

Female Genital Cosmetic Surgery: Legitimate Refinement or Illegal Mutilation ?

Ruth Gaffney-Rhys, University of South Wales

Abstract

The aim of this article is to assess whether Female Genital Cosmetic Surgery (FGCS), which refers to procedures which change the structure and appearance of healthy female genitalia for non-medical reasons, violates the Female Genital Mutilation Act 2003, in the light of CPS guidance issued in 2019 and literature regarding the motivations of women seeking FGCS and its effectiveness. The paper concludes that FGCS *does*, prima facie, constitute FGM and argues that the medical exception contained in the legislation should seldom be available - but based on CPS guidance, a criminal prosecution will rarely be in the public interest. The article ends by asserting that the distinction drawn in practice (if not in law) between the treatment of western and non-western women is problematic, not only because it is discriminatory, but because tolerating FGCS may serve to legitimise FGM and result in the circumvention of the FGM Act 2003.

Keywords - Genital Cosmetic Surgery, FGCS, FGM, Law, England and Wales

1. Introduction

Female Genital Cosmetic Surgery (FGCS) or Aesthetic Genital Surgery refers to ‘non-medically indicated cosmetic surgery which change the structure and appearance of the healthy external genitalia of women, or internally in the case of vaginal tightening.’¹ Such procedures are becoming more common: indeed, the International Society for Aesthetic Plastic Surgeons has reported that labiaplasty (or labial reduction) is the world’s fastest growing form of cosmetic surgery.² The popularity of female genital cosmetic surgery ‘has triggered a flurry of academic engagement in the topic’, both medical and non-medical.³ Some of this literature has explored the overlap between female genital cosmetic surgery and female genital mutilation (FGM), which is unsurprising given that the World Health Organisation’s definition of FGM is ‘the partial or total removal of external female genitalia or other injury to the female genital organs for non-medical reasons.’⁴ FGM is a criminal offence in England, Wales and Northern Ireland under the Female Genital Mutilation Act 2003: the legality of female genital cosmetic surgery can therefore be questioned.⁵ Most literature on this subject pre-dates the Crown Prosecution Service (CPS) guidance on female genital mutilation, which was published in October 2019 and specifically considers the

¹ Royal College of Obstetricians and Gynaecologists, 2013, ‘Ethical Opinion Paper. Ethical considerations in relation to female genital cosmetic surgery’ <https://www.rcog.org.uk/globalassets/documents/guidelines/ethics-issues-and-resources/rcog-fgcs-ethical-opinion-paper.pdf> retrieved 20 September 2020

² International Society of Aesthetic Plastic Surgeons, 2018, ‘Worldwide Cosmetic Surgery Trends to Watch for in 2018 !’ www.isaps.org/blog/worldwide-cosmetic-surgery-trends-watch-2018/ retrieved 20 September 2020

³ H. Mowat, K. McDonald, A. Shields Dobson, J. Fisher and M. Kirkman ‘The contribution of online content to the promotion and normalisation of female genital cosmetic surgery: a systematic review of the literature’ *BMC Women’s Health* 15 (2015) 110-120 p.112

⁴ World Health Organisation (2020) ‘Female Genital Mutilation’ <https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation> retrieved 20 September 2020

⁵ In Scotland the Prohibition of Female Genital Mutilation (Scotland) Act 2005 applies

application of the FGM Act 2003 to cosmetic surgery: the matter therefore needs to be reconsidered.⁶

The aim of this paper is to assess whether FGCS violates the Female Genital Mutilation Act 2003, in the light of CPS guidance and literature regarding the motivations of women seeking FGCS and its effectiveness. The article begins by identifying some of the different forms of cosmetic surgery and the reasons why women request such procedures. It then examines the provisions of the Female Genital Mutilation Act 2003, with reference to the CPS guidance and relevant literature, to assess whether FGCS can constitute FGM and if so, in what circumstances will the CPS prosecute a practitioner who performs it. The paper ends by evaluating the consequences of treating FGCS and FGM in a different manner.

2. Background

As explained above, female genital cosmetic surgery refers to procedures which change the structure and appearance of healthy female genitalia for non-medical reasons. It can take many forms, but according to the British Association of Aesthetic Plastic Surgeons, the procedures that are most commonly requested are labiaplasty i.e. the reduction of the labia and vaginoplasty or vaginal tightening.⁷ Other procedures designed to ‘give a more youthful appearance’ include liposuction, fat injections and laser therapy to remove wrinkles, whilst hoodectomy, the reduction or removal of skin around the clitoris is undertaken to increase clitoral sensitivity.⁸ In contrast, hymenoplasty reconstructs the hymen to ensure that the woman bleeds when she next has intercourse. It is sought for customary reasons by women who live in communities where loss of virginity prior to marriage can have serious consequences.⁹

Research relating to female genital cosmetic surgery considers a variety of issues such as: the risks associated with FGCS,¹⁰ how clinicians should respond to requests for FGCS¹¹ and how to act in a woman’s best interest,¹² but for the purpose of this paper, the most pertinent literature examines the motivations of women requesting genital surgery. Zwier categorises the reasons why women seek FGCS into two broad groups: functional, which includes physical discomfort experienced in sexual relationships and during exercise, and emotional, which covers feelings with a ‘social focus’ and those with a ‘sexual focus’.¹³ Veale et al cite

⁶ Crown Prosecution Service (2019) ‘Female Genital Mutilation Prosecution Guidance’ <https://www.cps.gov.uk/legal-guidance/female-genital-mutilation-prosecution-guidance> retrieved 20 September 2020

⁷ British Association of Aesthetic Plastic Surgeons (2017) ‘Aesthetic Genital Surgery Information Leaflet’ https://baaps.org.uk/patients/procedures/18/aesthetic_genital_surgery retrieved 20 September 2020

⁸ Ibid

⁹ L. Michala, L.M. Liao and S. Creighton ‘Female genital cosmetic surgery: how can clinicians act in women’s best interests?’ *The Obstetrician & Gynaecologist* 14 (2012) 203-206 at 203

¹⁰ D. Muraria, D.J. Jackowe, A.A. Parsa, F.D. Parsa ‘Comparison of wedge versus straight-line reduction labiaplasty’. *Plast Reconstr Surg* 125 (2010) 1046–1047

¹¹ L.M. Liao and S. Creighton ‘Requests for cosmetic genitoplasty: how should healthcare providers respond?’ *BMJ* 334 (2007) 1090-1092

¹² Supra 9

¹³ S. Zwier “‘What Motivates Her’: Motivations for Considering Labial reduction Surgery as Recounted on Women’s Online Communities and Surgeon’s Websites’ *Sexual Medicine* 2 (2014) 16-23.

the same motivations but place them into three categories: functional, sexual and cosmetic.¹⁴ Both studies centred on women seeking labiaplasty – the most common type of procedure – but the findings could apply to other forms of genital surgery, with the exception of hymenoplasty which is performed for cultural reasons.¹⁵ In Zwier’s study, 42.5% of respondents cited emotional motivations only, 16.3% only mentioned functional issues and 41.2% cited a combination of both.¹⁶ In total, 57.5% of participants mentioned functional reasons (either with or without emotional reasons): such procedures may not therefore be considered ‘cosmetic’ or ‘purely cosmetic’, but the Royal College of Obstetricians and Gynaecologists (RCOG) indicates that ‘there are no data on the efficacy of treatment for functional problems’ such as discomfort while exercising.¹⁷ 83.6% of respondents in Zwier’s study cited emotional motivations for requesting labiaplasty, which included fear of rejection by a sexual partner. Braun argues that a woman’s concern is ‘as much – sometimes more – about how another person will perceive and judge the genitalia, than about how the individual herself feels’.¹⁸ She suggests that the fear of rejection often ‘relates to an imagined sexual partner’ and that a partner’s preference is often ‘assumed or imagined’.¹⁹ The most common reason cited by participants in Zwier’s study was ‘feelings of emotional discomfort regarding the appearance of their labia’,²⁰ despite the fact that there is evidence that women’s genitalia is extremely diverse.²¹ Research conducted by Crouch et al,²² and Lloyd²³ found that women requesting labiaplasty usually fall within normal limits. In fact, *all* the women in Veale’s study had labia that measured in the normal range.²⁴ The reasons why women feel embarrassed about their genitalia or fear rejection by a sexual partner due to their appearance, if they do not suffer from an abnormality, therefore needs to be explored. The Royal College of Obstetricians and Gynaecologists has indicated that some women seeking genital surgery may be suffering from body dysmorphic disorder,²⁵ which is defined by the NHS as a ‘mental health condition where a person spends a lot of time worrying about flaws in their appearance. These flaws are often unnoticeable to others’.²⁶ Research has demonstrated a link between body distress and requests for cosmetic surgery²⁷ and although it is unclear how many women requesting FGCS suffer from body dysmorphic disorder, Veale et al found that 10 of the 55 women seeking labiaplasty, who participated in their study, met the diagnostic

¹⁴ D. Veale, N. Ellison, A. Costa, D. Robinson, A. Kavouni and L Cardozo. ‘Psychological characteristics and motivation of women seeking labiaplasty’ *Psychol Med* 44(3) 555-566

¹⁵ Supra 13 p.20

¹⁶ Ibid

¹⁷ Supra 1 para 5

¹⁸ V. Braun ‘Selling a perfect vulva’ in S. Creighton and L.M. Liao (eds) *Female Genital Cosmetic Surgery: Solution to what problem ?* (Cambridge, Cambridge University Press, 2019) p.24

¹⁹ Ibid pp.24-26

²⁰ Supra 13 p.20

²¹ J. Lloyd, N.S. Crouch, C.L. Minto, L.M. Liao and S. Creighton ‘Female genital appearance: “normality” unfolds’ *BJOG: An international Journal of Obstetrics and Gynaecology* 112 (2005) 643-646

²² N.S. Crouch, R. Deans, L. Michala, L.M. Liao and S.M. Creighton SM (2011) Clinical characteristics of well women seeking labial reduction surgery: a prospective study. *BJOG: An international Journal of Obstetrics and Gynaecology* 118 (2011) 1507-1510

²³ Supra 21

²⁴ Supra 14

²⁵ Supra 1 para 3

²⁶ NHS ‘Body Dysmorphia’ <https://www.nhs.uk/conditions/body-dysmorphia/> retrieved 20 September 2020

²⁷ T. Von Soest, I.L. Kvalem, H.E. Roald and K.C. Skolleboerg ‘The effects of cosmetic surgery on body image, self esteem and psychological problems’ *Journal of Plastic Reconstructive Aesthetic Surgery* 62 (2009) 1238-44

criteria for this condition.²⁸ In addition, research conducted amongst general practitioners in Australia indicated that more than half who had seen a patient requesting FGCS suspected that the patient suffered domestic abuse, a psychological problem, depression or body dysmorphic disorder.²⁹ The NHS website states that treatment for body dysmorphic disorder includes: cognitive behavioural therapy, anti-depressants and referral to support groups: it does not refer to cosmetic surgery as a form of therapy. Similarly, RCOG guidance provides that body dysmorphic disorder ‘requires appropriate psychotherapy’³⁰ and thus encourages clinicians to discuss alternatives to surgery, such as counselling.³¹ Moreover, Michala et al assert that most plastic surgeons and gynaecologists ‘are unlikely to understand the complexity of body distress’ and ‘unlikely to have the skills for carrying out a psychological assessment’ which suggests that surgery may be performed on women who require specialist psychological interventions.³² They further state that, in such cases, surgery may actually be ‘harmful to a woman’s long-term wellbeing’.³³

Those who do not suffer from body dysmorphic disorder and seek FGCS for emotional reasons, do so due to the availability of images of naked women, which, according to the British Association of Aesthetic Plastic Surgeons, makes them feel ‘that they compare unfavourably’.³⁴ This is because the portrayal of female genitalia does not reflect the diversity that actually exists. For example, Bramwell’s study demonstrates that the vast majority of women’s magazines depict the female pubic area as flat and smooth.³⁵ Similarly, Schick et al’s research relating to Playboy magazine, found the portrayal of female genitalia to be uniform, with little colour variation.³⁶ It now seems that the availability and homogeneity of online images causes feelings of inferiority amongst women, which is particularly problematic given that the ‘so-called norms’ that women are presented with ‘are often digitally modified’.³⁷ According to Boddy, the common practice of genital depilation is contributing to the problem, as it makes ‘visible physical structures that were previously covered up’.³⁸ Research in relation to the impact of online material has grown and in 2015, Mowat et al conducted a systematic review of the literature on ‘the contribution of online content to the promotion and normalisation’ of FGCS based on research from the UK, Nigeria, the Netherlands, Australia and the US.³⁹ One of the key themes that emerged from the literature is the pathologisation of genital diversity in cyberspace. According to the authors, all studies examined in the literature review found that ‘vulval diversity is

²⁸ Supra 14

²⁹ M. Simonis, R. Manocha and J.J. Ong ‘Female genital cosmetic surgery: a cross-sectional survey exploring knowledge, attitude and practice of general practitioners’ *British medical Journal* 6(9) (2016) 1-9

³⁰ Supra 1 para 3

³¹ Supra 1 para 6

³² Supra 9 p.204-205

³³ Supra 9 p.205

³⁴ Supra 7

³⁵ R. Bramwell ‘Invisible labia: The representation of female external genitals in women’s magazines’ *Sexual Relation Therapy* 17(2) (2002) 187-190

³⁶ V.R. Schick, B.N. Rima and S.K. Calabrese ‘Evulvulation: the portrayal of women’s external genitalia and physique across time and the current Barbie doll ideals’ *J Sex Res* 48(1) (2010) 74-81

³⁷ Supra 1 p.7

³⁸ J. Boddy, ‘The normal and the aberrant in female genital cutting – shifting paradigms’ *Journal of Ethnographic Theory* 6(2) (2016) 41-69, p.43

³⁹ Supra 3. See also C.A. Ashong and H.E. Batta ‘Sensationalising the female pudenda: An examination of public communication of aesthetic genital surgery’ *Global Journal of Health Science* 5(2) (2013) 153-165

pathologised' or regarded as abnormal, whilst 'a homogenised "clean slit" vulva' is promoted as 'ideal and desirable'.⁴⁰ They also report that FGCS providers utilise medical terminology such as 'labial hypertrophy' to problematize normal physical characteristics and depict 'the female body as degenerative' due to childbirth and ageing: it is thus 'improvable through surgery'.⁴¹ Skoda et al consequently argue that the 'cultural devaluing of ordinary female genitals contributes to the fertile ground for FGCS to flourish' and that 'there is a need for education to encourage more positive and accurate views of women's bodies'.⁴² Mowat's literature review also highlighted that female genital appearance is cited by providers of FGCS as important for emotional wellbeing and websites promote FGCS as a solution to an emotional problem.⁴³ As explained above, some women seeking FGCS may suffer from psychological problems and there is concern that surgery could actually be detrimental to their wellbeing. FGCS is also portrayed on websites as 'safe, easy and effective',⁴⁴ which has been questioned by medical practitioners and professional bodies. The Royal College of Obstetricians and Gynaecologists has criticised 'the presentation of female genital cosmetic surgery (FGCS) as an unproblematic lifestyle choice'⁴⁵ and, as explained earlier, has queried the efficacy of genital surgery for functional problems such as discomfort while exercising.⁴⁶ It also points to the lack of research on the risks associated with labiaplasty,⁴⁷ whilst Michala et al dispute the use of genital surgery to improve sexual satisfaction.⁴⁸ Providers may, therefore, be making unsubstantiated claims. The concerns raised by medical professionals regarding the safety and efficacy of the procedures and the motivations of women requesting genital cosmetic surgery and are pertinent to the legality of FGCS, which will be discussed in the next section of the paper.

3. The Law

As indicated above, FGCS seems to fall within the scope of the definition of FGM provided by the World Health Organisation. In fact, Kelly and Foster argue 'that there is little to distinguish FGM from many or most of the procedures involved in FGCS'.⁴⁹ The WHO classifies female genital mutilation into four categories.⁵⁰ Type I is clitoridectomy, which comprises the total or partial removal of the clitoris and/or its prepuce: hoodectomy would thus constitute type I FGM. Type II, or excision, involves the total or partial removal of the clitoris and labia minora, with or without the excision of the labia majora – within this broad

⁴⁰ Supra 3 p.115

⁴¹ Supra 3 p.117

⁴² K. Skoda, F.E. Oswald, L. Shorter and C.L. Pedersen, CL. 'Perceptions of Female Genitalia' *The Journal of Sex Research* (2020) p5

⁴³ Supra 3 p.116

⁴⁴ Supra 3 p.117

⁴⁵ Supra 1 para 1

⁴⁶ Supra 1 p.3

⁴⁷ Supra 1 para 5(1)

⁴⁸ Supra 9 p.204

⁴⁹ B. Kelly and C. Foster 'Should female genital cosmetic surgery and genital piercing be regarded ethically and legally as female genital mutilation?' *International Journal of Obstetricians* (2012) 389-392. p.390

⁵⁰ United Nations (2008) 'Eliminating FGM – An Interagency statement' https://www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf retrieved 20 September 2020

category are sub-categories e.g. Type IIa is the removal of the labia minora only.⁵¹ Labiaplasty aims to decrease the size of the labia minora and is therefore comparable to type IIa FGM. Vaginoplasty and hymen reconstruction can also involve some excision of labial tissue. Michala et al thus argue that ‘most FGCS procedures compare anatomically with type I or II female genital mutilation with regard to the amount of tissue removed’.⁵² Johnsdotter and Essen agree that if the context within which FGCS and FGM are performed are disregarded and one focuses on ‘what in the anatomy is removed’, FGCS and FGM ‘are indeed comparable’.⁵³ Infibulation is type III and consists of the narrowing of the vaginal opening by creating a covering seal, which is formed by the cutting and repositioning of the labia, sometimes in addition to type I. Vaginoplasty also involves the narrowing of the vagina, but not the other aspects of infibulation e.g. the creation of a covering seal. Finally, type IV covers other harmful practices such as piercing, scraping and cauterising and could potentially include fat injections, laser treatment and any other procedure that is not covered by types I-III.⁵⁴ The CPS is keen to point out that the WHO classifications have not been incorporated into domestic legislation, although prosecutors should be aware of them as they may be utilised by experts and investigators.⁵⁵

The relevant legislation in England, Wales and Northern Ireland is the Female Genital Mutilation Act 2003,⁵⁶ which replaced the Prohibition of Female Circumcision Act 1985.⁵⁷ Section 1(1) provides that ‘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, labia minora or clitoris’. The offence is punishable by up to fourteen years in prison, which emphasises its severity.⁵⁸ Labiaplasty, vaginoplasty and hoodectomy involve the excision of part of the labia or clitoris and are therefore prima facie, unlawful. The CPS guidance issued in 2019 confirms this to be the case, declaring that all forms of FGCS are ‘likely to be caught by the definition provided for by the 2003 Act’.⁵⁹ In such cases prosecutors are directed to ‘proceed to consider whether the medical exceptions provided for by the 2003 Act apply’, as discussed below. However, non-surgical procedures, such as laser therapy or fat injections do not involve excision (or infibulation) and although they fall within the scope of type IV FGM, they will only violate the FGM Act 2003 if the procedure constitutes mutilation. In *Re B and G (Children)(No 2)*, which concerned FGM in the context of care proceedings, Sir James Munby (President of the Family Division of the High Court) indicated that types I, II and III FGM constitute a criminal offence in England and Wales, but type IV ‘comes within the ambit of the criminal law only if involves “mutilation”’.⁶⁰ As there is no definition of ‘to mutilate’ within the statute, Munby referred to the Oxford English Dictionary, which defines it as ‘to deprive (a person or animal) of the use of a limb or bodily organ, by dismemberment or otherwise; to cut off or destroy (a limb or organ); to wound severely, inflict violent or disfiguring injury

⁵¹ Ibid p.30

⁵² Supra 9 p.205

⁵³ S. Johnsdotter and B. Essen ‘Genitals and ethnicity: the politics of genital modifications’ *Reproductive Health Matters* 18(35) (2010) 29-37. P.32

⁵⁴ Supra 50

⁵⁵ Supra 6

⁵⁶ Subsequently FGM Act 2003.

⁵⁷ The Prohibition of Female Genital Mutilation (Scotland) Act 2005 applies in Scotland

⁵⁸ Section 5 Female Genital Mutilation Act 2003

⁵⁹ Supra 6

⁶⁰ *Re B and G (Children)(No.2)* [2015] EWFC 3, para 11

on.⁶¹ Consequently, non-surgical genital procedures will only be regarded as FGM if they result in an injury. Based on the Code for Crown Prosecutors, the CPS will need to consider whether, in the light of the evidence, there is a 'realistic prospect of conviction'.⁶² If there is sufficient evidence, the prosecutor will then determine whether it is in the public interest to prosecute.⁶³ In cases of FGM that do not involve piercings or cosmetic surgery, the CPS has stated that 'it is highly likely to be in the public interest to prosecute', although each case needs to be reviewed on its merits.⁶⁴ The CPS goes on to declare that 'particular consideration arise in relation to piercings and cosmetic surgery' with the severity of the injury being one of them.⁶⁵ The CPS guidance lists (inter alia) the following as factors tending support prosecution: relatively severe and invasive procedure, significant physical/mental harm caused to the victim, real risk of future harm and real impact on the victim's quality of life'.⁶⁶ Conversely non-severe, non-invasive procedures, limited harm to the victim, negligible risk of future harm and negligible impact on the victim's quality of life are some of the factors that suggest that a prosecution is not in the public interest. This does not mean that the severity of the procedure is irrelevant in cases of FGM performed for cultural reasons, as the seriousness of the offence and the harm caused to the victim are two of the issues considered by the CPS when applying the general public interest test under the Code for Crown Prosecutors.⁶⁷ Other factors include: the circumstances of the victim, the culpability of the suspect, the suspect's age and maturity and the impact on the community.⁶⁸ According to the CPS a 'prosecution will usually take place unless the prosecutor is satisfied that there are public interest factors tending against prosecution which outweigh those tending in favour'.⁶⁹

3.1 Age

Although section 1(1) of the Female Genital Mutilation Act 2003 refers to a 'girl', section 6(1) makes it clear that the word *girl* includes *woman*: the legislation thus covers procedures performed on adult females as well as children. The fact that FGCS is normally performed on adults, whereas FGM is 'mostly carried out on young girls between infancy and age 15' does not therefore signify that FGCS is lawful.⁷⁰ However, the age of the female concerned will influence the decision of the CPS. The CPS guidance states that if a patient is under the age of eighteen 'a prosecution is highly likely to be in the public interest' (assuming that there is sufficient evidence that the offence has been committed).⁷¹ This is consistent with advice provided by the Royal College of Obstetricians and Gynaecologists⁷² and the British Society

⁶¹ Ibid para 12

⁶² Code for Crown Prosecutors (2018) <https://www.cps.gov.uk/publication/code-crown-prosecutors> para 4.6-4.8 retrieved 20 September 2020

⁶³ Ibid para 4.9-4.14

⁶⁴ Supra 6

⁶⁵ Ibid

⁶⁶ Ibid

⁶⁷ Supra 62 para 4.14

⁶⁸ Ibid

⁶⁹ Supra 6

⁷⁰ Supra 4

⁷¹ Supra 6

⁷² Supra 1 para 7

for Paediatric and Adolescent Gynaecology⁷³ both of which state that FGCS should not be performed on girls under the age of 18, as their development may not be complete. In cases involving FGCS performed on adult females, the CPS will consider other factors including: whether the victim supports a prosecution; whether there were any medical benefits; whether performance of the procedure was competent; whether the suspect was qualified and followed relevant guidelines; whether there is documented evidence of the victim's capacity to consent; whether the victim gave full and informed consent; whether there is documented evidence that the suspect made proper professional enquiry of the victim and discussed alternative treatments; whether there is evidence of marketing to women and whether the marketing contained inaccurate claims, in addition to the factors mentioned above regarding harm to the victim. These factors will be considered in the subsequent discussion.

3.2 The Medical Exception

No offence is committed by an approved person (i.e. a relevant medical professional), who performs a surgical operation on a girl or woman: 'which is necessary for her physical or mental health' or 'who is in any stage of labour, or has just given birth, for purposes connected with the labour or birth'.⁷⁴ According to the CPS, if there is some evidence that the procedure is medically required the defence may apply 'notwithstanding that the surgery has a cosmetic element'.⁷⁵ The CPS guidance indicates that the existence of a medical benefit is one of the factors tending against prosecution, while the performance of a procedure that provides no medical benefits is a factor tending in favour of prosecution. The NHS may fund labiaplasty 'where the labia are directly contributing to recurrent disease or infection or where repair of the labia is required after trauma'.⁷⁶ In such cases, the surgery is medically required, but may also improve the appearance of the genitals: the medical exception would therefore be available. Hussain and Rymer emphasise that it is important for clinicians to record the reason why genital surgery is carried out.⁷⁷ If they do not, it will be more difficult to assert the medical exception. Indeed, the existence of documented evidence that the clinician made proper professional enquiry of the victim is a factor tending against a criminal prosecution.⁷⁸ But if the practitioner did not do so, or if inaccurate claims were made in marketing materials regarding the efficacy of genital procedures to resolve functional problems, a prosecutor may consider it to be in the public interest to initiate criminal proceedings.⁷⁹

A procedure is also legitimate if it is necessary for the mental health of the woman concerned, which suggests that female genital cosmetic surgery *may be* legitimate, but *only* if

⁷³ British Society for Paediatric and Adolescent Gynaecology (2013) 'Position Statement – Labial reduction surgery (labiaplasty) on adolescents' https://www.rcog.org.uk/globalassets/documents/news/britspag_labiaplastypositionstatement.pdf retrieved 20 September 2020

⁷⁴ Section 1(2) Female Genital Mutilation Act 2003

⁷⁵ Supra 6

⁷⁶ NHS England (2013) 'Interim Clinical Commissioning Policy: Labiaplasty, Vaginoplasty and Hymenorrhaphy. Ref: N-SC/023' <https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC023.pdf> p.5 retrieved 20 September 2020

⁷⁷ S. Hussain and J. Rymer 'Tackling female genital mutilation in the UK' *The Obstetrician & Gynaecologist* <http://onlinetog.org>. 19 (2017) 273-278. p.275

⁷⁸ Supra 6

⁷⁹ Supra 6

it is necessary for the woman's mental health.⁸⁰ This seems to be confirmed by the explanatory notes that accompany the Act, which indicate that 'operations necessary for mental health could include, for example, cosmetic surgery resulting from the distress caused by a perception of abnormality'.⁸¹ However, the explanatory notes do not form part of the legislation and are not, therefore, legally binding. Whether FGCS could benefit from the medical exception has thus been the subject of academic debate.⁸² During the Parliamentary debates that preceded the 1985 Act, Lord Hatch stated that:

If a black girl – a girl from a society, African or Asian, where female circumcision is the norm – gets mental depression or psychological depression because she is not allowed to be circumcised in this country, she... has to work her way through that mental depression. If on the other hand, another girl, white or black – but certainly the vast majority, if not all such cases, will be white – gets mental depression because she cannot have a cosmetic operation, she is allowed to have that operation on the ground of mental health.

It did not, therefore, seem to be Parliament's intention to criminalise FGCS in the 1980s. However, the Keogh Report indicated that cosmetic surgery providers should have a clear understanding of the legislation on FGM, suggesting that it is, indeed, applicable,⁸³ and in response to a question posed by the House of Commons Select Committee, the Government stated that the FGM Act does 'not contain any exemption for cosmetic surgery'.⁸⁴ The Select Committee consequently reported that 'the police, midwives and campaigners would all like to see greater clarity on this point'.⁸⁵ The statement issued by the Government has been incorporated into the Multi-agency Statutory Guidance on Female Genital Mutilation published in 2020, which expressly states in bold lettering that '**the 2003 Act contains no special exemption for cosmetic surgery or female genital cosmetic surgery (FGCS)**'.⁸⁶

The use of the word 'necessary' is significant: it stresses that the procedure must not merely be requested or aesthetically desirable, but required as a matter of necessity. The CPS has made it clear that the medical exception 'is unlikely to apply where the surgery is purely to alter the appearance of the genitals'.⁸⁷ Parallels can be drawn between this and the policy of the NHS in terms of funding genital surgery. NHS guidance states that 'labiaplasty is rarely

⁸⁰ Section 1(2) Female Genital Mutilation Act 2003

⁸¹ Explanatory Notes to the Female Genital Mutilation Act 2003 para.6

⁸² K. Hayter 'Female Circumcision – Is there a legal solution?' *Journal of Social Welfare Law*, 6(6)(1984) pp.323-333, R Gaffney-Rhys 'From the Offences Against the Person Act 1857 to the Serious Crime Act 2015: the development of the law relating to female genital mutilation in England and Wales' *Journal of Social Welfare and Family Law*, 39(4) (2017) 417-434 and B Essen and S Johnsdotter 'Female Genital Mutilation in the West: traditional circumcision versus genital cosmetic surgery' *Acta Obstetrica et Gynecologica Scandinavica*, 83 (2004) 611-613

⁸³ Department of Health (2013) 'Review of the Regulation of Cosmetic Interventions'

<https://www.gov.uk/government/publications/review-of-the-regulation-of-cosmetic-interventions> retrieved 20 April 2021

⁸⁴ House of Commons Home Affairs Committee (2015) 'Sixteenth Report. Female Genital Mutilation Follow Up' <https://publications.parliament.uk/pa/cm201415/cmselect/cmhaff/961/96102.htm> Para 12. retrieved 20 April 2021

⁸⁵ Ibid para.14

⁸⁶ HM Government (2020) 'Multi-agency Statutory Guidance on Female Genital Mutilation'

<https://www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation>. p.20. retrieved 20 April 2021

⁸⁷ Supra 6

available on the NHS' because 'it's completely normal to have noticeable skin folds around the opening of your vagina' and 'in most cases, it does not cause any problems'.⁸⁸ In such cases, the procedure is aesthetic and based on the CPS guidance, the medical exception contained in the FGM Act would not apply, *unless* it can be argued that the procedure is necessary for the woman's mental health. As explained earlier, the explanatory notes to the Act suggest that surgery may be lawful if a woman suffers distress caused by a perception of abnormality. If a woman genuinely feels distress, she may suffer from a psychological problem, such as body dysmorphic disorder, however, as previously indicated, the NHS does not advocate cosmetic surgery as a form of therapy. It might therefore be argued that surgery is not 'necessary' under the FGM Act 2003.⁸⁹ However, a patient may refuse appropriate treatment and in such cases, a practitioner might claim that the surgery *is* necessary. Documentary evidence that the practitioner made proper enquiries and discussed alternative treatments are regarded by the CPS as factors tending against prosecution.⁹⁰ If surgery is actually 'harmful to a woman's long-term wellbeing', as Michala et al have suggested,⁹¹ the medical exception should not apply. But this does not mean that a prosecution will take place: as explained earlier, harm caused to the victim, the risk of future harm and the impact on the victim's quality of life will be considered by the CPS when deciding whether to prosecute. It is suggested that the harm, risk of future harm and impact on quality of life would need to be significant.

Genital surgery performed to improve sexual satisfaction could also potentially fall within the scope of the medical exception: one might argue that such a procedure is necessary for the woman's physical *and* mental health. However, as explained earlier, there is a lack of evidence that such procedures are effective. Michala et al state that 'the scientific basis of these procedures is highly suspect: reliable data on risk, effectiveness and patient experience are entirely absent'.⁹² If they are not effective, it is difficult to regard them as 'necessary'. In such cases, a prosecution may be in the public interest because the surgery provided no medical benefit; the inefficacy of the procedure may contribute to psychological harm and impact the woman's quality of life and there may be evidence of misleading advertising. Equally, a criminal prosecution may not be in the public interest because there is little or no actual harm to the woman and she does not support a prosecution.

3.3 Custom and Ritual – Section 1(5)

The application of the medical exception is further restricted by section 1(5) of the Female Genital Mutilation Act 2003, which provides that when 'determining whether an 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'. This provision was included because FGM is a cultural convention concentrated in parts of Africa, the Middle East and Asia and practiced amongst migrants from these areas.⁹³ If the medical exception was applied to those who perform genital procedures for customary reasons, on the basis that females would suffer psychological harm due to lack of acceptance for failing to undergo a

⁸⁸ Supra 76

⁸⁹ Section 1(2) Female Genital Mutilation Act 2003

⁹⁰ Supra 6

⁹¹ Supra 9 p.205

⁹² Supra 9 p.204

⁹³ Supra 4

traditional procedure, the legislation would be entirely ineffective. It can be argued that section 1(5) renders hymenoplasty, a procedure performed on women whose hymen is not intact to ensure that she can bleed the next time she has intercourse, unlawful. However, the surgeon may argue that the procedure *is* required for the woman's mental health, to avoid the stigma attached to a woman who is not a virgin when she marries and because virginity is required as a matter of custom, rather than the procedure itself. Furthermore, unless performance of the procedure is incompetent and causes harm to the woman, it is difficult to envisage the CPS prosecuting such cases. Indeed, they are unlikely to come the attention of the Crown Prosecution Service.

Many writers have pointed to the contextual similarities between FGM and FGCS. For example, Whitcomb argues that FGM and FGCS both derive from social and cultural pressures to conform.⁹⁴ Michala et al agree that both practices are performed 'for cultural reasons' and 'both are based on cultural expectations.'⁹⁵ Clearly, the cultural reasons for FGM and FGCS will sometimes differ, for example, some communities practice FGM because they believe that a woman who has not been cut will have an uncontrollable sexual appetite; that she is unclean and that the clitoris will grow if it is not removed,⁹⁶ whereas FGCS is performed due to the 'cultural preference for small labia'⁹⁷ and sometimes to improve sexual satisfaction. But there are also similarities: adherents of FGM often believe that men do not enjoy sexual intercourse with women who have not been cut and women who request FGCS may share this belief.⁹⁸ In both cases, healthy female genitalia is considered problematic and in need of improvement. Boddy consequently argues that 'the notional gap between "us" and "them" can no longer be sustained.'⁹⁹

Although FGCS, like FGM, appears to be performed due to cultural expectations, it is unclear whether this constitutes a 'custom or ritual' for the purpose of section 1(5) of the Act. Berer thus poses the question 'when does a fashion become part of culture or a custom or ritual?'¹⁰⁰ Even if genital surgery *is* regarded as a custom or ritual, a woman requesting FGCS may not consider the procedure 'to be *required* as a matter of custom or ritual' as specified in section 1(5). Of course, this does not render the procedure lawful, for there are difficulties in establishing that surgery is necessary for a woman's mental health, as discussed above. Equally, it may be difficult to argue that a prosecution is in the public interest.

3.4 Criminal Prosecutions

⁹⁴ M. Whitcomb (2011) 'Bodies of flesh, bodies of knowledge: Representations of Female Genital Cutting and Female Genital Cosmetic Surgery'

https://scholarsarchive.library.albany.edu/cgi/viewcontent.cgi?article=1000&context=honorscollege_wgss retrieved 20 April 2021

⁹⁵ Supra 9 p.205

⁹⁶ R. Gaffney-Rhys 'Female Genital Mutilation: the law in England and Wales viewed from a human rights perspective' *International Journal of Human Rights* 24(4) (2019) 457-482

⁹⁷ L.M. Liao and S. Creighton 'Female genital cosmetic surgery: a new dilemma for GPs' *British Journal of General Practice*. January (2011) 7

⁹⁸ Supra 13

⁹⁹ Supra 38 p61

¹⁰⁰ M. Berer 'Labia reduction for non-therapeutic reasons vs. female genital mutilation: contradictions in law and practice in Britain' *Reproductive Health Matters* 18(35) (2010) 106-110 p108

There have been no prosecutions under the Female Genital Mutilation Act 2003 (or the 1985 Act) for performing female genital cosmetic surgery, even in cases where the patient was dissatisfied with the results and lodged a complaint. In 2014 the *British Medical Journal* reported a case referred to the General Medical Council, of a GP (Dr Sureshkumar Pandya) who performed a labiaplasty on a patient and almost entirely removed her labia minora.¹⁰¹ This, according to the GMC, constituted ‘a serious clinical failure’ but despite this, Dr Pandya was cleared by the GMC and did not face prosecution by the CPS.¹⁰² It can be argued that the CPS guidance issued in 2019 marked a (small) change of attitude towards FGCS and it is expected that the CPS would now prosecute a case such as this. Based on the guidance, the procedure was relatively severe; provided no medical benefits; caused significant physical and mental harm to the victim; the GP was not qualified to undertake the procedure, performance was incompetent and guidelines were not followed: it would therefore be difficult to argue that it is not in the public interest to prosecute in such circumstances. In contrast, the CPS *did* prosecute Dr Dhanuson Dharmasena (a junior registrar in obstetrics and gynaecology), for stitching a woman (who had previously undergone type III FGM in Somalia) to stop her bleeding during child birth, as this constituted re-infibulation.¹⁰³ Dr Dharmasena was acquitted and many, including Professor Sarah Creighton, argued that the prosecution should not have been initiated, as the suturing took place to save the life of the woman concerned, during an emergency delivery and Dr Dharmasena had never been trained to deal with a woman who had previously undergone type III FGM.¹⁰⁴ The Director of Public Prosecutions, Alison Saunders, defended the decision to prosecute, asserting that ‘there was both a realistic prospect of conviction and ... it was in the public interest to prosecute’ confirming that evidence ‘was carefully reviewed at every stage’ of the case.¹⁰⁵ She indicated that as the Code Tests were fully satisfied, it was ‘the duty of the CPS to authorise prosecution. We are not entitled to wait for a case in which the evidence is stronger... nor could we wait until a “classic” case was submitted’.¹⁰⁶

These examples suggest differing attitudes towards FGCS and traditional forms of FGM. Although it is asserted that the CPS would now prosecute a case like that of Dr Pandya, its guidance implies that FGCS performed on a consenting adult will rarely result in criminal proceedings, even if the medical exception is arguably inapplicable. A prosecution will not be in the public interest if: the woman does not support it; there is documented evidence that the clinician made proper enquiry of the woman and explained the risks to her; she provided full, free and informed consent; the procedure was performed competently, in accordance with relevant guidelines; the procedure caused little or no physical or mental harm and there is no evidence of misleading advertising. Indeed, it is unlikely that surgery performed in such circumstances would be brought to the attention of the CPS. It is not, therefore, surprising, that female genital cosmetic surgery is commonly regarded as lawful. For example, Shahvisi

¹⁰¹ C. Dyer ‘London GP is cleared of practising female genital mutilation’ *British Medical Journal* (2014) 348

¹⁰² Ibid

¹⁰³ Sandra Laville ‘Dr found not guilty of FGM on patient at London hospital’ *The Guardian* 4 February 2015. <https://www.theguardian.com/society/2015/feb/04/doctor-not-guilty-fgm-dhanuson-dharmasena>

¹⁰⁴ Ibid

¹⁰⁵ UK Parliament (2015) ‘Female Genital Mutilation: Follow-up – Home Affairs – Prosecuting FGM’ <https://publications.parliament.uk/pa/cm201415/cmselect/cmhaff/961/96105.htm> retrieved 25 April 2021

¹⁰⁶ Ibid

and Earp state that FGCS is ‘treated as legal’¹⁰⁷ whilst Essen and Johnsdotter suggest that ‘genital alterations in non-African women seem to be widely accepted.’¹⁰⁸ They argue that a ‘double standard of morality’ is in operation in many western jurisdictions as migrants from Africa are ‘tacitly accused of being trapped in primitive culture.’¹⁰⁹ Iribarne and Seuffert thus refer to the ‘mutilated brown female’ who requires the protection of the law and the ‘privileged white woman’ who can choose to under genital cosmetic surgery.¹¹⁰ Shahvisi agrees that treating FGCS and FGM differently ‘is hypocritical’ and ‘infantilises women of particular cultures.’¹¹¹ Several writers, such as Gordon¹¹² and Arora and Jacobs,¹¹³ have consequently argued that competent adult females should be able to lawfully consent to genital alterations for customary reasons. Tolerating FGCS (while condemning FGM) is not only discriminatory – it may serve to frustrate the objectives of the Female Genital Mutilation Act 2003, which is to end a harmful traditional practice, primarily performed on children. Boddy explains that tolerating FGCS is a means to circumvent laws prohibiting FGM.¹¹⁴ She cites research undertaken by El-Gibaly et al¹¹⁵ on the medicalisation of FGM in Egypt, where FGM is a strong cultural tradition. They report that physicians performing genital surgery on girls deny that they are performing FGM (which is prohibited by law) and refer to the procedures as cosmetic operations. To quote one physician ‘I don’t call it circumcision... I call it refinement’.¹¹⁶ Boddy consequently argues that ‘the reframing of FGC (female genital cutting) as cosmetic surgery serves to legitimise the practice’. Boddy also reports that in Sudan, where the incidence of FGM has fallen in recent years, there are ‘rumours abound of husbands sending their uncut brides home to their mothers, asking for them to be fixed because their bodies don’t look right.’ She suggests that this is because ‘Sudanese men’s experience of women’s naked bodies and their notions of normality, like those of Western women seeking labiaplasties... have been shaped by the biomedically or digitally altered.’¹¹⁷ If FGCS is tolerated in England and Wales, there is little to prevent a woman who originates from a community that practices genital alterations for customary reasons, from approaching a private clinic for a cosmetic procedure under the guise that it is necessary for her mental health, because she is distressed about perceived abnormalities.

¹⁰⁷ A. Shahvisi and B.D. Earp ‘The law and ethics of female genital cutting’ in S.M. Creighton and L.M. Liao (eds) *Female Genital Cosmetic Surgery: Solution to What Problem ?* (Cambridge, Cambridge University Press, 2019) 58-71

¹⁰⁸ B Essen and S. Johnsdotter ‘Female Genital Mutilation in the West: traditional circumcision versus genital cosmetic surgery’ *Acta Obstetrica et Gynecologica Scandinavica* 83 (2004) 611-613, p.611

¹⁰⁹ Ibid

¹¹⁰ M. Iribarne and N. Seuffert ‘Imagined Legal Subjects and the Regulation of female genital cosmetic surgery’ *Australian Feminist Law Journal* 44(2) (2018) 175-201

¹¹¹ A. Shahvisi ‘Why UK doctors should be troubled by female genital mutilation legislation’ *Clinical Ethics* 12(2) (2017) 102-108, p.104

¹¹² J.S. Gordon ‘Human Rights and Cultural Identity’ *Baltic Journal of Law and Politics* 8(2) (2015) 112-131

¹¹³ K.S. Arora and A.J. Jacobs ‘Female genital alterations: A compromise solution ?’ *Journal of Medical Ethics* 42(3) (2016) 148-154

¹¹⁴ J. Boddy ‘Rethinking the zero tolerance approach to FGM/C: The debate around female genital cosmetic surgery’ *Current Sexual Health Reports* 12 (2020) 302-313

¹¹⁵ O. El-Gibaly, M. Aziz and H.S. Abou ‘Health care providers’ and mothers’ perceptions about the medicalization of female genital mutilation or cutting in Egypt: a cross-sectional qualitative study’ *BMC International health Human Rights* (2019) 19-26

¹¹⁶ Ibid p.19. cited in Boddy Supra 114 p.310

¹¹⁷ Supra 38 p61

4. Conclusion

Female Genital Cosmetic Surgery is becoming more common and has consequently been the subject of much medical and non-medical research. It was previously assumed by many that FGCS did not breach the Female Genital Mutilation Act 2003, either because the procedure did not constitute a mutilation or because it fell within the medical exception. The analysis of the legislation, the CPS statement that FGCS is ‘likely to be caught by the definition provided for by the 2003 Act’ and the Government declaration that ‘the 2003 Act contains no special exemption for cosmetic surgery’ demonstrates that female genital cosmetic surgery *does* constitute FGM. Furthermore, literature on the motivations of women seeking FGCS, the effectiveness of such procedures to deal with functional issues and their lack of suitability if a woman suffers from body dysmorphic disorder suggests that the medical exception should seldom be available. Based on the CPS guidance, a prosecution under the FGM Act is to be expected if a patient who has undergone genital cosmetic surgery is dissatisfied with her experience and lodges a complaint. However, in practice, it is argued that FGCS will rarely be prosecuted: it is clear from the CPS guidance that a prosecution will not be in the public interest if: an adult female is given clear information about the risks and is not subjected to misleading claims; she has capacity to consent and freely does so; the procedure is undertaken by a qualified and experienced clinician, following the correct guidelines; the surgery is performed competently and causes no harm to the woman. A distinction has thus been drawn in practice (if not in law) between the treatment of western and non-western women and the legality of western and non-western practices. This is problematic for several reasons. First, it is discriminatory. On the one hand it denies the autonomy of non-western women who may wish to have their genitals altered for customary reasons whilst upholding the autonomy of (predominantly) western women who seek to undergo procedures that are anatomically similar, for aesthetic or sexual reasons. On the other hand, it can be argued that the law does not, in practice, protect western women from what can be, a harmful practice. This is connected to the second key issue: that the acceptance of FGCS contributes to perpetuating the notion that normal female genitals are aberrant and in need of improvement, which is problematic for *all* females. Boddy therefore argues that the western practice of FGCS should be ‘de-trivialised’ and ‘exposed as equally political – equally subordinating’.¹¹⁸ Finally, tolerating FGCS may serve to legitimise FGM, as procedures performed for cultural reasons may be passed off as cosmetic enhancements, particularly when performed on older girls and adults. Given that FGM remains ‘a critical human rights issue’, a further shift in attitude towards female genital cosmetic surgery is required.¹¹⁹

¹¹⁸ Ibid

¹¹⁹ Supra 50 p21