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Chapter 1

Female Genital Cosmetic Surgery

Solution in Pursuit of Problem

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Background

Socially motivated female genital cutting has a long history in Europe. According to social historians, in ancient Rome, metal rings were passed through the labia minora of female slaves to prevent procreation. In medieval England, women in certain social strata were made to wear chastity belts to prevent them from engaging in sexual activities during their husbands' long absences. In Tsarist Russia and nineteenth-century England, France and the United States, clitoridectomy was performed to cure epilepsy, hysteria, insanity and masturbation [1]. In many countries today, a diverse range of lawful procedures subsumed under 'female genital cosmetic surgery' (FGCS) overlap with a diverse range of unlawful procedures subsumed under 'female genital mutilation' (FGM) (Chapter 7). The double standard is bewildering:

> How can it be that extensive genital modifications, including reduction of labial and clitoral tissue, are considered acceptable and perfectly legal in many European countries, while those same societies have legislation making female genital cutting illegal, and the World Health Organization bans even the 'pricking' of the female genitals? [2]

FGCS refers to lawful procedures to alter the structure and appearance of female external and internal genitalia in the absence of biomedical concerns. This definition refers to a large and growing number of operations including labiaplasty, clitoroplasty, introitoplasty, hymenoplasty and vaginal rejuvenation, tightening and reconstruction (Chapters 5 and 6). These operations are said to ameliorate women's worries about the appearance and function of their genitals, including the kinds of concerns expressed by our three informants - 'Madison', 'Kate' and 'Navaeh':

> Madison is sobbing. Next to her is her mother Nicole. Opposite them is the gynaecologist who has just examined Madison's vulva. The twenty-year-old has been complaining about soreness from the chaffing and rubbing of her vulva, especially when she wears her jeans. "It gets caught coz it sticks out too much," she says. She has recently cancelled a beach holiday with friends because, she says, her clitoris gets erect in hot weather and can be seen inside her swimwear. Far from feeling relieved by the gynaecologist's reassurance that her genitals are normal and healthy, Madison is miserable. Mother and daughter have spent months researching on the internet before concluding that surgical removal of "the excess tissue" (in the clitoris) was the right course of action for Madison. To Nicole, the persistent despair of her daughter is surely evidence enough that the problem is "not just in her head". Having had a private neck lift herself a few years ago, Nicole is aware of the high costs of private cosmetic surgery and bemoans the fact that it would take Madison years of working at the hair salon to save up enough money to "make the vagina right again".
>
> Kate lives alone. Her son and daughters live with their respective partners not far away. Kate's husband moved out last year; their divorce has just come through. After several years of stress over the uncertainty of her "rocky marriage", Kate is enjoying life again. She feels ready for a new relationship. After a routine smear test, she asks the friendly nurse about 'vaginal laxity'. It has been at the back of Kate's mind for a while to do something about it. For a few years before the divorce, her husband was initiating sex less often. When they had intercourse, he did not always orgasm. Kate took this to mean that sex with her was less enjoyable for him. Having given birth three times and being post-menopausal, she muses, her body "is bound to feel not as nice". In preparation for a new relationship, and as an act of doing something positive for herself, Kate is looking to see a doctor experienced in 'vaginal tightening'. She wants to know more about the procedure so as to be able to choose the best provider.
>
> After a successful term at school where she is a high achiever, Nevaeh is excited about her summer travels.

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> She buys her first pot of hot wax. At fourteen years of age, she is not the first among her friends to remove the unwanted hair growth on her legs. Nevaeh tries on her new bikini and notices her pubic hair escaping through the sides of her briefs. She instinctively proceeds to trim the hair off. An hour later, she is waxing her labia majora. It's extremely painful and her vulva is looking rather red. The enlarged hair follicles give the labial skin a pimpled appearance. Images of chicken skin come to mind and bring a sense of disgust. She despises her "purply fleshy" inner labia even more. She experiences a longing for a firm, smooth-skinned and evenly coloured vulva "without all the bits". Nevaeh shuts her eyes and imagines that different vulva and feels a sense of relief. She can't remember where she may have seen such a "vagina" – perhaps as a drawing in a biology book? Nevaeh feels that she would be so happy if she did not have to deal with the body part that is "so not me".

In 2007, we drew attention to the fivefold increase in the number of labiaplasty operations performed in the United Kingdom's National Health Service (NHS) in the preceding decade [3]. The article was not the first commentary on the topic in a medical journal [4], and there had been important feminist scholarship on the subject [5]. Since then, the FGCS industry has expanded considerably. According to a 2016 report by the International Society of Aesthetic Plastic Surgery (ISAPS), 138,033 labiaplasty operations were performed in the preceding year [6]. These figures come from voluntary data submissions and are almost certainly to be underestimates. The overall increase in the number of cosmetic operations in the year was 9%, but the increase for labiaplasty, which had enjoyed the steepest rise, was 45%. The successful mainstreaming of FGCS in high-income countries is mirrored in low- and middle-income countries, as evidenced, for example, by the specialist sessions on Cosmetic Gynaecology and Vaginal Rejuvenation at the All India Congress of Obstetrics and Gynaecology in 2017 and 2018 [7]. We know that there has not been a labial growth spurt worldwide. In any case, research shows that there is no difference in labial dimensions between women seeking and those not seeking labiaplasty [8]. We also know that surgical techniques do not change that quickly. Hence some other factors must account for the growth of labiaplasty. Psychologist and sexologist Leonore Tiefer explained in 2008 that the infinite possibility of disease mongering in consumerist medicine fits comfortably with our free market and encourages the growth of FGCS [9]. Does the sharp rise in labiaplasty [6] reflect successes of marketing campaigns? Have prices fallen as a result of greater competition so that more women can pay for the operation? Are banks encouraging women to take out personal loans for cosmetic surgery? Is there a new social acceptance of female genital cutting in the West and, if so, what are the implications for women and for society? Has female genital dissatisfaction and distress increased? Are these factors linked, and if so, how?

Female Genital Cosmetic Surgery: Solution to What Problem? is an interdisciplinary response to some of the questions asked. The volume combines historical and philosophical analyses and legal, pedagogic and clinical perspectives. Its aim is first to enable researchers to formulate questions about FGCS more strategically. An equally important aim is to enable education and health professionals to develop non-surgical alternatives to address genital dissatisfaction and the resulting distress (Chapters 11 to 15). The book was seeded by the experiences of women and girls who, like Madison, Kate and Nevaeh, experience doubt, concerns, worries, distress and disgust about the appearance and function of their genitals. It is hoped that some of the chapters will be of interest to the women and girls so affected. Although the volume is about FGCS, many of the discussions are relevant to cosmetic surgery more generally, so that some of the chapters may be of interest to wider audiences.

The contributions to the book by leading academic and clinical experts on the topic of FGCS combine to emphasise the critical importance of reframing the most frequently asked question about FGCS: "Why do women do it?" The question pre-locates the answers in the women and encourages the recycling of individualising discourses of free choice, self-improvement and female madness that exonerate FGCS (Chapter 8). These popularised discourses mask the powerful structural underpinnings of a cultural practice that is being promoted more or less unopposed.

In *Power, Interest and Psychology,* clinical psychologist David Smail proposed that to understand unhappiness, we should, rather than gain insight into ourselves, instead cultivate 'outsight' into the world around us, in particular in how social and economic factors mould our thoughts and feelings and organise our choices in ways that are often not obvious [10]. Outsight into FGCS is the aim of this chapter, in which we highlight and problematise the interrelated

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systemic processes, including (1) binary notions of sex and gender, (2) the pressure of suspect norms, (3) the effects of medical framing, (4) the ambivalent professional responses, and (5) the barriers to establishing high-quality evidence to guide consumer choice and professional practice. We return to our three informants as the discussion progresses and offer suggestions at the end of the chapter on limiting damage.

Binary Genitals

Like other sex characteristics, the genitalia are culturally constructed as discrete and non-overlapping biological entities that confer femaleness and maleness, two forms of existence also constructed as discrete and non-overlapping. The concept of binary sex is not supported by science. Human embryos have the same reproductive and genital structures to start with. Sex differentiation typically begins at about eight weeks of gestation, and a sex-undifferentiated fetus gradually assumes the anatomical structures and appearance of what we think of as female or male. In other words, the tissues that develop into ovaries, womb, vagina, clitoris and labia are the same as those that develop into testes, penis and scrotum. The developmental processes often, but not always, result in a female- or male-typical combination of chromosomes, physiology and anatomy. Nature prefers diversity and delivers a spectrum of possibilities that makes binary sex a myth so hard to sustain that in modern times, surgical interventions have been developed to 'correct' the less differentiated genitals in many Western(ised) societies. Although the genital differences are medically benign, children may undergo a series of genital operations to satisfy adult expectations of normative genital appearance and function. These interventions are increasingly positioned as a violation of human rights [11].

Binary understandings also extend to non-genital sex characteristics. Body hair, for example, is a biological reality of all human beings, but 'hirsutism', defined as 'an excess of body hair in the male distribution' [12], is a medical term applied only to women. Even if we were to accept that hirsutism is a medical condition for women, the distinction between normal and abnormal female hair growth is far from clear-cut. Women's customary hair removal makes it hard to determine the actual distribution of facial and body hair in the general population. Anthropological studies of cultures in which hair removal is unavailable or not practised indicate that women have the potential to develop hair growth in the same regions of the face and the body as men. The difference between men and women in the amount of hair growth has never been quantified. Nevertheless, clinicians have described women's extreme reactions such as shame and 'morbid preoccupation' even with insignificant hair growth. [13]. Nevaeh takes for granted as a *truth* that females have no body hair. It is a social norm that she has internalised and does not question. As she applies hot wax to remove her leg, armpit and pubic hair, she is merely acting on a commonsense understanding – a matter of *fact*, in her cultural context.

Likewise, although many women in the general population have relatively little breast tissue and many men have more, 'gynaecomastia' is a medical term applied only to men. NHS Choices explains that gynaecomastia is a *medical condition* in which boys' and men's breasts swell to become larger than *normal* [14]. The definition of normal is left to the imagination of providers of 'male breast sculpting', which usually involves a combination of liposuction and removal of glanular tissue. Widely advertised in the private sector, surgery supposedly helps men to "look good in a fitted shirt when the meeting gets heated" [15]. Surgery is intended not just to promote confidence in the board room; it is also said to enable men to "look forward to holidays in the sunshine again". [15]. The American Society of Plastic Surgeons (ASPS) reported a 30% increase between 2010 and 2016 in the number of male breast reductions performed [16].

As discussed above, genitals are socially constructed as mutually exclusively female or male. According to a medical report, a large penis in males "has always symbolized strength, virility, power, and domination in relationships." [17]. The claim is not only sexist but, in erasing cultural differences, racist. The claim is also flawed in *always*. The amount of genital mass proportionate to the overall body mass of the idealised male body form in today's pornographic images is different from that in many classical European artistic depictions. In our contemporary world, surgery on the genitals of men includes penile lengthening, penile girth *enhancement*, dual *augmentation* (length and girth enhancement combined), penile glanular enhancement, scrotal web resection and reconstruction. According to plastic surgeons, many men want to know how phalloplasty can improve their self-confidence, sexual relationships and female partners' sexual satisfaction. Despite these

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alluring suggestions, phalloplasty fell by 28% between 2015 and 2016 and was the least popular form of cosmetic surgery that year (8,434 operations) [6].

Just as male genitalia are constructed as present, external and pendulous, female genitals are constructed as absent and recessed. In other words, women *lack* genitals [18]; they have an internal receptacle instead. Some years ago, at a planning meeting for an academic event on FGCS, the organisers, who were familiar with the debates, requested that we substitute another word for genitals in the title because it was "a horrible word". They asked that we refer to "vagina" instead. The sensibility did not reflect ignorance on the part of the conference organisers, rather a culturally shared sense of incompatibility between *women* and *genitals*. Madison and Nevaeh refer to 'vagina' when they are talking about the clitoris and labia, which are part of the vulva (Chapter 2). In 1995, artist Joani Blank had the foresight to create *Femalia*, a book of photographs of the vulva. Blank wanted to counter the "unfortunate habit that most people have of calling a woman's vulva her vagina". She reasoned, "by teaching our little girls to call their genitals vaginas, we practice a sort of psychic genital mutilation". Blank forewarned that language could be "as powerful and swift as the surgeon's knife". In her words: "What is not named, does not exist."

Binary notions of genitals explain why men, who on average have a greater share of the burden of genital mass, tend not to complain about the kind of rubbing and chaffing of the genitals that bother women, nor are men known to have their genital mass surgically reduced to accommodate sporting activities such as cycling and horseback riding.

Suspect Norms

Historian Hera Cook (Chapter 9) explains that norms emerge in response to cultural beliefs about a given, regularly occurring action or state, and that individuals who do not conform are sanctioned. Social norms are not experienced as norms but taken for granted as reality and common sense and are not questioned. Individuals consciously or non-consciously scrutinise themselves (and others) and steer towards alignment with the taken-for-granted reality. Norms are therefore an effective form of social regulation, and not always in negative ways. The kind of social norms being interrogated here are the appearance norms that contribute to genital shame and that which are steering some women and girls towards FGCS.

In a classical series of social psychology experiments, researchers demonstrated how appearance norms operate in social contexts [19]. The research participants were randomly assigned to one of three conditions. They were asked to imagine having an allergy, epilepsy or a physical scar. They then interacted with a conversational partner who they believed to be aware of the condition but was in fact unaware of any of the three experimental conditions. The researchers demonstrated that people who believed that they had a visible defect were more sensitive about the conversational partner's behaviour and were more likely to interpret behaviours such as staring as reactions to the assumed physical defect. They also expressed less favourable impressions of the conversational partner thought to be having the reactions.

Few people can escape the pressure of appearance norms, but surveys consistently show that the majority of women are dissatisfied with or distressed by aspects of their physical appearance, so much so that body dissatisfaction and distress are synonymous with being female [20]. Furthermore, the majority of cosmetic operations are performed on women [6].

In the foregoing example, Madison's sense of threat comes from three *facts*: (1) women have flat vulvas; (2) her vulva is not flat enough; and (3) she will be shamed and humiliated if found out. Madison avoids exposure by withdrawing from certain activities until her sense of threat is removed. If she goes ahead with the beach holiday as planned, Madison is, according to the aforementioned psychological research, likely to feel self-conscious and interpret people's behaviours as intrusive. She is likely to think that her genitals have given rise to the unwelcome attention. She may disengage from social interaction. Convinced by her interpretation of the situation, she is not reassured by her friends' alternative explanations. Madison may decide to wear a sarong to the beach to cover up her presumed defect. In this case, her self-judgement is untested. Either way, her norm-based beliefs are maintained.

Gradual changes to sexual experiences and preferences in response to ageing and other life circumstances are not diseases, unless people choose to view them as such. In Kate's (sub)culture, a reduced capacity for orgasm in men contradicts the social norm of undiminished lustful urges in men. To Kate, her observation of the changes in her then

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husband needs explaining. As an older woman, 'vaginal laxity', not a recognisable condition, medical or otherwise, is culturally available as an explanation. Kate may be sexually experienced enough to know that enjoyable sex does not require a perfect body. She may remember the days when she and her then husband enjoyed coitus not long after she had given birth, so that 'vaginal laxity' is not a logical explanation. Kate may also remember that their relationship was not going well and that this was affecting their overall pattern of physical affection, not just their sexual experiences. Nevertheless, 'vaginal tightening' somehow sounds like a credible solution for something, albeit Kate has not quite thought through what kind of difference the intervention would make to her life and how. Kate may go ahead and benefit from the intervention. Alternatively, she may notice no difference after a while and regret wasting the money. It is also possible that Kate is harmed by the procedure to the extent that she never enjoys vaginal sex again. No one may hear of such an outcome, perhaps not even Kate's surgeon, because she may blame herself and just want to forget the entire episode. In the absence of independent research, no one can be sure what happens to the many women who undergo invasive interventions on their genitals.

It would be inaccurate to claim that the denigration of female genitals is caused by FGCS. In their 2001 research report, psychologists Virginia Braun and Sue Wilkinson identified seven persistent negative representations of the vagina [21]. The authors discussed how these representations had become culturally available resources for how the vagina and its functions were thought of, talked about and acted on. As the denigrating ideas become everyday understandings, they are no longer questioned and shut down other ways of thinking and talking about the vagina. Cultural devaluing of ordinary female genitals contributes to the fertile ground for FGCS to flourish.

Medical Framing

Citing advertisements of beauty products in popular magazines that target women, philosopher Luna Dolezal drew attention to the routine use of medical and scientific jargon in marketing [22]. Moisturising creams are said to be 'clinically tested' to be able to 'fight free radicals', having been developed through 'years of groundbreaking DNA research'. Scientific vocabularies are deployed to validate other types of products too. Certain toothpastes are claimed to be preferred by dentists. Food supplements are often said to contain nutrients more 'bioavailable' than those found in food. Advertisements for cleaning compounds may claim a capability for infection control in ordinary households. Product developers understand the cultural currency enjoyed by medicine and science and how to appropriate the vocabulary.

Medical framing of certain bodily attributes as normal and others as abnormal can have powerful effects on how people think and feel about (their) bodies. Words such as hirsutism and gynaecomastia trump the reality of diverse combinations of female-typical and male-typical sex characteristics in human beings and put pressure on people for self-surveillance, self-judgement and self-regulation of appearance and comportment to fit with cultural norms. The naming of bigger labia as 'labial hypertrophy' or 'luscious lips' constructs two realities that shape different actions and reactions. Even so, not all women who seek FGCS are duped into believing that they have a genital defect such as labial hypertrophy. On the contrary, many women know that they have ordinary genitals that are not especially flawed. Some even say explicitly that their desire to have the interventions is shaped by normative pressures. However, such awareness is not always enough to defend against the unrelenting feelings of being not good enough.

Invasive and irrevocable genital surgery can be justified only if the genitals are considered out of range and medical interventions as normalising (Chapters 7 to 9). Normal has to be redefined if more out of range vulvas were to be created to grow the FGCS industry. Historian Sarah Rodriguez (Chapter 4) accounts for how larger labia have become rarer through the changing conversations in medicine. Women used to be sold the dream vulva that was aspired to but known to be a statistical rarity. Today, they are being sold 'the new normal' (Chapter 3). Rhetorical sculpting both precedes and follows surgical sculpting of female genitalia.

The power of framing on medical decision-making was demonstrated experimentally by a group of researchers in Zurich [23]. These researchers were interested in how parents decide to allow cosmetic genital surgery on their children with medically benign genital differences. The researchers asked medical students to imagine that they were parents of a child born with 'ambiguous genitalia' – genitals not obviously female- or male-typical and with elements of both. Participants were randomly assigned

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to one of two scenarios which involved watching a video presenting either medicalised information about ambiguous genitalia by an actor claiming to be a physician or de-medicalised information by the same actor claiming to be a psychologist. Participants were then asked whether or not they would consent to corrective surgery for their imagined child. Research participants in the first scenario were three times more likely as those in the second one to choose surgery for their imagined child. Both groups believed that they had decided independently of any undue influence.

Medical framing sanctions norm-induced genital insecurities and simultaneously claims to resolve them. These transactions operate freely in neoliberal consumerist societies that vilify FGM as violence against girls and women. The rhetorical manoeuvre to separate FGCS from FGM by positioning the former as a cure for psychological distress (and therefore a clinical rather than cultural practice) is flimsy and losing credibility increasingly (Chapter 7). As Clare Chambers aptly observes, although supposedly it is legal to operate on healthy genitals only if proven *necessary* for the person's *mental health*, FGCS providers typically do not refer to mental health in their advertisements or state that they operate only on patients mentally troubled by their genitals (Chapter 8).

Professional Ambivalence

In the United Kingdom in 2012, the silicone breast implant scandal exposed woeful lapses in product quality, aftercare and record keeping [24]. About 300,000 women in 65 countries were believed to have received implants made by a French company, the Poly Implant Prothèse (PIP). The PIP implants were filled with industrial grade silicone rather than medical grade material suitable for use in a human body. The implants were twice as likely to burst and had been associated with toxicity. About 47,000 British women were thought to have had PIP implants. Attention was also drawn to the potential costs incurred by the NHS in dealing with the health problems caused by the implants inserted into women mostly by private practitioners.

Professor Sir Bruce Keogh was asked to chair a committee to review the regulation of cosmetic interventions in the United Kingdom. The report was published in 2013 and drew attention to widespread misleading advertising, inappropriate marketing and unsafe practices [25]. The report was especially critical of the lack of regulation with regards to non-surgical cosmetic interventions, stating that "a person having a non-surgical cosmetic intervention has no more protection and redress than someone buying a ballpoint pen or a toothbrush." The purchasing of FGCS and other cosmetic operations hopefully comes with some protection, although the actual amount of accessible protection is hard to quantify. While UK surgical providers have to be registered with the Care Quality Commission, the lack of clear standards for the provision of cosmetic surgery services means that regulatory bodies are unable to perform effective reviews.

With reference to FGCS, the Keogh Report acknowledged the increased demand in recent years and emphasised the need for providers to have a clear understanding of the legislation on FGM, as well as the importance of managing patient expectations. Like other reports, it alluded to the importance of psychological assessment. The idea of psychological assessment and 'education and counselling' [26] is an interesting one. Although body distress and a decision to have cosmetic surgery are psychological processes, the individual seeking surgery can be said to be accessing *psychology with a scalpel*. This makes actual psychological interventions, the kind provided by people with real psychological expertise, rather redundant. Madison may admit to intense preoccupations that are familiar to psychological practitioners, but she may also insist that the strong emotions will disappear with surgery.

The value of nuanced psychological interventions could be explored (Chapters 12 to 14). However, psychological experts may have to negotiate how their input is positioned, to ensure that they can bring tangible psychological benefits for the women and are not mobilised to salvage respectability for consumerist medicine or, worse still, be an alibi for maverick medicine. When surgery is clearly on offer and there is no decision to be made, psychological input is no more than a rubberstamping exercise for FGCS. This would be unproductive and undermining for both psychologist and client.

A number of opinions from professional bodies express reservations about FGCS, but none of them can claim to have had a significant impact on practice. It is understandably challenging for professional bodies to manage the conflicted interests of their memberships. A few years ago, the Royal College of Obstetricians and Gynaecologists (RCOG) established a new ethics committee under the impeccable stewardship of Dame Suzi

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Leather. It was our privilege to work alongside leading academics and practitioners and highly experienced lay representatives, to serve a distinguished institution and the general public. The committee's first task was to develop an ethical opinion paper on FGCS, a process that took two years from inception to eventual publication in 2013 [27]. The document had to accommodate multiple revisions. According to the eventual published opinion, labiaplasty performed for 'medical or functional reasons' is ethically unproblematic (despite an absence of medical indications), as opposed to the same operations carried out for 'aesthetic reasons'. Despite the dedicated input of a highly able multidisciplinary committee, the opinion has had no discernable impact. UK providers blatantly advertise for 'aesthetic' FGCS and make no mention of medical indications.

The challenge of managing conflicted interests is unlikely to be unique to any one institution. The influence of partisan interests may well have worked their way into all professional documents on FGCS. Professional opinions are not legally binding. A confident and unambiguous message can guide meaningful reflections and encourage practice improvements without prohibiting FGCS. At the same time that the RCOG paper was launched, the British Society for Paediatric and Adolescent Gynaecology (BritSPAG) released a position statement that expressed a much clearer collective view against performing labiaplasty on girls younger than the age of 18 years [28]. It is a duty of public bodies to centralise the interests of women and girls in the context of contentious practices such as FGCS.

In the United Kingdom, as in many other countries, cosmetic surgery is not a medical specialty in its own right. There is no recognised training and accreditation pathway, a fact that may not be known to many consumers, who may believe that their surgeons have undergone extensive training and supervised practice before being allowed to operate on them. The Keogh Report recommended the introduction of proper standards for training and accreditation. The principles and implementation of bioethics should be threaded through any training programme and continuing professional development. Demonstration of diligence in the application of bioethics principles should be a requirement for renewal of registration. Because cosmetic surgery is justified on the grounds of ill-defined psychological distress rather than recognisable diseases, a good working knowledge of relevant psychosocial research and methods should also be a learning outcome.

Barriers to Research

Research that yields replicable and generalisable findings to help women make an informed choice is as badly needed as it is unlikely to happen. In the United Kingdom, cosmetic surgery in the private sector was worth £720 million in 2005. Ten years later, the industry was worth an estimated £3.6 billion [25]. At this level of financial reward, it is difficult to imagine how practitioners could afford to spend time in collaborating on complex research studies. However, there are other obstacles.

Post-FGCS, the consumer's subjective appraisal falls along a spectrum of satisfaction and dissatisfaction. For the satisfied customer, the modified genitalia are no longer 'not me'. The idea is not for her to experience her genitalia as artificially constructed but as an assimilated and naturalised part of her. She is not likely to want to participate in longer-term research and be repeatedly reminded of the surgery. The women who are dissatisfied or not wholly satisfied are unlikely to re-engage with their surgeons for additional reasons. Many research reports do not specify attrition rates and those that do suggest that many patients are lost to follow-up (Chapter 6). These shortcomings vastly limit the generalisability of any conclusion. Dissatisfied women are the people whom FGCS providers have the most to learn from. Their scarcity in research deprives practitioners of the opportunities to hear about the limitations of what they do, so that they can adjust their claims and manage their own and their clients' expectations more effectively.

FGCS represents a loose assemblage of controversial procedures that are continually being added to and rebranded to attract new customers, so that any negative research findings can be said to be out of date. That is, providers can argue that techniques have changed and that the problems identified are no longer relevant. These conditions justify the classification of some FGCS procedures as experimental. The design of future research and data handling should therefore involve researchers who operate independently of the service providers and proprietors. If techniques keep

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changing and the evidence cannot catch up, it is imperative for women and girls like Madison, Kate and Nevaeh to know about the experimental nature of the procedures and make an informed choice.

Limiting Damage

The rise in the number of websites offering FGCS is being shadowed by a rise in the number of websites advertising repeat operations to overcome the problems of *botched labiaplasty* [29], referred to by some providers as "avoidable unintentional female genital mutilation" [30]. The same providers who offer repeat operations also provide primary labiaplasty [29]. All of the services imply that it is providers other than themselves who *botch* women's labia, exhibiting a pattern of self-serving ignorance. A review of the content of the advertisements has identified a lamentable lack of quality information on safety and effectiveness. The same women whose expectations are not met by their primary surgery are now being targeted for more of the same, with no more assurance than verbal claims. For women who undergo repeat genital operations, it is debatable how much more protection and redress they can readily access, compared to those available when buying a ballpoint pen or a toothbrush.

There is no question that FGCS providers need to be made much more accountable. The question is how. High-quality research may never be possible in the field, and the need for research should no longer be deployed to stall the implementation of much more rigorous regulatory measures. Therefore, submission of clinical data to a system designed by an independent, multidisciplinary research group should become mandatory. The findings should be freely accessible to the public. These activities should be funded by the profit-making services.

As well as training in bioethics for providers, a much tighter decision-making protocol for patients should be formulated nationally, to ensure consistency in implementation. Informed consent is an ethical imperative that transcends legal requirements. The principles are outlined by the General Medical Council, which recommends a two-stage process [31]. The period of reflection between stages gives patients the opportunity to consider the full implications of surgery. There can, however, be a gulf between ethical principles and ethical behaviours in this service context and perhaps cosmetic surgery more generally [32]. The decision to undergo FGCS is to a greater or less extent driven by emotions. The more emotive the situation, the more likely are consumers to selectively attend to the desired outcome and minimise the risks or filter out the potential for disappointment. The chance of a mismatch in understanding between provider and recipient is high. A rigorous protocol should elaborate on risk information and include a discussion of potential problems that have not been properly investigated. If during the consultation the patient is presented with the perfect 'after' images, she should also be shown the imperfect ones. The provider should offer a genuine space for women to discuss no surgery as a valid option, at least for the time being. The woman should be able to repeat back to the provider the risks, benefits and limitations discussed, to ensure that the information is processed. Further questions should of course always be encouraged. However, many women may not know what questions to ask, so that the onus is on the provider to ensure that all the bases are covered [32].

The FGCS industry exists at women's expense, physically, emotionally and financially. By definition it can grow only with more women feeling worse about their genitals. The more FGCS is normalised, the greater the industry's capacity to harm women and girls. Structural changes to the genitals do not materialise by magic, however strong the desire. Sensitive flesh without disease is subjected to invasive cutting and manipulating with unknown long-term effects. Given the law on FGM in many countries, legal changes are required to address the inconsistencies in genital cutting (Chapter 7). However, the relevant public bodies should not wait passively for these changes. Rather, they should take seriously the concerns raised by women's health advocates and campaigners about the social harm of FGCS (Chapter 10) and act decisively to limit the potential for harm. They could (1) introduce an ethically and psychosocially informed process of accountability that is mandatory for all registered providers; (2) stipulate strict advertising standards; (3) debunk rather than submit to the myths of choice and self-improvement in policy and guidance documents; and (4) facilitate critical conversations between relevant academic and professional disciplines, and make these conversations accessible to lay audiences. These are the least changes that women and girls like Madison, Kate and Nevaeh should be able to count on.

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