving wrinkles into the skin, pulling breasts down, inserting fat—and participate in Ms Ugly pageants, all of which would challenge 'the hold that the beauty imperative has on our imagination and our bodies'.[53] For Victoria Pitts-Taylor, piercing, tattooing, scarring and branding can be 'rebellious' acts of reclaiming the body, subverting 'traditional notions of feminine beauty'.[54] Contrary to radical feminists, who see these practices as forms of self-hatred, she suggests that the 'free' body is not that which is 'pristine and unmarked', but displacing classical notions of feminine beauty can be a successful approach to 'challenge gendered roles and practices of embodiment'.[55]

Notwithstanding the suspicion one might have about the radical feminist understanding of the unmodified body as 'liberated', framing certain bodily transformations as truly emancipatory might also have its downsides. Llewellyn Negrin warns about how body modifications aimed at posing a political critique might end up reinforcing consumer culture.[56] There is the danger that the body might turn into 'a commodity in constant need of upgrading', and 'subversive' uses of cosmetic surgery

[51] ibid.
[52] Morgan (n 6) 45.
[53] ibid 46.
[54] Pitts-Taylor (n 50) 49.
[55] ibid 72–75. For further discussion of 'non-mainstream' modification practices see eg Michael Atkinson, 'Pretty in Ink: Conformity, Resistance, and Negotiation in Women's Tattooing' (2002) 47 Sex Roles 219; Nikki Sullivan, 'Fleshing Out Pleasure: Canonisation or Crucifixion?' (1997) 12 Australian Feminist Studies 283.
[56] Llewellyn Negrin, 'Cosmetic Surgery and the Eclipse of Identity' (2002) 8 Body & Society 21, 36.

technology, such as Morgan's Ugly pageants, also run the risks of being co-opted by market logics.[57]

A recent account that aims to escape some of these problems has been advanced by Clare Chambers. She defends the idea of the unmodified body but, at the same time, is wary of the claim that reifying the 'natural' body is a liberating strategy.[58] Importantly, she distinguishes between the unmodified and the natural body, because nature, she explains, might be a 'frenemy'.[59] Whilst it may be 'a way of resisting repressive social meanings', it can also 'constitute repression in the next moment'.[60] Natural make-up, which is supposed to 'look as though it is not here', shows how 'nature' can be a double-edged sword.[61] What counts as a natural look or a natural figure is usually already the product of 'deceitful' efforts to present ourselves in a way that looks beautiful but effortless, concealing features in our bodies (eye bags, fat, wrinkles) which, despite being natural, do not go with the idea of a 'natural' look.[62] Acknowledging the artificiality of one's (seemingly natural) appearance can thus be revolutionary, as it enables us to break free from having to 'perform shame maintenance', and having to pretend that we have not devoted time and effort in looking 'better'.[63] Hence, 'wearing [make-up] proudly and applying it publicly' can be a form of rebellion, no longer concealing the process by which we make our bodies look more 'attractive' or 'acceptable'.[64] Instead of pretending that we

[57] ibid.
[58] Clare Chambers, *Intact: A Defence of the Unmodified Body* (Allen Lane (Penguin Books) 2022) 44.
[59] ibid 175.
[60] ibid.
[61] ibid 160.
[62] ibid 162.
[63] ibid 133.
[64] ibid 170.

do not need to modify our body, accepting and showing that we spend time and energy trying to make our bodies conform to what is considered beautiful can in itself be a liberating act.[65]

1.3 Agents

The 'agency' side of the structure-agency debate has been advocated by Kathy Davis, who strongly rejects the idea that women are 'blindly driven by forces over which they have no control or comprehension'.[66] After interviewing women who had undergone cosmetic procedures and listening to their reasons for doing so, she contends that cosmetic surgery is about women taking control and 'exercising power' under a set of circumstances they have not chosen.[67] Cosmetic surgery is not 'a form of self-inflicted subordination', but it should be framed as a 'dilemma' where women 'try to alleviate pain and negotiate some space for themselves in the context of a gendered social order'.[68] She argues that cosmetic surgery is primarily about identity, not beauty—a tool for women to remain themselves and not be trapped in a body that has been othered as old and ugly:

> Even under the bleakest conditions, individual women can discover resources which they did not know they had, as they manage to survive or in some cases, it even gives their lives a surprising turn for the better … [C]osmetic surgery can be an understandable step in the context of an

[65] ibid.
[66] Davis, *Reshaping the Female Body: The Dilemma of Cosmetic Surgery* (n 8) 163.
[67] ibid.
[68] ibid 166.

> individual woman's experience of embodiment and of her possibilities for taking action to alter her circumstances.[69]

While acknowledging the problematic context in which women opt for surgery, Davis makes clear that choosing surgery does not mean being more 'oppressed' or 'duped' by the system than rejecting it. Beauty norms affect everyone and what women who have cosmetic surgery do is find their preferred strategy to navigate them to succeed in life. Cosmetic surgery is the most rational strategy for some women, who are merely choosing how to survive in a world where certain embodied features are seen as ugly or deformed.[70]

Thus, Davis's 'agency' feminism admits that cosmetic surgery shapes the body in ways that are 'very traditionally gendered', but refuses to see the decision as coerced or exploitative, framing it instead as a decision 'women consciously make [to] make their bodies mean something to themselves and to others'.[71] Although having cosmetic surgery might be, from a societal perspective, feeding a system that is detrimental for women, at a micro-level, it is a 'rational and empowering' act since it might help those who go for it 'gain considerable self-esteem, status and social power'.[72] Women are not blindly driven by inner or outer pressures: their having surgery 'can be an understandable step in the context of an individual woman's experiences of embodiment and of her possibilities for taking action to alter her circumstances'.[73] In contrast with accounts of decision-making

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[69] ibid 157, 163.
[70] Kathy Davis, 'Revisiting Feminist Debates on Cosmetic Surgery: Some Reflections on Suffering, Agency, and Embodied Differences' in Cressida J Heyes and Meredith Jones (eds), *Cosmetic Surgery: A Feminist Primer* (Ashgate 2009) 45; For criticisms of Davis's account of cosmetic surgery, see eg Bordo (n 35) 31–32; Jeffreys (n 9) 11–13.
[71] Anne Balsamo, 'On the Cutting Edge: Cosmetic Surgery and the Technological Production of the Gendered Body' (1992) 10 Camera Obscura: Feminism, Culture, and Media Studies 206, 226.
[72] Rosemary Gillespie, 'Women, the Body and Brand Extension in Medicine: Cosmetic Surgery and the Paradox of Choice' (1997) 24 Women and Health 69, 81.
[73] Davis, *Reshaping the Female Body: The Dilemma of Cosmetic Surgery* (n 8) 163.

presented in the previous section, for agency feminism, resistance does not come from avoiding or subverting beauty practices, but from managing to live within (even if it is through compliance with) a universe of norms which are set against our imperfect bodies. Women pursuing cosmetic surgery are not more 'oppressed' than those who do not, as it is their way of making their lives more liveable under the current circumstances, and should not be shamed for being 'bad' feminists and giving in to patriarchal norms. In the words of Victoria Blum:

> There is really no difference between the 'good' feminists who resist the seduction and the 'bad' feminists who capitulate. Why would there be a greater degree of cultural emancipation in saying no to surgery than in saying yes? Is there an outside to the picture from which we can calmly assess the difference between our genuine desires and the distortions of consumer capitalism and gender normalisation?[74]

In other words, feminists should not feel guilty about wearing lipstick, wanting to lose weight or have surgery, if that is what makes them feel better.[75] These activities are not the problem per se; the '*the real problem is our lack of choice*',[76] since without putting on make-up, waxing or having surgery, many women 'feel invisible or inadequate'.[77] That is why Naomi Wolf dreams of a time when women 'are able thoughtlessly to adorn themselves with pretty objects when there is no question that *we* are not objects', when choosing what to wear or look like is 'simply one form of self-expression out of a full range of others'.[78] In contrast, Davis insists that, even under 'the bleakest conditions', women

[74] Virginia L Blum, *Flesh Wounds: The Culture of Cosmetic Surgery* (University of California Press 2003) 62–63.
[75] Naomi Wolf, *The Beauty Myth: How Images of Beauty Are Used Against Women* (Harper Collins 2002) 271.
[76] ibid 272-273 (emphasis in original).
[77] ibid 273.
[78] ibid 274.

already choose to 'become embodied subjects rather than objectified bodies'.[79] Nevertheless, both authors agree that 'free' choice is, somehow, possible. Whilst Wolf trusts in an utopian future, seeking to 'make new meanings for beauty',[80] Davis adopts a more pragmatic perspective, seeing cosmetic surgery as a remedy for women to 'alleviate pain and negotiate some space for themselves in the context of gendered social order'.[81] Either way, choice, in current precarious circumstances or in a new emancipated social order, is possible.

Nuancing the idea of 'free' decision-making by acknowledging social pressure without dismissing the possibility of choice altogether is the strategy Chambers also adopts. Already suspicious about whether treasuring the natural body constitutes an emancipatory strategy, she refuses to 'demonize modification' or to convince women that they must 'reject beauty ideals' in order to break free of oppression.[82] Instead of focusing on individual action, she thinks it is more productive to acknowledge that 'we have little choice but to modify our bodies',[83] since these are shaped by 'unjust norms' which make women believe that their 'natural body is deformed or deficient, and that surgery is required to rectify it'.[84] Thus, the answer is not to prohibit cosmetic surgery but to articulate 'collective and 'political' action to 'develop public policies that are effective in tackling body image and low self-esteem as public health issues'.[85] Specifically, in relation to vulval cosmetic surgeries, she claims choice should be enabled through state and communal

[79] Davis, *Reshaping the Female Body: The Dilemma of Cosmetic Surgery* (n 8) 161.
[80] Wolf (n 75) 274.
[81] Davis, *Reshaping the Female Body: The Dilemma of Cosmetic Surgery* (n 8) 180.
[82] Chambers, *Intact, A Defence of the Unmodified Body* (n 58) 38, 44.
[83] ibid 44.
[84] Chambers, 'Medicalised Genital Cutting and the Limits of Choice' (n 17) 75.
[85] Chambers, *Intact, A Defence of the Unmodified Body* (n 58) 295.

actions to reduce the pressure to undergo surgery.[86] For example, these could consist in the introduction of educational programmes to raise bodily awareness and self-esteem for girls and women, and the strict application of FGM legislation, thus restricting vulval surgery to only cases where it is medically indicated, and not when it is sought for cosmetic reasons.[87] (Chapter 5 explores what is meant by 'cosmetic' reasons.)

1.4 Beyond victims and agents

Seeking to get away from the structure-agency conundrum, some commentators refuse to resolve the tension between oppression and choice and instead consider that conceiving the practice of cosmetic surgery as a form of subject formation is a more productive route for feminist analysis. For Victoria Pitts-Taylor, the structure agency-debate—ie seeking the 'truth' about women being 'agents' or 'dupes'—neglects the fact that, whether women decide to have cosmetic surgery or not, and whatever the motivation for their decision is (eg feel prettier, normal, 'themselves'), their decision-making process is always already embedded in power relations.[88] In other words, all (self)-narratives developed around cosmetic surgery are constructed within the context in which cosmetic surgery occurs (and the different actors involved in it, such as doctors, the media and also feminist debates), constituting an 'intersubjective process' in which the cosmetic surgery patient, as such, is created.[89] The person who pursues cosmetic surgery acts, interacts and reacts to forms of intelligibility she has not herself created, but that are already in play and with which she

[86] Chambers (n 17) 75.
[87] ibid 77.
[88] Pitts-Taylor (n 5) 98.
[89] ibid 93.

engages, having a (self)-creative effect.[90] The agency (or lack thereof) that the cosmetic surgery patient is considered to exercise is produced through power relations, enabling various understandings or manifestations of what being a cosmetic surgery subject can be.[91] A feminist examination of this practice should focus on how these forms of subjectivity emerge and operate, rather than if agency itself is ever possible.[92]

Cressida Heyes follows this line of inquiry, arguing that cosmetic surgery is part of normalisation, a phenomenon encoded in modern power, understood in Foucauldian terms. Normalisation should not be interpreted as the process of (only) conforming to standards of beauty (either interpreted as 'subordination' or as a 'rational' strategy to 'survive'), but as a process of self-constitution.[93] There is no 'prior' identity upon which beauty norms are imposed and internalised by the cosmetic surgery patient, but her identity is constituted through her relationship with norms:

> [normalisation] individualises by creating a necessary relationship between each subject and the norm … One's body becomes, paradoxically, both the marker of a deep, inner truth, and a signifier of one's relationship to a social standard … the subjectivities that disciplinary power constructs for us become the fact of who we are—enabling the very grounds of our existence as individuals—and constraints on how our self-identity may be expressed.[94]

Except for this third stream of literature, concerned with analysing cosmetic surgery as a process of subject formation, the focus of feminist scholarship has been on the role of gendered or patriarchal oppression with regards to decision-making. The underlying

[90] ibid 159.
[91] Suzanne Fraser, 'The Agent Within: Agency Repertoires in Medical Discourse on Cosmetic Surgery' (2003) 18 Australian Feminist Studies 27, 32.
[92] ibid 27.
[93] Cressida J Heyes, 'Normalisation and the Psychic Life of Cosmetic Surgery' (2007) 22 Australian Feminist Studies 55, 56.
[94] ibid 59.

challenge of the structure-agency debate is to determine the connection between decision-making and patriarchal power, with the main dilemma being whether having cosmetic surgery, or any other sort of body modification, can ever be the product of free choice or a strategy for emancipation. This framing of oppression contrasts with how this discussion has taken place in the context of intersex surgeries, where, as we will see in the next section, the main challenge the literature encounters is not whether it is ever possible to make genuine choices under conditions of oppression, but rather the terms in which gendered norms leave intersex individuals without viable options other than surgery.

2 Intersex surgery

As an initial caveat, this section does not address the issue of proxy-decision making that, as introduced in Chapter 2, commonly features in discussions about intersex surgeries, with parents consenting on behalf of their children to irreversible interventions when they are still at a very young age. Rather, its focus is on studying how feminist literature and intersex activism have taken issue with whether and how decisions regarding surgery, usually made initially by parents and eventually by intersex patients themselves, are embedded in gendered ideals about the body.

2.1 Gender transgression

The argument put forward by feminist commentators that vulval cosmetic surgery is an intervention encoded in and committed to upholding patriarchal norms about the body also resonates in criticisms made in relation to intersex interventions. In a nutshell, some strands of feminist thought and intersex advocacy contend that the reason why the medical

profession has targeted intersex bodies for surgery is because they are seen as disrupting the gender binary.[95] Chapter 1 explained how Money's protocols, which ruled intersex management from the mid 1960s up until the early 2000s, insisted on early surgery to delineate clear genitalia, as well as on 'unconfused' gender rearing practices. Current guidelines on the clinical management of intersexuality are more cautious regarding the performance of early surgery and stress the importance of transparency with patients and family.[96] However, as Chapter 4 shows, these arguably continue to see intersexuality as a problematic embodied state which needs special medical, and also psychological, attention.

Foucauldian notions of power and discipline feature prominently in criticisms of the medical management of intersexuality. In her foundational work, Anne Fausto-Sterling contends that the medical treatment of intersex individuals 'provides a clear example of what … Foucault has called biopower'.[97] Medicine disseminates and imposes 'pervasive standards that structure and define social meaning', assessing, classifying and correcting intersex bodies so they fit into the normal gender binary that is expected of bodies.[98] The pathologisation of intersex embodiment 'as a form of natural error in need of correction'[99] consists in an instance of 'normalisation',[100] not only a process through which the medical apparatus imposes its vision of 'normal' embodiment upon unruly bodies, but also a

[95] See eg Stephanie S Turner, 'Intersex Identities: Locating New Intersections of Sex and Gender' (1999) 13 Gender and Society 458; Sharon E Preves, *Intersex and Identity: The Contested Self* (Rutgers University Press 2003) 11; Judith Butler, *Undoing Gender* (Routledge 2004) 58; Anne Fausto-Sterling, 'The Five Sexes' (1993) 40 The Sciences.
[96] IA Hughes and others, 'Consensus Statement on Management of Intersex Disorders' (2006) 91 Archives of Diseases of Childhood 554; Lee and others (n 3).
[97] Fausto-Sterling, 'The Five Sexes' (n 95) 24.
[98] Ellen K Feder, 'Imperatives of Normality: From "Intersex" to "Disorders of Sex Development"' (2009) 15 GLQ: A Journal of Lesbian and Gay Studies 225, 231.
[99] Hilary Malatino, *Queer Embodiment: Monstrosity, Medical Violence, and Intersex Experience* (University of Nevada Press 2019) 37.
[100] Feder (n 98) 231.

productive endeavour through which intersex people are constituted as subjects (that is, as deviant individuals in need of treatment).[101] Through a Foucauldian lens, therefore, it would be wrong to see the medical 'disciplining' of intersexual bodies (ie their classification as diseased and requiring medical attention) as only repressive, since their medicalisation and pathologisation also has a productive effect.[102]

In this regard, Jemina Repo argues that Money's protocols not only create a new idea of the intersex patient (as a subject who needed constant surveillance and policing in order to adequately learn to embody their manhood or womanhood), but also a new and pervasive notion of gender.[103] Indeed, Chapter 1 laid out how the idea of the 'intersexual' subject has shifted throughout history, and that it was not until the 1950s, with the popularisation of Money's work, that intersexuality came to be conceived as a condition that needed to be treated from infancy. The intersex child then became a subject who 'through surgical alteration of the genitals … could be psychologically managed into a different-sex desiring subject and hence became a subject useful for the reproduction of social order'.[104] Likewise, as discussed in the Introduction, it is with Money that the idea of gender as a human characteristic to be studied, diagnosed and upheld through several

[101] Morgan Holmes, *Intersex: A Perilous Difference* (Selinsgrove: Susquehanna University Press 2008) 53.
[102] Feder (n 98) 234.
[103] Jemima Repo, 'The Biopolitical Birth of Gender: Social Control, Hermaphroditism, and the New Sexual Apparatus' (2013) 38 Alternatives: Global, Local, Political 228, 240.
[104] ibid 235.

branches of medical expertise, from endocrinology to gynaecology and psychiatry, was born.[105]

Through a Foucauldian lens, the medical profession becomes an instance of power targeting intersex bodies for surgical and psychological treatment, making them 'docile' to uphold the 'normal' categories that atypical embodiment made impossible. The underlying fuel for this normalising endeavour is, Fausto-Sterling argues, the 'cultural need to maintain clear distinctions between the sexes', which intersexual bodies 'blur and bridge'.[106] When an intersex baby is born, the medical announcement 'it is a girl!' or 'it is a boy!', which, normally, 'shifts an infant from an "it" to a "she" or a "he"', and puts in motion a gendering process by which that baby will be 'girled' or 'boyed',[107] cannot happen, since the baby's genitals do not belong to either of the 'normal' categories which enable this binary classification. Genital ambiguity prevents the baby from fitting within the framework defining the 'normal' person and shaping the expectations of parents, doctors, and society in general.

Some parents with intersex babies recall their child's birth as traumatic because they felt as though their baby was in a 'limbo', with doctors advising them not to name them until tests revealed if they should be assigned male or female gender.[108] Likewise, after finding out about their diagnosis, some intersex patients explain that they found themselves in an 'impossible subject position', feeling like a 'failure' of the natural forms

[105] Jennifer Germon, *Gender: A Genealogy of an Idea* (Palgrave Macmillan 2009) 86–87.
[106] Fausto-Sterling, 'The Five Sexes' (n 95) 24.
[107] Judith Butler, *Bodies That Matter: On the Discursive Limits of Sex* (Routledge 1993) xviii.
[108] Katrina Karzakis, *Fixing Sex. Intersex, Medical Authority and Lived Experience* (Duke University Press 2008) 90.

of maleness and femaleness.[109] That is why Judith Butler contends that intersex individuals 'do not appear properly gendered', occupying the '"unliveable" or "uninhabitable" zones of social life',[110] at least until surgeries 'make the unruly body conform to one or the other gender'.[111] Intersex is seen as a state of 'exception' or 'emergency' which requires the intervention of the medical profession in order to bring it within the normal and intelligible dichotomous gender structure.[112]

The previous chapter illustrated how parents' anxieties about whether their child will have a 'normal' upbringing and development, potential issues of bullying or teasing by peers, as well as the stress that might come with the self-realisation of not belonging to either of the 'normal' gender categories, have been repeatedly deployed as rationales for (early) surgery. These justifications, some academics and intersex activists argue, despite relying on real concerns and problems intersex people might face, are embedded in binary visions of gender, which medical professionals, parents and intersex people should move beyond and challenge.[113] As Katrina Karzakis summarises:

> The rhetoric of technological ease, expertise, and improvement masks the anxiety raised by gender-atypical bodies and avoids any moral discussion of the pathologisation of such bodies, the conceptualisation of genitals as malleable organs—rather than healthy parts of people—and the cultural and medical imperative to make normatively gendered subjects … In short,

[109] Malatino (n 99) 18–19.
[110] Butler (n 107) xiii.
[111] Turner (n 95) 458.
[112] Georgiann Davis and Erin L Murphy, 'Intersex Bodies as States of Exception: An Empirical Explanation for Unnecessary Surgical Modification' (2013) 25 Feminist Formations 129, 147.
[113] Karzakis (n 108) 99; Cheryl Chase, 'Hermaphrodites with Attitude: Mapping the Emergence of Intersex Political Activism' (1998) 4 GLQ: A Journal of Lesbian and Gay Studies 191.

> surgery locates the problem in the child's genitals, not in social conceptualisations of what counts as sex.[114]

In order for the medical system to cease to enforce binarism on intersex bodies, Cheryl Chase, the founder of Intersex Society of North America (ISNA), once argued that the 'heteronormative assumptions that underlie the violence directed at our bodies' must be 'queered', opening the door for sexual ambiguity.[115] Indeed, the medical profession would not see it as necessary to surgically ensure that intersex bodies fit the anatomical ideals of 'men' and 'women' if we lived in a world where gender would 'multiply beyond currently imaginable limits', where we would not care 'if a "woman", defined as one who has breasts, a vagina, a uterus and ovaries and who menstruates, also has a clitoris large enough to penetrate the vagina of another woman'.[116] Trying to 'widen' the current dichotomous visions of gender, Fausto-Sterling, who first made the proposal of a five sex system,[117] attempting to cover all sorts of varied gendered anatomies, contends that we should 'turn everyone's focus away from the genitals'.[118] She argues for a world where 'medical science has been placed at the service of gender variability, and genders have multiplied beyond currently fathomable limits'.[119] In her view, we need to rethink how we see and interpret the body and reconsider 'the status of the natural and the continuities between sex, gender,

[114] Karzakis (n 108) 137.
[115] Chase, 'Hermaphrodites with Attitude: Mapping the Emergence of Intersex Political Activism' (n 113) 138.
[116] Fausto-Sterling, 'The Five Sexes' (n 95) 24.
[117] ibid 21.
[118] Anne Fausto-Sterling, *Sexing the Body. Gender Politics and the Construction of Sexuality* (Basic Books 2000) 110.
[119] ibid 101–110.

and sexuality', thus creating new possibilities of existence for those whose genitals appear to not 'make sense' along the male/female binary.[120]

On the basis of this idea of destabilising (binary) gender and its 'monolithic' correlation with anatomy, Chase and Fausto-Sterling each claim that early surgery to 'normalise' children's genitalia should not be considered proper medical practice. Surgery should only be indicated to tackle life-threatening conditions, such as removing cancerous gonads, unblocking the urinary tract or removing a hernia.[121] However, they also advocate gender assignment of all children as male or female.[122] Whilst acknowledging that, in an ideal world, gender 'multiplicity' would also entail rethinking gender assignment altogether, they acknowledge that this move currently asks for considerable, and perhaps excessive, braveness from intersex children and their families.[123] Admitting that 'the two sex/gender model is currently hegemonic', they argue that raising intersex children as boys or girls whilst leaving their genitalia untouched is already a 'wilful disruption of the assumed concordance between body shape and gender category'.[124]

This is the strategy of intersex management that was adopted in the 2006 Chicago Consensus Statement. Chase, having pioneered the fight against Money's protocols, was a key player in its elaboration.[125] The new statement established that, after careful

[120] Malatino (n 99) 24.
[121] Fausto-Sterling, 'The Five Sexes' (n 95) 24; Chase, 'Hermaphrodites with Attitude: Mapping the Emergence of Intersex Political Activism' (n 113) 198.
[122] Chase, 'Hermaphrodites with Attitude: Mapping the Emergence of Intersex Political Activism' (n 113) 198; Fausto-Sterling, 'The Five Sexes' (n 95) 24.
[123] Fausto-Sterling, 'The Five Sexes' (n 95) 24.
[124] Chase, 'Hermaphrodites with Attitude: Mapping the Emergence of Intersex Political Activism' (n 113) 198.
[125] Georgiann Davis, *Contesting Intersex: The Dubious Diagnosis* (New York University Press 2015) 44.

examination, all intersex babies should be assigned a gender, and early surgery should be discouraged (although, as Chapter 2 and 5 show, it is still not unusual to surgically 'fix' cases of 'severe virilisation' early on).[126] Advocating gender assignment, the Statement does not disrupt gender binarism or offer revolutionary new 'ways' of existing in the world for intersex individuals. However, in practical terms, it does represent a step towards stopping (or, at least, delaying) the surgical enforcement of gender norms on their bodies.

As previous chapters have discussed, gender norms also intersect with racialised ideals. Chapter 1 discussed how colonial science conflated intersexuality with blackness during the 19th century. Amanda Lock Swarr contends that this association still remains strong today, tracing how, although there is no clear evidence or data suggesting increased 'commonality of intersex among South Africans', 'countless studies' among the scientific literature have been repeating this unproven fact for more than fifty years.[127] The ease with which scientists and medical professionals have uncritically assumed that African people are naturally more prone to intersex conditions bears witness, she argues, to the colonial

[126] Hughes and others (n 96).
[127] Amanda Lock Swarr, *Envisioning African Intersex. Challenging Colonial and Racist Legacies in South African Medicine* (Duke University Press 2023) 56; See, for example JJL De Souza and others, 'True Hermaphroditism. A Case Report with Observations on Its Bizarre Presentation' (1984) 66 South African Medical Journal 855; IA Aaronson, 'True Hermaphroditism. A Review of 41 Cases with Observations on Testicular Histology and Function' (1985) 57 British Journal of Urology 775.

legacy which first laid down the association between doubtful and racialised embodiment.[128]

Perhaps the most recent case that exemplifies the conflation of gender ambiguity with blackness is the 'scandal' of Caster Semenya, the outstanding South African runner whose womanhood has been repeatedly questioned because of her alleged intersex condition. First banned from racing in 2009, Semenya was not allowed to participate in the Tokyo Olympic Games because she refused to artificially lower her naturally high levels of testosterone, which were seen to threaten fair competition.[129] Notwithstanding that the International Olympic Committee and World Athletics discontinued compulsory 'gender verification' tests for all female athletes in the late 1990s, they have now adopted a suspicion-based regime whereby athletes running in the female category might be requested to undergo testing if any suspicions arise that they might have higher levels of testosterone due to an intersex condition.[130] Signs of hyperandrogenism include being more muscular, strong and fast, which is why not only has Semenya been repeatedly singled out

[128] For a recent example, see Patrick Fénichel and others, 'Molecular Diagnosis of 5α-Reductase Deficiency in 4 Elite Young Female Athletes through Hormonal Screening for Hyperandrogenism' (2013) 98 Journal of Clinical Endocrinology and Metabolism 1055.
[129] For further discussion on the history of intersexuality in the sports world, see Mireia Garcés de Marcilla Musté, 'You Ain't Woman Enough: Tracing the Policing of Intersexuality in Sports and the Clinic' (2022) 31 Social and Legal Studies 857.
[130] ibid 855–858.

for testing, but also why she has been subject to constant public scrutiny and shameful comments about her body not being female enough.[131]

The ban imposed on Semenya, and most recently on two other African sprinters, Christine Mbomba and Beatrice Masilingi,[132] triggered a strong response in South Africa, where their treatment has been criticised for being a colonial legacy which carries on 'racist imposition[s] by the Global North'.[133] Both the popular press and academic scholarship have compared Semenya to Saartje Baartman (introduced in Chapter 1) as tragic 'paradigmatic examples' of how African women are publicly ridiculed by the West for failing to confirm to (Western) visions of fragile and delicate femininity.[134] With her case against World Athletics now pending in front of the European Court of Human Rights,[135] Semenya contends that she is a victim of 'racism', asking 'who are white people to question the make-up of an African girl?'.[136]

The Semenya case is exemplary of how debates about intersexuality not only feature concerns about the influence of binary visions of embodiment, but also about how

[131] For example, see David Smith, 'Caster Semenya Sex Row: "She's My Little Girl," Says Father' *The Guardian* (20 August 2009).
[132] 'Namibian Teenagers Out of Olympic 400m over Testosterone Levels' *BBC Sport* (2 July 2021).
[133] Swarr (n 127) 109.
[134] Brenna Munro, 'Caster Semenya: Gods and Monsters' (2010) 11 Safundi: The Journal of South African and American Studies 383, 390; Zine Magubane, 'Spectacles and Scholarship: Caster Semenya, Intersex Studies, and the Problem of Race in Feminist Theory' (2014) 39 Signs: Journal of Women in Culture and Society 761, 767; Swarr (n 127) 106.
[135] European Court of Human Rights, 'Notification of *Semenya v Switzerland* (Press Release)'.
[136] David Smith, 'Who Are White People to Question the Make-up of an African Girl? It Is Racism' *The Guardian* (23 August 2009).

the white gaze influences the reading of black bodies, at least in the sports context, as 'doubtful'.[137]

2.2 Stigma and trauma

Just as there have been disagreements between feminist commentators with regards to how oppression should be conceived and how resistance to it should be articulated regarding (vulval) cosmetic surgery, it has also been a dilemma within the intersex context. As the last section has shown, some scholars, such as Kessler, Karzakis, Butler or Fausto-Sterling, and activists, like Chase in the 1990s, have been keen on framing the medical management of intersexuality as an example of the oppressiveness of current conceptions of gender. Nevertheless, some sectors of intersex advocacy, Chase included, have been increasingly less willing to see their body as subversive or constrained by any gender norms.

During the early 2000s, Chase renounced her initial position that it is necessary to 'queer' the binary and 'destabilise the heteronormative assumptions that underlie the violence directed at our bodies'.[138] Instead, she is now suspicious of seeing the problems of how the medical profession treats intersex patients as having to do with gendered ideals about embodiment.[139] Distancing herself from the feminist academics introduced above, she criticises those she formerly considered allies for using intersexuality as a tool for the

[137] Neville Hoad, '"Run, Caster Semenya, Run!" Nativism and the Translations of Gender Variance' (2010) 11 The Journal of African and American Studies 397, 388.
[138] Cheryl Chase, '"Cultural Practice" or "Reconstructive Surgery"? US Genital Cutting, the Intersex Movement, and Medical Double Standards' in S James and C Robertson (eds), *Genital Cutting and Trasnational Sisterhood. Disputing US Polemics* (University of Illinois Press 2002) 138.
[139] David A Rubin, *Intersex Matters. Biomedical Embodiment, Gender Regulation, and Transnational Activism* (State University Press of New York 2017) 77; Karzakis (n 108) 247.

'ludicrous' endeavour of imagining more fluid ideas of gender.[140] This perspective, she argues, neglects what really is the core issue for intersex people: how doctors have been performing unnecessary surgery on them as new-borns, condemning them to a life of stigma, secrecy and shame.[141] Intersexuality, she insists, 'is primarily about stigma and trauma, not gender'.[142] In her own words:

> I think that a lot of people in women's studies imagine that the existence of intersex people is a justification for creating a future that is radically different. What I like to remind them is that intersex people have not been subjected to such intense and harmful medicalization for very long … So, radical restructuring is not required in order for us to make the world an easier place for intersex people to live in.[143]

Just as Kathy Davis claims that women's voices must be heard in order to understand their experience and desire for undergoing cosmetic surgery,[144] Chase argues that scholars who work on intersex matters should listen to intersex voices, and echo their concerns, which, she contends, are mostly about ending early surgery and tackling psychological trauma, and not about deconstructing or rethinking gender.[145] Intersex individuals should not be

[140] Vernon A Rosario, 'An Interview with Cheryl Chase' (2006) 10 Journal of Gay and Lesbian Psychotherapy 93, 94–96.
[141] ibid.
[142] Cheryl Chase, 'What Is the Agenda of the Intersex Patient Advocacy Movement?' (2003) 13 The Endocrinologist 240, 240.
[143] Rosario (n 140) 98–99.
[144] Davis, *Reshaping the Female Body: The Dilemma of Cosmetic Surgery* (n 8) 166–168.
[145] Emi Koyama and Lisa Weasel, 'From Social Construction to Social Justice: Transforming How We Teach About Intersexuality' (2002) 30 Women's Studies Quarterly 169, 175–176; D Dreger Alice and April M. Herndon, 'Progress and Politics in the Intersex Rights Movement. Feminist Theory in Action' (2009) 15 GLQ: A Journal of Lesbian and Gay Studies 199, 218.

used as 'hermaphrodite caryatids' bearing the burden of troubling gender, as though their ambiguous status 'oblige[d] [them] to act as advocate[s] of non-normative agendas'.[146]

Whilst they were still active, ISNA made clear that their main quest was not to eradicate gender.[147] ISNA and other intersex activists insist that the majority of intersex people are happy with their assigned gender at birth, and do not want to be used as 'concepts' by academic feminism and the LGBTIQ+ community to exemplify the instability of gender and possibilities for its challenge.[148] Like Chase, they insist that the key issue, rather than disrupting 'normal' gender expectations, is having had to undergo irreversible genital interventions at an early age, and the secrets, lies and shame that accompanied such operations.[149] Hence, some intersex individuals do not see themselves (and do not want to be seen) as disrupting the gender binary and not even part of the LGBTIQ+ community, since their priority is ending the human rights violations intersex people face from the moment of birth.[150] As Mitchell Travis and Fae Garland put it, some intersex individuals understand their struggle not in terms of 'doing queer', as what they want is just to have their bodily autonomy respected.[151] Therefore, the main contentious issue for some sectors of intersex activism is not that medical protocols enforce gender norms, but that they are undertaken with questionable ethical standards, which can and

[146] Holmes (n 101) 16–19.
[147] Intersex Society of North America (ISNA), 'Why Doesn't ISNA Want to Eradicate Gender?' <https://isna.org/faq/not_eradicating_gender/> accessed 8 April 2021.
[148] Mitchell Travis and F Garland, 'Queering the Queer/Non-Queer Binary: Problematizing the "I" in LGBTI+' in S Raj and P Dunne (eds), *The Queer Outside in Law* (Palgrave Macmillan 2021) 177.
[149] Intersex Society of North America (ISNA) (n 147).
[150] See eg 'ILGA-Europe: Intersex' <https://www.ilga-europe.org/what-we-do/our-advocacy-work/trans-and-intersex/intersex> accessed 23 April 2021.
[151] Travis and Garland (n 148) 173.

should be amended by working with the medical profession, without having to challenge gender altogether.

This is however not the homogeneous position among intersex activism, as there are also those who, refusing to collaborate with medical professionals, continue to see medical treatment as a catalyst for oppressive gender ideals. For instance, Organisation Intersex International Network (OII), in addition to advocating change to end 'the fear, shame, secrecy and stigma experienced by children and adults through the practice of non-consensual normalisation treatments', also claims that medical protocols naturally flow from society's 'rigid views on sex' and 'the cultural influence which demands only two sexes'.[152] Intersex surgeries, OII claims, constitute 'medical experimentation that has the primary aim of eliminating our differences from the ways it is possible to be human'.[153]

The 'fight' between these two perspectives on how to conceive intersexuality (and its management by the medical profession) is reflected in the very contentious issue of terminology, a controversy that was fuelled by the introduction of the much disputed label of 'Disorders of Sex Development' in the 2006 Chicago Consensus Statement.[154] As 'intersex' or 'hermaphroditism' had become terms perceived as 'pejorative by patients' and 'confusing to practitioners and parents', DSD was argued to be a more appropriate term, 'sensitive to the concerns of patients' and 'sufficiently flexible to incorporate new information yet robust enough to maintain a consistent framework'.[155] Nevertheless, OII considered this new label to be 'repugnant', as it defined intersex embodiment as

[152] 'OII Intersex Network' <https://oiiinternational.com/> accessed 23 April 2021.
[153] ibid.
[154] Hughes and others (n 96) 554.
[155] ibid.

'somehow variant from the natural order of things', providing a 'license to affect a "cure"'.[156] DSD foreclosed intersexuality to the medical world, deeming it a *medical* problem which needs *medical* expertise and requires *medical* treatment.[157] Seeking to steer away from this framing, 'Differences of Sex Development' was proposed as a better alternative, allowing for the conceptualisation of intersexuality as an anatomical variation while avoiding pathologisation.[158]

Whether intersexuality should be perceived as a difference or a disorder is a conundrum which presents interesting parallels with debates that have occupied a central place with regards to disability. An illustrative example where this discussion unfolded was the famous case of a deaf same sex female couple who sought a deaf sperm donor in order to increase the chances that they would have a deaf child.[159] These women did not see deafness as a medical problem needing prevention and cure, but precisely the opposite since, in their own words, 'a deaf baby would be a special blessing'.[160] For them, Deafness (with a capital D) constituted an identity, and sign language was a cultural asset they wanted their child to acquire. Drawing a parallel between being Deaf and Black or Latino, they explained they wanted a child who 'can feel related to that culture, bonded with that culture'.[161] For them, having a non-deaf child constituted a barrier they were not sure they could overcome, as they believed they could be 'better parents' if their child could be fully

[156] OII Intersex Network, 'About the Term Intersex Versus the Term DSD ' <https://oiiinternational.com/2524/term-intersex-term-dsd/> accessed 1 June 2022.
[157] Sarah S Topp, 'Against the Quiet Revolution: The Rhetorical Construction of Intersex Individuals as Disordered' (2013) 16 Sexualities 180, 189.
[158] ibid 191; Ellen K. Feder and Katrina Karkazis, 'What's in a Name?: The Controversy over "Disorders of Sex Development"' (2008) 38 Hastings Center Report 33, 34.
[159] Liza Mundy, 'A World of Their Own' *The Washington Post* (2002).
[160] ibid.
[161] ibid.

integrated in their community, as it would be easier to 'talk to [them], understand [their] emotions, guide [their] development, [and] pay attention to [their] friendships'.[162] Their decision was strongly criticised, and they were accused of 'being selfish',[163] and 'restricting the range of their children's options' by precluding them from experiencing the hearing world.[164] Rather than a cultural identity, deafness, for some, is an important 'limitation' in life which 'access to deaf culture' does not compensate for.[165]

Whilst OII shares a similar view to that of those mothers, seeing intersexuality as an identity to be treasured, reclaimed and defended against medicalisation,[166] Accord Alliance, the 'heir' organisation of ISNA after it closed its doors in 2008, like critics in the deafness debate, considers that intersexuality does not (and should not) constitute an identity since it is 'a condition that a person *has*, not who a person *is*'.[167]

This debate is helpful in showing that there are two main tendencies on how the discussion about the role of gender pressure or oppression has unfolded. On the one hand, there are those who frame lack of choice and negative physical and psychological effects of medical treatment as an issue of 'badly exercised' medical power. Within this understanding, choice can be enabled by tackling concrete aspects of intersex medical care, such as facilitating open communication between families and medical professionals, delaying irreversible surgical decisions until the child is old enough to consent, and

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[162] ibid.
[163] M Spriggs, 'Lesbian Couple Create a Child Who Is Deaf like Them' (2002) 28 Journal of Medical Ethics 283, 293.
[164] Neil Levy, 'Deafness, Culture, and Choice.' (2002) 28 Journal of Medical Ethics 284, 284.
[165] ibid.
[166] 'OII Intersex Network' (n 152).
[167] 'Accord Alliance - Better Lives. Better Outcomes' (emphasis in original) <https://www.accordalliance.org/> accessed 23 April 2021.

improving research on the long-term effects of normalising early and non-early surgeries.[168] On the other hand, others argue that intersex surgeries, during Money's era and still today, are underpinned by binary notions of gender which make it impossible to imagine 'normal' and 'healthy' bodies outside the male/female binary. Intersex individuals will not have a real option of saying 'no' to surgery without risking being othered until gender is reimagined and having ambiguous genitalia is no longer seen as a medical problem that requires medical solutions. Questioning and amending medical protocols is an important step in practical terms, but there also needs to be a conceptual shift on how gender is conceived in order for intersex people to be 'free' to live in their now deemed abnormal bodies.

In contrast with the debate regarding (vulval) cosmetic surgeries introduced above, the discussion about oppression within intersex interventions does not centre around determining the motivation behind, or the degree of autonomy in, having surgery. The issue is not whether intersex patients are dupes or agents, whether patriarchal oppression infiltrates their mind or whether it is a strategy for them to cope with ever increasing bodily ideals. Rather, within debates about intersexuality, there seems to be a relative agreement about why surgery is performed: to fix aspects of the genitals that are seen in need of fixing. The main topic of contention is whether and to what extent this need for, and sometimes enforcement of, surgery derives from constrained gendered ideals, or, on the contrary, has

[168] Accord Alliance (n 167). ISNA sponsored this new organisation, which 'promotes comprehensive and integrated approaches to care that enhance the health and well-being of people and families affected by differences of sex development'. .

nothing to do with gender, implying that the autonomy of patients can be upheld by ensuring certain ethical standards within the medical profession.

This distinct framing of cosmetic and intersex interventions is partly due to the fact that being subjected to irreversible unconsensual surgeries at an early age has not been a challenge cosmetic surgery patients have had to encounter. However, the fact that the literature discussing intersex operations is relatively uninterested in answering the question of 'why would someone submit themselves to surgery?' might also reveal presumptions about how the vulva operated on in each case is imagined to be like. In the context of intersex surgeries, the reasons why the medical profession sees the vulva in need of surgery is clear: it does not look like a 'definitive' vulva. With features like clitoral enlargement, labial fusion, scrotalised labia or a lack of or incomplete vaginal orifice, the genitals do not meet the standards for being seen as 'clear' vulvas and hence trigger medical attention. Thus, the reason why someone undergoes surgery is seen as almost self-explanatory. The dilemma that opens up is how to frame surgery, as a medical or gender issue, and how to ensure that intersex patients have their decision-making options enabled or enhanced, either through changing how gender is understood or by amending medical protocols.

3 Female Genital Mutilation

Feminist debates about FGM share a great degree of resemblance with those surrounding vulval cosmetic surgery. Scholars are also torn in their arguments about whether women have a choice or, in the contrary, are forced into undergoing this intervention. Nevertheless, in contrast with the discussion about cosmetic surgery, a great deal of which incorporates

a critique of consumer culture, most of the discussion regarding FGM has centred on the (post)colonial framing of this form of vulval cutting, with most criticisms concerning the negotiation around cultural imperialism, relativism and 'anti-African prejudice'.[169]

3.1 Inferiority

As shown in Chapter 1, it was because of the influence of the work of feminists like Fran Hosken that the World Health Organization (WHO) and other international organisations began to consider FGM a form of patriarchal abuse.[170] Indeed, FGM rose to prominence as a 'mission' of the 1970s feminist movement, with US feminist leaders like Hosken, Gloria Steinem and Mary Daly denouncing FGM as a 'barbaric atrocity' against women.[171] They saw it as a brutal manifestation of 'planetary patriarchy'[172] which required international 'sisterhood' from all over the world to fight against this abhorrent crime that 'deprives [women] of their own sexuality and "tightens [them] up" for their master's pleasures'.[173]

Hosken rejected the claim that cultural tolerance entails accepting FGM as a beneficial or harmless practice.[174] Defending herself from accusations of racism, she claimed that what is 'racist and sexist' is 'to pretend that little girls and women because they are black or brown and live in a different environment and culture do not feel pain and

[169] Lisa Wade, 'Learning from "Female Genital Mutilation": Lessons from 30 Years of Academic Discourse' (2012) 12 Ethnicities 26, 41.
[170] Nikki Sullivan, '"The Price to Pay for Our Common Good": Genital Modification and the Somatechnologies of Cultural (in)Difference' (2007) 17 Social Semiotics 395, 398.
[171] See eg Fran P Hosken, *The Hosken Report: Genital and Sexual Mutilation of Females* (Fourth revision, Women's International Network News 1994); Gloria Steinem, 'The International Crime of Female Genital Mutilation' (1979) Ms; Mary Daly, *Gyn/Ecology. The Metaethics of Radical Feminism* (Beacon Press 1978) 153.
[172] Daly (n 171) 154.
[173] ibid 160.
[174] Fran P Hosken, 'Female Circumcision and Fertility in Africa' (1975) 1 Women and Health 3, 10.

are not terribly damaged by having their genitalia excised'.[175] She draws a link between the development of women and the development of countries, and argues that, unless FGM is tackled, modernisation is 'bound to fail'.[176] Almost mimicking the narrative of colonial governments, discussed in Chapter 1, who tried to convince their population of abandoning FGM as it was 'holding [them] back',[177] she claims that a nation cannot 'develop if the potential of half of its population is kept in dependence, mutilated and in servitude as pawns of fertility to fulfil the aspirations of men'.[178] Thus, it is the duty of feminists around the world to raise awareness among the international community, so the UN and WHO can start programmes which put an end to the 'needless torture of female children'.[179]

In a similar vein, Daly also sees FGM as an 'African' phenomenon constitutive of an 'unspeakable atrocity'.[180] Those who accuse her of racism for 'nam[ing] these practices for what they are' are 'ignorant', as they fail to see that it is 'clearly in the interest of Black women that feminist of all races should speak out'.[181] Ignorance is precisely the reason other commentators offer for why some women who have FGM seem to be able to experience sexual pleasure.[182] Hanny Lightfooot-Klein argues that the fact that some women are 'unaware' that not being cut is an alternative might make them more 'adaptable'

[175] ibid.
[176] ibid.
[177] Heather Bell, *Frontiers of Medicine in the Anglo-Egyptian Sudan, 1899-1940* (Clarendon Press 1999) 25.
[178] Hosken, 'Female Circumcision and Fertility in Africa' (n 174) 10.
[179] ibid.
[180] Daly (n 171) 154.
[181] ibid.
[182] Hanny Lightfoot-Klein, 'The Sexual Experience and Marital Adjustment of Genitally Circumcised and Infibulated Females In The Sudan' (1989) 26 The Journal of Sex Research 375, 390.

to their realities, enabling them to 'persist despite physical pain and psychic trauma', within their 'rigid' societies where they are assigned a clear 'role and code of behaviour'.[183]

The framing of FGM as a distinctly African and backwards intervention whose practice and acceptability stems from ignorance and patriarchal subjugation, implying the responsibility of global feminists to intervene and help their African sisters, has encountered a severe backlash.[184] Nawal El Saadawi has challenged the vision of those who engage in FGM as 'barbaric, uncivilised, morally, mentally and sexually debased people', contending that this vision is yet another justification the West offers for its colonialist endeavours, disguising them as 'an emancipatory effort'.[185] Instead, she articulates her opposition to FGM by claiming that women's oppression must be contextualised, within global and local politics.[186] FGM is not markedly African but a 'universal phenomenon' which has 'nothing to do with any religion or any ethnic group', as it is 'related to the slave systems that have appeared in *all* continents *everywhere* in history'.[187] Engaging in what some might call a Marxist analysis, she claims that this form of vulval cutting must be read as part of the history and evolution of patriarchal societies, and understood as a technique adopted due to 'certain economic and political forces'.[188] In order to maintain their dominance over women, she claims, 'male dominated societies' had

[183] ibid 392.
[184] Wade (n 169) 39.
[185] Nawal El Saadawi, 'Imperialism and Sex in Africa' in Obioma NNaemeka (ed), *Female Circumcision and the Politics of Knowledge. African Women in Imperialist Discourses* (Praege Publicaitons 2005) 24.
[186] Nawal El Saadawi, *The Nawal El Saadawi Reader* (Zed Books) 66.
[187] ibid 65 (emphasis in original).
[188] Nawal El Saadawi, *The Hidden Face of Eve* (Zed Books 1980) 41.

to come up with 'ingenious devices' to keep women's sexuality under check and, in some contexts, vulval cutting was the chosen way to 'subjugate' and 'control' women.[189]

Seble Dawit and Salem Mekuria make a similar point, explaining that FGM must be understood to operate within 'part of the social fabric, stemming from power imbalance in relations between the sexes, from the levels of education and the low economic and social status of most women'.[190] They criticise accounts of FGM which portray African women as in need of saving, and Western feminist allies as 'heroine-savior[s]' who take their mission towards FGM as 'the gender oppression to end all oppressions'.[191]

3.2 Difference

As the previous section has shown, the view of Hosken and others has been accused of being underpinned by what Leslye Amede Obiora calls 'positional superiority', according to which FGM is seen as exotic, dangerous, oppressive and completely impermissible under Western (but universally invoked) standards of dignity and equality, without acknowledging the reality of those who practice it.[192] The conflation of FGM with 'savage' or 'religious' violence is thus seen to stem from the 'arrogant perception' from which the West, self-positioned as the 'centre of the universe', reads and imposes on the world its own vision of what is right or wrong, reinforcing colonial legacies of 'us versus them', where 'them' can only be perceived through 'our' lenses, having no independent existence

[189] ibid 38.
[190] Seble Dawit and Salem Mekuria, 'The West Just Doesn't Get It ' *The New York Times* (7 December 1993).
[191] ibid.
[192] L Amede Obiora, 'Bridges and Barricades: Rethinking Polemics and Intransigence in the Campaign against Female Circumcision' (1997) 47 Case Western Reserve Law Review 275, 377.

from the perception 'we' impose, thus leading to 'false' and 'oversimplified' accounts of what 'they' do.[193]

Acknowledging this critique, some scholars re-articulated their opposition to FGM through what Lisa Wade has referred to as the 'difference frame'.[194] Rather than seeing FGM as an inferior practice, some commentators have adopted a less hostile view, seeing it also as a sign of love, belonging and tradition.[195] In a similar vein to Kathy Davis's work on cosmetic surgery, some researchers have advocated paying attention to women's narratives and experiences.[196]

Studying the practice from the 'inside' shows that, rather than its passive victims, women might be active agents of vulval cutting. They are usually the ones performing the procedure and deciding whether their daughters will undergo FGM, choosing what sort of excision they will have.[197] Despite recognising that it is a painful procedure that might entail serious risks, women's first-person accounts often reveal that they *want* to undergo it, as it enables them, similarly to cosmetic surgery patients, to have a 'proper' and 'beautiful' vulva and/or it is a 'mark' of their belonging to the community and being a 'full' woman.[198] These 'insider' narratives thus contradict the framing of FGM as a male strategy

[193] IR Gunning, 'Arrogant Perception: Traveling and Multicultural Femininism: The Case of Female Genital Surgeries' (1992) 23 Columbia Humans Rights Law Review 189, 199.
[194] Wade (n 169) 41.
[195] ibid 40.
[196] Fuambai Ahmadu, 'Rites and Wrongs: An Insider/Outside Reflects on Power and Excision' in Bettina Shell-Duncan and Ylva Hernlund (eds), *Female 'Circumcision' in Africa: Culture, Controversy, and Change* (Lynne Rienner Publishers 2000) 285; Ellen Gruenbaum, 'Feminist Activism for the Abolition of FGC in Sudan' (2005) 1 Journal of Middle East Women's Studies 89.
[197] Rogia Mustafa Abusharaf, 'Virtuous Cuts: Female Genital Circumcision in an African Ontology' (2001) 12 Differences: A Journal of Feminist Cultural Studies 112, 133–135; Ahmadu (n 196) 294–299.
[198] Janice Boddy, 'The Normal and the Aberrant in Female Genital Cutting: Shifting Paradigms' (2016) 6 HAU: Journal of Ethnographic Theory 41, 50–52; Abusharaf (n 197) 121–134; Ahmadu (n 196) 286–303.

to control women's sexuality and police their bodies, since women sometimes seem to be active and keen actors in the performance of FGM.[199] For some commentators, these lived experiences demonstrate that, although FGM may seem terrible and cruel to Westerners, it is not necessarily so for those who engage in it, with the eradication strategy kickstarted by some Western feminists and adopted by the UN and WHO resulting from the incapability of the West of tolerating and understanding other cultural heritages and values.[200] In the words of Fuambai Ahmadu:

> My main quarrel with most studies on female initiation and the significance of genital cutting relates to the continued insistence that the latter is necessarily 'harmful' or that there is an urgent need to stop female genital mutilation in communities where it is done. … the aversion of some writers to the practice of female 'circumcision' has more to do with deeply imbedded Western cultural assumptions regarding women's bodies and their sexuality than with disputable health effects of genital operations on African women.[201]

Whilst it is true that FGM can have very serious sequalae, some believe that the fact that it might be dangerous and antihygienic is not, in itself, sufficient reason to prohibit it.[202] Both Richard Shweder and Wairimũ Ngaruiya Njambi separately draw an analogy between unsafe abortions and FGM, pointing out that, usually, the reaction to the former (anti-abortion groups aside) is not to get rid of them, but to make them safe, since women deserve to have the means they need to be in control of their bodies.[203] They claim that a similar strategy could be adopted in FGM, which would allow health risks to decline without

[199] See eg Boddy (n 198) 41; Ahmadu (n 196) 300.
[200] Richard A Shweder, 'What about "Female Genital Mutilation"? And Why Understanding Culture Matters in the First Place' (2000) 129 Daedalus 209, 227.
[201] Ahmadu (n 196) 284.
[202] Shweder (n 200) 224; Wairimũ Ngaruiya Njambi, 'Dualisms and Female Bodies in Representations of African Female Circumcision: A Feminist Critique' (2004) 5 Feminist Theory 281, 299.
[203] Shweder (n 200) 224; Njambi (n 202) 299.

'depriving [women] of their rite of passage and a system of meaning central to their cultural and personal identities and their overall sense of well-being'.[204] Moreover, Ahmadu suggests that more efforts should be put on educating girls and women on what excision and infibulation mean and their possible negative consequences so they can make an informed choice about participating in it or not.[205] Hence, medicalisation and modernisation, and not abolition, are proposed by some as preferable strategies to ensure women's safety.[206] Contrary to some critics, Ahmadu contends that clinicalisation would not legitimise FGM, as it is already legitimate within the communities where it is practised, but would allow women to live in accordance with their beliefs while reducing the health risks and social pressure involved in the procedure.[207]

From this perspective, and similarly to what some 'agency' feminists argue in relation to cosmetic surgery, choice is possible and steps should be taken so women can exercise it by giving them the tools to make a conscious and free decision about whether they want to undergo FGM. Acknowledging that many women currently do not have 'full' decision-making power, as they risk being 'othered' within their communities if they do not undergo FGM, Ahmadu considers that steps must be taken to ensure that it is a decision that is left to the judgement of each woman, by preparing her to understand what is at stake with this practice.[208] 'Choice' is thus not tantamount to saying 'no' or only possible through eliminating FGM completely, but, for some commentators, it means having the conditions

[204] Shweder (n 200) 224.
[205] Ahmadu (n 196) 309.
[206] Shweder (n 200) 224; Ahmadu (n 196) 309; Obiora (n 192) 367.
[207] Ahmadu (n 196) 309; Shweder (n 200) 224; For further discussion of the medicalisation strategy, see eg Bettina Shell-Duncan, 'The Medicalization of Female "'circumcision'": Harm Reduction or Promotion of a Dangerous Practice?' (2001) 52.
[208] Ahmadu (n 196) 309.

in which saying 'yes' or 'no' does not negatively impact on the physical and social well-being of women, regardless of their decision. From this perspective, therefore, and in parallel with arguments that some scholars like Wolf make in relation to cosmetic surgery, the problem with FGM is not the procedure per se, but rather the context in which it is currently performed, leaving no room for women to actually decide whether they want to have their vulvas modified or not. Changing the context, not getting rid of the practice, is therefore seen as the solution to enable choice.

However, others consider that women's narratives might not provide the definitive answer on whether and how oppression affects (or does not affect) decision-making. Although it would be too simplistic to deem women who undergo FGM passive victims of the patriarchy or dismiss their willingness to do so as false-consciousness, there are nuanced dynamics through which women are active actors in sustaining this intervention.[209] As Janice Boddy explains:

> If women are not free agents, neither are they powerless or blindly submissive … Materialist understandings of constraint and dominated consciousness are useful but insufficient to comprehend the intricacies of power relations and their continuous reproduction and transformation. For the issue is not so much how men oppress women, but how a system of gender asymmetric values and constraints is internalised by both, with their active participation, and as such becomes normalised, self-sustaining, and indeed unself-consciously 'real'.[210]

As with cosmetic surgery, a Foucauldian lens has also been deployed to examine FGM. Instead of seeing this intervention through an oppressor-oppressed dynamic, some consider

[209] Boddy (n 198) 41.
[210] Janice Boddy, 'Violence Embodied? Circumcision, Gender Politics, and Cultural Aesthetics', *Rethinking Violence Against Women* (SAGE Publications 1998) 97.

FGM a disciplinary practice productive of 'normal' femininity and sexuality, with women being active 'players' in the production of (their) 'docile bodies'.[211] FGM is 'embedded in an intricate web of habits, attitudes, and values'[212] whose detailed examination reveals how gender identity, womanhood and sexuality are shaped and reproduced.[213]

If FGM is recognised as a complex phenomenon where women are sometimes active and willing actors, criminalising the intervention might not be the most successful way to put an end on it.[214] Indeed, as Chapter 1 has shown, attempts to criminalise FGM in Sudan and Kenya did not produce the expected results, as the intervention remained common, and also became a catalyst for anti-colonial and pro-independence endeavours. With prohibition being seen as a Western or 'coercive' imposition to deeply held values,[215] more 'subtle' strategies, such as raising awareness among and mobilising 'local' women, or working with religious authorities to proselytise against this operation, have been proposed as alternatives.[216] This is the 'multidisciplinary' approach UN agencies currently

[211] Boddy (n 198) 61.
[212] Obiora (n 192) 295.
[213] Boddy (n 210) 101.
[214] Abusharaf (n 197) 136; Faye Ginsburg, 'What Do Women Want? Feminist Anthropology Confronts Clitoridectomy' (1991) 5 Medical Anthropology Quarterly 17, 18.
[215] Katherine Brennan, 'The Influence of Cultural Relativism on International Human Rights Law: Female Circumcision as a Case Study' (1989) 7 Law and Inequality 367, 397; Anke Van Der Kwaak, 'Female Circumcision and Gender Identity: A Questionable Alliance?' (1992) 35 Social Science and Medicine 777, 785.
[216] Gruenbaum (n 196) 104–105.

adopt, being convinced that achieving 'social change' to shift attitudes regarding FGM is the successful way to end the practice.[217]

Hence, feminist discussions have incorporated nuanced visions of oppression which do not base their criticism of FGM on it being backward or inferior, but by looking at women's realities, investigating the origins and dynamics of FGM, and analysing what saying 'no' to it might entail for those who refuse to undergo it.[218] Instead of invoking culture as a defence to justify or excuse FGM,[219] the literature often criticises FGM as an oppressive intervention whilst also being careful of not stereotyping or showing prejudice against cultures engaging in it. Moving from initial (Western) readings of FGM as the product of barbarism, feminist discussions, as Lisa Wade argues, have become 'sensitive to global power imbalances and attentive to the risk that [FGM] would foster Anti-African prejudice'.[220] The dilemma that remains for feminist scholarship, similar to that underpinning the discussion of cosmetic surgery, is to understand why women want to have their vulvas cut, teasing out the rationales driving them to believe that they are not complete, beautiful or pure unless they undergo vulval modification.

3.3 Continuum

So far, this section has shown how the Western/African binary is key in understanding how the feminist literature has discussed oppression and decision-making in relation to FGM.

[217] World Health Organization (n 4) 17; See also World Health Organization, 'Female Genital Mutilation. A Joint WHO/UNFPA/UNICEF Statement' (1997) 13; UNICEF, 'Female Genital Mutilation: A Statistical Overview and Exploration of the Dynamics of Change' (2013) 113.
[218] Brennan (n 215) 397.
[219] Anne Phillips, *Multiculturalism without Culture* (Princeton University Press 2007) 101.
[220] Wade (n 169) 41.

However, this sort of vulval cutting co-exists with other procedures, such as vulval cosmetic surgery. The high degree of anatomical similarity between these two interventions, as we have seen in Chapter 2 and will explore further in Chapter 5, has given rise to a long debate about whether these are comparable or, rather, are completely different, phenomena.[221]

For example, Martha C Nussbaum considers that vulval cosmetic surgery is completely distinct from FGM because, whereas the latter is 'carried out by force', Western dieting and body shaping are 'a matter of choice'.[222] Nevertheless, these differences are perhaps not as obvious and clear as they might seem. As Boddy suggests, both FGM and vulval cosmetic surgery shape the vulva to fit ideals of 'normal' womanhood.[223] Both interventions are the product of power relations which, albeit occurring in different contexts, deserve attention and analysis in order to unravel the multiple systems and discourses that make these operations possible, 'whether it is rural African villages or in urban France'.[224] Similarly, Simone Weil Davis explains that it would be a 'mistake' to 'imagine a quantum distinction between Euro-American and African shaping of women's bodies'.[225] Instead of drawing national, racial or hemispheric lines between vulval cosmetic surgery and FGM, these should be seen on a 'continuum'.[226] The contexts in which these interventions take place are not diametrically opposed, as Nussbaum suggests, but in cosmetic surgery too women's genitalia are inscribed within a social context in which

[221] Sullivan (n 170) 400.
[222] Martha C Nussbaum, *Sex and Social Justice* (Oxford University Press 1999) 123.
[223] Boddy (n 198) 61.
[224] Christine J Walley, 'Searching for "Voices": Feminism, Anthropology, and the Global Debate over Female Genital Operations' (1997) 12 Cultural Anthropology 405, 430.
[225] Davis, 'Loose Lips Sink Ships' (n 40) 21.
[226] ibid 29.

surgery becomes necessary or desirable to achieve beautiful or healthy genitalia.[227] Although the concrete circumstances in which the interventions take place differ, as 'there is not one patriarchy oppressing all women … and the forms of sex normalisation in each society are distinct', we can talk about 'pressures to conform to standards of appearance and sexed bodies' underpinning both practices.[228] In each instance, vulvas are seen as 'in need of improvement and continuous monitoring', imposing 'a desire to conform, to become who and what they "ought" to be'.[229]

In accordance with the idea that oppression exists in every context, Tamar Diana Wilson argues that cosmetic surgery (in particular, she uses the example of breast augmentation) and FGM are instances of body modification performed 'in the interest of male sensual pleasure', by which women 'mutilate' their bodies to attain 'power and affection from men', in the contexts of 'phallocentric capitalism' and 'patriarchy' respectively:[230]

> Pharaonic circumcision and reinfibulation are performed in the context of a patriarchal system that emphasizes virginity at marriage and marital fidelity in the interests of legitimate heirs and male prestige/honor. They are primarily a means of controlling women's reproductive function …Breast augmentation is performed in the context of capitalist systems suffused by phallocentrism. Phallocentrism, a diffuse form of male power over women,

[227] ibid.
[228] Courtney Smith, 'Who Defines "Mutilation"? Challenging Imperialism in the Discourse of Female Genital Cutting' (2011) 23 Feminist Formations 25, 37, 39.
[229] Boddy (n 198) 61.
[230] Tamar Diana Wilson, 'Pharaonic Circumcision Under Patriarchy and Breast Augmentation Under Phallocentric Capitalism' (2002) 8 Violence Against Women 495, 516.

> emphasizes female sexual allure in the interests of male pleasure, while de-emphasizing women's reproductive functions.[231]

That is why Jeffreys posits that vulval cosmetic surgery, and cosmetic procedures in general, should be regarded just as unequivocally harmful as FGM by the UN and other international organisations. Where a practice falls in the West/non-West divide should not be determinative when judging whether it is detrimental for women, since 'male supremacy' exists around the world, and not merely outside the West.[232] Challenging male domination entails acknowledging oppression wherever it is present, in all its forms, 'including the self-styled "free world" of the wealthy, metropolitan centres of the West'.[233]

The fundamental issue in feminist debates about FGM and oppression thus resembles the one presented in relation to vulval cosmetic surgery: is having your vulva cut a free choice or is it always already embedded in an oppressive framework? In the case of FGM, this question is traversed by racialised lines underpinning the dilemma of how oppression should be understood. Whilst some see FGM as an instance of patriarchal norms which should be overthrown, others, albeit regarding FGM as oppressive, are wary of how this view could reinforce colonial notions of the 'African' 'mutilated' woman, who might hence be 'doubly victimised: first from within (their culture) and second from without (their "saviours")'.[234] In turn, this reflection about FGM also entails re-thinking the divide between Western and non-Western vulval cutting, with some authors contending that FGM

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[231] ibid 516–517.
[232] Bronwyn Winter, Denise Thompson and Sheila Jeffreys, 'The UN Approach to Harmful Traditional Practices' (2002) 4 International Feminist Journal of Politics 72, 88; See also Jeffreys (n 9) 2.
[233] Winter, Thompson and Jeffreys (n 232) 88.
[234] Obioma Nnaemeka, 'If Female Circumcision Did Not Exist, Western Feminism Would Invent It' in Perry Susan and Celeste Schenk (eds), *Eye to Eye: Women Practising Development Across Cultures* (Zed Books 2001) 173.

and vulval cosmetic surgery are examples in different contexts of a continuum of patriarchal oppression women suffer around the world.

4 Conclusion

This chapter has examined how oppression features as a common thread in feminist debates about vulval cosmetic surgeries, intersex surgeries and FGM, and has unpacked the commonalities and differences in how this discussion takes places in each context.

In vulval cosmetic surgery and FGM—with the latter also being focused on the critical dilemma of whether and how it must be read as a racialised cut—the core issue seems to boil down to whether freely deciding to have your vulva cut is ever possible, with the literature trying to find explanations for why women willingly undergo these interventions. Where does their desire or need to have their vulvas cut come from? Is it from a male 'plot' to design women's genitalia for their pleasure and to subjugate them? Or, does it come from intricate power networks that dupe women into thinking their vulvas need trimming or refashioning? Or, on the contrary, is it a rational strategy women decide to embark upon in order to survive?

In contrast, the debate around oppression and choice in the context of intersex surgeries is not framed in terms of victims versus agents, and empowerment versus coercion, but in relation to how decision-making can be made possible. The main point of contention here is about discerning what prevents intersex patients from being completely free to decide whether they want to undergo surgery or not, with some scholars and activists contending that such freedom will not exist until we disrupt the gender binary, versus others

claiming that it is not a matter of gender, but of stigma and trauma, stressing the need to put adequate medical protocols in place, rather than creating new avenues for thinking about gender. So, why is oppression understood differently in each case?

Chapter 2 has shown how each intervention occurs in its own context. Vulval cosmetic surgery takes place in a medical, and often highly commercial, framework, where women 'willingly' enter the medical setting and ask the surgeon to cut their genitalia. In contrast, intersex patients are under constant medical surveillance since a very early age, which defines and marks their lived experience and also their (lack of) possibilities regarding surgical choice. Meanwhile, the international consensus is that FGM is a form of violence against women and child abuse, with local and global coordination being needed to put an end to it.

Likewise, there are several strands of feminist thought playing out in each and across the three interventions. For instance, Foucauldian visions of power seem to traverse and inform the discussion around (lack of) decision-making in all three practices, whilst radical feminist positions seem to be more prominent in discussions about vulval cosmetic surgery and FGM, in contrast with intersex surgery. Moreover, whilst postcolonial critiques are apposite surrounding FGM, at first sight, these do not seem to play such a relevant role in the other two discussions. Nevertheless, Section 2 showed how the Semenya affair has resurfaced concerns in South Africa about colonial assumptions being embedded in medical discourses about intersexuality. Likewise, the last section has argued

that the fact that these three interventions are seen as different to begin with might in itself be the product of racialised assumptions about bodily practices.

Notwithstanding the different context and conceptual perspectives, the distinct framing of oppression also reveals different underlying perceptions of the vulva. In discussions about cosmetic surgery, vulvas and vaginas targeted for cutting are regarded as clear vulvas and vaginas, although they may be seen to need a surgical touch to be more functional, or to live up to ideals of beauty and sexual fitness. It is the (perceived) lack of conformity with these standards what constitutes the main focus of debate. Something similar happens with FGM, which, rather than a practice targeting vulvas seen as ugly or dysfunctional, is often portrayed as a rite of passage for all women to be regarded as complete, fertile or beautiful. The discussion this chapter has surveyed shows how the discussion about FGM focuses on how these norms operate in practice, as well as how opposition to them should be framed in order to prevent reifications of the Western/non-Western divide.

However, the literature surrounding intersexuality presumes that genitals cut in this context are different from those in cosmetic surgeries or FGM, as they possess features which, rather than (or, in addition to) posing issues for beauty or function, more prominently challenge their classification as clearly male or female. That is taken as the main reason why surgery is needed and why patients are submitted to it, with the key area of contention being whether and how the intersex person's decision-making can be

enabled, either by changing how the world conceives gender or by tackling medical protocols.

Therefore, the extent to which the vulva is seen to be clear or doubtful, or clear but fixable or improvable, underlies how debates about oppression and choice play out in these three instances. The juxtaposition of feminist debates demonstrates that whether genitals are seen as clear vulvas, or as definitive but defective or unattractive ones, is central in ordering these discussions. The construction and criticism of oppression in each case thus reproduces different notions of the vulva for each intervention, reaffirming distinct visions of embodiment that contribute to the categorisation of vulval cosmetic surgery, intersex surgery and FGM as different practices.

What constitutes an attractive, clear or normal vulva requires further scrutiny. The next chapter starts this endeavour, focusing on how notions of vulval attractiveness, function and ambiguity are mediated by the discourse of mental health.

CHAPTER 4. THE PSYCHOLOGY OF VULVAL CUTTING

Along with oppression, Chapter 2 revealed that psychological well-being is also a common theme in relation to vulval cosmetic surgery, intersex surgery and Female Genital Mutilation (FGM). However, like oppression, the way in which mental health is talked about differs in each intervention. As Chapter 2 has shown and this chapter will analyse in depth, medical guidelines consider seeking to have your vulva refashioned as a potential sign of poor mental health, with medical professionals being urged to be on the lookout for symptoms of Body Dysmorphic Disorder and other anxieties that might underpin the request to have cosmetic surgery. Nevertheless, in the case of intersexuality, psychological aspects around surgery are not discussed in terms of (potentially) being the result of a mental condition; rather medical guidelines see them as inherently connected to having an intersex trait. Intersexuality is framed as an indicator that psychological support is needed, both to handle the idea of intersexuality itself and to make decisions about gender assignment and surgery. Finally, FGM is presented as an intervention women undergo, and have their daughters undergo, often because of psychological (and sometimes physical) coercion, with the Female Genital Mutilation Act 2003 (FGM Act 2003) having introduced a wide range of criminal and civil measures to protect those who are cut and/or are at risk of being cut.

What choices are considered psychologically healthy *versus* which ones are deemed psychologically damaging? Why does wanting to enhance your vulva trigger concerns about mental instability whilst having an intersex condition is seen as requiring psychological support? Why are decisions of parents of intersex children, in favour or

against surgery, assumed to be psychologically challenging and distressing (and therefore requiring the need of psychological professionals), whereas parents whose daughters undergo FGM are left on their own while facing the threat of criminal and civil sanctions? In the same way as the previous chapter juxtaposed feminist discourses on the topic of oppression, this chapter traces how medical guidelines, diagnostic categories, UN policies and the FGM Act 2003 frame psychology and mental wellbeing in each type of vulval cutting. It argues that a key factor in the different framing of psychological suffering in each case has to do with the extent to which the vulva, and the cut on the vulva, is seen to reaffirm or threaten binary and racialised expectations around genital cutting.

1 Vulval cosmetic surgery

1.1 Surgery as a cure for psychological pain

The link between appearance, cosmetic surgery and psychological well-being can be traced back historically to the 1920s and 1930s, when, as shown in Chapter 1, cosmetic surgery ceased to be seen as a 'quack' practice and came to be regarded as a proper medical specialty instead. According to Elisabeth Haiken, this was the result of a combination of factors. The First World War gave cosmetic surgeons an opportunity to show that they were not charlatans or mere 'beauty doctors', as they could help returning disfigured soldiers fix their appearance in order to be able to have a more 'normal' life.[1] Psychology, as a science, rose to prominence at that time, and Alfred Adler's 'inferiority complex' was

[1] Elizabeth Haiken, *Venus Envy: A History of Cosmetic Surgery* (Johns Hopkins University Press 1997) 30–35.

deployed as the psychological framework through which cosmetic surgery became widely seen as an intervention with a psychological underpinning.[2] Adler argued that physical problems, if they made people feel inferior or inadequate, could lead to psychological disorders which prevented 'normal' social adjustment.[3] Cosmetic surgery was thus presented as one of the cures for such problems, as it could eliminate the physical cause triggering them.[4]

Given the increasing importance of patients' feelings about their anatomy, the notion of 'deformity' also shifted, no longer being an obvious feature defined by the (objective) eye of the surgeon.[5] As even the smallest imperfections or flaws had the potential to cause feelings of inadequacy, depending on how each person perceived them, the individual patient became the one defining what 'deformed' was *for them*, through their (subjective) judgement. The patient would identify to the surgeon the root of their feelings of anguish, in order to have what was preventing success in their lives surgically fixed.[6] In other words, psychological theories provided surgeons with a scientific basis for their work, transforming what had previously been seen as quackery into a legitimate medical intervention because of its psychological benefits.[7] In the words of Haiken: '[p]sychology offered surgeons a new way to think and talk about their patients, their specialty and

[2] ibid 111–119; Sander L Gilman, *Creating Beauty to Cure the Soul. Race and Psychology in the Shaping of Aesthetic Surgery* (Duke University Press 1998) 100.
[3] Alfred Adler, *Understanding Life: An Introduction to the Psychology of Alfred Adler* (Colin Brett ed, Oneworld Publications 1997) 105.
[4] Haiken (n 1) 117.
[5] ibid 122.
[6] ibid 123.
[7] ibid 94.

themselves … No longer was it merely vanity surgery, it was "psychiatry with a scalpel", vital to mental health'.[8]

In relation to the vulva and vagina specifically, psychoanalytic theories advanced by Sigmund Freud (who was a close colleague of Adler, until their divergent views led to Adler's resignation from the Vienna Psychoanalytic Society)[9] played a crucial role in shaping the understanding of sexual development and the need for surgery in the vulval area. As Chapter 1 discussed, Freud and his followers relied heavily on the concept of frigidity to explain women's lack of interest in engaging in or feeling pleasure through penetrative sex, preferring clitoral stimulation instead. Freud traced the origins of frigidity back to an abnormal or incomplete development of women's sexuality.[10] According to him, women's psychological and sexual development was crucially affected by the realisation that they lacked a penis—the so-called 'castration complex'.[11] Women who refused to accept their own castration and failed to transfer their feelings of arousability from their clitoris to their vagina were thus considered to remain stuck in their infantile sexuality.[12]

In accordance with this vision, the 'frigid' woman was not completely asexual, but would only achieve genital pleasure through clitoral, not vaginal, stimulation. Marie Bonaparte, one of Freud's mentees, who has already been introduced in Chapter 1, was diagnosed with this form of frigidity, as she was not able to feel pleasure through penile

[8] ibid 108.
[9] Adler (n 3) 2.
[10] FE Small, 'The Psychology of Women: A Psychoanalytic Review' (1989) 34 Canadian Journal of Psychiatry 872, 873; James Stratchey and others (eds), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (The Hogarth Press 1964) 126.
[11] Stratchey and others (n 10) 126–128.
[12] Small (n 10) 873; Stratchey and others (n 10) 126.

penetration; it was through clitoral titillation that she managed to experience orgasm.[13] As she wanted to attain what she regarded as normal mature femininity, she decided to have surgery to locate her clitoris closer to her vaginal entry, which would enable the transference of pleasure to the place it belonged.[14] Unlike Freud, who thought psychotherapy was the tool to help women get over their frigidity, Bonaparte believed surgery was a useful resource for those, like herself, who struggled to get over their 'infantile sexuality'.[15]

However, as Chapter 1 also explained, the influence of psychoanalysis declined during the mid of the 20th century, and the work of Alfred Kinsey[16] and William Masters and Virginia Johnson[17] served as the scientific basis to reclaim the clitoris as the organ of pleasure. It was also then that feminist thinkers, such as Anne Koedt[18] and Elizabeth Grosz[19] began to criticise Freud's theories for conceiving sex and sexual pleasure too narrowly, calling for new ways of ensuring 'mutual enjoyment'.[20] Since the 1960s, cosmetic surgery has dominated the discourse around vulval and vaginal interventions, with patients, after having self-examined, presenting an account to the surgeon of what genital parts they believe need fixing. Whilst Chapter 5 explores in depth the rationales surgeons use to justify these interventions, and the blurred boundary between psychological and physical benefits, the next section examines the link between cosmetic

[13] Peter Cryle and Alison Moore, *Frigidity: An Intellectual History* (Palgrave Macmillan 2011) 235.
[14] ibid.
[15] ibid 234.
[16] Alfred C Kinsey and others, *Sexual Behaviour in the Human Female* (WB Saunders Company 1953).
[17] William H Masters and Virginia E Johnson, *Human Sexual Response* (J & A Churchill 1966).
[18] Anne Koedt, *The Myth of the Vaginal Orgasm* (Pittsburgh, Pa: Know Inc 1970).
[19] Elizabeth Grosz, *Sexual Subversions: Three French Feminists* (Allen & Unwin 1989) 133.
[20] Koedt (n 18) para 79.

surgery, self-perception and its impact upon psychological well-being, unpacking the connections that psychiatrists and surgeons draw between seeking to cosmetically alter one's body and mental pathology.[21]

1.2 Desire for surgery as a psychological disorder

Chapter 2 set out how, nowadays, seeking vulval cosmetic surgery usually triggers suspicions that this may be a manifestation of a psychological problem. The medical profession is concerned about ensuring that those who access this type of surgery do so with full decision-making capacity, for which measures like screening for mental disorders or attending psychological counselling before having surgery have been proposed to ensure that patients' desires are 'genuine' and 'healthy'.[22] Doctors are advised to be on the lookout for signs that desire for surgery might be connected to a mental disturbance, such as having 'unrealistic expectations' or a history of 'repeated cosmetic surgery procedures', referring patients with these symptoms to a psychological professional instead of performing surgery on them.[23]

Therefore, those who want surgery must exhibit good mental health. John Jordan calls this framework the 'wrong body, right mind' discourse, according to which patients who want cosmetic surgery must 'externalise their complaints while demonstrating mental

[21] Victoria Pitts-Taylor, *Surgery Junkies: Wellness and Pathology in Cosmetic Culture* (Rutgers University Press 2007) 102.
[22] General Medical Council, 'Guidance for Doctors Who Offer Cosmetic Interventions' (2016) 19; Royal College of Obstetricians and Gynaecologists, 'Ethical Opinion Paper: Ethical Considerations in Relation to Female Genital Cosmetic Surgery (FGCS)' (2013) 9.
[23] Royal College of Obstetricians and Gynaecologists (n 22) 7.

competence'.[24] That is, patients, whilst claiming that their bodies are 'wrong' and explaining how their embodiment causes them 'psychological distress', must 'perform' good mental health in order to get through the surgeon's door and be considered appropriate candidates for cosmetic surgery.[25] As he puts it:

> [patients must] characterize themselves as dissatisfied enough with their bodies to desire surgery, but mentally stable enough not to appear obsessed or delusional about body alteration … Applicants cannot exhibit the wrong kind of illness or express it in the wrong way or they will be rejected by surgeons who 'suspect their patients of trying to solve emotional problems by altering their bodies' and warn their colleagues to reject applicants who appear too eager or too desperate.[26]

Patients must thus deploy 'appropriate' or 'moderate' psychological suffering, providing a 'coherent' account of how their wrong body prevents them from living the life they want.[27] In the case of vulval cosmetic surgery, psychological suffering is usually framed in terms of feeling uncomfortable while wearing tight clothes or doing certain sports, such as cycling, not enjoying sex, or feeling ashamed of their vulva's appearance.[28] Those who are not able to narrate their psychological struggle through the appropriate discourse, failing to show a 'psychologically balanced' account of how their bodies make them suffer, and

[24] John W Jordan, 'The Rhetorical Limits of the "Plastic Body"' (2004) 90 Quarterly Journal of Speech 327, 339.
[25] ibid.
[26] ibid 338.
[27] ibid 339.
[28] See eg Michael P Goodman, 'Philosophy, Rationale, and Patient Selection' in Michael P Goodman (ed), *Female Genital Plastic and Cosmetic Surgery* (Wiley-Blackwell 2016) 35.

how they envision being operated on will help them live the life they want, will be refused surgery on the grounds of mental 'imbalance'.[29]

Early psychological conceptualisations of cosmetic surgery already drew a connection between mental (in)competence and (im)proper desire for cosmetic surgery.[30] With adjectives like 'insatiable' or 'surgerophiles', cosmetic surgeons during the 1960s started to classify their patients, and to draw a distinction between those who were mentally stable and those who were mentally ill.[31] The reason why the latter were not considered apt for cosmetic procedures is that the origin of their mental anguish was not due to a healthy correlation between a (real or imagined) bodily feature and their mind, but an obsessional or delusional state that complicated their relationship with and perception of their bodies.[32] Given the pathological source of their discontent, surgical treatment was deemed inadequate, since surgically modifying the (actual or perceived) bodily flaw would not ease, but exacerbate, the patient's worries.[33] Some 'trigger warnings' of mental pathology were low-self-esteem, excessive preoccupation with perceived or real, but minimal, deformities, inordinate complaints about appearance, bringing pictures or photographs of what they expected to look like after the procedure to their appointment with the surgeon, or seeking repetitive surgical operations.[34] This symptomatology is remarkably similar to the current diagnostic features of Body Dysmorphic Disorder (BDD), which, as Chapter 2

[29] Jordan (n 24) 341; Gilman (n 2) 14.
[30] See eg MT Edgerton, WE Jacobson and E Meyer, 'Surgical-Psychiatric Study of Patients Seeking Plastic (Cosmetic) Surgery: Ninety-Eight Consecutive Patients with Minimal Deformity' (1960) 13 British Journal of Plastic Surgery 136; NJ Knorr, MT Edgerton and Hoopes J E, 'The "Insatiable" Cosmetic Surgery Patient' (1967) 40 Plastic and Reconstructive Surgery; Louis Joel Feit, 'The "Somato-Psychic" Aspects of Cosmetic Surgery' (1961) 2 Psychosomatics 39.
[31] Knorr, Edgerton and Meyer (n 30); Feit (n 30) 40.
[32] Feit (n 30) 39–40.
[33] ibid 41.
[34] ibid 40; Knorr, Edgerton and Meyer (n 30) 286–287.

has indicated, is the mental pathology mostly associated with desire for cosmetic surgery, as it is the only psychiatric category 'directly addressing body image concerns'.[35]

BDD can be traced back to the late 19th century, when the Italian psychiatrist Enrico Morselli coined the term 'dysmorphophobia' to refer to 'the sudden appearance and fixation in the consciousness of the idea of one's own deformity; the individual fears that he has become deformed or might become deformed, and experiences at this thought a feeling of an inexpressible anxiety'.[36] He described the dysmorphophobic sufferer as a 'veritably unhappy individual, who in the midst of his daily affairs, in conversations, while reading, at table, in fact anywhere and at any hour of the day, is suddenly overcome by the fear of some deformity that might have developed in his body without his noticing it'.[37] Dysmorphophobia remained a relatively unused term until the late second half of the 20th century, when it was added to the two 'bibles' of mental illness: the World Health Organization International Statistical Classification of Diseases (ICD), and the American Psychiatric Association Diagnostic Statistic Manual (DSM).[38] Introduced for the first time in 1993, BDD now has its own diagnostic category under the ICD-11 and is classified as an obsessive-compulsive disorder, characterised by the 'persistent preoccupation with one or more perceived defects or flaws in appearance that are either unnoticeable or only slightly noticeable to others'.[39] This definition is very similar to the one offered by the

[35] David B Sarwer and others, 'The Psychology of Cosmetic Surgery: A Review and Reconceptualization' (1998) 18 Clinical Psychology Review 1, 15.
[36] Enrico Morselli, 'Dysmorphophobia and Taphephobia: Two Hithereto Undescribed Forms of Insanity with Fixed Ideas' (2001) 12 History of Psychiatry 107, 107.
[37] ibid 108.
[38] Massimo Cuzzolaro and Umberto Nizzoli, 'Enrico Morselli and the Invention of Dysmorphophobia', *Body Image, Eating, and Weight* (Springer 2018) 93.
[39] WHO, 'ICD-11 for Mortality and Morbidity Statistics' <https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/731724655> accessed 30 May 2021.

DSM-5, which included BDD for the first time in its third edition in 1987, currently considering it too an obsessive-compulsive disorder, highlighting the 'intrusive, unwanted, time-consuming' preoccupation for inexistent or minor flaws, which leads to 'comparing one's appearance with that of other individuals, repeatedly checking perceived defects in mirrors, excessively grooming, camouflaging, seeking reassurance, excessively exercising and weight lifting, and seeking cosmetic procedures'.[40]

In accordance with these diagnostic descriptions, excessiveness seems to be the core feature of BDD. From 1960s until today, suspicions about mental stability seem to arise when preoccupation about one's body features and wanting to have cosmetic surgery become 'too much'. Paying attention to one's looks, wanting to look pretty, or seeking to have a symmetrical vulva or a tight vagina are not, per se, psychologically problematic desires symptomatic of a mental disorder. In fact, being focused on or somehow worried about one's appearance is the very basis and the necessary psychological state for having cosmetic surgery, since, as explained above, its goal is to provide mental ease by fixing the bodily features that are the source of anguish. As the psychologist David Sarwer explains, body image dissatisfaction—ie having negative 'perceptions, thoughts, and feelings about one's body'—is considered the core motivation for undergoing cosmetic surgery:[41]

> it is the interaction between body image valence and body image value that leads to the decision to pursue cosmetic surgery … Individuals with a high body image valence, for whom body image is an important part of self-

[40] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-5* (American Psychiatric Association Publishing 2013) 243.
[41] David B Sarwer and Heather M Polansky, 'Psychological Aspects of Cosmetic Surgery and Minimally Invasive Treatments' in Mimis N Cohen and Seth R Thaller (eds), *The Unfavourable Result in Plastic Surgery: Avoidance and Treatment* (Thieme 2018) 15.

> esteem, and who have a significant degree of body image dissatisfaction, may well comprise the majority of cosmetic surgery patients.[42]

Nevertheless, although the medical world assumes that 'reducing dissatisfaction with one's appearance' is the motivation underlying seeking cosmetic surgery,[43] if dissatisfaction crosses a certain threshold and becomes excessive, it is no longer deemed healthy. Hence, the difference between healthy and ill cosmetic surgery desire seems to be of degree, and not of kind, since pathology arises when self-awareness, body dissatisfaction and preoccupation about one's appearance are not kept at bay and become uncontrollable, even though a certain degree of this sort of dissatisfaction is necessary for the (healthy) desire for cosmetic surgery to arise. Seeing this, Cressida Heyes considers the classification of feelings of bodily dissatisfaction as healthy or unhealthy (which then leads to patients being accepted for or refused surgery), depending on their intensity, to be paradoxical. Cosmetic surgery seems to be precisely designed to deal with people's feelings of inadequacy, and yet it rejects those who feel *very* inadequate about their bodies.[44] Deeming patients who are too keen on having surgery and are too preoccupied about their bodies bad candidates for surgery is a strategy, she argues, for cosmetic surgery to be seen as 'medically serious and ethically responsible', whilst it turns away those patients who seem less manageable, more difficult to deal with and satisfy, and hence eventually less profitable.[45] At the heart of her critique is the claim that cosmetic surgery is a form of modern power which creates the categories it claims to describe and manage:[46] cosmetic surgeons and psychiatrists do

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[42] Sarwer and others (n 35) 16.
[43] David B Sarwer and others, 'Body Image Dissatisfaction and Body Dysmorphic Disorder in 100 Cosmetic Surgery Patients' 1644, 1644.
[44] Cressida J Heyes, 'Diagnosing Culture: Body Dysmorphic Disorder and Cosmetic Surgery' (2009) 15 Body & Society 73, 88.
[45] ibid 85–88.
[46] See Chapter 3 for further discussion of Foucauldian conceptualisations of cosmetic surgery.

not just classify sorts of desires for cosmetic surgery, but they *create* the dichotomous categories of mental stability vs instability which patients then fall under.[47]

According to this critical perspective, excessive desire for surgery should not be understood in isolation and seen as a problem that stems from a disordered mind and can be fixed through psychotherapy, tailored to each person's needs.[48] Instead, we should adopt a broader perspective, 'ask[ing] whether [cosmetic surgery] industry and its culture ought to exercise such power to define body image and the body-self'.[49] Susan Bordo, despite not focusing on cosmetic surgery in particular, makes a similar claim in relation to anorexia nervosa, contending that 'psychopathologies … far from being anomalies or aberrations [are] characteristic expressions of culture … the crystallisation of much of what is wrong with it'.[50] Similarly to BDD, anorexia's defining feature is intensity or excessiveness, in this case with regards to weight and fat.[51] Being conscious of one's diet, exercising, controlling calorie intake, are 'normal' (and even desirable and admirable) behaviours that keep us healthy and allow us to have a good figure, but are pathologised when they become 'too much'. Bordo, refusing to see anorexia as a deviation from the 'normal' desire to be thin, considers it is a 'symptom of some of the multifaceted and heterogeneous distresses

[47] Heyes (n 44) 79.
[48] Pitts-Taylor (n 21) 124.
[49] ibid 127.
[50] Susan Bordo, *Unbearable Weight. Feminism, Western Culture, and the Body* (University of California Press 1993) 141.
[51] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-5.* (American Psychiatric Association 2013) 338.

of our age', all of which 'converge in anorexia' and 'find their perfect, precise expression in it'.[52]

These critical accounts of BDD are useful in shedding light on the fact that, in mainstream medical discourse, the core issue in the decision to undergo cosmetic surgery is how the mind relates to the body, and whether it does so in a healthy way. When assessing the healthiness of desire for surgery, the core issue is not whether the body has actual flaws or not, but how the patient narrates their desire for bodily change to the cosmetic surgeon, a conversation in which not all discourses are accepted as valid, with excessive concerns being dismissed as stemming from mental pathology. The mind is thus the origin of and trigger for cosmetic surgery desire. A (flawed) bodily feature does not have to be, per se, a source of preoccupation, but it is how the mind interprets it that will determine whether feelings of dissatisfaction arise and, if so, how intense they are, determining whether surgery is eventually performed, or the patient is turned away for being too eager to alter their bodily features.

2 Intersex surgery

If one of the core issues regarding the decision to have cosmetic surgery is mental (in)stability, with patients being suspected to be in a mentally precarious state, and surgeons having to ensure that their desire for altering their bodies is not pathological; decision-making regarding intersex surgery seems to have been framed as inevitably

[52] Bordo (n 50) 142.

psychologically challenging, seeing surgery as a solution to (but also a cause of) psychological suffering for intersex individuals and their families.

2.1 The body as a source of psychological problems

(i) Surgery as psychological treatment

As shown in previous chapters, Money's protocols ruled intersex management until the Chicago Consensus Statement introduced new principles in 2006. For Money, the birth of an intersex child was an event which required urgent medical care.[53] If, owing to 'errors, excesses, or deficiencies of hormones', children were born 'improperly differentiated',[54] it was of 'extreme desirability' to assign without delay a gender to the baby, which should be followed with prompt genital surgical (re)construction.[55] Although Money rejected the idea that gender was biologically determined, it was crucial that (at least external) genitalia were coherent with the assigned gender, since the 'appearance of genital organs' was a critical feature for the development of one's gender identity/role.[56] (Chapter 5 looks at Money's conception of gender in depth.) As we saw in Chapter 1, the criterion for gender assignment of intersex new-borns was neither chromosomal nor gonadal sex, but genital morphology and the 'ease' with which an 'ambiguous' vagina, clitoris or penis could be reconstructed to resemble 'normal' genitalia.[57] If left unmodified, the intersex body could

[53] John Money, Joan G Hampson and John L Hampson, 'Imprinting and the Establishment of Gender Role' (1957) 77 MA Arch NeurPsych 333, 334.
[54] John Money and Anke A Ehrhardt, *Man & Woman: Boy & Girl* (The John Hopkins University Press 1972) 5–6.
[55] Money, Hampson and Hampson (n 53) 335.
[56] ibid 334–335.
[57] ibid 334.

hinder normal gender development, with Money framing surgery as a 'pre-emptive psychological treatment, on the grounds that an individual's sense of gender will follow from the experience of having dichotomously sexed anatomy'.[58]

The conceptualisation of doubtful genitalia as a source of pathology constrained the choices of parents since, although they theoretically had the option of not consenting to surgery, not having their children's genitals 'fixed' was framed as forcing them to inhabit a body that would bring them psychological problems.[59] Money's conflation between clear gender development and psychological health, by which intersex children could only develop healthily if their anatomy was unambiguously consistent with that of 'normal' boys or girls, steered parental decision-making towards saying 'yes' to surgery, as letting their children grow up 'uncorrected' was considered 'psychologically injurious'.[60]Without surgery, parents would be condemning their children to a life of doubt and confusion, leaving them 'swing[ing] on a boy-girl pendulum', with Money warning that 'most human beings cannot tolerate such a biographical inconsistency'.[61] Moreover, as discussed in Chapter 1, most parents were provided with biased or inaccurate information about what

[58] Ian Morland, 'Intersex' (2014) 1 TSQ: Transgender Studies Quarterly 111.
[59] J David Hester, 'Intersex(es) and Informed Consent: How Physicians' Rhetoric Constrains Choice' (2004) 25 Theoretical Medicine and Bioethics 21, 38.
[60] Money, Hampson and Hampson (n 53) 336.
[61] Money and Ehrhardt (n 54) 15.

surgery entailed, concealing or minimising the need for follow-up surgeries or the impact it would have on their child's sexual function and future sex life.[62]

In addition to having their children operated on, Money also suggested parents should educate them in a manner that would ensure their 'normal' gender development,[63] as the 'the ultimate purpose in the treatment of any hermaphroditic patient is to ensure the establishment and maintenance of a stable and a pervasive gender role'.[64] For instance, he advised them not to use the words 'half-and-half' or 'two-sexed' to refer to their child, but, as we have seen in previous chapters, encouraged the notion of their being 'genitally unfinished'.[65] Whilst parents should be prepared to answer their children's questions about their anatomy and sexual development, they should not cast any doubts about the unequivocal character of their gender.[66] In practice, this entailed not only extreme caution and secrecy with regards to discussing their 'exceptional' genital anatomy, but also policing behaviours that would clearly delineate gender.[67] Dressing girls with pink dresses, growing their hair long, educating them to be neat, fostering their future domesticity through playing 'house'; whilst letting boys be dirty and play with cars and sports were some of the rearing practices parents were encouraged to engage with, policing from an early age what sorts of behaviour belong to each gender.[68] Parents were also supposed to be role models of manhood and womanhood themselves, being warned that their

[62] Katrina Karzakis, *Fixing Sex. Intersex, Medical Authority and Lived Experience* (Duke University Press 2008) 198.
[63] Jemima Repo, 'The Biopolitical Birth of Gender: Social Control, Hermaphroditism, and the New Sexual Apparatus' (2013) 38 Alternatives: Global, Local, Political 228, 325.
[64] J Money, JG Hampson and JL Hampson, 'Hermaphroditism: Recommendations Concerning Case Management' (1956) Journal of Clinical Endocrinology and Metabolism 547, 549.
[65] ibid 553.
[66] ibid.
[67] Repo (n 63) 236.
[68] Money and Ehrhardt (n 54) 119–121.

engagement with gender 'non-conforming' conducts, such as homosexuality and transgenderism, would 'burden children with blurring of gender differences'.[69]

Parents whose children were treated under Money's protocols explain that their decisions about gender rearing and surgery, which they made whilst experiencing high levels of stress, confusion and preoccupation, sought to ensure that their child would grow up 'normal', wanting to protect them from internal (deviant psychosexual development) and external (bullying, teasing, ridicule) harm.[70] Their testimonies reveal that most of them thought they had 'no choice', seeing surgical procedures and medical examinations as 'both an attempt to foster moral growth and to teach a difficult lesson in training for social acceptance'.[71] For instance, a mother of two girls with Congenital Adrenal Hyperplasia explains that, albeit she felt that surgeries and examinations were discomforting, she believed they were necessary for their daughters to grow up healthily: '[my daughter] is angry with me as an adult. She felt she was raped, medically raped. And she is right … But it was necessary … I told my daughters I wish I didn't have to do this'.[72] (The next section explores intersex individuals' psychological suffering due to medical interventions.)

Therefore, in the Money era, parental choices were confined to only one possibility: having their child assigned one gender, in accordance with their genital morphology, having them operated on so their bodies were as consistent as possible with this gender,

[69] ibid 14.
[70] Karzakis (n 62) 197.
[71] This was not, however, always the case, as some parents 'exceptionally' asked for more information and refused to have their children operated on. See eg Ellen K Feder, *Making Sense of Intersex: Changing Ethical Perspectives in Biomedicine* (Indiana University Press 2014) 57; Peter A Lee and John Money, 'Communicating with Parents of the Newborn with Intersex: Transcript of an Interview' (2004) 17 Journal of Pediatric Endocrinology and Metabolism 925.
[72] Feder (n 71) 49.

and educating them through the clear delimitation of the two genders. If all of this was done correctly, Money assured parents that their intersex child could be 'as thoroughly healthy, psychologically, as his anatomically normal sibling, and that he need by no means exclude marriage from his expectations in normal life'.[73]

(ii) The need for psychological support

Post 2006, with the Chicago Consensus Statement marking a supposedly new beginning, parents remain the primary decision-makers about treatment options for their intersex children. Together with the medical team, and 'after expert evaluation', they are the ones facing decisions regarding gender assignment and potential hormonal and surgical treatments for their child.[74] Like in the Money era, having an intersex child continues to be associated with preoccupation and psychological distress,[75] with studies even suggesting that some mothers and fathers suffer from levels of post-traumatic stress disorder comparable to those parents of children diagnosed with cancer.[76] Uncertainty about their children's (present and future) wellbeing is what causes most anxiety for parents, along with having to wait a long time for diagnostic tests 'revealing' the gender of their children, not fully understanding their children's conditions and being confused about the benefits and risks of early surgery.[77] Although these worries are remarkably similar to those of

[73] Money, Hampson and Hampson (n 64) 544.
[74] IA Hughes and others, 'Consensus Statement on Management of Intersex Disorders' (2006) 91 Archives of Diseases of Childhood 554, 556.
[75] See eg Halley P Crissman and others, 'Children with Disorders of Sex Development: A Qualitative Study of Early Parental Experience' (2011) 10 International Journal of Pediatric Endocrinology.
[76] Vickie Pasterski and others, 'Predictors of Posttraumatic Stress in Parents of Children Diagnosed with a Disorder of Sex Development' (2014) 43 Archives of Sexual Behavior 369, 373.
[77] Crissman and others (n 75) 7–8; Limor Meoded Danon and Anike Krämer, 'Between Concealing and Revealing Intersexed Bodies: Parental Strategies' (2017) 27 Qualitative Health Research 1562.

parents whose children were treated during Money's reign, the medical world's attitude in handling them seems to be striving for change. Nevertheless, as this section argues, this change has not really occurred.

Whilst Money, for whom unequivocal gender rearing was a priority, opted for early surgery and ambiguous information, with terms like 'genital unfinishedness' and keeping the diagnosis secret from children, current medical protocols stress the importance of transparency and information sharing:

> Shared-decision making is necessary and can be viewed as the 'crux of patient-centred care', combining expert healthcare knowledge and the right of a patient or a surrogate to make fully informed decisions. This entails a process of education, sharing of risks/benefits, articulating the uncertainties in DSD care and providing time for the patient and family to articulate back the risks and benefits of each option. The goal of all involved should be to individualise and prioritise each patient.[78]

Crucially, the Chicago Consensus Statement sees psychological assistance by 'mental health staff' as an 'integral part' of new intersex management protocols.[79] It considers peer support networks an important source of 'education and psychological support',[80] since being in touch with families with similar experiences might be 'comforting' for parents and children, helping them feel less 'isolated, overwhelmed and immobilised'.[81] Some see this acknowledgement of psychological care as a possibility to 'shift conceptions of intersex embodiment away from the medical framework of disorder'.[82] For instance, Fae

[78] Peter A Lee and others, 'Global Disorders of Sex Development Update since 2006: Perceptions, Approach and Care' (2016) 85 Hormone Research in Paediatrics 158, 170.
[79] Hughes and others (n 74) 557; See also Lee and others (n 78) 170.
[80] Lee and others (n 78) 170.
[81] ibid 160.
[82] Fae Garland and Mitchell Travis, *Intersex Embodiment: Legal Frameworks beyond Identity and Disorder* (Bristol University Press 2023) 147.

Garland and Mitchell Travis argue that the inclusion of psychologists in the multidisciplinary team can contribute to steer away 'the focus from immediate surgeries towards a new focus on self-acceptance, growth and the way in which individuals develop through their interactions with the social environment around them'.[83] Unfortunately, this has not been the change that has ensued from the Chicago Consensus Statement, which may be due to several factors.

First, although eleven psychologists participated in the elaboration of the Statement, some were specialists in neuroscience and brain-imaging, rather than in 'clinical support'.[84] Furthermore, the research outputs of some of them reflect a rather binary and essentialist view of gender identity and sexual attraction. For example, Kenneth Zucker has supported conversion therapy for transgender patients and Heino Meyer-Bahbulrg considers that brain chemistry is the origin of homosexual desire.[85]

Second, the Statement does not really challenge the idea of intersex embodiment as a source of problems that need medical attention.[86] It talks about psychosocial management as key to 'promote positive adaptation', since 'this expertise can facilitate team decisions about gender assignment/reassignment, timing of surgery, and sex hormone replacement'.[87] As Garland and Travis argue, 'adaptation' seems to imply 'change' and not 'acceptance or support'.[88] Besides, the Statement assumes surgery to be necessary for the management of an intersex condition, seeing the provision of psychological support as

[83] ibid.
[84] ibid 148.
[85] ibid.
[86] ibid 149.
[87] Hughes and others (n 74) 447.
[88] Garland and Travis (n 82) 151.

an 'additional' treatment method to facilitate adaptation.[89] Rather than contributing to creating a framework of bodily acceptance and de-stigmatisation, the role of psychological professionals is framed as facilitating the performance of surgical procedures, acting as liaison between the rest of the medical team and the family.[90]

Perhaps unsurprisingly, the psychosocial model introduced by the Consensus Statement has not led to a non-pathological conceptualisation of intersexuality. In fact, current practice in England reveals that it is even doubtful whether such psychological support has been implemented. Recent data suggests that psychological care is often offered only after (early) surgery is performed or when a particular psychological problem, such as depression, is detected, rather than being a core element of medical care since the child is born or diagnosed.[91] As Chapter 2 argued, surgeons and endocrinologists still take the lead in multidisciplinary medical teams, with psychological expertise being relegated to a peripheral position.[92] Recent empirical work with professionals treating intersex patients confirms the limited role of psychologists, as the centrality of medical management relies on 'multiple biomedical specialists who carry out routine inspections and molecular and imaging studies'.[93] In the words of Lih-Mei Liao and Katrina Roen, who interviewed British and Swedish specialists:

> The single most salient finding … was the centrality of a medical process that was taken for granted rather than negotiated. The foregrounding of

[89] Hughes and others (n 74) 557.
[90] Garland and Travis (n 82) 151.
[91] Fae Garland and others, 'Management of "Disorders of Sex Development"/Intersex Variations in Children: Results from a Freedom of Information Exercise' (2021) 21 Medical Law International 116, 139.
[92] ibid.
[93] Lih Mei Liao and Katrina Roen, 'The Role of Psychologists in Multi-Disciplinary Teams for Intersex/Diverse Sex Development: Interviews with British and Swedish Clinical Specialists' (2021) 12 Psychology and Sexuality 202, 212.

> intersex traits as pathology seemed to dictate clinical priorities and hierarchical arrangements, leaving very little space for psychosocial staff to formulate different ideas and solutions.[94]

Hence, with psychosocial care not being provided in a timely manner and, when it is, as an 'appendix' to ensure the success of surgical treatment, the current framing of psychosocial care seems to carry on Money's view of the intersex body as problematic and in need of normalisation.[95]

Current guidelines also try—but fail—to introduce a notion of psychological welfare that is not so dependent on having a binary gendered identity. In contrast with Money, whose definition of psychological health was rather narrow, associating binary gendered identity with mental well-being, current protocols adopt, at least in theory, a more holistic vision of welfare, explaining that 'quality of life encompasses falling in love, dating, attraction, ability to develop intimate relationships, sexual functioning, and the opportunity to marry and to raise children, regardless of biological indicators of sex'.[96] Furthermore, the Chicago Consensus Statement leaves behind some of the urgency underpinning Money's protocols, warning that the eighteen months threshold for gender assignment and surgical treatment proposed by Money 'should be treated with caution'.[97]

Striving for transparency and communication, new guidelines make clear that children should be made aware of their 'condition' and the 'process of disclosure' should be 'planned with parents from the time of diagnosis'.[98] Although 'all individuals should

[94] ibid.
[95] Garland and Travis (n 82) 151.
[96] Hughes and others (n 74) 558.
[97] ibid 557.
[98] ibid 558.

receive gender assignment', it is acknowledged that their gender identity can change, opening the possibility for children, as they grow up, to 'explore feelings about gender' through a 'comprehensive psychological evaluation' with a 'qualified clinician'.[99] Psychological support should be offered throughout childhood and adolescence, being considered of crucial importance during the latter, given its role for providing a space for intersex individuals to share their anxieties regarding their sexual development and 'intimate relationships', which can help to 'avoid problems', like 'sexual aversion' and 'lack of arousability'.[100]

Psychological help for intersex children is also considered crucial to deal with cases of gender dysphoria, with the Statement suggesting that 'atypical gender role behaviour is more common in children with DSD than in the general population'.[101] Following a similar logic, the DSM-5 considers intersexuality a 'specifier' (that is, a subtype) of gender dysphoria.[102] The DSM-5 coincides with the Statement in considering that 'gender atypical behaviour'—that is, expressing 'somatic features or behaviours that are not typical (in a statistical sense) of individuals with the same assigned gender'—is 'frequently associated with intersexuality', [103] although it also points out that it is not that frequent for intersex individuals to experience gender dysphoria.[104] While the DSM-5 explains that becoming 'increasingly aware of their medical history and condition' might cause intersex people to have more doubts about their gender, it also clarifies that this is not necessarily followed

[99] ibid 557.
[100] ibid 558.
[101] ibid 557.
[102] American Psychiatric Association (n 51) 451–453.
[103] ibid 451.
[104] ibid 456.

by their 'developing a firm conviction that they are another gender'.[105] However, gender 'atypicality' remains closely associated with intersexual anatomy, since possessing (and talking about) intersex traits is considered to likely entail inner self-doubts about whether one does really belong to the gender they have been assigned.[106]

Therefore, although new medical protocols seem to strive for more openness and transparency, they still frame giving birth to and being an intersex child as a source of psychological problems. Considering the shock parents (and later on, children) must feel, the medical world tries to help them cope by: (1) assigning gender (and thus providing a 'normal' point of reference upon which parents can hold on to, offering them a stable category in the gender binary upon which to refer to their child)[107] and (2) providing psychological attention as part of the multidisciplinary medical support. For children, besides being assigned a binary gendered identity, psychological assistance is also provided to ensure that their development, 'despite' their 'ambiguous' bodies, is psychologically healthy, with especial emphasis on the importance of ensuring that they feel identified with the gender they have been assigned, and on helping them transition to another gender, if they show signs of gender dysphoria.[108] Hence, although intersexuality might no longer be seen as a medical emergency, it is still, to some extent, regarded as traumatic. Even though it is through the new vocabulary of 'psychological support', 'patient-centred care' and 'transparency', with 'harm' no longer being deployed in terms

[105] ibid.
[106] For a criticism of the connection the current version of the DSM draws between gender dysphoria and intersexuality, see Cynthia Kraus, 'Classifying Intersex in DSM-5: Critical Reflections on Gender Dysphoria' (2015) 44 Archives of Sexual Behavior 1147.
[107] Hughes and others (n 74) 555.
[108] ibid 557.

of children having an 'unclear' upbringing, medical discourse continues to frame having a baby with 'ambiguous' genitalia as an unsettling event requiring medical (and now also psychological) resources in order to be appropriately dealt with. In other words, current medical discourse keeps drawing an almost automatic link between psychological harm and intersexuality, with the assumption that being born or having an intersex child is a medical problem that has an increased risk of psychological suffering and needs medical and psychological attention throughout life.[109]

2.2 Iatrogenic psychological suffering

As we have seen, unless overruled by a court acting in a child's best interests, parents are responsible for medical decisions for their young children. Whereas some parents consent to surgeries with the belief that they will protect their children against future problems, like social exclusion, bullying, feelings of shame or loneliness; others accept their children's 'natural' embodiment, as they think that acknowledging 'their own corporeality and uniqueness' is what is best for them.[110] Likewise, some parents conceal the intersex diagnosis from friends or acquaintances, while others talk about it openly in everyday conversations.[111] However, deciding how to 'handle' their child's intersex traits is challenging for most parents, who are put in a position where they have to decide between wanting to protect their child from being perceived as 'different' and wanting to spare them 'unnecessary' surgeries.[112]

[109] Karzakis (n 62) 249.
[110] Danon and Krämer (n 77) 1570.
[111] ibid.
[112] Feder (n 71) 62.

As explained in previous chapters, intersex activism and voices within the ethical and legal debates have proposed to limit parental authority, arguing that intersex individuals themselves should be the ones making decisions over their own bodies, calling for measures like a moratorium on non-medically necessary interventions, or judicial oversight of these sort of decisions.[113] Underpinning this critique is the belief that intersex individuals should not be seen through their genitals, reduced to objects of medical treatment, but they should be regarded as agents with full (future) autonomy.[114] With this aim, clinical guidelines offered by the Intersex Society of North America (ISNA) stress the importance of 'patient-centred' care, advising clinicians to avoid 'objectifying language', acknowledging the status as agent of the child with phrases like 'your little one', rather than 'it',[115] as well as pushing for the 'delay [of] elective surgical and hormonal elements until the patient can actively participate in decision-making about how his or her own body will look, feel and function'.[116]

Besides advocating for the acknowledgement of intersex children as subjects and primary decision-makers, intersex activism has also challenged the link between having intersex traits and psychological trauma, considering that medical interventions, and not the intersex body, are the main cause of intersex individuals' psychological suffering.[117]

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[113] Cheryl Chase, 'Hermaphrodites with Attitude: Mapping the Emergence of Intersex Political Activism' (1998) 4 GLQ: A Journal of Lesbian and Gay Studies; Brian D Earp, 'In Defense of Genital Autonomy for Children' (2016) 42 Journal of Medical Ethics; Karzakis (n 62) 161; Melanie Newbould, 'When Parents Choose Gender: Intersex, Children, and the Law' (2016) 24 Medical Law Review 474.

[114] M Morgan Holmes, 'Mind the Gaps: Intersex and (Re-Productive) Spaces in Disability Studies and Bioethics' (2008) 5 Journal of Bioethical Inquiry 169, 175; Feder (n 71) 47.

[115] Consortium on the Management of Disorders of Sex Development and Intersex Society of North America (ISNA), 'Clinical Guidelines for the Management of Disorders of Sex Development in Childhood' (2006) 31.

[116] ibid 3.

[117] See eg 'Intersex Society of North America' <https://isna.org/> accessed 23 April 2021; 'OII Intersex Network' <https://oiiinternational.com/> accessed 23 April 2021.

Rather than genital ambiguity itself, it is how the medical world has dealt with it which has harmed intersex patients. ISNA made this clear in its founding statement, explaining that its mission was to 'advocate for patients and families who they felt had been harmed by their experience with the healthcare system'.[118] Organisation Intersex International Network (OII) shares the same goal, aiming for 'systematic change to end the fear, shame, secrecy and stigma experienced by children and adults through the practice of non-consensual normalisation treatments for people with atypical anatomy'.[119]

There are several elements of medical care that have been identified as a source of suffering. Secrecy, the rule under Money's protocols, seems to have been one of the most damaging aspects, leaving children to wonder why their genitalia looked different, and what was 'wrong' with them, not being provided with the true reason for their multiple medical visits and surgeries during childhood.[120] ISNA founder Cheryl Chase, recalling her own experience, explains how she grew up confused as to why she underwent so many surgeries as a child, finding out only when she was an adult that she was born with both testes and ovaries, being first assigned male but later female gender, a discovery that was deeply traumatising for her, as she struggled to 'accept' not only her intersex condition, but also the fact that she had her clitoris removed without her consent or knowledge:

> I was so traumatised by discovering the circumstances that produced my embodiment that I could not speak of these matters with anyone … I could not accept my image of a hermaphroditic body any more than I could accept the butchered one left me by the surgeons. Thoughts of myself as a

[118] Intersex Society of North America (n 117).
[119] OII Intersex Network (n 117).
[120] Sharon E Preves, 'For the Sake of the Children: Destigmatizing Intersexuality' in Alice Domurat Dreger (ed), *Intersex in the Age of Ethics* (University Publishing Group 1999) 56.

> Frankenstein patchwork alternated with longings for scape by death, only to be followed by outrage, anger and determination to survive.[121]

Thus, although operations such as clitoridectomies or clitoroplasties are meant to 'fix' genital abnormality and eliminate the origin of (psychological) problems for intersex individuals, these interventions seem to have been precisely a source of stigma and trauma, with intersex patients feeling as though their bodies, targeted for 'normalising' interventions, are deviant and abnormal.[122] Other aspects of medical management, such as the prescription of vaginal dilation,[123] genital examinations,[124] and genital photography[125] have also been reported to have a deeply negative psychological impact on patients, who explain that being watched, touched and photographed made them feel not only invaded, but also like they were 'freaks' with 'aberrant' genitals. A woman diagnosed with Congenital Adrenal Hyperplasia shared her experience in a doctor's visit as it follows:

> They made me be naked in a room and take pictures of me and they took pieces of my skin and left two marks one on each arm and nobody said to me why they were doing it. Those marks are still there, and I look at them and I think 'Why did they do that?' You know, why did they make me stand in a room and have pictures taken with no clothes on and humiliate me like that without saying anything to me. Why, what was wrong with me?[126]

Despite pursuing the goal of ensuring psychological well-being, medical management has thus been criticised for having had the opposite effect, nurturing the stigmatisation,

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[121] Cheryl Chase, '"Cultural Practice" or "Reconstructive Surgery"? US Genital Cutting, the Intersex Movement, and Medical Double Standards' in S James and C Robertson (eds), *Genital Cutting and Trasnational Sisterhood. Disputing US Polemics* (University of Illinois Press 2002) 134–135.
[122] Bonnie Hart and Jane Shakespeare-Finch, 'Intersex Lived Experience: Trauma and Posttraumatic Growth in Narratives' (2021) 00 Psychology & Sexuality 1, 3.
[123] Preves (n 120) 58.
[124] Heino FL Meyer-Bahlburg and others, 'Stigma in Medical Settings as Reported Retrospectively by Women with Congenital Adrenal Hyperplasia (CAH) for Their Childhood and Adolescence' (2017) 42 Journal of Pediatric Psychology 496.
[125] S Creighton and others, 'Medical Photography: Ethics, Consent and the Intersex Patient' (2002) 89 BJU International 67.
[126] ibid 69.

pathologisation and othering of intersex individuals.[127] Thanks to the protests of intersex activists, medical protocols underwent revision, with the 2006 Chicago Consensus Statement seeking to be more respectful, open and transparent with intersex patients and their families.[128]

These changes have not, however, had a homogeneous reception by intersex activism. As seen in the previous chapter, there are important disagreements among intersex communities with regards to how intersexuality should be conceived and how the medical profession should react to it. On the one hand, organisations like OII advocate for its depathologisation altogether, rejecting any and all medical labels, arguing that conceptions of 'healthy' and 'normal' in current medical discourse are encoded in binary and oppressive conceptions of gender.[129] They thus reject the term Disorders of Sex Development, introduced by the Statement. They are also against both the idea that a multidisciplinary medical team, together with parents, should choose the gender of the child after 'expert evaluation', since 'being intersex itself is not a disorder which requires medical treatment', calling on parents to instead 'do all that is necessary so their children can live according to their choice'.[130] On the other hand, other activists, like the organisation Accord Alliance, consider that intersexuality is, to some extent, a medical issue that should be handled by medical professionals, and its aim is to work *together* with

[127] Preves (n 120) 62; Karzakis (n 62) 248.
[128] For a detailed account of how intersex activism has challenged the medical management of intersexuality since the 1990s, see Georgiann Davis, *Contesting Intersex: The Dubious Diagnosis* (New York University Press 2015) 36–54.
[129] See Chapter 3 for further discussion on how intersex activism has framed oppression in relation to decision-making and intersex surgeries.
[130] OII Intersex Network (n 117).

the medical community to achieve better care of intersex individuals.[131] For instance, Chase, who was instrumental in the creation of the 2006 Consensus Statement, is clear in saying that she thinks that 'an intersex condition is something that is not going to make your child happier'.[132] She insists that improvements are needed in the standards of care and informed consent practices, since intersex people 'have a right to the best surgery we can provide', which requires further research, refinement of existing surgical techniques and appropriate communication with patients.[133] This branch of intersex activism shares a similar underpinning to the mainstream medical discourse outlined above, with the intersex body being seen as a source of problems which can and should be handled by medical professionals, who need to adopt appropriate standards of psychological support, information-sharing and informed consent procedures.

Therefore, there are two competing discourses of psychological well-being surrounding intersex interventions: the medical discourse, which suggests that intersexuality is a source of stress and psychological suffering for intersex children and their families, offering gender assignment, surgery and psychological attention to cope with such challenges; and the counter-discourse of intersex activism, which considers that it is

[131] See eg Intersex Society of North America (n 117); 'Accord Alliance - Better Lives. Better Outcomes.' <https://www.accordalliance.org/> accessed 23 April 2021.
[132] Vernon A Rosario, 'An Interview with Cheryl Chase' (2006) 10 Journal of Gay and Lesbian Psychotherapy 93, 98.
[133] ibid 97.

how the medical world handles intersexuality, rather than intersex embodiment itself, that causes a great deal of psychological pain for patients.

Both discourses can be compared with that surrounding vulval cosmetic surgery, which, as argued above, seems to frame psychological welfare in terms of concern for the patient's mental state, since she is suspected of having precarious mental health when her requests are 'too much'. Psychological well-being in intersex surgery is not discussed in order to ascertain what drives parents or intersex individuals to have surgery, but rather in terms of *dealing with* their already existing psychological suffering, or preventing future (but almost certain) psychological harm. If in the previous section I argued that the mind and how it reads the body, rather than the body itself, is the key element in how the medical literature frames the decision to have vulval cosmetic surgery, in intersex surgery, the body, and how it is treated, seems to be the crucial element that underpins the understanding of mental well-being. Put differently, the reading of the intersex body as in need of fixing is the key factor connecting psychological health and choice. Both in Money's and in current protocols, the core issue seems to be whether and how ambiguous genitalia affect the child's mental health. Surgery is deployed as a possibility for children to solve or prevent psychological problems that may ensue because of their embodiment, ensuring, under Money's protocols, that they will have an unconfused and unequivocal gender identity/role and, under current guidance, that they will receive the psychological attention they and their family need to cope with the psychological challenges that come with not having clearly defined genitals.

3 Female Genital Mutilation

In contrast with vulval cosmetic surgery, where psychological suffering and well-being are discussed in terms of mental instability, and, in intersex surgery, where the debate is framed in terms of coping with (potential) psychological problems resulting from intersex traits, mainstream medical and policy discourse in relation to FGM is perhaps less explicit when discussing mental welfare, although the decision to have this intervention is deemed as both psychologically coerced and psychologically damaging, with a range of measures in place to deter, criminalise and monitor this practice.

3.1 The pressure to be cut

Like intersex surgeries, FGM often takes place at a young age. UNICEF's 2013 study suggests that most girls are cut before the age of 15, and in some countries, such as Nigeria, Mali, Eritrea, Ghana or Mauritania, girls typically experience FGM before their fifth birthday.[134] It is thus usually up to parents and, mainly, mothers, to decide if their daughters will be excised and, if so, what sort of cutting they receive.[135] As seen in previous chapters, FGM has a very important social and cultural value, and is considered a rite of passage for many of those who engage in it, without which women are believed not to achieve full

[134] UNICEF, 'Female Genital Mutilation: A Statistical Overview and Exploration of the Dynamics of Change' (2013) 47; Nevertheless, some adult women do undergo FGM as well. For instance, the practice of post birth re-infibulation is common in some communities. See eg Edberg AK Berggren, V; Musa Ahmed, S; Hernlund, Y; Johansson, E; Habbani B, 'Being Victims or Beneficiaries? Perspectives on Female Genital'.
[135] World Health Organization, 'Eliminating Female Genital Mutilation. An Interagency Statement' (2008) 7; Tahereh Pashaei and others, 'Daughters at Risk of Female Genital Mutilation: Examining the Determinants of Mothers' Intentions to Allow Their Daughters to Undergo Female Genital Mutilation' (2016) 11 PLoS ONE 1, 7.

womanhood, a clean vulva or adequate management of sexual desire.[136] Hence, many mothers, despite acknowledging that FGM is a painful procedure which they have themselves undergone, think that it is in the best interests of their daughters, as it will ensure that they have a 'proper' body and are socially accepted.[137] As Susie Costello and others explain:

> [t]he motivation for [FGM] is not malice or violence, as outsiders might assume. Parents decide to subject their daughters to [FGM] in the belief that it is in their daughters' best interests that the benefits outweigh the risks … In practising countries, [FGM] can be seen as the only pathway to economic and social security for women, such that girls themselves want to be cut.[138]

The Western legal and medical worlds acknowledge that deciding to undergo this procedure is the result of social pressure and gender oppression.[139] As previous chapters have explained, the issue of whether FGM can ever be the product of free choice has received considerable attention, with the United Nations (UN) and other international organisations deeming it an instance of patriarchal violence, believing that women's willingness to have this intervention (and to have their daughters cut) stems from their oppression, as refusing FGM is not a realistic possibility for them.[140] UNICEF considers this practice a 'social norm' where 'individuals expect that a sufficiently large segment of

[136] See eg Rogia Mustafa Abusharaf, 'Virtuous Cuts: Female Genital Circumcision in an African Ontology' (2001) 12 Differences: A Journal of Feminist Cultural Studies 112, 133–135.
[137] Pashaei and others (n 135) 7; EL Ahanonu and O Victor, 'Mothers' Perceptions of Female Genital Mutilation' (2014) 29 Health Education Research 683, 688; UNICEF (n 134) 9.
[138] Susie Costello and others, 'In the Best Interests of the Child: Preventing Female Genital Cutting (FGC)' (2015) 45 British Journal of Social Work 1259, 1264.
[139] World Health Organization (n 135) 2; Resolution adopted by the General Assembly on 20 December 2012 2013 1; Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence (2011).
[140] See eg Resolution adopted by the General Assembly on 20 December 2012; Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence, Article 23; World Health Organization (n 135) 2; European Institute for Gender Equality, 'Female Genital Mutilation in the European Union and Croatia' (2013).

their social group will cut their daughters and they believe that a sufficiently large segment of their social group thinks that they ought to cut their daughters and may sanction them if they do not'.[141] Likewise, the World Health Organization (WHO) explains that FGM is 'widely practised, usually without question, and anyone departing from the norm may face condemnation, harassment, and ostracism', suggesting that 'girls themselves may desire to undergo the procedure as a result of social pressures from peers because of fear of stigmatisation and rejection from their communities if they do not follow the tradition'.[142] For instance, some mothers explain that, even though they are against the practice and resent their mothers for having them excised and/or infibulated, they will have their daughters cut, as it is the only way for them to have a 'life' within their community.[143] The social context is hence framed as what makes FGM a compulsory practice, since not engaging in it might have burdensome consequences, such as 'ostracism from families or kinship structures and the loss of loved ones, geographic spaces and, for some, jobs or material possessions'.[144]

From this perspective, having your vulva and your daughter's vulva excised is not truly a free choice, as the context makes it the *only* choice for ensuring the (present and future) wellbeing of your child. That is why, as Chapter 1 showed, the WHO advocates for 'social change', explaining that, besides a legal prohibition, there needs to be

[141] UNICEF (n 134) 14.
[142] World Health Organization (n 135) 4–5.
[143] Yohannes Mehretie Adinew and Beza Tamirat Mekete, 'I Knew How It Feels but Couldn't Save My Daughter; Testimony of an Ethiopian Mother on Female Genital Mutilation/Cutting' (2017) 14 Reproductive Health 1.
[144] Sarilee Kahn, '"You See, One Day They Cut": The Evolution, Expression, and Consequences of Resistance for Women Who Oppose Female Genital Cutting' (2016) 26 Journal of Human Behavior in the Social Environment 622, 629.

'multisectoral', 'sustained' and 'community-led' actions, fostering a 'process of positive social change at community level', with programmes like '"empowering" education, discussion and debate, public pledges and organised diffusion'.[145] 'Educating' women and making them 'aware' that it is possible to live a good life without being cut will foster their 'active contribution to decision-making and enhance their ability to discontinue this practice'.[146] Hence, the assumption underpinning global policy is that women are coerced and forced into this practice but, if the conditions change, they will be able to say 'no' to it without facing the current negative social consequences (Chapter 3 explored how this perception has been criticised for stemming from Western bias, looking at how the discussion around oppression has been articulated within feminist debates).

3.2 Criminalising decision-making and protecting girls

In England and Wales, as Chapter 2 explained, the FGM Act 2003 criminalises the 'excision, infibulation or otherwise mutilation of a girl's labia majora, minora or clitoris', as well as assisting her to mutilate herself, collaborating so someone else cuts her and, in case of having parental responsibility over her and her being under 16, the failure to protect her from FGM.[147] Except for this last offence, these criminal protections are in place regardless of the age of the woman, and whether she consents to being cut or not, as consent cannot be used as a defence for criminal liability. Indeed, the English legal framework is in line with the view of UN agencies that FGM is a compulsory social practice, framing

[145] World Health Organization (n 135) 13–14; See also UNICEF (n 134) 117–118.
[146] World Health Organization (n 135) 17.
[147] Female Genital Mutilation Act 2003 ss 1, 2, 3, 3A.

women who are cut via FGM as helpless victims who do not really know what they want—or, rather, who only think they know what they want because they are oppressed.

The idea of the woman who undergoes FGM as powerless is exemplified in the wording of the FGM Act 2003, which refers to all women who have FGM as 'girls', explaining that it includes 'woman'.[148] The use of the term 'girl' is infantilizing, treating women as they were children who have to rely on someone else's authority to make decisions on their behalf. This is also the feeling one might have when reading about the first, and one of the very few, FGM cases that was brought to trial. In 2015, a doctor was prosecuted (although eventually found not guilty) for suturing his patient's vulva after she gave birth to prevent her from bleeding out, as she had been previously infibulated.[149] The patient did not support the prosecution, but instead gave evidence for the defence,[150] and refused to give a statement to the police, explaining to the court that 'as far as she was concerned, the doctor had delivered her baby'.[151] Nevertheless, the Crown Prosecution Service (CPS) decided to move forward with the charges, contending that the doctor did not act within the medical exception of the FGM Act 2003. Although both patient and doctor, the latter with the back-up of the president of the RCOG,[152] denied that what had

[148] ibid s 6(1).
[149] Sandra Laville, 'Doctor Found Not Guilty of FGM on Patient at London Hospital' *The Guardian* (4 February 2015).
[150] Charlotte Proudman, *Female Genital Mutilation. When Culture and Law Clash* (Oxford University Press 2022) 86.
[151] Sandra Laville (n 149).
[152] Royal College of Obstetricians and Gynaecologists, 'FGM Trial – the Wrong Prosecution' <https://www.rcog.org.uk/en/blog/FGM-trial-the-wrong-prosecution> accessed 16 February 2021.

happened amounted to FGM, the CPS claimed that what the doctor did was not medically necessary but aimed at returning his patient to her previously infibulated state.[153]

Current CPS guidelines consider that the victim's support of the prosecution is a relevant factor when deciding whether it is in the public interest to prosecute.[154] Not distinguishing between adult and underage women who might undergo FGM, the CPS also makes clear that 'these cases will often involve vulnerable victims who may have had little or no dealings with the criminal justice process'.[155] Maintaining the narrative that having FGM is the product of social pressure, the CPS stresses that 'victims of FGM can often retain a loyalty to their family/community and this may make them reluctant to support a prosecution'.[156] The CPS also expresses the concern that 'victims' might be 'threatened, pressurised or intimated' into not giving evidence or supporting the prosecution, warning that the case may continue without them if there is sufficient evidence to prove the charges without the victim's cooperation.[157] As Charlotte Proudman highlights, acting against the victims' wishes and forcing them to cooperate in the prosecution can 're-victimise and re-traumatise them', which can 'further alienate community members from engaging with the criminal justice system'.[158]

This scepticism about taking women's accounts at face value is also reflected in how mental health is taken into account in relation to these interventions. As introduced in Chapter 2, the FGM Act 2003 makes clear that 'no offence is committed by an approved

[153] Sandra Laville (n 149).
[154] Crown Prosecution Service, 'Female Genital Mutilation Prosecution Guidance' (2019).
[155] ibid.
[156] ibid.
[157] ibid.
[158] Proudman (n 150) 89.

person who performs a surgical operation to a girl which is necessary for her physical or mental health'.[159] The Act adds the crucial caveat that, when establishing whether the operation is 'necessary for the mental health of a girl it is immaterial whether she or any other person believes that the operation is required as a matter of custom or ritual'.[160] Hence, it is not permissible for a woman who feels anxious or concerned about her vulva to have FGM in order to feel better. This prohibition is in direct contrast with vulval cosmetic surgery, which, as the first section showed, is precisely designed to provide psychological relief to those who are dissatisfied (but not excessively so) with their genitals. Whilst the medico-legal framework accepts some women's mental suffering (provided it does not stem from a psychiatric condition) as legitimate and offers surgery as a solution, it refuses to see the psychological angst that might drive others towards FGM as genuine, deeming their desire for doing so to be solely the product of social pressure. To put it in the words of Moira Dustin:

> If you are a British girl or woman who believes her genitals are abnormal, it is permissible to have surgery to fit in with the ideals of the majority society. However, if you are from a minority, your mental health is culturally determined—you have a group delusion rather than an individual one—and you do not have the same rights as members of the majority society to alter your body.[161]

Therefore, the law seems to make assumptions about women's autonomy depending on their race and ethnicity, differentiating between 'cultural' and 'cosmetic' cuts.[162] While white women are considered 'rational agents' who choose to beautify or enhance their

[159] Female Genital Mutilation Act 2003 s 1(2)(a).
[160] ibid s 1(2).
[161] Moira Dustin, 'Female Genital Mutilation/Cutting in the UK: Challenging the Inconsistencies' (2010) 17 European Journal of Women's Studies 7, 16.
[162] Moira Dustin and Anne Phillips, 'Whose Agenda Is It?: Abuses of Women and Abuses of "culture" in Britain' (2008) 8 Ethnicities 405, 417.

vulvas, women of colour are 'victims of their cultures' and forced to carry on mutilating traditions.[163] However, as Dustin and Anne Phillips argue, the difference between 'cultural' and 'cosmetic' motivations is blurry, since 'cosmetic' cuts might be sought as a result of cosmetic pressure and 'cultural' motivations for cutting do not necessarily exclude 'deliberate and reflective choice', as Chapter 3 has shown.[164] The framing of FGM as 'cultural' seems to imply that only non-Western cultures have 'culture', with the West having no cultural biases and, as a result, assuming that those seeking cosmetic surgery are not pressured by culture or family.[165]

When those being cut—or at the risk of being cut—are underage, there are additional protections in place. In addition to care proceedings, discussed in Chapter 2, family courts have the prerogative of issuing FGM Protection Orders (FGMPOs).[166] Either by their own volition or resulting from an application by a (potential) victim or a 'relevant third party', FGMPOs are in place for girls in danger of or who have been already subjected to FGM.[167] So far, the number of FGMPOs has been small, with a total of 570 applications and 808 orders as of December 2022 since its introduction in July 2015, and the cases

[163] Arianne Shahvisi, '"FGM" vs. Female "Cosmetic" Surgeries: Why Do They Continue to Be Treated Separately?' [2021] International Journal of Impotence Research 1, 3.
[164] Dustin and Phillips (n 162) 417.
[165] Proudman (n 150) 78.
[166] Female Genital Mutilation Act 2003 Schedule 2.
[167] ibid.

where they have been granted have usually entailed measures like the surrender of passports and the prohibition of travel, both for the potential victim and/or her parents.[168]

In *Re E (Children) (Female Genital Mutilation Protection Orders)*, the mother of three girls under 15 applied for an FGMPO, as she feared that their father, from whom she was now divorced and who lived in Nigeria, would have them cut whilst they were visiting him during the school holidays, having sent ceremonial robes to prepare them for the ritual.[169] The court considered that the girls were at 'significant risk of being victims of a genital mutilation offence', issuing an FGMPO restraining both parents from removing their children from England and Wales and also forbidding their father 'from coming within a restricting radius of their home'.[170]

A similar decision was made in *A Local Authority v MC*, where the court concluded that a girl, who was fourteen months at the time and the daughter of an English mother and an Egyptian father, would only be allowed to come in contact with her father in England and Wales, being forbidden to travel abroad, with her passport surrendered until 2032.[171] Prohibition of travel abroad was also the measure adopted in *Re Z (A Child) (FGMPO: Prevalence of FGM)*, where it was considered necessary to protect Z, who was six-and-a-half-years-old at the time, from not only going to Guinea, her father's country, but also anywhere else in the world, in order to avoid her arriving there via third countries, until she

[168] Ministry of Justice, 'Family Court Statistics Quarterly: October to December 2022' <https://www.gov.uk/government/statistics/family-court-statistics-quarterly-october-to-december-2022/family-court-statistics-quarterly-october-to-december-2022#forced-marriage-protection-orders-and-female-genital-mutilation-protection-orders> accessed 12 April 2023.
[169] *Re E (Children) (Female Genital Mutilation Protection Orders)* [2015] EWHC 2275 (Fam) [5].
[170] ibid [24–27].
[171] *A Local Authority v MC* [2017] EWCH 2898 (Fam) [81–83].

reached the age of seventeen.[172] The justification behind not letting girls travel abroad is that they are believed to be better protected in England and Wales, rather than in countries with a 'high prevalence' of FGM, where the girls themselves and their families are 'more likely [to] succumb to pressure' from other family members and their community.[173]

Moreover, as Chapter 5 discusses, as a result of the Serious Crime Act 2015 amendments to the FGM Act 2003, healthcare professionals, teachers and social care workers have a duty to notify the police if they 'discover that an act of female genital mutilation appears to have been carried out on a girl who is aged under 18'.[174] Additionally, since 2016, the FGM Enhanced Dataset, a repository collecting individual data from healthcare providers in England regarding FGM, has been in place.[175] Although it gathers confidential information, such as the child's name, surname and NHS number, as well as their family history with FGM, the type of FGM, and when and where it was performed, these data are anonymised before publication.[176] According to the most recent report, there

[172] *Re Z (A Child) (FGMPO: Prevalence of FGM)* EWHC 3566 (Fam) 1 [57].
[173] ibid [59].
[174] Female Genital Mutilation Act 2003 s 5B(1).
[175] NHS Digital, 'Female Genital Mutilation - January to March 2021' <https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/january-to-march-2021> accessed 21 June 2021.
[176] NHS Digital, 'Patients - Your FGM Information and How We Use It' <https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/female-genital-mutilation-datasets/patients-your-fgm-information-and-how-we-use-it> accessed 21 June 2021.

were 770 newly reported cases in England and Wales between October 2022 and December 2022.[177]

There is disagreement over whether these criminal, civil and information-sharing arrangements are appropriate mechanisms to tackle FGM, or whether they have the potential for (further) marginalising people from communities that already face social exclusion. First, criminalisation, mandatory reporting and FGMPOs might reinforce the stigma and alienation that the UN strategy seeks to counteract. Sarah M Creighton and others point out that it is not uncommon for cases where a risk of FGM is reported for it later to be found that the risk was non-existent or that the girl was never cut; but only after girls and their families have had to deal with the emotional and financial stress of social services and police investigations.[178]

This seems to have been the case in *Re E*, mentioned above, where it was found that the allegations justifying the FGMPO were 'unsubstantiated'.[179] The children were eventually allowed to travel to Nigeria, but that was only after they had gone through several court proceedings, which initially ruled that they were in a situation of high risk.[180] In fact, *Re E* also shows how FGM is a matter intersecting criminal, family and immigration law, since the High Court concluded that the FGMPO in this case had been sought as part

[177] NHS Digital, 'Female Genital Mutilation, October 2022 - December 2022 ' <https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/october-2022---december-2022#> accessed 12 April 2023.
[178] Sarah M Creighton and others, 'Tackling Female Genital Mutilation in the UK' (2019) 364 BMJ (Online) 7, 1.
[179] Joseph Home and others, 'A Review of the Law Surrounding Female Genital Mutilation Protection Orders' (2020) 28 British Journal of Midwifery 418, 6.
[180] ibid 7.

of an 'immigration scam'.[181] In order to secure asylum, the mother seems to have manufactured a story about her ex-husband forcing her to undergo FGM and wanting to subject their children to FGM as well.[182] However, it was later discovered that he never had the intention to do so,[183] with the judge ruling that not only did the mother 'fundamentally and dishonestly misrepresent the true position',[184] but had also harmed their children by trying to scare them from being with their father.[185] Eventually, the High Court ruled that the children were to be removed from their mother's care and instead live with their father, who was granted permission to take them to Nigeria.[186]

Second, if a minor is found to have been a victim of FGM, care proceedings by which she might be removed from her parents, and criminal proceedings by which her parents might be prosecuted, will be initiated, which could put her in a vulnerable position, being doubly victimised, 'as a victim of FGM and having her parents as suspects within the criminal justice system'.[187] In addition, criminal sanctions and civil actions might result in less willingness to report or share concerns with healthcare or social workers, all of which, rather than disrupt the social norms that are seen as the main factor underpinning this practice, might instead drive it underground.[188] That is why some propose that, instead of criminalisation and increased surveillance, efforts should be directed to 'begin healing

[181] *CE v NE* [2016] EWHC 1052 (Fam) [8].
[182] ibid [26].
[183] ibid [108].
[184] ibid [8].
[185] ibid [108].
[186] ibid [119].
[187] Home and others (n 179) 5.
[188] Home and others (n 179); Felicity Gerry and others, 'Why It Is Time for an FGM Commissioner—Practical Responses to Feminised Issued' (2020) Family Law 1317, 1327.

relations with individuals, families and communities who have abandoned the practice, and to support women and girls in the UK who have been cut'.[189]

One can see how the medico-legal framework puts those who decide to be and/or have their daughters cut in a precarious and somewhat contradictory position: while their decision-making power is assumed to be constrained by family pressures and social conventions, they are also considered fully responsible, in the eyes of the law, for their decisions, which might result in criminal sanctions and severe civil consequences, such as care proceedings or the surrender of passports. Girls and their family members from already marginalised groups are under constant scrutiny and observation, since being related to someone who has had FGM, having had FGM or belonging to a community where FGM is common practice are triggers of concern for healthcare and social workers, who have a duty to be on the lookout for possible signs of FGM, and to report to the authorities if they discover that a girl has been excised or infibulated. Like parents of intersex children, those who have their daughters cut are assumed to do so because they believe it is in their best interests. However, unlike decisions of intersex parents, FGM decision-making is deemed to stem from coercion and to have unequivocally harmful consequences, for which criminalising, surveillance and protection measures are in place.

4 Conclusion

Each of these cuts gives rise to different framings of and concerns about mental health. As advanced in the previous chapter, where I suggested that gender and race are key vectors

[189] Creighton and others (n 178) 2.

in how feminist literature has discussed oppression in relation to each of these cuts, the distinct conceptualisation of mental welfare is also informed by racialised and gendered ideals of genital anatomy. Indeed, whether the vulva is seen as (un)ambiguous and healthy and whether the reasons for cutting (provide psychological healthiness, ease the mind, enable compliance with social norms) are considered to be acceptable or not underpins the understanding of mental welfare in each sort of vulval cut.

Section 1 showed that the main perceived challenge for mental health in vulval cosmetic surgery is the mind, since the vulva and vagina, in most instances, are already perceived to be within the bounds of health and normality. The fact that patients might be excessively concerned about a minor or perceived flaw is the principal cause of preoccupation for doctors, who must ensure that their patients are psychologically balanced before agreeing to their surgical demands. Not all narratives about bodily dissatisfaction are accepted as healthy, with doctors having the role to act as gate-keepers to ensure that those who access surgery do not suffer from BDD or anxiety.

Although parents and intersex children are not perceived to be psychologically imbalanced (as the cosmetic surgery patient is suspected to be), they are assumed to be in a psychologically dangerous or complicated position, given the problems that are taken to be attached to having anomalous genitalia. Money's protocols convinced parents to consent to surgery by suggesting that leaving their children 'unfinished' would hinder their normal gender development. Now, in part responding to the demands of intersex activism, current protocols have attempted to leave behind such a strong link between binary gender identity/role and psychological well-being. However, they continue to see intersexuality as

a psychologically traumatic experience which might give rise to gender identity and psychosexual problems, which require specialised and continuous mental health support.

Unlike cosmetic and intersex surgeries, psychological drives and mental (in)stability are not key issues when discussing FGM; rather it is the influence of non-Western cultural and social surroundings which is seen as the most concerning factor. The main focus is neither how the mind interacts with the body nor the body itself as a potential source of psychological stress, but the context and culture which force women to have their vulvas, and their daughters' vulvas, cut. FGM is framed as a practice that is only believed to make sense within certain contexts and environments, with efforts and resources having been dedicated not only to punish those who cut and protect those who are cut, but also to strive for social change so everyone ceases to see FGM as a necessary and beneficial intervention. Despite parallels with vulval cosmetic surgery, where societal pressure is also a factor that might underpin women's anxieties about their vulval appearance, under no circumstances is FGM considered a legitimate strategy to ease mental pain. Rather, women who might feel their vulvas do not fit the standards of beauty or womanhood need to be educated out of their wrong beliefs.

Hence, whether the vulva is considered to be healthy and (un)ambiguous, and whether the cuts performed are seen to be the product of (wrong) social expectations and traditions, underpins the construction of distinct discourses about mental health in each of these three interventions. Psychological discourses draw different connections between mind, body and culture in each case, depending on the perception of (cuts on) the vulva as threatening or reifying embodied social and gendered expectations. That is why the next

chapter focuses on analysing the definitions of the vulva as doubtful, healthy or deformed, as well as the rationales for performing vulval cosmetic surgeries, intersex surgeries and FGM.

CHAPTER 5. THE RATIONALES FOR VULVAL CUTTING

The preceding chapters have examined the ways in which vulval cutting is differently framed and discussed depending on the extent to which the vulva and the cuts on it are perceived to align with or contradict racialised and gendered expectations of genital anatomy. Chapter 1 traced the history of each of these interventions, Chapter 2 provided a picture of how the current medico-legal discourse frames them, Chapter 3 zoomed in on oppression through the lenses of feminist scholarship and Chapter 4 focused on mental welfare.

This chapter analyses the rationale deployed to justify each cut. What is the justification for cutting? What type of benefit, or harm, does the cut bring about in each case? What effects is each cut seen to produce on the body, and on the mind? To what extent do the several actors involved in cutting (patients, families, medical professionals, victims, traditional barbers) have disparate perceptions of what the cut means and what its effects are? Juxtaposing the answers to these questions reveals that 1) each type of cut is read as shaping the vulva in ways that relate differently to medical standards of 'health', 'deformity' and 'harm' and 2) intersections of race and gender inform the medico-legal understanding of what these terms mean.

1 Vulval cosmetic surgery

1.1 Therapy and enhancement

One of the central issues in the medical discussion around vulval cosmetic surgeries is determining whether these interventions are therapeutic (that is, tackle a clinical need) or enhancing (there is no underlying physical abnormality requiring surgery, but the patient believes that her body is improved through the intervention). This confusion is reflected in the various definitions of vulval cosmetic surgery offered by several UK medical professional bodies. For instance, according to the Royal College of Obstetricians and Gynaecologists (RCOG), '[vulval cosmetic surgery] refers to *non-medically* indicated *cosmetic* procedures which change the structure and appearance of the *healthy* external genitalia of women, or internally in the case of vaginal tightening'.[1] A similar definition, focused on the elective and enhancing character of these interventions, is offered by the British Association of Aesthetic Plastic Surgeons (BAAPS), which explains that 'aesthetic surgery of the female genitalia, or "designer vaginas", includes a number of surgical procedures designed to *improve* their appearance'.[2] The British Society for Paediatric and Adolescent Gynaecology (BritSPAG) also stresses the optional nature of these surgeries and the fact that they modify genitalia that present no abnormalities, considering that their main aim is 'to alter the structure and appearance of the healthy vulva'.[3] In contrast, whilst

[1] Royal College of Obstetricians and Gynaecologists, 'Ethical Opinion Paper: Ethical Considerations in Relation to Female Genital Cosmetic Surgery (FGCS)' (2013) 2 (emphasis added).
[2] British Association of Aesthetic Plastic Surgeons, 'Aesthetic Genital Surgery' <https://baaps.org.uk/patients/procedures/18/aesthetic_genital_surgery> accessed 2 December 2021 (emphasis added).
[3] British Society for Paediatric & Adolescent Gynaecology, 'Labial Reduction Surgery (Labiaplasty) on Adolescents' 9, para 2.1.

admitting that these procedures are 'often requested on purely aesthetic grounds', the British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS) acknowledges that these surgeries may tackle functional aspects of the genitalia, as they 'may also relate to sexual dysfunction and general discomfort'.[4]

The clinical or aesthetic rationale seems to be more or less pronounced depending on what the procedure entails. For instance, in surgical repairs for so-called birth trauma, the vagina is framed as needing 'reconstructive work' to 'resolve' its 'abnormalities'.[5] This sort of operation is indicated when there has been 'a great deal of cutting and tearing during childbirth', which can also affect the rectum and the sphincter, causing 'acute discomfort and pain during sexual intercourse'.[6] The surgery seeks to 'tidy up the perineum' and fix any vaginal tearing.[7] Likewise, 'reconstruction' might be also needed in cases of 'rare vaginal abnormalities', such as a not fully opened hymen or vaginal stenosis, in order to 'enable the patient to achieve full sexual function and fertility in later life'.[8] ('Abnormalities' related to intersex conditions will be studied in Section 2.) In contrast, the clinical, therapeutic or functional need of operations like labiaplasty, vaginal tightening, liposuction of the mons pubis or hoodectomy (trimming of the clitoral hood) is less clear, with the vulva and vagina not being clearly considered to have a physical problem warranting surgery. For instance, according to the NHS and the RCOG, the surgical reduction or trimming of the labia minora, although sometimes aimed at removing

[4] British Association of Plastic Reconstructive and Aesthetic Surgeons, 'Female Genital Tract Surgery ' <https://www.bapras.org.uk/public/patient-information/surgery-guides/female-genital-tract-surgery> accessed 2 December 2021.
[5] ibid.
[6] ibid.
[7] ibid.
[8] ibid.

(pre)cancerous vulval tissue, is most often performed on women 'because they do not like the look of their labia'.[9] Recontouring or removing fat from the mons pubis also has been deemed to mainly respond to cosmetic reasons, since 'in women of a certain age, the mons pubis can drop, causing what some patients find to be an aesthetically unappealing bulge'.[10]

In order to account for the clinical or aesthetic justification of the intervention, the medical profession has come up with objective scales classifying vulvas and vaginas 'according to their degree of "deformity"'.[11] Medical research largely relies on the so-called Franco classification to measure labia minora, in accordance to which labial hypertrophy is classified in four levels: 'class I (0 to 2 cm), class II (2 to 4 cm), and class III (>4 cm)'.[12] There is controversy as to which degree of labial width is necessary to reach the 'deformity' threshold, with some experts considering that 5 cm is a 'clear' limit of normal labia,[13] and others suggesting that, in addition to size or width, where the protrusion is located and whether and how it extends to other organs, such as the clitoris or perineum, should also be factors to consider when classifying labial variations and deciding which ones amount to an abnormality.[14] Categorising labia into different levels is important to

[9] NHS, 'Cosmetic Procedures - Labiaplasty (Vulval Surgery)' <https://www.nhs.uk/conditions/cosmetic-procedures/labiaplasty/> accessed 3 January 2021; Royal College of Obstetricians and Gynaecologists, 'Ethical Opinion Paper: Ethical Considerations in Relation to Female Genital Cosmetic Surgery (FGCS)' (n 1) 2.
[10] British Association of Plastic Reconstructive and Aesthetic Surgeons (n 4).
[11] Lina Michala, 'Clinical Evidence of the Effects of Female Genital Cosmetic Surgery' in Sarah M Creighton and Lih-Mei Liao (eds), *Female Genital Cosmetic Surgery: Solution to What Problem?* (Cambridge University Press 2019) 52.
[12] Saba Motakef and others, 'Vaginal Labiaplasty: Current Practices and a Simplified Classification System for Labial Protrusion' (2015) 135 Plastic and Reconstructive Surgery 774, 782; Warren A Ellsworth and others, 'Techniques for Labia Minora Reduction: An Algorithmic Approach' (2010) 34 Aesthetic Plastic Surgery 105, 107.
[13] Ellsworth and others (n 12) 107.
[14] Peter Chang and others, 'Vaginal Labiaplasty: Defense of the Simple "Clip and Snip" and a New Classification System' (2013) 37 Aesthetic Plastic Surgery 887, 887.

decide which surgical approach to take (edge resection, wedge resection, laser labiaplasty, inter alia), with each class of labial hypertrophy employing a different technique.[15]

A similar taxonomy of 'deformity' is adopted for vaginal rejuvenation or tightening procedures. Adam Ostrzenski and others proposed in 2011 a four level classification of vaginal width, depending on vaginal rugation and the presence of site-specific defects, and how these affect the 'sensation of wide vagina; feeling of empty hole … feeling significant decreased penile strokes movements … [or] lack of enjoyment generated from sensation of frictional strokes during coitus'.[16] The clitoris is also subject to classification, depending on the extent to which it might be 'buried' under the clitoral hood or the thickness or elongation of the clitoral hood skin.[17] Depending on the quantity of excess of clitoral hood tissue and the degree of adherence with the glans clitoris, clitoral phimosis might give rise to different sorts of complications, including loss of sensitivity and hygiene problems, since smegma might accumulate under the clitoral foreskin.[18]

Despite the development of these taxonomies, several papers stress that there are no concrete measurements of what normal and healthy vulvas are like, but that the values of what constitutes healthy genitalia are rather broad.[19] Labial width can extend up to 5 cm,

[15] Chang and others (n 14); Carlo Maria Oranges, Andrea Sisti and Giovanni Sisti, 'Labia Minora Reduction Techniques: A Comprehensive Literature Review' (2015) 35 Aesthetic Surgery Journal 419.
[16] Adam Ostrzenski, 'An Acquired Sensation of Wide/Smooth Vagina: A New Classification' (2011) 158 European Journal of Obstetrics and Gynecology and Reproductive Biology 97, 98–100.
[17] Lina Triana and Ana Maria Robledo, 'Aesthetic Surgery of Female External Genitalia' (2015) 35 Aesthetic Surgery Journal 165, 167; Roman Chmel and others, 'Clitoral Phimosis: Effects on Female Sexual Function and Surgical Treatment Outcomes' (2019) 16 Journal of Sexual Medicine 257, 258.
[18] Triana and Robledo (n 17) 168–171.
[19] Katie Brodie and others, 'A Study of Adolescent Female Genitalia: What Is Normal?' (2019) 32 Journal of Pediatric and Adolescent Gynecology 27, 1; Julian Lloyd and others, 'Female Genital Appearance: "Normality" Unfolds' (2005) 112 BJOG: An International Journal of Obstetrics and Gynaecology 643; Haim Krissi and others, 'Anatomical Diversity of the Female External Genitalia and Its Association to Sexual Function' (2016) 196 European Journal of Obstetrics and Gynecology and Reproductive Biology 44, 44;

labial length varies between 5-100mm, and labial asymmetry and protruding labia minora are also common.[20] Likewise, vaginal length spans varies between 6.5 and 12.5cm,[21] and something similar is true of the clitoris, which can measure between 2-4 cm.[22]

Nevertheless, 'objective' scales and measurements are not sufficient to account for all the instances in which vulval cosmetic surgery is performed. Some women seek surgery even though their genitals are within the (medically defined) norm. For example, a study by Naomi S Crouch and others found that, despite being reassured by their gynaecologist that their vulvas were normal, 40% of women remained committed to going ahead with cosmetic surgery, as they felt 'distressed' about the appearance of their labia, with some of them also reporting experiencing physical discomfort.[23] Self-perceptions of abnormality and self-consciousness about appearance or function, including sensation of looseness or embarrassment about the vulva's protrusion or asymmetry, which might also lead to difficulties experiencing orgasm, are major underpinning drivers for surgery.[24] Seeking vulval cosmetic surgery is a highly personal decision, encompassing subjective factors that extend beyond the aforementioned classification scales, such as expectations of 'increased

Annemette Wildfang Lykkebo and others, 'The Size of Labia Minora and Perception of Genital Appearance: A Cross-Sectional Study' (2017) 21 Journal of Lower Genital Tract Disease 198.

[20] Jennifer A Hayes and Meredith J Temple-Smith, 'What Is the Anatomical Basis of Labiaplasty? A Review of Normative Datasets for Female Genital Anatomy' (2020) 61 Australian and New Zealand Journal of Obstetrics and Gynaecology 3; Naomi S Crouch, 'Female Genital Anatomy' in Sarah M Creighton and Lih-Mei Liao (eds), *Female Genital Cosmetic Surgery. Solution to What Problem?* (Cambridge University Press 2019) 13.

[21] Lloyd and others (n 19) 645; M Basaran and others, 'Characteristics of External Genitalia in Pre- and Postmenopausal Women' (2008) 11 Climacteric 416.

[22] Fatih Akbiyik and Alev Oguz Kutlu, 'External Genital Proportions in Prepubertal Girls: A Morphometric Reference for Female Genitoplasty' (2010) 184 Journal of Urology 1476, 1479; Crouch (n 20) 14.

[23] NS Crouch and others, 'Clinical Characteristics of Well Women Seeking Labial Reduction Surgery: A Prospective Study' (2011) 118 BJOG: An International Journal of Obstetrics and Gynaecology 1507, 1509.

[24] Chang and others (n 14) 890; Michael P Goodman and others, 'A Large Multicenter Outcome Study of Female Genital Plastic Surgery' (2010) 7 Journal of Sexual Medicine 1565, 1568.

confidence' or 'improved self-image'.[25] Although genitalia might be considered to not objectively need or benefit from surgery, women might seek surgical alteration in order to feel better about their body. As surgeons Michael Goodman and Otto Placik explain:

> [t]he assumption is made that these procedures, since they are basically cosmetic and sexual in nature, are not a 'medical necessity' and thus trivial. As in other parts of her body, nature has provided women with an enormous natural diversity in the size, shape and design of her genitalia. Because a body part is deemed by others to be 'in the normal range', however, does not necessarily mean that its form or function is satisfactory to its 'wearer'.[26]

Feeling uncomfortable with one's vulva and vagina, although these might be considered 'normal' under the established classification scales, might also translate into physical pain and lack of pleasure during sex, and impair daily activities, like wearing tight clothes, cycling or jogging.[27] Recognising this, the BritSPAG explains that 'a girl unhappy about their vulva is likely to be sensitised towards all vulval sensations and ascribe negative meanings to them', since 'physical and psychological complaints are most likely to be related'.[28]

Having a vulva which conforms to what is considered normal or healthy does not therefore necessarily prevent the feelings of abnormality that might push someone to seek surgery, since our anatomy interacts with 'multiple factors, including cultural, relational, and psychological dimensions'.[29] The social embeddedness through which we see and

[25] Michael P Goodman and others, 'Evaluation of Body Image and Sexual Satisfaction in Women Undergoing Female Genital Plastic/Cosmetic Surgery' (2016) 36 Aesthetic Surgery Journal 1048, 1055.
[26] Goodman and others, 'A Large Multicenter Outcome Study of Female Genital Plastic Surgery' (n 24) 1576.
[27] C Clerico and others, 'Anatomy and Aesthetics of the Labia Minora: The Ideal Vulva?' (2017) 41 Aesthetic Plastic Surgery 714, 716.
[28] British Society for Paediatric & Adolescent Gynaecology (n 3) para 3.1.
[29] Giussy Barbara and others, 'Vaginal Rejuvenation: Current Perspectives' (2017) 9 International Journal of Women's Health 513, 518.

experience our body has led the Nuffield Council on Bioethics to argue that 'it is simply not possible to draw a consistent and coherent distinction between what is reconstructive and cosmetic, or even between what is cosmetic and therapeutic/clinical'.[30] What is defined as therapeutic or enhancing is 'dependent on the cultural context' and our own desires or needs to be or feel more normal are also shaped by social expectations, and the attitudes and commentaries of others.[31]

Indeed, Chapter 1 introduced how 19th and 20th medical understandings of vulval anatomy were developed through gendered and racial imaginaries of embodiment. Although current medical accounts of the vulva and vulval surgeries do not draw such direct connections between 'racial and sexual deviancy', they remain somewhat invested in the colonial racial imaginary about what constitutes a normal and healthy vulva.[32] For example, in a 1978 article, LH Honoré and KE O'Hara, after not being able to find a 'pathological' origin accounting for the labial enlargement of two women in their case study, resulted to race to explain this form of 'excessive' 'developmental abnormality'.[33] Likewise, carrying on the vision that enlarged labial size is an inherent black feature, a recent 2018 study which sought to 'set up a database that represents reliable standard values of the vulva' only included Caucasian women.[34] The authors explain that the exclusion of African women in their study was a 'conscious' decision, as they wanted to have an

[30] Nuffield Council on Bioethics, 'Cosmetic Procedures: Ethical Issues' (2017) para 7.3.
[31] ibid paras 7.4-7.6.
[32] Camille Nurka and Bethany Jones, 'Labiaplasty, Race and the Colonial Imagination' (2013) 28 Australian Feminist Studies 417, 427.
[33] LH Honoré and KE O'Hara, 'Benign Enlargement of the Labia Minora: Report of Two Cases' (1978) 8 European Journal of Obstetrics and Gynecology and Reproductive Biology 61, 63.
[34] A Kreklau and others, 'Measurements of a "Normal Vulva" in Women Aged 15–84: A Cross-Sectional Prospective Single-Centre Study' (2018) 125 BJOG: An International Journal of Obstetrics and Gynaecology 1656, 3.

'homogeneous group of women without diversities based on ethnicity'.[35] The aim in creating this dataset was to 'present a baseline for the appearance of a normal Caucasian vulva', setting the standards for when cosmetic surgery might be indicated.[36]

As we saw above, labial size must currently be contained within certain parameters (at most, 5 cm), since bigger labia are associated with ugliness and uncomfortableness, requiring labiaplasty to be normalised. As Camille Nurka and Bethany Jones argue, the fact that vulval 'neatness' underpins the performance and justification of this intervention reflects and perpetuates 'deeply held anxieties about feminine non-conformity' which have its origins in colonial ideals of sexuality and femininity.[37] In their own words:

> [t]he current existence of the vulval 'norm' would not have come about without prior racist medico-discursive practices of physiognomic measurement for the purposes of producing a heteronormatively compliant body. For us, the growing demand for labiaplasty procedures is 'new' only in so far as it resurrects, albeit in a different fashion, certain historically entrenched narratives that make the female body a border object; a historical and cultural artefact situated between human and animal, white and black.[38]

1.2 Controversial benefits

The General Medical Council (GMC) makes clear that cosmetic surgery should only be performed when it will benefit the patient, with doctors having to assess why the procedure is sought and what the patient expects from it.[39] In assessing potential benefit, the RCOG stresses the importance of differentiating between patients whose vulvas and vaginas 'give

[35] ibid 6.
[36] ibid 7.
[37] Nurka and Jones (n 32) 437.
[38] ibid.
[39] General Medical Council, 'Guidance for Doctors Who Offer Cosmetic Interventions' (2016) para 18.

rise to functional problems that provide therapeutic grounds for the procedure' and those who have 'no such functional problems' and their seeking surgery is 'primarily a concern about [their] genital appearance'.[40] Whilst it does not see the former as especially problematic, it sees the latter as giving rise to a wide range of concerns, including its potential overlap with FGM (see next section), its demand being due to cosmetic pressure (discussed in relation to feminist debates in Chapter 3) or triggered by a mental disorder (explored in Chapter 4).

Both the BAAPS and RCOG urge doctors to provide information to their patients about the 'normal variations in the female genitalia', and also to determine whether 'there really is a problem with the genitalia or whether another solution would be more rewarding'.[41] In this regard, when the request for surgery is not based on a physical abnormality, the RCOG proposes that 'counselling should be offered as part of the process of obtaining informed consent' as it might be 'more appropriate than surgery'.[42] Albeit being tailored to adolescent care, best practice guidance issued by the BritSPAG might be helpful to see what doctors are expected to do in response to a vulval cosmetic surgery request. They should first perform a visual inspection of the vulva and, if they do identify any anomalies, a referral to an (adolescent) gynaecologist should be the next step.[43] In 'the most likely finding [of a] normal vulva', doctors should communicate this 'sensitively and

[40] Royal College of Obstetricians and Gynaecologists, 'Ethical Opinion Paper: Ethical Considerations in Relation to Female Genital Cosmetic Surgery (FGCS)' (n 1) 7.
[41] British Association of Plastic Reconstructive and Aesthetic Surgeons (n 4); Royal College of Obstetricians and Gynaecologists, 'Ethical Opinion Paper: Ethical Considerations in Relation to Female Genital Cosmetic Surgery (FGCS)' (n 1) 7.
[42] Royal College of Obstetricians and Gynaecologists, 'Ethical Opinion Paper: Ethical Considerations in Relation to Female Genital Cosmetic Surgery (FGCS)' (n 1) 7.
[43] British Society for Paediatric & Adolescent Gynaecology (n 3) para 5.1.

unambiguously', informing their patients about 'normal variations' of vulval anatomy.[44] Instead of surgery, other measures to relieve physical and psychological discomfort should be explained, such as the use of comfortable underwear or emollients, a recommendation to avoid using shower gels or the effects of pubic hair removal.[45] If there are signs of 'significant psychological distress,' the doctor should make a referral to psychological counselling.[46]

The medical profession thus exercises caution regarding demands for vulval cosmetic surgery when there are no physical abnormalities, with a preference for non-surgical solutions for these cases. As explained in Chapter 2 and Chapter 4, clinical guidance urges surgeons to pay attention to their patients' 'vulnerabilities and psychological needs'.[47] Surgery is usually counter-indicated when a mental health problem, such as Body Dysmorphic Disorder (BDD), underpins patients' desire for surgery, as it might worsen their obsessive or intrusive thoughts about their (perceived, real or exaggerated) flaws. For such patients, counselling might be a better treatment for their anxieties.[48]

Even after screening out psychological disorders, the beneficial character of vulval cosmetic surgery remains controversial, given the lack of high quality data on its long term effects and satisfaction rates, especially when there is no physical functional issue

[44] ibid para 5.2.
[45] ibid para 5.4.
[46] ibid para 5.5.
[47] General Medical Council (n 39) para 19.
[48] See, eg Lori A Brotto, Maggie Bryce and Nicole Todd, 'Female Genital Cosmetic Surgery: Psychological Aspects and Approaches' in Sarah M Creighton and Lih-Mei Liao (eds), *Female Genital Cosmetic Surgery: Solution to What Problem?* (Cambridge University Press 2019) 123–126.

triggering the need for the procedure.[49] Research on this area has blossomed since the 2000s, but most studies have important methodological limitations, such as being based on a small sample of subject studies, short follow-up questionnaires, lack of a control group or no blind analysis by independent researchers.[50] Albeit scanty, however, the data suggest that the effects of this type of intervention are largely positive.[51] After initial post-surgical discomfort and some 'minor or temporary' complications, most patients seem to be satisfied with the outcome of surgery, largely benefiting from the 'increased comfort with their genitalia and enhanced sexual pleasure' derived from it.[52] Rates of 'genital, body and sexual satisfaction' seem to improve, at least in the short term, which has been interpreted to suggest that 'dissatisfaction with a presumed defect is a key motivator for [vulval cosmetic surgery]',[53] and that surgery, if properly performed, does not diminish, but can, in fact increase, sensitivity and pleasure.[54]

Like any sort of surgical procedure, vulval cosmetic surgery also carries risks. Although the reported complications rate is low, and is highly dependent on the surgical approach chosen by the surgeon (which will vary depending on where the genitalia fall on

[49] Royal College of Obstetricians and Gynaecologists, 'Ethical Opinion Paper: Ethical Considerations in Relation to Female Genital Cosmetic Surgery (FGCS)' (n 1) 3; British Society for Paediatric & Adolescent Gynaecology (n 3) 2; LM Liao, L Michala and SM Creighton, 'Labial Surgery for Well Women: A Review of the Literature' (2010) 117 BJOG: An International Journal of Obstetrics and Gynaecology 20; Virginia Braun, 'Female Genital Cosmetic Surgery: A Critical Review of Current Knowledge and Contemporary Debates' (2010) 19 Journal of Women's Health 1393, 1394.
[50] Michala (n 11) 52–55.
[51] ibid 56.
[52] Goodman and others, 'A Large Multicenter Outcome Study of Female Genital Plastic Surgery' (n 24) 1576.
[53] Goodman and others, 'Evaluation of Body Image and Sexual Satisfaction in Women Undergoing Female Genital Plastic/Cosmetic Surgery' (n 25) 1053.
[54] Otto J Placik and John P Arkins, 'A Prospective Evaluation of Female External Genitalia Sensitivity to Pressure Following Labia Minora Reduction and Clitoral Hood Reduction' (2015) 136 Plastic and Reconstructive Surgery 442e, 450; David Veale and others, 'Psychosexual Outcome after Labiaplasty: A Prospective Case-Comparison Study' (2014) 25 International Urogynecology Journal and Pelvic Floor Dysfunction 831.

the various classificatory scales introduced above),[55] some women do experience problems with scar healing, excessive bleeding or dyspareunia (painful intercourse).[56] Other problems associated with these sort of interventions are possible infections, fistulae and contractures of the pelvic floor, in addition to risks linked to specific procedures, such as diffusion to the rectum or bladder with the use of laser or radio frequency in vaginal rejuvenation.[57] The NHS website highlights 'what can go wrong', laying out, in addition to the potential complications above, that there are risks of 'blood clots in a vein' and of 'an allergic reaction to the anaesthetic', which patients should be informed about before undergoing surgery.[58] The BAPRAS also places weight on the possibility of post-surgical adverse effects, which can entail 'severe discomfort and ongoing problems with daily function', and this is why they consider that vulval cosmetic surgery 'should therefore only be performed when necessary and only ever by a properly qualified surgeon'.[59]

When discussing risks and potential complications, it is worth noting that some of these procedures are performed by private providers. As Chapter 2 argued, (vulval) cosmetic surgery sits in both the medical and consumer worlds, being widely advertised and having become a profitable private enterprise. Although medical guidance and safeguards have been introduced since the Keogh Report in 2013, with measures like new GMC and Royal College of Surgeons (RCS) guidance, and the RCS Cosmetic Surgery

[55] Oranges, Sisti and Sisti (n 15) 429.
[56] Goodman and others, 'A Large Multicenter Outcome Study of Female Genital Plastic Surgery' (n 24) 1571.
[57] Michala (n 11) 55.
[58] NHS, 'Cosmetic Procedures - Labiaplasty (Vulval Surgery)' (n 9).
[59] British Association of Plastic Reconstructive and Aesthetic Surgeons, 'BAPRAS Responds to Research Published on Female Genital Cosmetic Surgery' <https://www.bapras.org.uk/media-government/news-and-views/view/bapras-responds-to-research-published-on-female-genital-cosmetic-surgery> accessed 8 February 2021.

Certification Scheme, the Care Quality Commission, in its latest inspection report in 2019, found several 'areas of concern', such as lack of appropriate training, poor monitoring practices and 'lack of attention to fundamental safety processes'.[60]

The NHS might also perform vulval cosmetic surgery. However, as we saw in Chapter 2, the NHS is unlikely to provide these interventions if there are no underpinning physical issues, such as cancerous tissue, malformation or the repair of birth trauma.[61] General Practitioners are the ones acting as 'gate-keepers' of vulval cosmetic interventions within the NHS, often being the first healthcare professionals to deal with requests or consultations for this type of surgery, with patients seeking reassurance about whether their vulvas and vaginas are normal.[62] In these situations, 'GPs face a dilemma', as Lih Mei Liao and Sarah Creighton put it, as they might 'feel compelled to alleviate distress, but they are also duty-bound to follow evidence-based practice and to do no harm'.[63] That is why the RCOG stresses the importance of training and promoting awareness of the wide range of normal genital diversity among GPs and nurses.[64] It is important that GPs are able to offer alternatives other than surgery, which might involve counselling, but also 'practical' solutions, such as explaining to women that their feeling uncomfortable might be due to their wearing certain clothes or garments, as well as discussing the effect that hair removal

[60] Care Quality Commission, 'Independent Cosmetic Surgery Services – Emerging Concerns' (2019) <https://www.cqc.org.uk/news/stories/independent-cosmetic-surgery-services-emerging-concerns> accessed 5 February 2021.
[61] NHS, 'Cosmetic Procedures - Labiaplasty (Vulval Surgery)' (n 9).
[62] Magdalena Simonis, 'Female Genital Cosmetic Surgery and the Role of the General Practitioner' in Sarah M Creighton and Lih-Mei Liao (eds), *Female Genital Cosmetic Surgery. Solution to What Problem?* (Cambridge University Press 2019) 108.
[63] Lih Mei Liao and Sarah M Creighton, 'Female Genital Cosmetic Surgery: A New Dilemma for GPs' (2011) 61 British Journal of General Practice 7, 8.
[64] Royal College of Obstetricians and Gynaecologists, 'Ethical Opinion Paper: Ethical Considerations in Relation to Female Genital Cosmetic Surgery (FGCS)' (n 1) 8.

might have on their vulvas.[65] If GPs do decide to refer their patients to a gynaecologist, they should also make clear that referral is not a 'passport to surgery' but only in order to receive advice from a specialised medical professional.[66]

1.3 Overlap with FGM

As explained in previous chapters, there is some degree of overlap between vulval cosmetic surgery and the statutory offence of FGM.[67] Section 1(2) of the Female Genital Mutilation Act 2003 (FGM Act 2003) establishes that no offence is committed if the intervention is performed by 'an approved person' (ie a registered medical practitioner) provided it is 'necessary for [the patient's] physical or mental health' (See Introduction for further discussion on the 'proper medical treatment' exception in the criminal law). An exception of this sort was also included in the Prohibition of Female Circumcision Act 1985, since medical bodies were concerned about the criminalisation of vulval cosmetic surgery.[68] The President of the RCOG, in a letter sent to Baroness Masham of Ilton during parliamentary discussions, stressed how 'important [it is] to have "mental" and "physical" included, as mental conditions may require surgical treatment to get rid of mental problems'.[69] The Explanatory Notes to the FGM Act 2003 explicitly mention that cosmetic surgery can be subsumed under Section 1(2), stating that 'operations necessary for mental health could include, for example, cosmetic surgery resulting from the distress caused by a perception

[65] Simonis (n 62) 112.
[66] Liao and Creighton (n 63) 8.
[67] Female Genital Mutilation Act 2003 s 1(1).
[68] Moira Dustin and Anne Phillips, 'Whose Agenda Is It?: Abuses of Women and Abuses of "culture" in Britain' (2008) 8 Ethnicities 405, para 414.
[69] Prohibition of Female Circumcision Bill Deb 18 June 1985 vol 465 col 214.

of abnormality'.[70] In order for surgery to be lawful, there is thus no need for the genitals to be diagnosed with a physical problem or abnormality, but it is sufficient that the surgery seeks to tackle the psychological distress stemming from a perceived abnormality (Chapter 4 examined the double standard of the law in not allowing someone to modify her vulva because her mental health might be affected if she does not conform to her (minority) customs or rituals).

Notwithstanding this clarification in the Explanatory Notes, there remains uncertainty as to the legal status of some of these operations, with the Nuffield Council on Bioethics, the RCOG and the RCS complaining about the legal ambiguity that surrounds vulval and vaginal cosmetic surgery.[71] For example, the RCOG explains that 'distress caused by a perception of abnormality is open to interpretation, giving rise to some ambiguity around the legal status of some Female Genital Cosmetic Surgery (FGCS) procedures'.[72]

Two examples are illustrative of the complex overlap between FGM and vulval cosmetic surgeries. First, the case of Sureshkumar Pandya, a London GP whose fitness to practice was challenged in front of the Medical Practitioners Tribunal Service in 2012. He had performed a labiaplasty on a 33 year old woman who felt uncomfortable because she

[70] Explanatory Notes - FGM Act 2003 para 6.
[71] Royal College of Obstetricians and Gynaecologists, 'Ethical Opinion Paper: Ethical Considerations in Relation to Female Genital Cosmetic Surgery (FGCS)' (n 1) 2; Royal College of Surgeons, 'Cosmetic Surgery Standards FAQ ' <https://www.rcseng.ac.uk/standards-and-research/standards-and-guidance/service-standards/cosmetic-surgery/faq/> accessed 22 February 2021; Nuffield Council on Bioethics (n 30) xx.
[72] Royal College of Obstetricians and Gynaecologists, 'Ethical Opinion Paper: Ethical Considerations in Relation to Female Genital Cosmetic Surgery (FGCS)' (n 1) 2.

thought her vulva was 'ugly' as her 'labia felt too big'.[73] The patient was unhappy with the surgery and sought a second opinion from another GP because the procedure was not 'as expected' and she felt she was not told 'the whole truth … wondering if she had been circumcised'.[74] Pandya admitted that the surgery did not go as planned, but denied having had any intention to perform FGM or to remove the patient's inner labia, explaining that the result of surgery was the materialisation of a risk present even where all 'due care, vigilance and manual dexterity' is exercised.[75] He was eventually considered fit to practice, although he admitted that he should have kept accurate records of the preoperative discussions with the patient, which is now considered good practice in accordance with the RCOG's guidance,[76] and a relevant factor when considering whether prosecution would be in the public interest under 2019 Crown Prosecution Service Guidance relating to FGM (see below for further discussion on current CPS guidance).

Second, in 2011, a psychiatrist and a surgeon were involved in the performance of a clitoridectomy, also to a 33-year-old woman, who reported suffering from a life-long aversion to her genitals, even though there were no diagnosable problems in her clitoris or labia.[77] She had already undergone a labiaplasty the year before and now requested to have her clitoris removed. Despite her persistent discontent about her vulva, she was considered not to tick the boxes of any psychiatric disorder.[78] The psychiatrist in that case decided that

[73] Clare Dyer, 'London GP Is Cleared of Practising Female Genital Mutilation' (2014) 348 BMJ 1.
[74] ibid.
[75] ibid.
[76] Royal College of Obstetricians and Gynaecologists, 'Ethical Opinion Paper: Ethical Considerations in Relation to Female Genital Cosmetic Surgery (FGCS)' (n 1) 8.
[77] David Veale and Joe Daniels, 'Cosmetic Clitoridectomy in a 33-Year-Old Woman' (2012) 41 Archives of Sexual Behavior 725.
[78] ibid 726.

'it was safe to proceed [with the surgery]', considering that it would have 'psychosocial' benefits to the patient.[79] After having her clitoris removed, the patient was reported to be 'very grateful and satisfied … [and] pleased with the improvement in her sexual life'.[80] The doctors published this case in *Archives of Sexual Behaviour*, calling for the need of further research on the psychological implications of vulval cosmetic surgery.[81] After reading about it, Professor and obstetrician Susan Bewley referred the case to the CPS, as she believed that the surgical procedure amounted to FGM.[82] After three years, the CPS eventually decided not to press charges. The two medical professionals who were involved in the surgery always maintained that what they did was not comparable to FGM, but it was a medical intervention undertaken with the patient's consent designed to ameliorate her psychological health:

> FGM is an abhorrent practice conducted on girls against their consent motivated by a desire to control female sexuality, but [cosmetic genital surgery] is provided for adult women with capacity to consent and motivated by a desire to improve their appearance and sexuality. It's no different to any other cosmetic surgery.[83]

The RCOG makes clear in its 2015 guidance that 'all surgeons who undertake [vulval cosmetic surgery] must take appropriate measures to comply with the FGM Act',[84] warning them that '[vulval cosmetic surgery] may be prohibited unless it is necessary for the patient's physical or mental health'.[85] In order to ensure and demonstrate compliance with

[79] ibid.
[80] ibid 729.
[81] ibid.
[82] Charlotte Proudman, *Female Genital Mutilation. When Culture and Law Clash* (Oxford University Press 2022) 147.
[83] Martin Bentham, 'Doctor Cleared over FGM Says Women Should Be Free to Have Intimate Surgery | London Evening Standard' *Evening Standard* (2017).
[84] Royal College of Obstetricians and Gynaecologists, 'Female Genital Mutilation and Its Management' (2015) 10.
[85] ibid 20.

the law, the RCOG considers it good medical practice that written records of the mental or physical reasons why the procedure is deemed necessary are kept, as well as patient consent forms.[86]

Moreover, in 2019, the CPS issued guidance that sheds some more light on when surgeons who perform vulval cosmetic surgery might be more likely to face prosecution. In order for the Section 1(2) defence to apply, surgery must have, the CPS insists, a 'therapeutic element'.[87] It might be of psychological nature, and can thus be present when the surgery 'has a cosmetic element, if there is some evidence available of medical reason for the procedure'. However, such defence will not apply 'where the surgery is purely to alter the appearance of the genitals'.[88] If the health necessity fails, the CPS must consider whether prosecution would be in the public interest, setting out a list of factors in favour and against prosecution, such as severity and invasiveness of the procedure, harm caused to the victim, risk of future harm, medical qualification of the person performing the procedure, (lack of) documented evidence of the informed consent process, evidence of marketing or advertising, with inaccurate claims, or evidence of financial benefit.[89] As Chapter 2 explained, there has only been one successful conviction for FGM so far, involving a mother cutting the vulva of her three-year old daughter,[90] and only one of the four prosecutions that have been brought has had a medical professional as the defendant,

[86] Royal College of Obstetricians and Gynaecologists, 'Ethical Opinion Paper: Ethical Considerations in Relation to Female Genital Cosmetic Surgery (FGCS)' (n 1) 8.
[87] Crown Prosecution Service, 'Female Genital Mutilation Prosecution Guidance' (2019).
[88] ibid.
[89] ibid.
[90] Sarah Marsh, 'Mother Jailed for 11 Years in First British FGM Conviction' *The Guardian* (8 March 2019).

who was eventually acquitted for suturing his patient's labia following an incision made to enable the delivery of her baby.[91]

1.4 Therapy through enhancement

What is the rationale for vulval cosmetic surgery? The short answer is: to benefit the patient. Its beneficial character is a necessary requirement for its propriety and lawfulness, with the GMC warning doctors that they should never operate on anyone if they do not believe it will bring any benefit to them, and it is also necessary to insulate the surgeon from criminal liability under the FGM Act 2003.

The benefits of vulval cosmetic surgery have a split nature, depending on the status of the genitalia under the scalpel. On the one hand, it is possible to talk about functional or physical benefit in cases where surgery tackles a physical problem, such as birth trauma, hypertrophied labia or clitoral phimosis. On the other hand, psychological benefit, although it might also derive from cases where the operation tackles an underlying physical issue, is more prominent where the genitals present no abnormality or malformation. In these cases, the beneficial impact of surgery mostly derives from helping the patient achieve higher levels of body image satisfaction, enabling them to regain confidence to engage in and enjoy daily activities, like sex or sports.

These two sorts of rationales of vulval cosmetic surgery might illuminate why the line between therapy and enhancement seems rather blurred, as this operation can be seen

[91] Sandra Laville, 'Doctor Found Not Guilty of FGM on Patient at London Hospital' *The Guardian* (4 February 2015).

as often consisting in the latter (enhancement of a body that is already deemed to be normal and healthy) but producing the former results (psychological therapeutic effects). In other words, the therapeutic character of these surgeries may result from their effect on psychological well-being, even though the scalpel is not seen as curing or fixing any physical issues, but rather as enhancing or improving already healthy genital features. By drawing a link between enhancing the body and easing the suffering of the mind, cosmetic surgeons can surgically alter parts of the vulva and vagina that do not physically warrant modification whilst respecting their Hippocratic duties, as well as remaining insulated from criminal prosecution for FGM.

The idea that vulval cosmetic surgery, and cosmetic surgery more generally, can be understood to provide a psychological benefit through a seemingly physically unnecessary intervention has been controversial. The first aspect that appears contentious is the origin of the psychological distress that surgery is deployed to alleviate, with some authors contending that the marketisation of these practices, embedded in the broader context of beauty norms (see Chapter 3), might be complicit in fuelling demands for a surgery patients would not otherwise feel that they need.[92] Moreover, the fact that these surgeries are, in many instances, a commercial enterprise performed outside the NHS, where there is a payment exchange between patients and surgeons, might transform surgery into a rather consumerist endeavour, dominated by 'preference and ability to pay' rather than medical benefit.[93] The selfless aims of medicine may thus be somewhat tainted by the consumer-

[92] Danielle Griffiths and Alexandra Mullock, 'The Medical Exception and Cosmetic Surgery: Culpable Doctors and Harmful Enhancement?' in Sara Fovargue and Alexandra Mullock (eds), *The Legitimacy of Medical Treatment. What Role for the Medical Exception?* (Routledge 2016) 108–109.
[93] Franklin G Miller, Howard Brody and Kevin C Chung, 'Cosmetic Surgery and the Internal Morality of Medicine' (2000) 9 Cambridge Quarterly of Healthcare Ethics 353, 354–355.

oriented nature of many of these interventions, where medical treatment might be conflated with selling a service, catering to the needs of consumer demand, rather than seeking objectively to benefit the patient.[94]

Second, there is also scepticism regarding the psychological therapeutic effect of cosmetic surgery. Those who are considered to psychologically benefit from it must experience some degree of body image dissatisfaction and suffer from some sort of psychological distress. Such anguish, as seen in the previous chapter, must however be kept under control, since exhibiting excessive worry might mean that they suffer from a mental disorder which warrants other sorts of treatment. Franklin G Miller and others have read the requirement for absence of 'diagnosable disease' to mean that the suffering cosmetic surgery is supposed to ease does not 'belong within the purview of medicine'.[95] Although suffering may be real and seriously impair daily life, they argue that medicine should only concern pain that can be traced back to a diagnosable medical condition, which is not the case for the psychological pain cosmetic surgery is intended to alleviate.[96] This line of argumentation is used by Dennis Baker to contend that 'surgeons and other medical practitioners do not have carte blanche to inflict harm on others under the disguise of medicine'.[97] If psychological health is the justification for surgery, the medical profession should work harder to prove that surgical intervention is the only available medical response to it, explaining why other less invasive and risky alternatives, such as

[94] Griffiths and Mullock (n 92) 109; Miller, Brody and Chung (n 93) 354.
[95] Miller, Brody and Chung (n 93) 354.
[96] ibid 358.
[97] Dennis J Baker, 'Should Unnecessary Harmful Non-Therapeutic Cosmetic Surgery Be Criminalized?' (2014) 17 New Criminal Law Review 587, 612.

counselling, are not appropriate.[98] Unless this is the case, surgeons are doing 'more harm than good', submitting their patients to dangerous surgical procedures which might carry serious and lifelong adverse consequences.[99]

Albeit contentious, the rationale for vulval cosmetic surgery is to ease psychological suffering through improving the already physically healthy vulva, vagina or clitoris, although some procedures are aimed at tackling physical problems as well, like so-called birth trauma. Furthermore, the operation being physically or psychologically beneficial is a necessary requirement for it to fall outside of the scope of the FGM Act 2003.

2 Intersex surgery

2.1 Cutting to establish 'normality'

As previous chapters have explained, Money and his colleagues, whose protocols shaped the clinical management of intersexuality since the 1950s until early 2000s, focused their attention on intersexual children. The idea of health informing Money's recommendations was underpinned by the concept he himself coined of 'gender identity-role' (G-I/R). G-I/R encompassed 'gender identity' (one's experience and self-perception as male or female) and 'gender role' (one's 'public manifestation' of their gender identity).[100] Money created the new term of G-I/R to capture nuances about one's body and its interaction with the

[98] ibid 613.
[99] ibid 614.
[100] John Money, 'Gender: History, Theory and Usage of the Term in Sexology and Its Relationship to Nature/Nurture' (1985) 11 Journal of Sex and Marital Therapy 71, 78.

world that 'sex' did not allow him to. 'Sex', he thought, denoted that all sexual variables ('chromosomal or genetic sex, gonadal sex, prenatal hormonal sex, internal morphologic sex, external morphologic sex, and pubertal hormonal sex') were a 'unified entity'.[101] However, as intersexual bodies showed, there could be plenty of 'contradictions' between them. Moreover, he wanted a term that could convey the connection between each sexual anatomical variable and 'the hermaphroditic person's existence in society as a boy or a girl, man or woman'.[102] That is why he decided to 'borrow gender from its sequestered place in grammar and philology', creating the new term of G-I/R.[103]

With G-I/R, Money wanted to 'bridge the chasm' between the social and the biological, seeing gender identity and gender role as 'two sides of the same coin'.[104] Gender identity was not purely biological, stemming from one's anatomical sexual structures; and gender role was not solely a social construction either. G-I/R was 'neither nature nor nurture', since Money wanted to substitute 'such simple polarization' with a 'theoretical earthquake' that would shift the paradigm away from this binary.[105] Instead, he considered the *interaction*, rather than the dichotomisation, of 'the innate versus the acquired, the biological versus the psychological, or the instinctive versus the learned' the basic proposition of his new theoretical landscape.[106] As we have seen in previous chapters, he argued that G-I/R did not automatically derive from one's sexual characteristics, like the

[101] John Money, 'The Conceptual Neutering of Gender and the Criminalization of Sex' (1985) 14 Archives of Sexual Behavior 279, 280.
[102] ibid 281.
[103] ibid.
[104] Money (n 100) 285.
[105] ibid 74.
[106] John Money and Anke A Ehrhardt, *Man & Woman: Boy & Girl* (The John Hopkins University Press 1972) 1.

gonads, hormones or external morphology, but it was acquired through life, 'through causal and unplanned learning, and through explicit instruction and inculcation'.[107]

Money analogised G-I/R with the development of one's native language. Learning to speak is not an innate experience, but a postnatal, social, process.[108] Nevertheless, there is one point in which language 'gets into our brain' and 'it stays there, as permanently ineradicable as if it had been programmed there prenatally'.[109] Just as bilingual children are said to benefit from clear boundaries between the two languages that are spoken to them, enabling them to distinguish 'around what would otherwise be a chaotic confusion of sound waves', intersexual children also need clear demarcations between genders in order to differentiate their G-I/R.[110]

According to Money, G-I/R differentiation occurs through two complementary processes. First, 'identification', through which children learn their G-I/R by 'copying, imitating or modelling' their peers, parents and popular heroes.[111] Second, 'complementation', where children learn to distinguish and behave vis-à-vis those who they perceive as different from them, like girls in relation to her fathers or brothers.[112] Parents, as Chapter 4 explained, were seen to play a crucial role in these processes, being given the responsibility to act as gender role models, and policing clear gender 'typical' behaviour, leaving no place for ambiguity about their child's G-I/R.[113] If this mission

[107] Joan G Hampson, John Money and John L Hampson, 'Hermaphroditism: Recommendations Concerning Case Management' (1956) 16 Journal of Clinical Endocrinology & Metabolism 549.
[108] Money (n 100) 75.
[109] ibid.
[110] Money and Ehrhardt (n 106) 18–19.
[111] Money (n 100) 76.
[112] ibid.
[113] Hampson, Money and Hampson (n 107) 552.

failed, children may 'swing on the boy/girl pendulum', which might entail 'too much cognitive dissonance', leaving them 'handicapped'.[114]

A crucial element for G-I/R to be unequivocal was the securement of unambiguous genitalia, which would enable the correct signalling towards the child themselves and those around them that they were truly boys or girls.[115] Early surgery to fix the appearance of the genitals was a key recommendation from Money's team: 'the less ambiguous our patients could be made to appear as a result of well-timed plastic surgery and hormonal therapy, consistent with their rearing, the sturdier … their psychological healthiness'.[116] Money, as I argued in Chapter 4, conflated having a clear G-I/R with being psychologically healthy. Leaving intersex children unmodified was 'psychologically injurious', as their own perception, and that of parents, teachers or friends, of their being 'half-and-half' or 'two-sexed' would prevent their developing a clear female or male identity.[117] Some parents admitted to Money that they would not let their (unmodified) baby alone with babysitters or other carers because of the fear that their child's abnormality would be discovered.[118] This finding would not only be stigmatising and shameful, for the baby and their parents,

[114] Money and Ehrhardt (n 106) 15.
[115] Hampson, Money and Hampson (n 107) 549.
[116] John Money, Joan G Hampson and John L Hampson, 'Imprinting and the Establishment of Gender Role' (1957) 77 MA Arch NeurPsych 333, 334.
[117] Hampson, Money and Hampson (n 107) 553.
[118] Christopher J Dewhurst and Ronald R Gordon, *The Intersexual Disorders* (Baillière Tindall & Cassell 1969) 39.

but it would also bring confusion about the baby's gender, which could seriously endanger their healthy psychological development.[119]

As Chapter 1 showed, the morphology of external genitalia and the 'ease with which these organs can be surgically reconstructed to be consistent with the assigned sex' was the deciding factor when determining whether intersex children would be raised as boys or girls.[120] If the degree of genital ambiguity was such that the genitals could be reconstructed to be either male or female, the guiding factors would be 'gonadal and hormonal considerations'.[121] Babies diagnosed with 'male pseudohermaphrotidism',[122] due to, for instance, Androgen Insensitivity Syndrome (that is, babies with 46, XY karyotype and varying degrees of so-called 'undermasculinised' external genitalia), were supposed to be assigned male or female depending 'entirely by the size of the phallus'.[123] If its size resembled more that of a clitoris, then the baby was to be raised as a girl.[124] Female assignment was also indicated for cases of so-called 'female pseudohermaphroditism', such as those diagnosed with Congenital Adrenal Hyperplasia, with 46, XX chromosomes and 'masculinised' genitalia.[125] Those with mixed gonadal dysgenesis (that is, cases where gonads were not properly formed), and 'true hermaphrodites' (presence of ovotestis or one testicle and one ovary) were supposed to

[119] ibid.
[120] Money, Hampson and Hampson (n 116) 334.
[121] Hampson, Money and Hampson (n 107) 550.
[122] After 2006, the taxonomy and nomenclature of intersexuality conditions changed and these sort of variations are now called 46, XY DSD. See next section for further discussion.
[123] Patricia K Donahoe, David M Powell and Mary M Lee, 'Clinical Management of Intersex Abnormalities' (1991) 28 Current Problems in Surgery 519, 537.
[124] ibid.
[125] ibid 540.

receive female assignment as well, which entailed 'feminising' surgeries of various degrees depending on the morphology of the external genitalia.[126]

The key deciding feature for gender assignment was the (enlarged) clitoris or the (micro) penis. Depending on the centimetres of the organ, whether it had a urethra and the location of the meatus, it was deemed a clitoris or a penis, with surgery being performed accordingly.[127] Medical standards would often deem organs over 2.5 cm penises, although, regardless of size, if what could potentially be a phallus did not have a urethral tube, it was considered a clitoris.[128] Likewise, 'normal' clitorises were expected to be under 1 cm, but it seems that surgeons did not always follow objective classifications of clitoral size, using personal judgement to determine whether the organ resembled a clitoris or a penis.[129] Other genital features, such as scrotalisation of the labia or adherence of the clitoral hood, were not considered as clinically determinative of gender assignment, since these features were expected, in some cases, to still have some margin of natural 'normalisation' during the child's upbringing as a result of androgen production.[130] The reason why the focus was on the penis/clitoris was because of the concern about the child's ability to adequately perform sexually later in life.[131] Whilst re-constructing a vagina apt for penile penetration and removing a phallic-looking clitoris was feasible, surgically and hormonally treating a micropenis so it would fulfil the sexual performance expectations of an adequate phallus

[126] ibid 242–243.
[127] Suzzane J Kessler, *Lessons from the Intersexed* (Rutgers University Press 2002) 40–43.
[128] ibid 41.
[129] ibid 43; Anne Fausto-Sterling, *Sexing the Body. Gender Politics and the Construction of Sexuality* (Basic Books 2000) 60.
[130] Kessler (n 127) 44.
[131] Dewhurst and Gordon (n 118) 45; Milton Diamond and Keith Sigmundson, 'Sex Reassignment at Birth' (1997) 151 Archives of Pediatrics & Adolescent Medicine 298, 298.

was considerably more challenging,[132] with the phrase 'you can make a hole but you can't build a pole' being popular among surgeons at that time.[133]

Once the baby was assigned female, she was supposed to undergo a wide range of surgeries, some of which were considered more time sensitive than others. Clitoral surgery was the most urgent one, with some surgeons even advising its performance during the child's stay in hospital after birth.[134] In a few cases, hormonal treatment could shrink the clitoris to a normal size.[135] However, in most cases, where this was insufficient, clitoral reduction was needed, either through amputating or resecting the organ. Money dismissed the hesitations of some surgeons that clitoridectomy involved loss of sensitivity, arguing that patients undergoing this operation showed to have 'subsequently been erotically responsive to experience orgasm'.[136] Besides, clitoridectomy provided patients with the 'reassurance of womanly adequacy', with Money concluding that 'the chances of undesirable psychologic sequalae are negligible'.[137]

Division of labioscrotal folds, if indicated, was usually delayed until the child was older, as it could derive in serious complications, like 'imperfect healing and perhaps scarring', if performed before the child had bladder and bowel control.[138] With regards to the vagina, the concrete surgical procedure depended on what the vagina and the rest of

[132] John Money, Gregory K Lehne and Frantz Pierre-Jerome, 'Micropenis: Adult Follow-up and Comparison of Size against New Norms' (1984) 10 Journal of Sex and Marital Therapy 105.
[133] Fausto-Sterling (n 129) 59.
[134] Dewhurst and Gordon (n 118) 39.
[135] ibid; H Kumar and others, 'Clitoroplasty: Experience During a 19 Year Period' (1974) 111 Journal of Urology 81, 83.
[136] Hampson, Money and Hampson (n 107) 551.
[137] Money, Hampson and Hampson (n 116) 334; for further discussion on clitoral surgical techniques during the Money era, see Kessler (n 127).
[138] Dewhurst and Gordon (n 118) 41.

Müllerian structures (cervix, vagina, uterus, oviduct), or lack thereof, were like. In cases of absent or short vagina, a neovagina was to be built, using skin grafts or bowel parts.[139] Where the vagina was present but considered 'imperfect' (for instance, because its opening was obstructed), surgery was required to allow menstrual flow, tampon use and/or penetrative intercourse.[140] Not having a normal vagina was, according to Money, 'of remarkably little concern to younger girls', since its function did not become crucial until they reached puberty.[141] This meant that surgery was often not deemed urgent and was delayed until adolescence. Her pelvis would have fully formed by then and her cooperation was important for the success of the operation, which usually required several follow-up procedures, with her also having to use dilators, apply oestrogen cream and take care of the wound.[142] That said, some parents and surgeons did opt for the performance of so-called 'one stage' vaginoplasty early on, thinking that one intervention could spare the trauma of having to undergo multiple surgeries at an age where the child would already remember them, enabling the family to 'bury' the fact that their baby had been born with anomalous genitals.[143] Nevertheless, 'one-stage' approaches involved several complications, such as persistent discharge of mucus, stenosis or the risk of carcinoma of the skin or bowel used for the neovagina as an adult, which meant that there was no 'quick

[139] Naomi S Crouch and Sarah M Creighton, 'Minimal Surgical Intervention in the Management of Intersex Conditions' (2004) 17 Journal of Pediatric Endocrinology and Metabolism 1591, 1592.
[140] ibid.
[141] Hampson, Money and Hampson (n 107) 49.
[142] Kessler (n 127) 49; LE Allen, BE Hardy and BM Churchill, 'The Surgical Management of the Enlarged Clitoris' (1982) 128 Journal of Urology 351, 354; Crouch and Creighton (n 139) 1592–1593.
[143] Kessler (n 127) 49.

fix' but that the child would still have to undergo follow-up interventions and medical appointments throughout her childhood and adolescence.[144]

Although perhaps not immediately after birth either, ovarian and testicle removal (in cases where the external genitalia did not coincide with internal gonadal structures) was also deemed necessary in order to 'prevent the appearance of heterosexual manifestations about the time of puberty' and eliminate the possibility of gonadoblastomas, especially concerning in cases where testes remained undescended.[145] In contrast with having a clitoris that might be confused with a penis (or vice versa), being sterile was not, for Money, a factor that damaged the securement of a stable G-I/R.[146] The impact of not being able to bear children could be 'eased' by managing the child's expectations since an early age, talking to her about other options, such as adoption, so she could grow up with a 'modified' dream of motherhood, which was also important for her successfully developing her female G-I/R.[147] Not only was reproductive capacity neglected because it was not considered a determinative factor when assigning gender, but gonadal and reproductive structures were put at the service of external genital morphology, having to be removed to prevent the development of inconsistent sexual traits.[148]

Under Money's protocols, the intersexual body was seen as disordered and in need of fixing, since its natural form was not sufficiently unambiguous to enable healthy psychological development. Fixing its abnormalities early so the body would be coherent

[144] Crouch and Creighton (n 139) 1593.
[145] Donahoe, Powell and Lee (n 123) 542.
[146] Elisabeth Reis, *Bodies in Doubt: An American History of Intersex* (The John Hopkins Press 2009) 48.
[147] Hampson, Money and Hampson (n 107) 555.
[148] Dewhurst and Gordon (n 118) 48.

with the assigned gender was a necessary step for the child's establishment of a secure G-I/R, otherwise risking being psychologically 'handicapped' for life.[149]

2.2 The harms of imposed normality

Money's postulates, despite being a totem for the medical management of intersexuality until the mid 2000s, did not go unquestioned. In 1970, Bernard Zuger challenged Money's theory that intersexual children could be moulded into being boys or girls regardless of their anatomy, provided they were adequately reared in accordance with their maleness or femaleness.[150] Drawing on Money's own clinical data and exploring the flaws in his methodology, he argued that Money's hypothesis did not withstand analysis, disagreeing with his premise that one's identifying and behaving as a man or a woman could be boiled down to rearing practices, suggesting instead that biological factors were also important determinants of one's feeling identified as a man or a woman.[151] Milton Diamond made a similar point, contesting the idea that individuals are 'gender neutral' at birth, and that it is through interaction with the environment that we acquire our gender:[152]

> [t]he evidence seems overwhelming that normal humans are not psychosexually neutral at birth but are, in keeping with their mammalian heritage, predisposed and biased to interact with environmental, familial, and social forces in either a male or female mode … Concomitantly, no support exists for the postulates that individuals are psychosexually neutral at birth or that healthy psychosexual development is dependent on the

[149] Money and Ehrhardt (n 106) 15.
[150] Bernard Zuger, 'Gender Role Determination: A Critical Review of the Evidence from Hermaphroditism' (1970) 32 Psychosomatic Medicine 449.
[151] ibid 459–460.
[152] For further discussion about the challenges of Diamond to Money, see Fausto-Sterling (n 129) 67–71.

> appearance of the genitals. Certainly long-term follow-up on other cases is needed.[153]

Diamond's criticism started to receive wider attention in the late 1990s, when he used the failure of the John/Joan case (see Chapter 1), highly publicised by Money's team as evidence of the success of their protocols, as a springboard for his critique. Drawing on the testimony of 'John', who never accepted his gender reassignment as a girl, he called for the need of 'inspection and review' of intersex protocols, since the outcome of this case proved that the key postulates on which medical practice had been based on since the 1950s were flawed.[154]

Diamond's challenges preceded the rise of intersex activism in the early 2000s. Intersex Society of North America (ISNA) deemed Money's protocols 'bad medicine', since not only did children treated under his approach '[get] the message that they were so freakish even their doctors could not speak the truth of their bodies to them', but also because surgeons had been 'cutting away … healthy genital tissue' using 'standards for genital anatomy [that] have been arbitrary and illogical'.[155] As we saw in Chapter 4, Cheryl Chase, founder of ISNA and diagnosed with 'true hermaphroditism' (see below for discussions about nomenclature), underwent multiple surgeries as a child which removed her gonads and transformed her first deemed micropenis into female-looking external

[153] Diamond and Sigmundson (n 131) 303.
[154] ibid 302.
[155] Intersex Society of North America, 'What's Wrong with the Way Intersex Has Traditionally Been Treated?' <https://isna.org/faq/concealment/> accessed 20 December 2021.

genitalia, which left her with no clitoris or inner labia, preventing her from being able to experience orgasm.[156]

Surgical approaches to so-called feminising surgery did change over the fifty years of Money's reign. For instance, until the 1960s, clitoridectomy, one of the interventions Chase underwent, was the preferred technique to tackle cases of clitoral enlargement, being considered to have 'satisfactory' results.[157] With more research emphasising 'the importance of the clitoris in normal sexual development', this surgical approach was increasingly substituted for clitoral resection, which was supposed to 'maintain the erotic properties of the organ'.[158] However, data backing up the success of these (new) surgeries seemed to be based on rather flawed methodology, with the use of different sample sizes and ages when assessing surgical outcomes, lack of uniform criteria of evaluation and lack of patients' subjective assessment.[159] Furthermore, assessment of certain factors, like sexual function, was not thorough, being described only in (positive) broad terms ('accurate', 'satisfactory'), without explaining in detail what these actually meant for patients.[160]

In the early 2000s, voices within the medical community started to raise concerns about the lack of methodologically sound research, calling for the need to gather more

[156] Cheryl Chase, 'Hermaphrodites with Attitude: Mapping the Emergence of Intersex Political Activism' (1998) 4 GLQ: A Journal of Lesbian and Gay Studies 193–194.
[157] Allen, Hardy and Churchill (n 142) 351.
[158] ibid 354; John P Gearhart, Arthur Burnett and Jeffrey H Owen, 'Measurement of Pudendal Evoked Potentials during Feminizing Genitoplasty: Technique and Applications.' (1995) 153 The Journal of Urology 486, 486.
[159] Katrina Karzakis, *Fixing Sex. Intersex, Medical Authority and Lived Experience* (Duke University Press 2008) 165.
[160] Sarah Creighton, 'Surgery for Intersex' (2001) 95 Journal of the Royal Society of Medicine 57, 219.

accurate and long-term information confirming the positive effects of these irreversible major surgical procedures performed on very young children.[161] In doing so, it became apparent that intersexual surgeries did carry serious physical and psychological sequelae. Even with clitoral resection (instead of amputation), sexual function seemed to be compromised, causing 'pain, scarring and loss of sensation',[162] and 'failure to achieve orgasm and higher rates of non-sensuality'.[163] Early vaginoplasty, in addition to sometimes not securing a vagina which allowed for the enjoyment of sexual intercourse, included complications like 'persistent discharge requiring the wearing of pads, and stenosis of the graft', as well as long-term risk of carcinoma where bowel was used to build the neovagina.[164] These physical complications were accompanied, as Chapter 4 looked at in detail, with profound psychological trauma, pain and shame.

Surgeries performed to uphold Money's protocols treasured appearance more than function. Money's idea of 'fixing' 'doubtful' genitalia entailed getting rid of healthy (albeit ambiguous) tissue: gonads were to be removed if they were to cause contradictions with the assigned gender, even though that entailed loss of reproductive capacity, and external sexual organs were to be cut to resemble normal penises or clitorises, at the cost of

[161] Sarah M Creighton and Catherine L Minto, 'Managing Intersex. Most Vaginal Surgery in Childhood Should Be Deferred' (2001) 323 BMJ 1264, 1265; Sarah Creighton and Catherine Minto, 'Managing Intersex: Most Vaginal Surgery in Childhood Should Be Deferred' (2001) 323 BMJ 1264, 219; Sarah M Creighton and others, 'Objective Cosmetic and Anatomical Outcomes at Adolescence of Feminising Surgery for Ambiguous Genitalia Done in Childhood Cold Feet and Prolonged Sleep-Onset Latency in Vasospastic Syndrome' (2001) 358 The Lancet 124, 124; Catherine L Minto, Sarah Creighton and Christopher Woodhouse, 'Long Term Sexual Function in Intersex Conditions with Ambiguous Genitalia' (2001) 14 Journal of Pediatric and Adolescent Gynecoology 141, 141.
[162] Creighton and Minto, 'Managing Intersex. Most Vaginal Surgery in Childhood Should Be Deferred' (n 161) 1265; Creighton (n 160) 219.
[163] Catherine L Minto and others, 'The Effect of Clitoral Surgery on Sexual Outcome in Individuals Who Have Intersex Conditions with Ambiguous Genitalia: A Cross-Sectional Study' (2003) 361 Lancet 1252, 1256; Justine M Schober, 'Feminizing Genitoplasty: A Synopsis of Issues Relating to Genital Surgery in Intersex Individuals' (2004) 17 Journal of Pediatric Endocrinology and Metabolism 697, 700.
[164] Crouch and Creighton (n 139) 1593.

destroying sexual capability. The aim was to produce a body that would not threaten the appearance of 'normal' femaleness, even though the expectations of 'normal' femaleness could not actually be fulfilled following surgery (clitoral pleasure could not be felt, vaginas were not penetrable, sex could not be enjoyed). Put differently, intersexual surgeries, during Money's reign, despite being justified in terms of restoring normality that was lost with unambiguous anatomy, seemed to have had the opposite effect, damaging healthy organs and impairing sexual and reproductive functions.

2.3 Function not form?

Some critiques outlined in the last section, catapulted by intersex activism, culminated in 2006 with the elaboration of the Chicago Consensus Statement, which marked a turning point in the treatment of intersexuality.[165] Chapter 4 drew attention to the psychosocial model introduced by the Statement, with psychological support being a key part of the medical care package for intersex patients and their families. Now, I shall focus on current rationales for gender assignment and surgery, and to what extent they differ from those under Money's reign.

i) Diagnostic categories and criteria for gender assignment

The 2006 Chicago Consensus Statement substituted Money's classification of intersexuality (male pseudohermaphroditism, female pseudohermaphroditism, true hermaphroditism, XX male or XX sex reversal, and XY sex reversal) with new diagnostic

[165] Georgiann Davis, *Contesting Intersex: The Dubious Diagnosis* (New York University Press 2015) 39–46.

categories and nomenclature—'Disorders of Sex Development' (DSD). Money's terminology had become too controversial, so 'new lexicon [was] needed to integrate progress in molecular genetic aspects of sex development' (for the implications of this new nomenclature within intersex activism, see Chapter 3).[166] The revised nomenclature and classifications sought to 'be descriptive and reflect genetic aetiology when available, and accommodate the spectrum of phenotypical variation', organising DSDs in three categories: sex chromosome DSD, 46, XY DSD and 46, XX DSD.[167] The following table,

[166] IA Hughes and others, 'Consensus Statement on Management of Intersex Disorders' (2006) 91 Archives of Diseases of Childhood 554, 554.
[167] ibid 554–555.

retrieved from the Consensus Statement, provides a snapshot of the current taxonomy of DSDs:[168]

Sex chromosomes DSD	46, XY DSD	46, XX DSD
46, X Turner syndrome and variants 47, XXY Klinefelter syndrome and variants 45, X/46, XY(mixed gonadal dysgenesis, ovotesticular DSD) 46, XX/46, XY (chimeric, ovotesticular DSD	Disorders of gonadal (testicular) development: ·Complete gonadal dygensis (Swyer syndrome) ·Partial gonadal dysgenesis ·Gonadal regression ·Ovotesticular DSD Disorders in androgen synthesis or action ·Androgen biosynthesis defect (eg, 17- hydroxysteroid dehydrogenase deficiency, 5a reductase deficiency, StAR mutations ·Defect in androgen action (eg, CAIS, PAIS) ·LH receptor defects (eg, Leydig cell hypoplasia, aplasia) 4. Disorders of AMH and AMH receptor (persistent mullerian duct syndrome) **Other**: eg, severe hypospadias, cloacal extrophy	Disorders of gonadal (ovarian) development · Ovotesticular DSD · Testicular DSD (eg, SRY+, dup SOX9) · Gonadal dysgenesis Androgen excess · Fetal (eg, 21-hydroxylase deficiency, 11-hydroxylase deficiency) · Fetoplacental (aromatase deficiency, POR) 3. · Maternal (leutoma, exogenous, etc) **Other**: eg. cloacal extrophy, vaginal atresia, MURCS, other syndromes)

Current protocols insist that all patients should receive male or female gender assignment.[169] Whilst Money considered the morphology of external genitalia the critical

[168] ibid 555.

factor for assigning gender, current protocols adopt a more holistic perspective, weighing in 'genital appearance, surgical options, need for life long replacement therapy, the potential for fertility, views of the family, and sometimes the circumstances relating to cultural practices'.[170] For instance, data suggests that babies with hypospadias and micropenises, who would have been likely assigned females during Money's reign, may grow up male with appropriate body image and psychosexual functioning.[171] The key criterion, 'while the most difficult to predict', is 'the anticipated quality of sexual function'.[172] Although each patient should receive individualised care, current guidelines suggest female assignment for cases of (1) 46, XX and Congenital Adrenal Hyperplasia (CAH), with available data confirming that 95% grow up to have a female gender identity (2) complete Androgen Insensitivity Syndrome (AIS) and (3) 46, XY LH receptor deficiency.[173] 46, XY babies with 'undermasculinised' genitalia, who would have been assigned female under Money's protocols, are now more likely to be reared as males, taking into account their prenatal androgen exposure and responsiveness.[174] For example, male assignment would still be indicated for patients with partial AIS 'upon a demonstrable response of phallic growth to testosterone therapy and genetic assessment if a causative

[169] ibid.
[170] ibid 556.
[171] Peter A Lee and others, 'Global Disorders of Sex Development Update since 2006: Perceptions, Approach and Care' (2016) 85 Hormone Research in Paediatrics 158, 169.
[172] ibid 168.
[173] ibid.
[174] ibid 169.

variant of the gene is found', but they should be assigned female if there is no evidence of androgen effects.[175]

Current guidelines let go of Money's interactionist model of gender and his unified concept of G-I/R, focusing on DSD patients having a healthy 'psychosexual development', in which biological factors seem to play a considerable role.[176] The Consensus Statement explains that psychosexual development has three components: gender identity ('a person's self-representation as male or female'), gender role ('psychological characteristics that are sexually dimorphic within the general population, such as toy preferences and physical aggression'), and sexual orientation ('the direction(s) of erotic interest').[177] The latter is no longer considered a marker of gender (dis)satisfaction, and (non)heterosexual preferences are not factored in to measure the success of gender assignment.[178] Whilst 'social circumstances and family dynamics' are considered one of the 'multiple factors' influencing psychosexual development, the rest of them are of biological nature, like 'exposure to androgens, sex chromosome genes, and brain structure'.[179] Although 'a biomarker of gender identity is not (yet) available',[180] the 2006 Chicago Consensus Statement stresses the association between prenatal androgen exposure and gender role,

[175] ibid.
[176] Hughes and others (n 166) 554.
[177] ibid.
[178] ibid.
[179] ibid.
[180] Lee and others (n 171) 168.

seeing correlations between higher levels of testosterone and masculine behaviour, such as playing with boys' toys, and associations with 'maternal instinct and sexual orientation'.[181]

ii) Surgical management: rationales, approaches and outcomes

Following gender assignment, prompt surgery was the logical and necessary next step in Money's protocols, since his view was that no child should grow up with ambiguous genitalia. Currently, early surgery, albeit not being completely ruled out, is treated more cautiously, with a wide range of factors being considered for its performance:

> (1) minimizing physical and psychosocial risk; (2) preserving potential for fertility; (3) upholding the individual's rights to participate in decisions that will affect their now or later; (4) leaving options open for the future by avoiding irreversible treatments that are not medically necessary until the individual has the capacity to con- sent; (5) providing psychosocial support and [peer support]; (6) supporting the individual's healthy sexual and gender identity development; (7) using a shared decision-making approach that respects the individual's and parents' wishes and beliefs; (8) respecting the family and parent- child relationships, and (9) providing patients with full medical information appropriate for age, developmental stage and cognitive abilities.[182]

Surgery very much remains the 'automatic' treatment for intersex individuals, sooner or later in life. In fact, neither the Consensus Statement nor its 2016 update explicitly explain why surgery is needed, but both documents take for granted that it is the de facto treatment, with their focus on when it should be performed and which surgical approaches are preferable. Nevertheless, the Consensus Statement does add a disclaimer with regards to justifications for surgery, perhaps in order to distance itself from Money's views, clarifying

[181] Hughes and others (n 166) 554.
[182] Lee and others (n 171) 176.

that ‘systematic evidence’ for the belief that ‘surgery that is carried out for cosmetic reasons in the first year of life relieves parental distress and improves attachment between the child and the parents’ is lacking.[183] It also sheds doubt on Money’s window for gender (re)assignment of eighteen months, and, as explained in Chapter 4, draws less strong links between binary G-I/R and psychological health.

Recognising that there is no consensus or sufficiently robust evidence about the positive or negative impact of surgery vs non-surgery in early childhood, the 2016 update of the Consensus Statement considers it a matter that needs further research and is to be decided on a case-by-case basis, where ‘multidisciplinary expert teams [should] design collaborative prospective studies involving all parties and using protocols of evaluation’ (however, Chapter 2 showed the predisposition of UK guidelines in favour of early surgery).[184] That said, there are some aspects on which experts seem to agree. First, the early performance of surgery on the external genitalia highly depends on the degree of ‘virilisation’, being considered appropriate only when it is severe, in accordance with the Prader Scale.[185] This scale assesses how ‘masculinised’ genitalia are, taking into account aspects like ‘the length of the genital tubercle and the availability of urethral tissue to refashion the vaginal introitus’ and ‘the fusion of the genital folds’.[186] Introitoplasty (that is, the creation of a vaginal opening by reconstructing the perineum) is indicated in cases of stage III ‘virilisation’, where the clitoris is mildly enlarged and the vaginal orifice is reduced.[187] Introitoplasty and clitoral reduction are to be performed in cases of reaching

[183] Hughes and others (n 166) 557.
[184] Lee and others (n 171) 176.
[185] Hughes and others (n 166) 557; Lee and others (n 171) 174.
[186] Lee and others (n 171) 174.
[187] Zograb Makiyan, ‘Systematization of Ambiguous Genitalia’ (2016) 12 Organogenesis 169, 173.

stage IV (the clitoris resembles a phallus, with complete fusion of the labia minora and a small urethral or vaginal opening near the clitoris), and stage V (labial folds are completely fused and there is a normal penile structure with a single urethral orifice at the glans penis).[188]

Second, asymptomatic Müllerian organs (vagina, uterus) are supposed to be kept during childhood, and their removal, if considered necessary, is to be scheduled for later on in life.[189] The practice of 'one stage' vaginoplasty, already controversial in the Money era, continues to be treated with caution, since it requires several follow-up procedures during childhood and puberty.[190] Likewise, vaginal dilation should be avoided until the child reaches adolescence.[191] Third, gonads should either be removed (to prevent tumour growth or late virilisation), biopsied (to monitor potential pathologies whilst preserving gonadal structures for reproduction), or, in some cases of undescended testis, moved into the scrotum.[192] The 2016 update provides detailed guidance about when each procedure is appropriate, taking into account DSD diagnosis, gender assignment and risk for cancer development.[193] Whilst tumour risk is higher where gonads have not been fully formed,

[188] ibid.
[189] Lee and others (n 171) 176.
[190] Hughes and others (n 166) 557.
[191] ibid; Lee and others (n 171) 176.
[192] Lee and others (n 171) 174.
[193] ibid.

like in gonadal dysgenesis, in other cases, such as complete AIS, risk of cancer is low, and testicle removal is managed more conservatively, being postponed until puberty.[194]

When/if any of these surgeries are performed, contrary to Money's protocols, function, and not appearance, is the current guiding consideration. Clitoral surgery should 'preserve erectile function and the innervation of the clitoris', with 'emphasis on functional outcome rather than strictly cosmetic appearance'.[195] Fertility should also be preserved. For instance, patients with bilateral ovotestes, who are 'potentially fertile from functional ovarian tissue', should have the testicular and ovarian tissue separated in a way that the latter can be preserved.[196] The use of assisted reproductive technologies is also a possibility, retrieving sperm from individuals with testicles and stimulating ovulation or using fertilised donated embryos in those who have functional Mullerian structures.[197]

To sum up, under current protocols, surgery remains the de facto treatment for intersexuality, although its rationale, timing and approaches have changed since Money's era. The current guiding factor is quality of life and function, rather than appearance. In fact, quality of function is key not only for considering surgery, but it is the central element underpinning all aspects of current guidance, including gender assignment, seeking to anticipate which gender and bodily transformations will enable the best life for the intersex child.[198] Rather than achieving a 'convincing' male or female appearance and securing an unconfused G-I/R, the aim is to ensure that patients have a healthy 'psychosexual

[194] ibid.
[195] Hughes and others (n 166) 558.
[196] ibid 557.
[197] Lee and others (n 171) 176.
[198] ibid 168.

development' through surgeries that, while aiming to make genitals more normal (reduce the clitoris to a standard size, open the vagina to a normal degree, create a vaginal cavity of sufficient width), also preserve sexual and reproductive function. In other words, surgery remains at the heart of intersexual management, with a similar purpose to the one it had for Money (tackle abnormal genital structures to provide them with some degree of normality). Nevertheless, the aspects taken into consideration when assigning gender and performing surgery have changed, with function now trumping appearance, together with a more holistic (yet limited) understanding of psychological health (see Chapter 4).

Most interventions that have been covered so far tackle deformities in the external or internal genitalia which, despite consisting in an abnormality, according to classificatory scales, do not represent a threat to the physical health of the child, potential gonadoblastomas aside. This is why these interventions are sometimes referred to as 'cosmetic'.[199] Most of them touch on healthy tissue that, if left unmodified, would not interfere with the patient's life expectancy or physical functions (although there are problems of psychological nature that the child is said to potentially face, such as bullying).[200] The elective or cosmetic character of these surgeries is precisely a core aspect intersex activism has highlighted, arguing that these are not necessary and they should at

[199] Hughes and others (n 166) 557; Creighton (n 160) 219; Creighton and Minto, 'Managing Intersex. Most Vaginal Surgery in Childhood Should Be Deferred' (n 161) 1265; Creighton and others (n 161) 125; Crouch and Creighton (n 139) 1595.

[200] Francisca Yankovic and others, 'Current Practice in Feminizing Surgery for Congenital Adrenal Hyperplasia; A Specialist Survey' (2013) 9 Journal of Pediatric Urology 1103, 1106; Isabelle Vidal and others, 'Surgical Options in Disorders of Sex Development (DSD) with Ambiguous Genitalia' (2010) 24 Best Practice and Research: Clinical Endocrinology and Metabolism 311, 311; Sarah M Creighton and others, 'Childhood Surgery for Ambiguous Genitalia: Glimpses of Practice Changes or More of the Same?' (2014) 5 Psychology and Sexuality 34, 40; A Binet and others, 'Should We Question Early Feminizing Genitoplasty for Patients with Congenital Adrenal Hyperplasia and XX Karyotype?' (2016) 51 Journal of Pediatric Surgery 465.

least be postponed until the child is old enough to provide consent, a posture with which increasingly more medical professionals have agreed with, as reflected in the Consensus Statement and its 2016 update.[201]

Nevertheless, there are some surgical interventions on intersex children without which their physical quality of life, or life itself, would be threatened. Examples of this sort of operations are gonadal removal to prevent the growth of cancerous tissue, reparation of the urinary tract to avoid incontinence or infections, or removal of tissue to enable menstrual flow.[202] The most dramatic—and only immediately life-threatening—problem in intersexual conditions are adrenal crises, which some patients with CAH are at risk of. Those who have a severe 21-hydroxylase deficiency, because their adrenal glands do not work properly, might lose too much cortisol, which might lead to death if not treated in time. The first crisis might even happen within the first weeks of life, with permanent risk of re-occurrence, even with life-long hormonal treatment, especially in situations of high physical stress.[203] This sort of hormonal treatment and surgical operations removing potential tumours or preventing infections and obstructions can be distinguished from those aiming to modify an enlarged clitoris or an imperfect vagina. The former bring about a clear direct physical benefit, since without them the health, and even life, of the child would be in danger. The latter, albeit tackling a deformity, modify parts of the body that could go

[201] See, for example, Consortium on the Management of Disorders of Sex Development and Intersex Society of North America (ISNA), 'Clinical Guidelines for the Management of Disorders of Sex Development in Childhood' (2006) 28.
[202] David A Diamond and others, 'Management of Pediatric Patients with DSD and Ambiguous Genitalia: Balancing the Child's Moral Claims to Self-Determination with Parental Values and Preferences' (2018) 14 Journal of Pediatric Urology 416.e1, 416.
[203] Zoltan Antal and Ping Zhou, 'Congenital Adrenal Hyperplasia: Diagnosis, Evaluation, and Management' (2009) 30 Pediatrics in Review 53–54.

unmodified without entailing physical harm. In these cases, as seen above, the benefit of surgery largely derives from the psychological ramifications that the abnormality may entail for the child's psychosexual development.

At this point, it might be interesting to compare ideas of 'benefit' and 'need' between intersex and cosmetic surgeries. As this section has shown, the former mostly tackle genitals that are considered ambiguous and not clearly seen as 'female'. Genital features targeted for surgical treatment in this context are seen as suffering from various degrees of 'virilisation' or 'masculinisation', depending on how they resemble a penis or scrotum.[204] Whilst some of these operations might tackle physical problems that hinder sexual or urinary functions (such as a urinary obstruction), they are also designed to contribute to the patient's psychological health by 'normalising' their anatomy—ie facilitating a genital appearance that, whilst maintaining erotic and reproductive function, enables patients to secure a healthy psychosexual development.

Even though vulval cosmetic surgery might potentially deal with similar functional issues to intersex interventions (such as difficulties with penetration, discomfort and pain in menstruation, urination or sexual intercourse), it is not framed as an antidote or prevention for gender identity problems. Rather, as we saw in the previous chapter, the mental health discourse around cosmetic surgeries focuses on its effects to increase body satisfaction, comfort and sexual pleasure, together with concerns about the patient suffering from anxiety or BDD. Furthermore, the vocabulary describing the effect of cosmetic surgeries is not that of 'feminisation', but rather that of 'reconstruction' or

[204] Hughes and others (n 166) 557.

'improvement'.[205] In vulval cosmetic surgery, the medical profession does not see the cut as modifying genitals so they can align more with the female standard, but the scalpel is supposed to fix or enhance features already seen as belonging to the female category. Cosmetic surgery does not change the status from 'doubtful' to 'definitive' vulvas and vaginas. It fixes a problem that, although it may also bring physical negative consequences, is not seen as hindering the definition of those genital structures as a vulva. Therefore, notwithstanding that both sorts of interventions are designed to contribute to improving physical and psychological health, and may even tackle similar physical problems, the way in which they are narrated is influenced by the extent to which the genitals that are operated on are seen as more or less 'normal' female looking.

3 Female Genital Mutilation

3.1 To cut is to harm

The WHO has gathered a long list of potential risks, complications and negative-side effects that might result from FGM. Immediate health problems include extreme pain, during the intervention, if performed without anaesthesia, and after, together with septic shock, excessive bleeding, swelling, which can obstruct passing urine and faeces.[206] If surgical instruments are not adequately sterilised, there is high risk of infection and transmission of HIV, which can lead to life-long problems and even death.[207] Long term,

[205] See eg British Association of Plastic Reconstructive and Aesthetic Surgeons (n 4); British Association of Aesthetic Plastic Surgeons (n 2).
[206] World Health Organization, 'Eliminating Female Genital Mutilation. An Interagency Statement' (2008) 33.
[207] ibid.

FGM may cause chronic pain, if nerves have been trapped during the intervention, chronic infections in the pelvis or in the urinary tract, which can, in turn, result in kidney failure, keloid scars, painful urination, painful intercourse and/or loss of sensitivity.[208] There might also be birth complications, such as postpartum haemorrhages or obstetric fistulas, all of which increases the risk of the child dying during childbirth.[209] Moreover, type III FGM (that is, where the labia have been narrowed, with or without clitoral removal or trimming) carries the additional challenge of requiring surgical opening later in life, to enable penile penetration and childbirth, and often complicates menstruation and urination, which can lead to further pain and infections.[210] In addition to these physical problems, FGM has also been reported to have considerable psychological sequalae.[211] Emotional disturbances, post-traumatic distress disorders, bad memories, nightmares, feelings of powerlessness, apathy, anxiety, depression or memory loss have been associated with this sort of procedure.[212] Sexual functioning might be impaired too, with some women reporting feeling less aroused and satisfied with sexual intercourse,[213] since the procedure might

[208] ibid 34.
[209] ibid.
[210] ibid 35.
[211] ibid 33; Royal College of Obstetricians and Gynaecologists, 'Female Genital Mutilation and Its Management' (n 84) 8.
[212] World Health Organization (n 206) 33–34; Royal College of Obstetricians and Gynaecologists, 'Female Genital Mutilation and Its Management' (n 84) 9; Erick Vloeberghs and others, 'Coping and Chronic Psychosocial Consequences of Female Genital Mutilation in the Netherlands' (2012) 17 Ethnicity and Health 677, 684; Alice Behrendt and Steffen Moritz, 'Posttraumatic Stress Disorder and Memory Problems after Female Genital Mutilation' (2005) 162 American Journal of Psychiatry 1000, 1001.
[213] Sharifa A Alsibiani and Abdulrahim A Rouzi, 'Sexual Function in Women with Female Genital Mutilation' (2010) 93 Fertility and Sterility 722, 772; Joel Anderson and others, 'Knowing Your Own Strength: Accurate Self-Assessment as a Requirement for Personal Autonomy' (2004) 11 Philosophy, Psychiatry & Psychology 279, 1608.

damage sensitive areas and the healing process might involve scar formation, reducing sensitivity.[214]

However, there is some debate within the literature about whether FGM necessarily entails such harmful consequences. Carla Obermeyer, for example, challenges the idea that FGM always carries devastating effects, shedding doubt upon the methodological accuracy of the data available on the prevalence, complications and mortality of FGM.[215] In a similar vein, Bettina Shell-Duncan is critical of the automatic association of FGM with adverse health effects, pointing out two main problems about the medical 'facts' available.[216] First, she warns that international organisations generalise about the consequences of FGM, conflating the effects of infibulation with other less invasive types of cutting.[217] Second, she is also concerned about the selection bias of some of the data, pointing out that not all women undergoing FGM have the same access to medical services, as well as the need to consider that some of them might not seek medical help due to fear of criminalisation.[218] Although Obermeyer and Shell-Duncan formulated these criticisms in the early 2000s, these may still have value, since the WHO, in its 2008 report, when elaborating the list

[214] Rigmor C Berg and Eva Denison, 'Does Female Genital Mutilation/Cutting (FGM/C) Affect Women's Sexual Functioning? A Systematic Review of the Sexual Consequences of FGM/C' (2012) 9 Sexuality Research and Social Policy 41, 49–50.
[215] Carla Makhlouf Obermeyer, 'Female Genital Surgeries: The Known, the Unknown, and the Unknowable' (1999) 13 Medical Anthropology Quarterly 79, 91; Gerry Mackie, 'Female Genital Cutting: A Harmless Practice?' (2003) 17 Medical Anthropology Quarterly 135, For further discussion, see.
[216] Bettina Shell-Duncan, 'The Medicalization of Female "'circumcision'": Harm Reduction or Promotion of a Dangerous Practice?' (2001) 52, 1016.
[217] ibid.
[218] ibid.

summarised above about the negative effects of FGM, relies heavily on studies conducted during the 1980s and 1990s.[219]

Some first-person accounts also contradict the narrative of FGM as unequivocally harmful and traumatising. The anthropologist Fuambai Ahmadu, telling her own experience of being cut in a coming-of-age ceremony in Sierra Leone, explains that, whilst she was very scared and remembers the procedure as being very painful, the pain subsided several days later and she did not experience any adverse effects on her sexuality.[220] She claims that the long-term sequalae of FGM have been exaggerated, arguing that, contrary to what the WHO and other international organisations suggest, fertility, obstetrical and gynaecological problems have not been an issue for Kono women (the group she was part of and which was the object of her study), who have engaged with vulval cutting for hundreds of years.[221] She also contends that short-term risks, such as infection, can be 'significantly reduced' if these interventions are performed under 'the right conditions', which, in her opinion, would justify the 'limited medicalisation' of FGM.[222] 'Limited' because the medicalisation she is arguing for would not entail moving the intervention to the hospital, as this would vitiate the practice and remove authority from 'female ritual leaders and female elders'.[223] Rather, the medicalisation she defends would consist in providing 'available basic, modern hygienic equipment and medications to traditional

[219] World Health Organization (n 206) 33.
[220] Fuambai Ahmadu, 'Rites and Wrongs: An Insider/Outside Reflects on Power and Excision' in Bettina Shell-Duncan and Ylva Hernlund (eds), *Female 'Circumcision' in Africa: Culture, Controversy, and Change* (Lynne Rienner Publishers 2000) 293.
[221] ibid 303.
[222] ibid 304.
[223] ibid 309.

officials to use during rituals'.[224] Instead of eradication, she considers that FGM should be maintained, calling for the need of 'a deeper appreciation of the historical and cultural relevance of this ancient practice and its symbolically dynamic and fluid links to women's changing sources and notions of power'.[225]

The question of whether medicalisation is a legitimate strategy has been a topic of controversy within the literature.[226] Whilst Ahmadu defends medicalisation as a method to maintain FGM by ensuring some protections, others support medicalisation as a strategy that, in addition to reducing the health hazards involved in the procedure, might promote the substitution of more invasive by 'milder' forms of cutting and eventually lead to the elimination of the practice.[227] This latter approach to medicalisation, which resembles the one adopted by the Wolff Sisters in Sudan in the 1920s, when they instructed local cutters to use sterile equipment and to practice less invasive forms of cutting (see Chapter 1),[228] might seem coherent with the WHO's framing of FGM as an intervention threatening women's health. It seeks to promote education about the harmful consequences of this practice, whilst making it safe, with the end goal of reducing its prevalence.[229] However, in some instances, raising awareness about the health risks of FGM seems to have had the consequence of moving it into the hospital. Egypt is an example where mothers, who were cut by traditional barbers, continue to have their daughters excised, but by medical

[224] ibid.
[225] ibid 308.
[226] Bettina Shell-Duncan, Carolyne Njue and Zhuzhi Moore, 'Trends in Medicalisation of Female Genital Mutilation/Cutting: What Do the Data Reveal? Updated October 2018' (2018) 2.
[227] Marie Hélène Doucet, Christina Pallitto and Danielle Groleau, 'Understanding the Motivations of Health-Care Providers in Performing Female Genital Mutilation: An Integrative Review of the Literature' (2017) 14 Reproductive health 46, 11; Shell-Duncan (n 216) 1014.
[228] Heather Bell, *Frontiers of Medicine in the Anglo-Egyptian Sudan, 1899-1940* (Clarendon Press 1999) 204.
[229] Doucet, Pallitto and Groleau (n 227) 11.

professionals, to reduce potential risks and complications.[230] This is precisely the problem detractors of the medicalisation of FGM warn about, contending that having medical professionals performing this intervention may contribute to (further) normalise the practice, instead of eliminating it.[231]

3.2 A trigger for medical attention

The WHO has condemned the medicalisation of FGM, stating that 'trained health professionals who perform female genital mutilation are violating girls' and women's right to life, right to physical integrity and right to health', shedding doubts on the benefits of medicalisation as a harm reduction strategy.[232] In 1994, the International Federation of Gynaecology and Obstetrics also 'oppose[d] any attempt to medicalize the procedure or to allow its performance, under any circumstances, in health establishments or by health professionals',[233] a position that was reinstated in 2019.[234]

The UK has adhered to the anti-medicalisation trend. Not only must medical professionals refrain from performing FGM, under the threat of facing criminal charges, but they also have positive obligations towards its prevention, detection and elimination.

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[230] NF Toubia and EH Sharief, 'Female Genital Mutilation: Have We Made Progress?' (2003) 82 International Journal of Gynecology & Obstetrics 251, 255.
[231] Nina Van Eekert and others, 'The Medicalisation of Female Genital Cutting: Harm Reduction or Social Norm?' (2021) 43 Sociology of Health and Illness 263, 266; For further discussion regarding medicalisation of FGM, see, for example Samuel Kimani and Bettina Shell-Duncan, 'Medicalized Female Genital Mutilation/Cutting: Contentious Practices and Persistent Debates' (2018) 10 Current Sexual Health Reports 25; Andrew J Pearce and Susan Bewley, 'Medicalization of Female Genital Mutilation. Harm Reduction or Unethical?' (2014) 24 Obstetrics, Gynaecology and Reproductive Medicine 29.
[232] World Health Organization (n 206) 12.
[233] International Federation of Gynaecology and Obstetrics, 'Resolution on Female Genital Mutilation' (1994) 2.
[234] International Federation of Gynaecology and Obstetrics, 'Against the Medicalisation of FGM/C ' (2019) <https://www.figo.org/news/against-medicalisation-fgmc> accessed 29 December 2021.

According to the FGM Act 2003, healthcare professionals (as well as teachers and social workers) have a duty to notify the police if a girl under 18 tells them she has undergone FGM, they observe 'physical signs on the girl appearing to show that an act of female genital mutilation has been carried out on her' or they 'have no reason to believe that the act was, or was part of, a surgical operation within section 1(2)(a) or (b)' (ie the so called 'therapeutic exception').[235] FGM is considered child abuse and it must also be reported to Local Safeguarding Children Boards, even without the parents' consent.[236]

Therefore, regulated professionals must be on the lookout for girls who might be at risk of FGM, which is considered to be the case where their mother or other members of their family have had FGM, and/or they belong to a community which practises FGM.[237] If, given 'their family history', a regulated professional suspects that a child is at a serious or imminent risk of FGM, they should 'act in accordance with their local safeguarding procedures', which usually entails referral to the local Children's Services.[238] In order to ensure the protection of those at risk of FGM, there are also information sharing arrangements in place, so that everyone involved in the child's care, such as their GP or school nurse, can decide 'what the best course of action' to 'protect' them from FGM is.[239] Department of Health guidance sets out the information that should be shared with other key professionals, like whether the girl has undergone FGM, if they were underage when

[235] Female Genital Mutilation Act 2003 s 5B.
[236] Royal College of Obstetricians and Gynaecologists, 'Female Genital Mutilation and Its Management' (n 84) 12.
[237] Department of Health, 'Female Genital Mutilation Risk and Safeguarding. Guidance for Professionals' (2016) 1–2.
[238] ibid 3.
[239] ibid 2.

they did and whether her mother has been cut, keeping an updated record of the girl's FGM status.[240]

No mandatory obligation to report exists once the girl is over eighteen years old, but a risk assessment should still be carried out to determine whether safeguarding procedures, such as the involvement of social services, are indicated. In assessing risk, the medical professional should consider whether the woman belongs to a family and/or comes from a region where FGM is practiced, whether she and her family have integrated within the UK, whether she believes FGM is 'integral to cultural or religious identity' and also whether she is considered a 'vulnerable adult'.[241] If she is pregnant, the medical assessment must determine if and to what extent her unborn child or any children in her family might be at risk of FGM, having to report to social services and/or the police if the risk is significant or imminent.[242]

The duty to report must be distinguished from healthcare professionals' duty to record. As seen in Chapter 4, when they identify a woman who has undergone FGM, they must always document it in her medical records.[243] Moreover, her personal data (including age at which 'FGM was performed, country where it was performed, date of entry to the UK and past history of de/re-infibulation') should be submitted, without anonymisation, to

[240] ibid 5–14.
[241] Department of Health and Social Care, 'Safeguarding Women and Girls at Risk of FGM ' <https://www.gov.uk/government/publications/safeguarding-women-and-girls-at-risk-of-fgm> accessed 29 December 2021.
[242] Royal College of Obstetricians and Gynaecologists, 'Female Genital Mutilation and Its Management' (n 84) 21.
[243] ibid 2.

the Health and Social Care Information Centre (HSCIC) FGM Enhanced Dataset, although her information will be anonymised for statistical analysis and publication.[244]

Many professionals object to the introduction of mandatory reporting and recording. Given the confidentiality concerns that arise from the fact that the FGM Enhanced Dataset collects 'patient-identifiable information', one of their main preoccupations is the negative impact for the doctor-patient relationship and public trust towards the medical profession.[245] Moreover, there is also the concern that the duties to report and record might drive the practice (even more) underground, since women might be reluctant to open up with their nurses and doctors, or even seek medical assistance, due to fear of criminal consequences.[246] The British Association of Social Workers (BASW) is also critical of their new reporting responsibilities under the FGM Act 2003.[247] BASW's main preoccupation is that mandatory reporting hinders their role to 'prevent harm and to address any emotional harm or trauma associated with this harm', as they are now forced to participate in 'punish[ing] parents for past harm', which should fall under the purview of the police and the criminal justice system, not social workers.[248]

Empirical research among women from practising communities in the UK confirms that the introduction of these duties might not help to prevent FGM and protect those who

[244] ibid 22.
[245] Joel Naftalin and Susan Bewley, 'Mandatory Reporting of FGM' (2015) 65 British Journal of General Practice 450, 451.
[246] Joseph Home and others, 'A Review of the Law Surrounding Female Genital Mutilation Protection Orders' (2020) 28 British Journal of Midwifery 418, 420.
[247] British Association of Social Workers, 'FGM: Social Workers Should Not Take on the Role of the Police' <https://www.basw.co.uk/media/news/2015/feb/fgm-social-workers-should-not-take-role-police> accessed 31 January 2023.
[248] ibid.

have undergone it. FORWARD, a charity which seeks to 'advance to rights of women and girls in UK and in Africa', issued a report in 2016 showing that most women are unaware of the existence of specialist services, that they do not feel comfortable or ready to share with their GPs that they have been cut, and that there is a generalised fear that their visiting their GP might trigger social worker or police investigations.[249] That is why, rather than intrusive surveillance measures which expand the boundaries of the criminal law, FORWARD suggests that efforts should be devoted to 'increase support and funding for community-based organisations, increase awareness-raising and education on FGM, and better signposting to specific FGM services'.[250]

Beyond mandatory reporting and recording, in terms of clinical management, when a woman with FGM is identified, healthcare professionals should follow the referral pathway in place at their trust or health board, all of which should have 'a designated consultant and a midwife responsible for the care of women with FGM'.[251] Women, either through self-referral or through her GP's referral, should be seen by the 'designated obstetrician or gynaecologist responsible for the care of women and girls with FGM', who should examine them closely, identifying what type of FGM was performed on them, whether they suffer from any physical sequalae and whether de-infibulation is indicated (see below). All women should be offered 'psychological assessment and treatment for

[249] Kate Norman, SB Gegzabher and Naana Otoo-Oyortey, '"Between Two Cultures": A Rapid PEER Study Exploring Migrant Communities' Views on Female Genital Mutilation in Essex and Norfolk, UK' (2016) 42.
[250] ibid 43.
[251] Royal College of Obstetricians and Gynaecologists, 'Female Genital Mutilation and Its Management' (n 84) 13.

HIV, hepatitis B and C and sexual health screening', as well as a specialist referral, such as to sexual health or infertility specialist, if appropriate.[252]

In cases of type III FGM, de-infibulation might be indicated if the introitus opening is insufficient to allow 'normal urinary and menstrual flow, vaginal examination, comfortable sexual intercourse, safe vaginal delivery' or 'cervical smears, sexual health screens and gynaecological surgery', like management of miscarriage or termination of pregnancy.[253] If de-infibulation is necessary to enable childbirth, medical professionals and the pregnant woman must discuss whether to perform it antenatally or during labour, taking into consideration the risks it would involve for vaginal delivery.[254] Whilst de-infibulation is considered appropriate in order to help mitigate the harmful effects of FGM, the RCOG is more cautious with other procedures, such as clitoral reconstruction, since there is not sufficient evidence that this sort of intervention can restore sexual function, often resulting in further complications instead.[255]

International organisations like the WHO and the UK medical profession thus see FGM as a harmful cut potentially causing a wide range of long and short-term negative effects and complications. Medical professionals must never perform these interventions

[252] ibid 14.
[253] ibid 15.
[254] ibid 16–17.
[255] ibid 15.

and the identification of a woman who has had FGM triggers for them various obligations, in terms of reporting, recording and medical management.

4 Conclusion

Analysing the distinct medico-legal readings of the rationales and effects of vulval cosmetic interventions, intersex surgeries and FGM has revealed the intricate ways in which gender and race structure how each of these operations is read to benefit or harm those who undergo them.

Entanglements with embodied gendered and racialised ideals first become apparent in the different degrees of tolerance of harms and risks depending on whether and to what extent each cut facilitates or threatens vulval ideals of symmetry, non-protrusion and femininity. The clearest example is intersex surgeries, which, despite having been widely reported as producing several adverse physical and psychological consequences, especially if performed early on and without the patient's consent, remain to be considered the de facto treatment for intersex conditions. Something similar happens with vulval cosmetic surgeries, which also carry substantial risks and, in most instances, are not primarily aimed at fixing a physical problem. However, even if several medical guidelines and literature acknowledge the lack of sufficiently rigorous research of relieving psychological anxiety through surgical change, cosmetic surgery remains to be considered proper medical treatment. In contrast with these forms of 'good medicine', FGM is deemed a 'bad mutilation',[256] since the international legal order and English medico-legal landscape have

[256] Camille Nurka, *Female Genital Cosmetic Surgery. Deviance, Desire and the Pursuit of Perfection* (Palgrave Macmillan 2019) 213.

adopted the unequivocal view that FGM is always harmful and produces a never-ending list of short and long-term sequalae.

Furthermore, the ways in which cosmetic and intersex surgeries are justified as proper medical practice, and FGM, on the contrary, is framed as an unlawful cut, also respond to seeing embodiment along gendered and racialised lines. The justification of intersex surgeries lies on the perceived need for 'feminisation' of intersex vulvas, in response to the fear that having a 'masculinised' appearance might give rise to potential psychosexual problems. Similarly, even though cosmetic surgeries are not performed in response to concerns about gender identity, but rather under the auspices of enhancing function and body image dissatisfaction, colonial vestiges influence current medical accounts of what constitutes a normal vulva, othering traits, such as large labia, as ugly and dysfunctional. Finally, albeit the unequivocal negative effects of FGM have been contested by the literature, and its distinction from vulval cosmetic surgery is sometimes extremely difficult to draw, FGM is considered a harmful intervention that must never be performed by medical professionals (or anyone else), as it is seen as a form of violence that destroys healthy tissue and hinders physical, psychological and sexual health.

Thus, discourses around vulval cutting are structured around two predominant, and mutually reinforcing, dichotomies. They are traversed by the (illusive) contrast between, as Nurka puts it, the "oppressed" African woman [versus] the "liberated" white woman',[257] and the commitment to classifying bodies as either male or female. These binaries underlie the understanding of intersex surgeries as normalising what are invoked to be ambiguous

[257] ibid 222.

genitals, cosmetic surgeries as enhancing already normal, or fixing potentially dysfunctional, but unambiguous, vulvas, and FGM as always and only having mutilating effects. Indeed, as Chapter 1 advanced, ideas of harm, health and benefit informing vulval cutting are not value-free, but constructed through binary and exclusionary assumptions of race and gender.

CONCLUSION

1 Three patients in the waiting room

Let's go back to the three patients we encountered in the Introduction. The goal of this thesis has been to find the 'conditions of possibility' through which the medico-legal discourse, as well as its critical appraisal by feminist literature and intersex activism, considers that these three individuals have different medical needs, face different challenges and have different reasons for being in the same waiting room.[1] Each chapter has deconstructed the discourses and logics—about autonomy, oppression, health, harm, benefit, and need—through which cosmetic surgery, intersex surgery and Female Genital Mutilation (FGM) are understood to be different from one another. Thus, we can now see the intricacies of how, across the three interventions, the vulva shifts meanings as a marker for gender identity, a vehicle for sexual satisfaction, a source of mental health problems or an object of abuse, with the patients in the waiting room becoming three distinct subjects: a 'cosmetic surgery patient/customer', an 'intersex patient' and a 'mutilated woman'.

Chapter 1 shed light on how the historical background of each intervention has preceded their present status as medical treatment or unlawful cuts. By showing the interconnection between medical, cultural and social discourses on femininity and sexuality since the late 19th century, this chapter argued that the evolution of vulval cosmetic surgeries, intersex surgeries and FGM is ingrained in—and also evolves through—racial and gendered narratives about embodiment. The policing of 'proper'

[1] Michel Foucault, *The Order of Things. An Archaeology of the Human Sciences* (Routledge 1989) xxii.

womanhood, racial hierarchies and gender differences are crucial axes structuring the historical development of these interventions as three 'types' of cutting.

Chapter 2 teased out the main issues underpinning the medico-legal debates about the lawfulness and ethical acceptability of each intervention. Through this juxtaposition, it showed that each of these patients is said to face distinct challenges within the medical gaze (consumer and cosmetic pressure, gender identity problems or abuse and harm), to have different issues with decision-making (mental health problems, challenges with proxy-decision making or oppressive surroundings), and to have vulvas giving rise to different health concerns (of body image, psychosexual development, or physical and psychological harm).

Chapter 3 examined how feminist scholarship conceptualises vulval cosmetic surgeries, intersex surgeries and FGM as oppressive practices hindering free choice. Whilst the structure-agency debate is central in (vulval) cosmetic surgery, it is substituted by one focused on the (controversial) role and influence of gendered ideals in the medical management of intersexuality and traversed by criticisms of Western 'blindness' in the context of FGM. The chapter suggested that underlying conceptions of the vulva as normal or healthy underpin the different ways in which gender or patriarchal forces are seen to impair decision-making.

Chapter 4 compared the discourses of psychological well-being across the three operations and argued that mind, body and culture are distinctly framed as the main challenge to mental health in each case. It contended that distinct deployments of cultural beliefs versus mental health, and gender identity versus body image problems, are built

upon and make sense because they rely on gendered and racialised stereotypes about decision-making and embodiment.

Chapter 5 analysed the contradictions in deeming FGM as always unequivocally harmful whilst accepting intersex surgeries on young infants as beneficial treatment for their psychosexual development, and vulval cosmetic surgeries as improving (adult) patients' bodily image satisfaction. It argued that perceptions of these interventions as belonging to Western science and reifying the male/female binary underlie contradictory iterations of physical and psychological health across the three cuts. As a consequence, cosmetic surgery is perceived to relieve psychological anxieties over appearance, intersex surgery to enable healthy psychosexual development and FGM to destroy healthy vulval tissue.

2 The glue holding the differences together

In tracing these differences, each of these chapters argued that an underpinning conception of vulval anatomy along gendered and racialised lines constitutes the 'conceptual' glue enabling us to see these patients as suffering from distinct forms of oppression, having different mental health problems and undergoing cuts affecting them in different ways.

Whether the cuts have a medical or ritual character, respond to cosmetic, therapeutic or cultural needs, or produce beneficial or harmful effects depends upon race and geography.[2] In addition to medical standards of vulval health (particularly regarding

[2] Sarah B Rodriguez, *Female Circumcision and Clitoridectomy in the United States* (University of Rochester Press 2014) 180.

vulval labia), racial ideals of sexuality and gender nurture different constructions of gender oppression and autonomy, all of which inform the medico-legal classification of these interventions as legitimate, beneficial or abusive. The policing of the gender binary also plays into the 'hoped-for difference' between vulval cosmetic surgeries, intersex surgeries and FGM.[3] Scientific discourses of bodily (dys)functions, gender identity and psychological health are governed by the idea of the vulva as a marker of gender, with vulval cuts sometimes being read as 'feminising' 'masculinised' genitalia, or providing self-confidence and psychological reassurance to regain joy in sex, or at other times destroying functional vulval anatomy.

The gendered and racial logics behind there being three distinct frameworks for very similar, if not identical, interventions on the vulva allows us to see that medico-legal classifications of vulval cutting are 'historically and culturally situated'.[4] Rather than transcribing how normal vulval anatomy really is or objectively describing the effects of cutting it, law and medicine 'invent' what it means to have a healthy, ambiguous or mutilated vulva.[5] This does not mean that the vulva is only a social construction and that the harm or pleasure someone feels through it (perhaps as a result of a cut) is a pure social invention. Rather, it means that these experiences are always mediated and interpreted by the scientific discourse that is, at the same time, built upon social and cultural norms. To put it in the words of Judith Butler, 'the matter of bodies will be indissociable from the

[3] ibid.
[4] David Andrew Griffiths, 'Shifting Syndromes: Sex Chromosome Variations and Intersex Classifications' (2018) 48 Social Studies of Science 125, 129.
[5] Clare Chambers, *Intact: A Defence of the Unmodified Body* (Allen Lane (Penguin Books) 2022) 206.

regulatory norms that govern their materialisation and the signification of those material effects'.[6]

Therefore, the rationales and challenges of vulval cosmetic surgery, intersex surgeries and FGM generate meanings about, and must always be read against, the cultural, historical and social norms about what it means to have a vulva. In producing and disseminating understandings of vulval cutting, not only are scientific and legal discourses determining the terms in which cuts on the vulva occur and the effects they have, but also the ways in which we can think about ourselves. Depending on how our vulva fits the medical standards of normality, beauty and (un)ambiguity, we face different types of oppression, medical needs and functional problems. As intersex patients, our 'masculinised' vulvas threaten our having a female gender identity, but as vulval cosmetic surgery patients, our mental health is endangered by a potential obsession over a (perceived or real) anatomical flaw. If we undergo FGM, regardless of our perspective on the intervention, we are mutilated and considered victims who need protection by the criminal justice system.

The medico-legal regulation of vulval cutting thus constitutes a discursive framework creating different associations between vulval anatomy, beauty, gender, culture and health. Entanglements of race and gender structure what we understand as 'healthy',

[6] Judith Butler, *Bodies That Matter: On the Discursive Limits of Sex* (Routledge 1993) xii.

'cultural' and 'scientific' and, consequently, inform the classification of the vulva as ambiguously gendered, functionally impaired or cosmetically enhanced.

3 Looking ahead

This thesis focused on teasing out and questioning the assumptions about embodiment, gender and race lying behind the tripartite conceptions of vulval cuts as vulval cosmetic surgery, intersex surgery and FGM. In doing so, as discussed in the Introduction, there have been some interventions, including gender reassignment surgeries, that have been left unconsidered. Nevertheless, this thesis hopes to have opened a new critical route for investigating how these medical practices imagine and shape selfhood, identity and bodily integrity. Particularly given the connections with intersex embodiment, this thesis might have paved the way for a parallel investigation, similar to the one undertaken here, juxtaposing how transgender and intersex bodies have fallen under the medical gaze. Such an analysis may include examining their distinct histories and access to (but also shielding from) the medical profession, the mobilisation (and contraposition) of feminist discourses on sex and gender, and the role of parental decision-making and children's decision-making capacities. This future research project, centred on studying how meanings of gender identity and autonomy are generated and shift across medico-legal discourses concerning trans and intersex embodiment, might offer a different and fresh perspective on

what has become a polarised discussion between identity-based accounts and essentialised views of gender.

Continuing the endeavour of unpacking scientific understandings of embodiment and health, a more detailed examination of cosmetic surgery (beyond the vulva) also seems necessary. Starting with a detailed historical inquiry into how cosmetic surgery became established as proper medical treatment in the United Kingdom,[7] there is also scope for further research on the current regulatory challenges—about safeguards, products and control—posed by cosmetic surgery.[8] Moreover, more attention should be paid to who is allowed access to cosmetic surgery and how race and gender influence patients' and doctors' conceptions of beauty, health and normality.

Finally, intersex embodiment might also prompt a re-examination of the current legal approach to gender. Notwithstanding that several strands of intersex activism have contested the conception of intersexuality as synonymous with non-binary (see Chapter 3), countries like Germany have introduced third gender markers with the aim of providing intersex individuals with a legal category that does not force them to commit to either the female or male gender.[9] Nevertheless, as discussed in Chapter 2, the German experience has proved problematic, as most parents are not keen on leaving their child in a gender

[7] Most research on the history of cosmetic surgery has focused on the US context. See, for example, Elizabeth Haiken, *Venus Envy: A History of Cosmetic Surgery* (Johns Hopkins University Press 1997); Sander L Gilman, *Creating Beauty to Cure the Soul. Race and Psychology in the Shaping of Aesthetic Surgery* (Duke University Press 1998).
[8] See, for instance, Alexandra Topping, 'Cosmetic Procedure Industry Is like the "Wild West", Say Campaigners ' *The Guardian* (2021).
[9] Fae Garland and Mitchell Travis, *Intersex Embodiment: Legal Frameworks beyond Identity and Disorder* (Bristol University Press 2023) 54.

'limbo', both in legal and embodied terms.[10] In the UK context, while the Government has put on hold reforming the Gender Recognition Act 2004, some academics have recently considered the implications of abolishing legal gender status.[11] As discussed in the Introduction, gender decertification, Davina Cooper and others suggest, 'offers benefits to people who do not fit the current binary framework of women and men, and who are placed, or feel obliged, to squeeze into one category or another'.[12] When imagining the future of legal gender, as well as reflecting on what our bodies mean for our gender identity, future research should acknowledge the lived experiences and needs of the intersex community, examining the implications of reconfiguring legal gender for them.

For now, this thesis hopes to have contributed to deconstructing and questioning the gendered and racialised assumptions about embodiment that sustain notions of 'health', 'autonomy' and 'function' underpinning the medico-legal classification of vulval cuts as mutilating, therapeutic or enhancing.

[10] ibid 68.
[11] D Cooper and others, 'Abolishing Legal Sex Status: The Challenge and Consequences of Gender-Related Law Reform, Future of Legal Gender Project. Final Report' (2022).
[12] ibid 16.

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