

# Toward a Feminist Model for Women's Healthcare: The Problem of False Consciousness and the Moral Status of Female Genital Cosmetic Surgery

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**Abstract:** This article is concerned with “all-or-nothing” approaches to female genital cosmetic surgeries, those that overemphasize either women’s autonomy to defend total accessibility or the oppressive social context affecting women to defend the total banning of the procedures. By contrast, the author takes both phenomena into consideration. The author argues identifying patterns of false consciousness and weighing those against harm done to a patient provides a moral basis for a doctor to possibly deny their consent at face value. This also requires a shift in understanding the doctor–patient relationship as a first step toward a feminist model for women’s healthcare.

**Keywords:** cosmetic surgery, deliberative healthcare, epistemic injustice, false consciousness, feminist healthcare, FGCS, women’s healthcare

## 1. Introduction

The literature on plastic, cosmetic, and reconstructive surgeries has widely captured the complexity of the ethical dimension of the phenomenon and its consequences (Goupil and Ferneini 2019; Gupta et al. 2019; Gallo et al. 2018; Teven and Grant 2018; Nejadsarvari et al. 2016; Sterodimas et al. 2011). The rapidly growing popularity of female genital cosmetic surgeries (FGCS)—even among minors—during the past few years (Young 2017; Mackenzie 2017), however, calls for further normative consideration. In this article, I focus on the normative dimension of FGCS by characterizing the approaches toward the practices, which usually become the matter of either a total ban or total accessibility without further taking into consideration what kind of context or potential outcome might play a role in either the permissibility or its lack, such as the case of hymenoplasty in the United Kingdom and Iran.

Since January 2022, it has been an offense to carry out, aid, and offer hymenoplasty, with or without consent, in the United Kingdom for everyone—including both citizens and habitual residents—as well as for UK citizens overseas (Health and Care Act 2022).<sup>1</sup> As Health Minister Robin Swann points out, the primary purpose of the ban is to prevent women from being “coerced, forced, and shamed” into the procedure leading to trauma in the victim, which has “even been linked to suicide” (UK Department of Health 2022). The high level of government intervention in the United Kingdom highlights that regardless of patients’ consent or circumstances, they are denied access to this procedure.

In Iran, in contrast with the United Kingdom, hymenoplasty is a popular procedure, this being due to various factors, including the importance of brides proving their virginity on their wedding night (Bastami 2015). Indeed, in many parts of the country, such as Kerman, exhibiting “blood-stained bed sheets” is still a significant indicator of virginity for brides, where the lack of such performance, half of the time, results in a violent reaction by the groom (Rashidi, Ghorashi, and Esmailzadeh 2020). As a result, many women undergo hymenoplasty to increase the chance of this performance. The lack of any kind of intervention in Iran ignores that women are often forced to undergo this surgery due to religious or cultural factors and highlights that a patient’s consent to the procedure takes priority over the kind of harm done to women in cases where they are not genuinely willing to undergo the procedure.

Although at first glance it might seem that the two countries’ approaches toward hymenoplasty are broadly the opposite of one another, in fact, they both demonstrate what I call an “all-or-nothing” approach to an FGCS practice. Broadly speaking, an all-or-nothing approach to women’s healthcare either focuses on the negative consequences of a medical procedure so as to ban it regardless of women’s adaptive preferences or ignores the oppressive context that pushes women toward such procedures regardless of the consequences of such accessibility. This paper is primarily concerned with characterizing all-or-nothing approaches to FGCS procedures. As the focal point of this article, I argue that all-or-nothing approaches to FGCS overemphasize either women’s autonomy so as to defend total accessibility to the procedures or the oppressive social context affecting women as to defend the total banning of the procedures, yet both such extremes ignore that the practice of autonomy can coexist and coincide with facing up to oppression.

I argue what these approaches have in common is that both rely on an autonomy-centric definition of adaptive preferences, which on its own is problematic. Autonomy, in this sense, should be understood as rationality in the sense of being fully informed on a subject matter. If adaptive preferences are to be understood based on how autonomy deficits they are and that a type of such preferences are autonomy deficits specifically because they are shaped, formed, and reinforced by oppressive social contexts, then there is a genuine dichotomy

between autonomy and oppression in this sense. However, as I show, not only should adaptive preferences, even the ones shaped by oppressive social contexts, not be understood in terms of one's autonomy but also the dichotomy between autonomy and oppression is a false one.

Alternatively, I propose an "in-between" approach that takes both phenomena into consideration. This in-between approach further provides moral grounds for doctors to deny patients' consent at face value when necessary rather than completely banning an FGCS procedure and thus proposes a step toward a feminist model for women's healthcare. I argue that merely emphasizing the negative consequences of an FGCS procedure is not adequate to justify the total banning of it. It is rather the phenomenon of epistemic injustice, particularly in the form of false consciousness (FC) understood as an epistemic agent's weakened or lack of ability to recognize that they have false beliefs on a particular subject matter that can justify the doctor in denying a patient's consent to an FGCS procedure at face value. I show that the type of adaptive preferences that are shaped, formed, or reinforced based on one's FC are the ones requiring a kind of social intervention. However, rather than leaving it to the government to overexercise its power over women's bodies, I argue that this kind of intervention should be placed within the normative boundaries of the doctor-patient relationship.

I then argue that identifying patterns of FC shaping one's adaptive preferences regarding an FGCS procedure and weighing those against other forms of potential harm done to a patient is a multifaceted phenomenon that requires a substantial shift in understanding the doctor-patient relationship, which recenters it on the development of moral deliberations between the two parties. Based on this deliberative model of the doctor-patient relationship, the doctor's responsibility is to "help the patient determine and choose the best health-related values that can be realized in the clinical situation" (Emanuel and Emanuel 1992: 2222). In other words, the doctor is placed in a similar role as a teacher or a friend to the patient and contributes to their empowerment by knowing them, suggesting what course of action is most admirable, and engaging in dialogue with them regarding health-related values (Emanuel and Emanuel 1992). I argue that through this deliberative model, it is possible to take into consideration to deny a patient's consent to an FGCS procedure at face value.

It should be noted that one of the major objections against the deliberative model concerns "whether it is proper for physicians to judge patients' values and promote particular health-related values" (Emanuel and Emanuel 1992: 2225). In other words, the objection lays emphasis on the importance of "value-free" clinical practice (Grovit 1982). However, the feminist women's health movement has highlighted that the paternalistic so-called value-free approach puts doctors in the position of "technicians" and takes away their responsibility to be part of the process of epistemically empowering women regarding their health-related values. I argue that the significance of the deliberative model of

the doctor–patient relationship—proposed as a first step toward a feminist model for women’s healthcare—lies in its grounding an “in-between” approach to FGCS where the denial or acceptance of the patient’s consent to an FGCS procedure at face value relies on their epistemic situatedness.

## 2. All-or-nothing approaches to female genital cosmetic surgeries

FGCS<sup>2</sup> is defined as “the surgical alteration of the vulvovaginal anatomy intended for cosmesis in women who have no apparent structural or functional abnormality” and is an umbrella term referring to different procedures including labiaplasty, clitoral hood reduction, hymenoplasty, labia majora augmentation, vaginoplasty, and G-spot amplification (ACOG Committee Opinion 2020). *Labiaplasty* refers to a medical procedure reducing the length of the labia minora (Özer et al. 2018), clitoral hood reduction is a procedure reducing excess folds of the clitoral hood (Zeplin 2016), *hymenoplasty* refers to a procedure building the hymen (Saraiya 2015), labia majora augmentation is a procedure increasing the labia majora (Jabbour et al. 2017), *vaginoplasty* refers to a procedure tightening the vagina (Davies and Creighton 2007), and G-spot amplification is a procedure increasing the size and sensitivity of the G-spot (Bachelet et al. 2014).

In light of this definition, FGCS does not include medical procedures performed for clinical purposes, such as sexual dysfunction or interference in athletic activities (ACOG Committee Opinion 2020). For instance, someone might undergo labiaplasty because their enlarged labia cause a sense of discomfort or dysfunction during horse riding or cycling (Canadian Medical 2022), but that procedure is not considered a type of FGCS. Additionally, FGCS does not include gender-affirming care (ACOG Committee Opinion 2020). Some types of surgeries that would count as FGCS in a different setting, such as vaginoplasty, are used in gender-affirming care as well (Horbach et al. 2015). However, whether it is about a transgender or a cisgender woman (Schall and Moses 2023), gender-affirming care—broadly speaking—is a complex and multifaceted phenomenon and should not be reduced to a mere matter of cosmetic enhancement of a body part. Consequently, this article is concerned with FGCS procedures that are solely performed for the purpose of mere aesthetic enhancement of the vulva due to different religious, cultural, or social norms.

The literature on FGCS is relatively new and still developing with the first scholarly discussion on the matter published in 1984 by Hodgkinson and Hait and the emergence of the literature in public discourse a decade later in 1998 (Tiefer 2008; Goodman 2009). In parallel with the growing literature on the topic, the demand for FGCS has significantly increased during the past few years. For example, labiaplasty<sup>3</sup> is currently the most popular FGCS procedure and is among the fastest-growing cosmetic procedures in general, having increased by more than 50 percent between 2014 and 2018, followed by vaginal rejuvenation

procedures, which just in one year, between 2005 to 2006, increased by 30 percent primarily due to aesthetic reasons (ACOG Committee Opinion 2020; International Society of Aesthetic Plastic Surgery 2018; Guissy et al. 2017).

It is also worth mentioning that the rapidly increasing popularity of FGCS is not merely among adults. In the UK, for instance, reports show that girls as early as nine are seeking FGCS, particularly labiaplasty (Young 2017; Mackenzie 2017). In the past few years, there has been a growing concern among women, particularly young girls, regarding how their vulvas look, reflecting a growing belief among this demographic that there is something wrong with the way that their vulvas are to the point of expressing disgust and hatred toward them (Young 2017). For example, Ana (her pseudonym), a fourteen-year-old British girl, explains how she sought labiaplasty because her vulva did not look “tidy” or “neat” enough to her (Mackenzie 2017). As she points out, people around her watched pornography, and from this, she had formed the idea that her vulva should be “symmetrical” and “not sticking out” (Mackenzie 2017).

There is a great deal of speculation as well as studies regarding the causes of the increasing popularity of FGCS procedures. Some doctors and surgeons have reported that women bring vulva pictures from porn magazines during their visits (Braun 2005; Green 2005). Indeed, pornography is among the top factors in the theories explaining the rise of FGCS during the past few years (Green 2005; Rodrigues 2012). For instance, according to one theory, it is the biopolitical situatedness of women's vaginas centering around the easy accessibility of pornography that regulates “vulval aesthetics” to create more “optimal,” “useful,” and “exceptional” vaginas (Rodrigues 2012). However, many empirical studies show that there is no strong correlation between consuming pornography among women and a high level of genital dissatisfaction across different countries, ages, levels of education, and sexual orientations (Rothman 2021; Sorrice-Virk et al. 2020; Laemmler-Ruff et al. 2019; Jones and Nurka 2015; Jones et al. 2015; Kvaem et al. 2014). Other approaches to pornography as a major cause of genital dissatisfaction focus more on the dynamics of pornographic culture, such as the positive association between cisgender men partners' pornography consumption and objectifying women's bodies in heterosexual relationships (Tylka and Van Diest 2014), self-objectification as a form of internalizing a sexualized view of one's body via visual consumption (Jones et al. 2015), and public hair removal (Green 2005; Koning et al. 2009; Rodrigues 2012). Some scholars point out other causes such as the corporate pharmaceutical market and its associated commercial interests (Tiefer 2008), and the negative side effects of FGCS procedures, such as scarring, infection, hypersensitivity or loss of sensation, dyspareunia, and wound dehiscence (ACOG Committee Opinion 2020). The same goes for the negative side effects or ambiguity in FGCS practices. As Ion and Creighton (2019) explain, despite the popularity of the procedures, especially labiaplasty, the practices are “poorly described” (11) and there is a lack of standardization and uniformity.

Although there is no mutual agreement on the cause, the ambiguity in the practices, and the negative side effects of FGCS procedures, the empirical importance of these issues plays a role in determining whether the procedure is beneficial to a patient or what the doctor's responsibility in a given case is.<sup>4</sup> In this article, however, the core of the normative deliberation surrounding FGCS procedures is in a sphere beyond context-specific empirical studies. In other words, while the significance of these issues should not be dismissed, the main arguments of this article still stand even if in the future, such procedures become much less ambiguous or have many fewer negative side effects on a patient. The same goes for the cause of the recently gained popularity of such procedures. It is true that with more accurate empirical studies on the cause of this recent popularity, there will be a more comprehensive understanding of the procedures. However, capturing the moral and epistemic dimensions of FGCS procedures, especially regarding all-or-nothing approaches, although empirically informed, belongs to a normative sphere beyond that.

Due to the controversial nature of FGCS procedures, different attitudes to these practices might seem the opposite of one another, such as the total ban on hymenoplasty in the United Kingdom or the total accessibility of the practice in Iran. However, what is missing in the literature is an articulation of how both sides are similar in terms of sharing an all-or-nothing approach to FGCS procedures, which is the focal point of this article. Although, at first glance, these attitudes seem to be completely in disagreement with one another, filling the gap in the literature on how they both share an underlying similar core helps understand what is unique about the case of FGCS procedures. It additionally helps understand the importance of a well-shaped articulation of the so-called tension between autonomy and oppression. In order to fill this gap, comparing the following policies and drawing out the normative assumptions as well as the consequences of each is crucial.

In the case of the ban on hymenoplasty in the United Kingdom, the main reason cited to justify the ban is announced to be a combination of psychophysical factors such as preventing women from being shamed into or traumatized by the procedure. It should be noted that in the case of hymenoplasty, this attitude is not limited to the United Kingdom. Indeed, in 2018, the World Health Organization called for banning "virginity testing" for a variety of reasons including gender discrimination and negative health impacts. Nevertheless, for a variety of reasons, depending on the context, a doctor might be justified in performing the surgery. For instance, in Iran, hymenoplasty is popular due to a variety of factors, such as the importance of a woman's proving her virginity on the wedding night. While there are many good reasons to call out and argue against the underlying misogyny of this norm, it is important to note that having access to this procedure also opens a path for some Iranian women to enjoy an active premarital sex life without facing serious consequences after marriage. In other words, the increasing number of hymenoplasties in Iran is not merely

a sign of the increasing oppression that women face regarding the virginity norm but also an indicator of the number of women who engage in an active sex life before marriage (Kaivanara 2016).

Taking this context into consideration, seeking hymenoplasty can also be interpreted as a sign of rebellion and resistance through which Iranian women “negotiate between dominant models of gender and their own subjective experiences” (Kaivanara 2016, 71). That is, “by manipulating the medicalization of virginity, women inadvertently resist dichotomous gendered classifications that constrain them as either the deviant woman who has premarital sex or the normal woman who remains virginal until marriage” (Ahmadi 2015, 222). Consequently, for this group of women, both of these empirical studies suggest that lack of accessibility to hymenoplasty implies a lack of an active premarital sexual life to a certain degree, one that enables them to rebel against the discriminatory values that require the virginity of the bride as a marker for being a “good” or “normal” woman. Therefore, despite being aware of the severity of the norms regarding bridal virginity and the side effects of the procedure, some women in Iran are willing to undergo the surgery to have control over their lifestyles in a society that is still bound to strong gender norms, boundaries, and roles for women.

Additionally, to undergo the surgery is to prevent serious consequences and violence from men, whether from the groom himself or other men in the families, due to the “failure” to perform virginity on the wedding night. For instance, in Kerman, where the “blood-stained bed sheets” tradition is still a significant virginity indicator for brides, failure to exhibit such a performance directly results in grooms becoming violent in half of all cases (Rashidi, Ghoraishi, and Esmaeilzadeh 2020). As a result, for a group of Iranian women, despite knowing and resisting such norms, undergoing the procedure is a way to make sure there is a higher rate of successfully performing virginity on the wedding night to keep themselves safe from domestic violence. Therefore, in this case, as well, the benefits of keeping themselves safe outweigh the common psychophysical side effects of the procedure.

In response to the preceding argument, one might object that although, in this case, hymenoplasty seems emancipatory, by participating in it, the oppression that Iranian women face is still upheld and perpetuated. It is important, however, to note that there are different ways of challenging oppression and patriarchal norms. Broadly speaking, in the case of having an active sex life for a woman, much still needs to be done in Iranian society. As one study suggests, in Iran, girls from young ages get a unified message from teachers and parents “to avoid any friendly relationship with the opposite sex during adolescence” (Alimoradi et al. 2019, 2908). With the lack of appropriate sex education while promoting “the belief that future good wives did not have friendships with the opposite sex” (Alimoradi et al. 2019, 2909) by society at large, it would be difficult to conceive a situation in which direct collective actions of women,

particularly in more conservative areas of the country, would cause sustainable social change regarding how the society views women's sexuality. The alternative, in this case, would be to either adhere to the cultural norms or have an active sex life in the least costly manner. As a result, the question of whether viewing hymenoplasty as emancipatory leads to perpetuating oppression does not capture the depth and complexity of this issue. Rather, the question here is why "non-virgin" unmarried Iranian women, the targets of severe patriarchal norms, should be solely the ones who pay the cost of such needed drastic social change. In such cases, in which the law and the culture are hand in hand against women having an active premarital sex life, having access to hymenoplasty can be a means for social change through which women do not have to completely adhere to the norms while not being the only ones facing the costly consequences of those norms regarding their sexualities.

More importantly, what this objection ignores is that social change requires a transformation in the external materiality of social structures as well (Haslanger 2015, 2017). In other words, whether, by participating in hymenoplasty, Iranian women are perpetuating oppression against themselves is not only not an accurate question to be asked in this case, but it also further ignores under what circumstances progress becomes possible in the first place. When it comes to social change, especially in this sense, it is not merely enough to highlight whether a collective of women themselves are willing to change their course of action. Rather, it is also important to highlight patterns of structural gender inequality, intertwined with other forms of inequality, especially socio-economic and ethno-racial in this case, to point out that progress in this sense requires a drastic societal shift on how to view women's sexuality in the first place, which is not up to any particular woman individual. For instance, besides Iran, Egypt is another country where women seek hymenoplasty to perform virginity on their wedding night (Wynn 2016). Disguising any bodily evidence of "premarital" sexual activities, not only many women but also doctors are on board to perform the surgery because it is perceived to be a cost-effective way of saving women's lives against shame, stigma, and domestic violence (Farouk 2021; Wynn 2016). Consequently, with highlighting the structural patterns in which women or healthcare professionals make such decisions as the point of departure, the question becomes about how to make structural progress possible rather than pointing out to individual women's course of action, which then opens up space to further interpret seeking hymenoplasty as a sign of rebellion and resistance.

Nonetheless, it is important to acknowledge that there are many cases in which women are forced into an FGCS procedure due to the stigma surrounding the normative performativity of the vagina, such as a lack of virginity. For instance, Hafsah (her pseudonym), a thirty-year-old Kurdish-British woman, explains that her parents emotionally blackmailed her to undergo hymenoplasty against her will because she was raped as a child and they were "obsessed



with the idea of presenting her as pure on her wedding night” (Summers 2022). When there is total accessibility to FGCS procedures, women in Hafsah’s position are forced into the procedures despite their own wishes and so only consent to the procedure on the official paperwork.

The difference between the two cases described earlier lies in recognizing that fighting oppression, especially in the form of misogynistic and patriarchal norms, takes a long time and is a matter of intergenerational resistance. Consequently, women should be allowed to resist oppressive norms however they can and want to. Indeed, what is worrisome about approaches that deny the difference between the two cases is that they implicitly imply how women should practice their autonomy to resist in *the* only acceptable way. While no one should be actively forced into any FGCS procedures against their will, undergoing an FGCS procedure as an extension of wanting an active sex life does not automatically translate into a lack of awareness toward oppression and, instead, can be a response to it, depending on the social context.

A response to the preceding argument can be that instead of banning FGCS procedures that might be beneficial in specific contexts, there is still the option of banning certain FGCS procedures for a specific demographic. In other words, one might argue that an all-or-nothing approach to FGCS is still beneficial in certain cases. For instance, despite an increasing trend of seeking labiaplasty among minors, it is “desirable” to not perform an FGCS procedure until the age of eighteen (Kalampalikis and Michala 2021). In 2015, approximately 400 minor girls underwent labiaplasty, with an 80 percent increase from 2014 (Women’s Wellness Institute of Dallas, n.d.). However, even in this case, it is still not a justifiable option to completely ban FGCS procedures for minors because a situation is still conceivable where there might be some benefits for a minor to undergo the surgery, such as preventing serious suicidal thoughts. Therefore, the problem with a total ban on any FGCS procedures for any particular demographic is that it is always possible to come up with a real-life scenario in which the practice can save someone’s life or benefit them despite the negative consequences.

Simultaneously, my earlier argument does not endorse the idea that all choices should be allowed regarding FGCS procedures without any kind of social intervention. As Clare Chambers (2019) argues, “the desire to be normal” is crucial in the decision-making process to undergo an FGCS procedure. However, as she explains, all our choices “are made within a social context,” surrounded by norms and expectations. Nonetheless, the problem is that her view implies that one’s adaptive preferences in a position of disadvantage in society are a case of injustice and a ground for further governmental intervention. In other words, the challenge is to take the path of not banning any FGCS procedures while still rejecting the idea that all choices are acceptable without falling into victimizing women or further reinforcing governmental authority over their bodies.

One way to find a path between the two sides, I argue, is to articulate the coexistence of autonomy and oppression in a way that leads to a theoretical shift from all-or-nothing approaches to FGCS, as well as from looking only at the negative consequences of the procedures. Alternatively, I argue that by offering a comprehensive account of FC shaping, forming, and reinforcing one's adaptive preferences regarding an FGCS procedure, understood as a form of epistemic injustice, there is a morally justifiable basis for doctors to consider denying a patient's consent at face value by a case-by-case evaluation.

### 3. FC and the problem of adaptive preferences

To demonstrate the underlying similarities between all-or-nothing approaches to FGCS procedures and make a case for an in-between approach, I argue that denying the coexistence of the oppression women face and their autonomy rather portrays an oversimplified picture relying on the false dichotomy between the two. In her book, *Adaptive Preferences and Women's Empowerment*, Serene Khader (2011) extensively argues that adaptive preferences, even those shaped by oppressive social contexts, or as she calls *inappropriate adaptive preferences*, are not necessarily autonomy deficits. Broadly speaking, "self-depriving desires people form under unjust conditions are typically referred to as 'adaptive preferences'" (Khader 2011, 4). Based on Khader's argument, it is impossible to have an autonomy-based definition for adaptive preferences without facing major inconsistencies with our intuitions. In her argument, Khader considers a variety of definitions of different types of autonomy—with its sister concepts, such as agency or rationality—in the literature, and in every single case, she argues that defining adaptive preferences based on that particular definition fails. For the purpose of this article, I highlight part of Khader's argument against understanding adaptive preferences based on autonomy as rationality in the sense of being fully informed on a subject matter. The reason that this specific part of Khader's argument is crucial to laying out the underlying similarities between all-or-nothing approaches to FGCS procedures is that this definition is appealing to make a case for governmental intervention, or its lack, similar to the United Kingdom's and Iran's cases as well as Clare Chamber's suggestion.

Based on an underlying assumption in such all-or-nothing approaches, adaptive preferences should be understood via autonomy in a relational sense of being fully informed. In other words, under this definition, to have a genuinely oppression-free preference is to be fully informed regarding that preference and its consequences. Perhaps then if a group of women seek hymenoplasty in the United Kingdom, it is because they are not fully informed about being forced into the procedures as well as its negative consequences, such as anxiety. Also, in the case of minor girls seeking labiaplasty, perhaps if they just get exposed to the idea that their vulvas are not abnormal, they become fully informed and do not seek such procedures. The articulation of adaptive

preferences shaped, formed, and reinforced by oppressive social contexts as information deficits are then appealing for making a case for governmental intervention because it takes place within one's instrumental preferences, being unaware of what an issue and its consequences *really* are. Perhaps then the UK government's intervention in denying a patient's consent to hymenoplasty is still within the liberal boundaries of a state because it is just interfering with the coercive forces and the negative consequences leading to hymenoplasty that a patient is not entirely aware of; or as [Clare Chambers \(2019\)](#) suggests, one's adaptive preferences in the position of disadvantage in society justify government intervention because had the patient not been in that position, they would not have their adaptive preferences. That is, it is being oppressed that prevents one from having access to being fully informed on a subject matter to having a different preference that justifies government interventions. Similarly, the lack of government intervention in Iran ignores the oppressive context that pushes women toward such procedures regardless of the consequences of such accessibility. Perhaps, then, one's consent to an FGCS procedure implies that the patient is fully informed and that no coercive social forces shaped their adaptive preferences to seek the procedure.

What is missing in both cases, however, is an acknowledgment that broader social contexts that shape adaptive preferences might even matter more than merely exposing people to other formerly unknown alternatives. Instead of completely ignoring the oppressive contexts or justifying government intervention, such cases require "support for the creation of social networks" that celebrate one's growing independence and allow one to navigate the challenges within a social support system ([Khader 2011](#)). In other words, any kind of appropriate social intervention that one might think of in such situations is more difficult to achieve than merely denying women's consent or denying oppressive social contexts shaping their adaptive preferences.

The problem with the earlier definition is that in many cases of adaptive preferences shaped by oppressive contexts, "we would expect adaptive preferences to disappear when deprived people are exposed to new information" ([Khader 2011](#), 79). However, that is simply not the case in many instances of seeking FGCS procedures. For example, in the case of hymenoplasty in Iran, many women are indeed fully aware of the context through which they make the choice of undergoing the surgery, including the serious consequences they would face if they fail to perform virginity on their wedding nights. Also, in the case of minors seeking labiaplasty, exposing them to the idea that there is no abnormality to their vulvas is not merely enough to address why they falsely believe that their vulvas are not normal. In other words, in such cases that would be left out of consideration by the all-or-nothing approaches to FGCS procedures, the problem is not with practicing autonomy as not being fully informed, so understanding these types of adaptive preferences based on rationality/information deficits is not justified.

If, as Khader argues, we do not define adaptive preferences—shaped by oppressive social contexts—based on autonomy, then there is no genuine tension between one’s autonomy in the sense of rationality as being informed and being oppressed. In other words, denying the coexistence of autonomy in this sense and oppression relies on having an autonomy-centric understanding of adaptive preferences within such oppressive contexts, which, as shown earlier, is problematic on its own. Alternatively, there should be a way of characterizing adaptive preferences—shaped by oppressive social contexts—beyond the sphere of autonomy in this sense. Additionally, while the preceding argument shows that mere governmental intervention in such cases is not justified, it does not imply that any sort of social intervention should not exist or cannot be effective. All the earlier argument implies is that intervention—even when it is appropriate—is much more complicated than what we might initially believe.

As a response to the analysis above, one might object that individual context-specific cases within broader sociocultural discourses can still give us a path to identify patterns under which women might be coerced by social forces to undergo such surgeries (Braun 2009). According to this objection, it might still be helpful to use the choice rhetoric as a theoretical tool to highlight the difference between FGCS procedures and female genital cutting (FGC) based on the “individual choices” of a woman “beyond” and “prior” to one’s culture (Braun 2009). The problem with this objection, however, is that it still relies on an autonomic-centric understanding of adaptive preferences, which is not justified. Moreover, what might come as a pre-cultural individual choice of a woman, particularly in the Western context, is still part of the broader socio-structural context impacting and shaping one’s adaptive preferences (Braun 2009). More importantly, even if we along with the rhetoric of distinguishing these medical procedures, namely FGC, hymenoplasty, and other FGCS surgeries, it will not explain whether, how, and to what extent public intervention is justified in each case.

Consequently, even when there are good reasons to publicly intervene in a harmful medical procedure, the outcome is not necessarily guaranteed. Going back to the hymenoplasty case, one might point out that there is a nuance between hymenoplasty and other FGCS procedures. However, regardless of whether this is indeed true or not, even a global consensus on the wrongness of a medical practice on its own is not enough to (a) justify state intervention, especially in the form of overextending states’ power over marginalized social groups; (b) guarantee the outcome of any form of public intervention; and (c) raise the question on if the problem is whether the social group in question, in this case women, are informed enough about their decisions. As a case in point, there is a global consensus on how harmful FGC is especially in the case of minors undergoing the procedure. However, despite international and governmental efforts to eliminate FGC, it has the opposite impact in many countries, including Kenya. Accordingly, since the ban on practice became

effective in 2011, not only many practices have existed underground for the past decade but also, but the numbers are still on the rise (Parsitau 2018). As a result, what my earlier argument shows is that when it comes to public intervention in any form, intervening in one cause isolated from the rest of a social structure not only is usually ineffective but further ignores the importance of designing a support system as a way of socially intervening. In other words, by ignoring the importance of having an *ecosystem* emerging from the entirety of a social structure, this line of reasoning overlooks how certain forms of public intervention, especially state intervention, can indeed work in the opposite direction of what the initial desirable outcome of the intervention is.

In the literature on adaptive preferences, there is a growing concern regarding understanding them as merely caused by false beliefs (Enoch 2020; Bruckner 2009). However, I argue that there is a type of adaptive preference—shaped by oppressive social contexts—that requires social intervention not because it is grounded in one's false beliefs regarding the procedures; rather, it is rooted in FC, one's weakened or lack of ability to recognize those false beliefs. As a concept, FC has historical roots in Marxism and refers to the normalization of a construct held by disadvantaged groups in society (Eyerman 1981).<sup>5</sup> As Lewis (2021) explains, FC is not a “distorted belief” nor a “lack of critical discernment.” It is rather holding beliefs that are in contrast with the interests of individuals or social groups that contribute to further marginalizing and putting them in disadvantaged positions (Elster 1982; Eagleton 1991; Meyerson 1991). Both Fricker (2017) and Meyerson (1991) have emphasized the significance of the concept in the fields of epistemology and philosophy of mind. Based on an oversimplified articulation of FC, it occurs iff one has a set of false beliefs and cannot recognize how this set normatively forms one's adaptive preferences; consider, for example, a low-income Walmart employee who believes that the United States is the land of unlimited opportunity despite the fact that no one in their family has gone to college (Enoch 2020). Even though this person's political choices are motivated by some false beliefs, as Enoch (2020) points out, it is not adequate for an account of FC.

Although false beliefs can lead to misconceiving where one's interests lie (Lukes 2011), a major problem with this kind of articulation of the concept is that it presumes an objective truth that exists completely separably from epistemic agents and that some of these agents are unable to conceive *rightfully*. However, being motivated by false beliefs can be far more complex than that. In the same case of the Walmart employee, it is possible that when reviewing facts in different forms, such as data and reports regarding poverty or class differences in the country, they will still come up with a narrative to make sense for themselves that they are living in the land of unlimited opportunity. In other words, what this oversimplified account fails to take into consideration is that irrecognizable false beliefs can be a powerful source of shaping one's desires and feelings toward a matter that will not easily change. Additionally, irrecognizable

false beliefs are not necessarily irrecognizable because one is unable to comprehend the facts for what they *really* are; rather, they can be irrecognizable due to one's generating other false beliefs to make sense of the facts differently in the light of their broader belief system.

Consequently, having false beliefs on its own does not suffice for someone to have FC. Rather, it is a necessary condition, such that if one has FC, one necessarily has a set of false beliefs on some subject matter. On top of that, it is the inability to recognize one's own false beliefs and how central to one's social identity those beliefs are that suffices for an epistemic agent to have FC. For instance, imagine the weather is sunny today but I have a false belief that it is raining now despite not having gone out or looked out of the window. I might even form other beliefs, such that today the weather is cold and so further mischaracterize it. Nonetheless, this false belief on its own or my misperception of the weather does not imply that I have FC. I would still be able to take a look out the window, see that it is sunny outside, and form a new true belief that the weather is sunny today. Consequently, it is important to note that the inability to recognize one's own false beliefs in an FC case is *relative*. While in most severe cases of FC, an epistemic agent is completely unable to recognize such false beliefs, in the majority of FC cases, this lack of capability is relative and more in the sense of a weakened ability, which could be intensified into a more severe form if it remains unaddressed or expands into other areas of one's broader belief system.

In contrast, in an FC case, it is an epistemic agent's lack of ability to recognize that they have false beliefs on a particular subject matter and how crucial those beliefs are to one's social identity that causes FC. In other words, FC wrongs epistemic agents because it weakens their ability to recognize those false beliefs and reassess their significance in their belief system as an epistemic agent. Consequently, there is a unique epistemic aspect to this type of wrongdoing that highlights how FC is a form of epistemic injustice. Broadly speaking, epistemic injustice refers to "forms of unfair treatment that relate to issues of knowledge, understanding, and participation in communicative practices," including "a wide range of topics concerning the wrongful treatment and unjust structures in meaning-making and knowledge producing practices," such as "exclusion and silencing" or "having one's meanings or contributions systematically distorted, misheard, or misrepresented" (Kidd, Medina, and Pohlhaus 2017, 1). In the case of FC, as it weakens the agent's capability to recognize a set of false beliefs, it is a kind of wrongful treatment done to them because it contributes or reinforces a sense of distorted or misrepresented understanding of a given subject matter in the agent's belief system.

Let us recall the Walmart employee case. It is not the denial of systematic racial inequality that makes this person have FC; it would rather be that this person is unable to recognize that they have such false beliefs, given their socioeconomically vulnerable social context, that can make this example an FC case. It is

also worth mentioning that the “inability” to recognize false beliefs is *relative*, not essential. This kind of inability can be internalized in individuals or social groups gradually and can also be reversed through individual or institutional changes to help the epistemic agents who are wronged, to gradually become epistemically empowered on a given subject matter and identify such false beliefs and their impacts. Consequently, the centrality and importance of the initial false beliefs as well as the path to generating secondary false beliefs are determined by an epistemic agent's social identity, situatedness, and positionality. In this case, the false belief that the United States is the land of unlimited opportunity is not only central to the Walmart employee's social identity and situatedness as a patriot, but it further determines the secondary false beliefs in their belief system, namely, denying systematic racial inequality in the country.

FC can also be used as a ground to justify doctors denying patients' consent to an FGCS procedure at face value on a case-by-case analysis. It is common knowledge in women's health that women's vaginas and vulvas come in different forms, shapes, and sizes. However, if a woman, particularly a young girl in an epistemically vulnerable position—due to a variety of factors—believes in the false proposition that her vulva does not look *normal* to the point that she is motivated to seek an FGCS procedure, that person may have FC if she is unable to recognize there is no abnormalcy in her vulva. In contrast, if the same person seeks the procedure because, despite knowing about the side effects, she has further reasons justifying that choice, that person does not have FC.

One of the major false beliefs of some women willing to undergo an FGCS procedure is that their vulva is not normal or beautiful and so needs alteration, which is caused by a certain level of genital appearance dissatisfaction (Schick et al. 2010). In general, studies find that greater dissatisfaction with genital appearance is correlated not only with higher self-consciousness of the genital image during sex but also with lower sexual esteem, and satisfaction (Schick et al. 2010). Such a negative perception of the genitalia affects women's well-being, including sexual well-being, for different age groups such as young women, who are often more sexually vulnerable (Schick et al. 2010). Although such a high level of dissatisfaction with the genitalia and the urge to aesthetically alter it on its own is not adequate for someone to have FC, in some cases, the severity of how deeply such misperceptions affect one's sexual well-being and life is fueled by the inability to recognize those false beliefs due to a variety of factors and can push someone further into generating other false beliefs, by adhering to a sense of genital abnormality to undergo an FGCS procedure.

Consider patient A and patient B in the same oppressive and discriminatory context. Let us also assume that they both are willing to undergo the same FGCS procedure with the same doctor. The only difference between the two is that patient A is motivated to undergo the surgery because she has FC—she falsely believes that her vulva is not normal and is unable to recognize that false belief and how it has affected her life—while this is not the case for patient B.

The reason patient B is willing to undergo the surgery is that it would help her adhere to a sense of vaginal performative or aesthetic normalcy widely accepted in society as her way of coping with and resisting the same social context. I argue that the doctor is morally justified to deny patient A's consent to the surgery at face value, while this is not the case for patient B because the procedure can indeed help patient B in the way that she wanted. For patient A, undergoing the surgery would actually fuel her inability to recognize her false belief that her vulva is not normal. Instead, it might be the case that referring patient A to other professionals, such as a therapist, a social worker, or a psychiatrist would be more beneficial for her as such a comprehensive approach to healthcare can contribute to epistemically empowering her and her gaining the ability to form true beliefs regarding the normalcy of her vulva.

It is also worth mentioning that the argument above does not entail that it is a moral obligation for a doctor to deny a patient's consent who has FC regarding her vulva and is willing to undergo an FGCS procedure. The argument rather implies that on a case-by-case analysis, it is permissible to do so. The ground for moral permissibility to deny the patient's consent at face value, in this case, opens up room for what an all-or-nothing approach to totally banning or denying patients' consent is unable to accept since it is always possible to conceive a scenario in which a patient even with a high level of FC can benefit from undergoing an FGCS procedure, such as preventing suicidal thoughts.

#### **4. Epistemic solidarity and the deliberative model of the doctor–patient relationship**

A key component in the earlier argument relies on doctors being able to identify patterns of FC and weigh those against the potential benefits or costs for a patient. However, this requires a substantial shift in understanding the doctor–patient relationship that centers it on the development of moral discussion between the two parties. According to the deliberative model of the doctor–patient relationship, it is the doctor's responsibility to help the patient choose “the best health-related values” in a given medical situation (Emanuel and Emanuel 1992). To achieve this goal, the doctor demonstrates “the types of values embodied in the available options” and reasons “why certain health-related values are more worthy and should be aspired to” (Emanuel and Emanuel 1992, 2222). At the heart of this kind of shift in understanding the doctor–patient relationship<sup>6</sup> lies engaging in a kind of moral deliberation regarding the kind of values in question that place the doctor in a similar position as a teacher or friend, and as knowing the patient and providing options to them by discussing what decision is also morally “admirable” (Emanuel and Emanuel 1992). In this kind of doctor–patient relationship then, the patient's autonomy is primarily reflected in the course of “moral self-development”—beyond a sense of merely being fully informed—in which the doctor not only contributes to their empowerment but also contributes to considering



“alternative health-related values, their worthiness, and their implications for treatment” (Emanuel and Emanuel 1992, 2222).

I argue that, through this deliberative model, it is possible for a doctor to identify patterns of FC and possibly deny a patient's consent to an FGCS surgery at face value. As Goodin and Spiekermann (2015) argue, epistemic solidarity helps overcome FC. Based on their argument, the group practices of epistemic solidarity can help social groups or what they call “masses” to know more about their true interest in the political sphere and overcome a form of elitism that holds on to knowledge and its promotion regarding the true interests of social groups in an epistemically divided and segregated space. Analogously, group practices of epistemic solidarity among women in different settings, such as school or family, can help them to overcome FC in considering FGCS. However, the difference is that while Goodin and Spiekermann argue that as long as the social groups practice epistemic solidarity the outcome will be effective for them regardless of whether the elites also do so, I argue that the participation of “elites” in this case, the healthcare professionals, is crucial in the group practice of epistemic solidarity regarding FC on FGCS procedures.

With the rapid increase of FGCS procedures, it is crucial to be able to have grounded knowledge regarding the procedures and the reasons many women seek them. While in the process of knowledge production in this regard, a variety of epistemic agents, such as parents, teachers, sex educators, and counselors play important roles, the role of medical professionals is also crucial. If doctors remain in the role of mere technical experts who do not engage in contributing to the formation of health-related values for patients, it will be difficult for patients struggling with FC to become epistemically empowered and develop a morally positive sense of self on their own. Especially in the current sphere where the discussion on a more comprehensive sex education program regarding sexual well-being or body image (Winter et al. 2019) and the role of parents in empowering their young daughters' sexualities (Pop and Rusu 2015) are relatively new and underdeveloped topics, without the help of healthcare professionals, it will be difficult to conceive a situation in which women, particularly young women, are able to overcome their FC.

Alternatively, accepting the role of medical professionals in the group-practice of epistemic solidarity to overcome FC in FGCS procedures requires a shift in understanding the doctor–patient relationship in which the doctor engages in dialogues regarding what is morally admirable in a given medical situation and contributes to the patient's empowerment. Under the deliberative model of the doctor–patient relationship not only is it possible for the doctor to identify patterns of FC and possibly offer other options, such as referral, over the patient's consent to an FGCS procedure at face value, but they can also contribute to the practice of epistemic solidarity in the rise of FGCS procedures and their growing popularity among women, particularly young women. The deliberative model, therefore, provides the moral basis for doctors adopting a

new role in both the epistemic practice of solidarity as well as the denial of a patient's consent with FC when it is appropriate.

It is also worth noting that the argument above does not entail that medical professionals are epistemically situated outside of their cultural norms. It is important to note that on one hand, nowadays in many countries, healthcare is a profitable enterprise (Saharso 2022; de Lora 2015). For instance, in Iran, providing "certificates of virginity" is a profitable practice for gynecologists (Alijani 2018). On the other hand, in countries where virginity is of high importance, healthcare professionals face cases that performing such surgeries is lifesaving (Saharso 2022; de Lora 2015). For instance, an Iranian gynecologist who practices in the United Kingdom reports that "she had provided 'certificates of virginity,' as well as certificates stating that a woman's hymen had been pierced because of an 'accident' and not because of sexual relations" (Ershad 2018). In Iran, viewing virginity as highly valuable threatens unmarried women's lives as many gynecologists refuse to perform pap tests used to detect cervical cancer because of the risk of damaging a woman's hymen (Ershad 2018). With cervical cancer being the fifth-most common cause of death for Iranian women, medical professionals contribute to leaving the risk of developing undetected cervical cancer unknown because, in their views, the risk of being a "non-virgin" unmarried woman outweighs the risk of potentially having cancer (Ershad 2018).

Nonetheless, the healthcare professionals' epistemic situatedness and their highly specialized knowledge within certain social contexts are also crucial to the praxis of epistemic solidarity. While it is important to acknowledge that healthcare professionals are also within the same social and, in many cases, oppressive contexts, ultimately, their epistemic situatedness in such cases is not similar to patients, particularly vulnerable young girls. For instance, in the case of hymenoplasty in Iran, some physicians experience guilt because of the "deceiving" nature of the surgery as well as not believing in the "medicalization of virginity" yet they perform hymenoplasty because of its "potentially severe repercussions" that may have on a woman, including domestic violence and honor killing (Ahmadi 2014). In other words, in these cases, a healthcare professional knows that, personally and professionally, hymenoplasty is wrong, but they are capable of preventing greater harm by performing it because of how they are epistemically situated within certain social contexts. In another example in Australia, while 35 percent of the general practitioners had examined minor patients regarding FGCS procedures, 75 percent of them reported that their knowledge of FGCS surgeries and their risks is not adequate (Kalamalikis and Michala 2021).<sup>7</sup> In response to similar issues, the Royal College of Obstetricians and Gynecologists (RCOG) released an ethical opinion paper. Accordingly, healthcare professionals should inform patients seeking FGCS surgeries about "the wide variations of normal genital anatomy" addressing their insecurities, and in the case of minors, specifically, healthcare professionals should refer the patient to be evaluated for "any underlying

psychological problems, such as Body Dysmorphic Disorder” (Kalamalikis and Michala 2021, 194).

Both examples above demonstrate how crucial the physicians' knowledge and epistemic attitudes toward FGCS are to the praxis of epistemic solidarity. Whether it is to save a woman's life from domestic violence in the case of hymenoplasty or to save a minor's life from committing suicide in the case of labiaplasty potentially related to body dysmorphia, the healthcare professionals' knowledge, how they navigate the relevant social context, and make an informed decision are why the physicians' unique epistemic situatedness is at the core of the praxis of epistemic solidarity. While, as argued previously, parents and the education system play crucial roles in such praxis, the doctor's role in the deliberative model is also important to help patients overcome FC in seeking FGCS procedures through a variety of ways, including engaging in dialogues regarding what is morally admirable in a given medical situation and contributes to the patient's empowerment.

This further matters in the process of how a physician denies a patient's consent to an FGCS procedure at face value as well. It is important to note that denying a patient's consent due to identifying patterns of FC does not automatically translate into saying “no” to a patient directly. Rather, the moral ground to deny a patient's consent to an FGCS procedure at face value is to further continue the moral deliberation and take an appropriate measurement in a given FC case. For instance, with many minors seeking an FGCS surgery, as the RCOG's ethical opinion paper suggests, it is important that the doctor refers the patient for additional psychological evaluation. Consequently, what is unique about the deliberative model is that despite the patient making a final decision, healthcare professionals also play a crucial role in shaping the patient's informed decision. Thus, rather than accepting a patient's initial consent at face value, by identifying a pattern of FC and participating in the praxis of epistemic solidarity, a doctor plays a substantial part in the process of what kind of values and dialogues can help a patient to come to a conclusion regarding their final informed decision. In other words, instead of viewing doctors as technicians, by highlighting their unique epistemic situatedness in the praxis of epistemic solidarity within the deliberative model, processes such as referral or participating in knowledge production regarding different forms, shapes, and sizes of vulvas demonstrate different morally permissible ways of denying a patient's consent at its face value to further contribute to breaking away from patterns of FC in a patient, especially minors, seeking an FGCS procedure.

One of the main objections against the deliberative model of the doctor-patient relationship is that it is not proper for doctors to either judge or promote the health-related values of their patients as clinical practices at their core are, and must be, value-free (Grovit 1982). However, the feminist women's health movement indeed has been addressing the paternalistic approaches to healthcare to contribute to empowering women through knowledge production processes

regarding their health (Shai, Koffler, and Hashiloni-Delov 2021). Alternatively, the specific case of FGCS reveals the significance of the deliberative model of the doctor–patient relationship as the first step toward a feminist model for women’s healthcare. In particular, I argue that in order to make a case for the deliberative model centering on the case of FGCS, there should also be a shift toward a feminist model of women’s healthcare.

As Linda Andrist (1997) argues, the goal of a feminist model is to change how healthcare is delivered to women at the individual level while seeking social transformation at four different stages. Consequently, by exploring each of the stages of Andrist’s model, I make a case for the deliberative model focusing on FGCS procedures. First, there should be a symmetry in the doctor–patient relationship, implying an attempt on the healthcare professional side to “reduce the inequalities that have existed in the healthcare environment” (Andrist 1997, 269). This stage is an initial step in the praxis of epistemic solidarity for physicians, which is an extension of understanding their roles as a teacher or a friend to patients rather than a technician. In other words, considering the deliberative model of the doctor–patient relationship, the first stage of Andrist’s model makes epistemic solidarity as healthcare professionals should do the epistemic labor of participating in moral deliberations through recognizing “mutual reciprocity” in the doctor–patient relationship (Andrist 1997).

The second stage of Andrist’s (1997) model is to improve having access to information, which refers to “the manner in which information is presented by clinicians and the availability of other information for patients.” (270). Based on the deliberative model, the doctor’s participation in the related health-related values of the patient can be achieved through a variety of practices, such as assessing the patient’s knowledge, perspective, or accessibility to the related information that originally led them to seek a medical procedure. This stage is also crucial to the praxis of epistemic solidarity through which the physicians’ unique epistemic situatedness within certain social contexts is highlighted. In other words, through the praxis, the physicians should play a role in shaping the related values to the medical practice in question, such as to what extent a patient is aware of the normalcy of different sizes, forms, and shapes of vulvas.

The third stage of Andrist’s (1997) model centers around shared decision-making processes indicating that physicians should consider that “people will vary regarding their ability and desire to share in decision making.” (270). As Andrist argues, there are high numbers of patients who are willing to rely on the institutional authority of medicine without participating in the decision-making processes regarding their treatment. It is then part of the praxis of epistemic solidarity to epistemically empower patients to not only learn about the values shaping the details of the options available to them but also to have the option of participating in such decision-making processes. It is also worth mentioning that this stage does not entail forcing a patient to participate in such processes. Rather, the importance of this stage is to provide an option and build

confidence in patients that they are able to participate in such processes if they choose to engage in substantial moral deliberations.

As the last step in [Andrist's \(1997\)](#) model, through social change, doctors should be "familiar with the latest literature, both professional and lay, in order to critically analyze research studies, our colleagues' interpretations of those studies and how recommendations for practice are reached." (268). In other words, healthcare professionals are able to work with the public "to strive for change within the healthcare system and society as a whole" ([Andrist 1997](#), 268). The unique epistemic situatedness of physicians highlights how they can contribute to social change regarding women's healthcare, and in particular FGCS procedures, both top down through the healthcare system and bottom up through moral deliberation with the patients.

The value of an "in-between" approach to FGCS, then, is that it can accommodate the denial of a patient's consent at face value in an FC case, and it can contribute to the praxis of epistemic solidarity to not only resist FC but also expand knowledge production processes regarding FGCS procedures and the normalcy of different shapes, forms, and sizes of vulvas and push against aesthetically performative norms within different social settings. While a full and expansive theoretical discussion of this feminist model requires multiple layers of analysis, this article aims to highlight the importance of the normative dimensions of FGCS procedures as they are gaining rapid popularity among women, specifically younger generations. Overall, this analysis helps validate the rejection of all-or-nothing approaches to FGCS procedures and illustrates the important role of doctors in the deliberative model and the feminist model of women's healthcare, an analysis that explains how individual and collective normative practices in this regard can be justified while leaving room for changes from both sides, patients as well as doctors, in the healthcare system and society as a whole.

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## NOTES

1. **Health and Care Act 2022** Amendments: 231H, 231J, 231K, 231L, 231M, 231N, 231P, 231Q, 231R, 231S, 231T, 231U, 313ZA, 313ZB, 313ZC, 313ZD, 313ZE, 313ZF, 313ZG, 313ZH, 313ZJ, 313ZK, 313ZL, 313ZM, 314B.
2. Although there is a need to be more inclusive in the use of technical terms in medicine, this urge should stem from the medical professionals and scholarly works themselves. Thus, in this article, whenever I—as the author—am referring to a part of my own argument, I use the terms *vulva*, *vagina*, or *genitalia* and whenever I am referring to the technical term for this type of cosmetic surgery in question, I use the common technical term in medicine, *female genital*, or, more specifically, *female genital cosmetic surgery*.
3. In the United States, labiaplasty is not only the most popular FGCS procedure but also among the fastest-growing cosmetic procedures at large. In just one year, 2015–2016, there is also a 39 percent increase, of which over 5 percent were undergone by girls under the age of sixteen ([American Society for Aesthetic Plastic Surgery 2016](#)).
4. In this paper I use the terms “doctor,” “physician,” “medical professional,” and “healthcare professional” interchangeably.
5. Here, the use of false consciousness as a term is intentional because historically, minority women—including Middle-Eastern and African women—are often portrayed as passive without having any autonomy through the use of false consciousness. However, the use of this term in the paper is to show there are other ways of characterizing this concept that can explain why, as an example, an Iranian or an Egyptian woman undergoing hymenoplasty is not necessarily a case of false consciousness but a Western woman undergoing labiaplasty might rather be.
6. When it comes to the healthcare professional patient relationship, it is important to note that I am not arguing for a position that all the cognitive and epistemic labor of participating in a patient’s moral deliberation should be on one doctor. Indeed, what is unique and distinctive about the deliberative model is that it is compatible with having a more comprehensive approach to healthcare in general, including women’s health care. In other words, this framework is compatible with having a team of health care professionals contributing to a patient’s moral deliberation. However, due to the complexity of the lack of comprehensive approaches to women’s health care at large, an in-depth exploration of this topic requires a normative and structural analysis in a separate paper.
7. Here, the topic of educating healthcare professionals—especially at the systematic level—although related, requires an in-depth exploration in a separate paper.

## REFERENCES

- ACOG Committee Opinion.** 2020. “Elective Female Genital Cosmetic Surgery.” *Obstetrics & Gynecology* 135(1): 249–50. <https://doi.org/10.1097/aog.0000000000003617>.
- Ahmadi, Azal.** 2014. “Ethical Issues in Hymenoplasty: Views from Tehran’s Physicians.” *Journal of Medical Ethics* 40: 429–30. <https://doi.org/10.1136/medethics-2013-101367>.
- Ahmadi, Azal.** 2015. “Recreating Virginity in Iran: Hymenoplasty as a Form of Resistance.” *Medical Anthropology Quarterly* 30(2): 222–37. <https://doi.org/10.1111/maq.12202>.

- Alimoradi, Zainab, Nourossadat Kariman, Fazlollah Ahmadi, Masomeh Simbar, and Kelly-Ann Allen. 2019. "Iranian Adolescent Girls' Perceptions of Premarital Sexual Relationships: A Qualitative Study." *The Qualitative Report* 24(11): 2903–15. <https://doi.org/10.46743/2160-3715/2019.3690>
- American Society for Aesthetic Plastic Surgery. 2016. "ASAPS Stats 2016." <https://www.surgery.org/sites/default/files/ASAPS-Stats2016.pdf>.
- Andrist, Linda. 1997. "A Feminist Model for Women's Health Care." *Nursing Inquiry* 4: 268–74. <https://doi.org/10.1111/j.1440-1800.1997.tb00113.x>.
- Bachelet J., A. Mojallal, and F. Boucher. 2014. "Female Genital Surgery, G-Spot Amplification Techniques – State of the Science" [in French]. *Annales de Chirurgie Plastique Esthétique* 59(5): 344–47. <https://doi.org/10.1016/j.anplas.2014.05.003>.
- Bastami, Sohaila. 2015. "When Bleeding Is Vital: Surgically Ensuring the 'Virginal' State." *Journal of Clinical Ethics* 26(2): 153–57. <https://doi.org/10.1086/jce.2015.262153>.
- Braun, Virginia. 2005. "In Search of (Better) Sexual Pleasure: Female Genital 'Cosmetic' Surgery." *Sexualities* 8(4): 407–24. <https://doi.org/10.1177/1363460705056625>.
- Bruckner, Donald W. 2009. "In Defense of Adaptive Preferences." *Philosophical Studies: An International Journal for Philosophy in the Analytic Tradition* 142(3): 307–24. <https://doi.org/10.1007/s11098-007-9188-7>.
- Canadian Medical. 2022. "Labioplasty: All Your Questions Answered by Our Gynaecologist and Obstetrician." March 17, 2022. <https://www.canadian.cz/en/articles-and-news/labiplasty-all-your-questions-answered-by-our-gynaecologist-and-obstetrician-dr-jiri-chod/>.
- Chambers, Clare. 2019. "Choice and Female Genital Cosmetic Surgery." In *Female Genital Cosmetic Surgery: Solution to What Problem?*, edited by Sarah M. Creighton and Lih-Mei Liao, 72–9. Cambridge, UK: Cambridge University Press.
- Davies, Melissa C., and Sarah M. Creighton. 2007. "Vaginoplasty. Current Opinion." *Urology* 17(6): 415–18. <https://doi.org/10.1097/mou.0b013e3282f0d5b3>.
- de Lora, Pablo. 2015. "Is Multiculturalism Bad for Health Care? The Case for Re-Virgination." *Theoretical Medicine and Bioethics* 36(2):141–66. <https://doi.org/10.1007/s11017-015-9322-z>
- Eagleton. Terry. 1991. *Ideology*. London: Verso.
- Elster, Jon. 1982. "Belief, Bias, and Ideology." In *Rationality and Relativism*, edited by M. Hollis and S. Lukes. Oxford: Basil Blackwell.
- Emanuel, Ezekiel J., and Linda L. Emanuel. 1992. "Four Models of the Physician-Patient Relationship." *JAMA* 267(16): 2221–26. <https://doi.org/10.1001/jama.267.16.2221>
- Enoch, David. 2020. "False Consciousness for Liberals, Part I: Consent, Autonomy, and Adaptive Preferences." *The Philosophical Review* 129(2): 159–210. <https://doi.org/10.1215/00318108-8012836>
- Ershad, Alijani. 2018. "Virginity Pills and Surgery: Iran's Fake Hymen Industry." *France 24*, January 1, 2018. <https://observers.france24.com/en/20180122-virginity-pills-surgery-iran-fake-hymen>
- Eyerman, Ron. 1981. "False Consciousness and Ideology in Marxist Theory." *Acta Scientologica* 24(1–2): 43–56. <https://doi.org/10.1177/000169938102400104>.
- Farouk, Menna A. 2021. "In Conservative Egypt, Women Seek Low-Cost Ways to 'Prove' Virginity" in Reuters, 5 December 2021. <https://www.reuters.com/article/idUSKBN2IL006/>.

- Fricker, Miranda. 2017. "Evolving Concepts of Epistemic Injustice." In *Routledge Handbook of Epistemic Injustice*, edited by Ian James Kidd, José Medina and Gaile Pohlhaus, Jr., 53–61. Oxfordshire, UK: Routledge.
- Gallo, Lucas, Charmaine Baxter, Jessica Murphy, Lisa Schwartz, and Achilleas Thoma. 2018. "Ethics in Plastic Surgery: Applying the Four Common Principles to Practice." *Plastic and Reconstructive Surgery* 142(3): 813–18. <https://doi.org/10.1097/prs.0000000000004674>.
- Goodin, Robert E., and Kai Spiekermann. 2015. "Epistemic Solidarity as Political Strategy." *Episteme* 12(4): 439–57. <https://doi.org/10.1017/epi.2015.29>.
- Goodman, Michael P. 2009. "Current Commentary: Female Genital Cosmetic Surgery." *Obstetrics & Gynecology* 113(4): 154–59.
- Goupil, Michael T., and Elie M. Ferneini. 2019. "Is Cosmetic Surgery Ethical?" *The American Journal of Cosmetic Surgery* 36(3): 109–10. <https://doi.org/10.1177/0748806819868302>.
- Green, Fiona J. 2005. "From Clitoridectomies to "Designer Vaginas": The Medical Construction of Heteronormative Female Bodies and Sexuality through Female Genital Cutting." *Sexualities, Evolution & Gender* 7(2): 153–87. <https://doi.org/10.1080/14616660500200223>.
- Grovitz, Samuel. 1982. *Doctor's Dilemmas: Moral Conflict and Medical Care*. New York: Macmillan.
- Guissy, Barbara, Federica Facchin, Laura Buggio, Daniela Alberico, Maria Frattaruolo, and Alessandra Kustermann. 2017. "Vaginal Rejuvenation: Current Perspectives." *International Journal of Women's Health* 9:513–19. <https://doi.org/10.2147/ijwh.s99700>.
- Gupta, Nisha, Robert Dorfman, Sean Saadat, and Jason Roostaeian. 2020. "The Plastic Surgery Social Media Influencer: Ethical Considerations and a Literature Review." *Aesthetic Surgery Journal* 40(6): 691–99. <https://doi.org/10.1093/asj/sjz329>.
- Haslanger, Sally. 2015. "Social Structure, Narrative, and Explanation." *Canadian Journal of Philosophy* 45(1): 1–15. <https://doi.org/10.1080/00455091.2015.1019176>.
- Haslanger, Sally. 2017. "Racism, Ideology, and Social Movements." *Res Philosophica* 94(1): 1–22. <https://doi.org/10.11612/resphil.1547>.
- Health and Care Act. 2022. UK Parliament. <https://bills.parliament.uk/bills/3022/stages/15953/amendments>
- Hodgkinson, D.J., and Hait, G. 1984. "Aesthetic Vaginal Labioplasty." *Plastic and Reconstructive Surgery*, 74(3): 414–416. <https://doi.org/10.1097/00006534-198409000-00015>.
- Horbach, Sophie E. R., Mark-Bram Bouman, Jan Maerten Smit, Müjde Özer, Marlon E. Buncamper, and Margriet G. Mullender. 2015. "Outcome of Vaginoplasty in Male-to-Female Transgender: A Systematic Review of Surgical Techniques" *The Journal of Sexual Medicine* 12(6): 1499–512. <https://doi.org/10.1111/jsm.12868>.
- International Society of Aesthetic Plastic Surgery. 2018. "ISAPS International Survey on Aesthetic/Cosmetic Procedures Performed in 2018." Hanover, NH: International Society of Aesthetic Plastic Surgery. <https://www.isaps.org/media/wifiy300/isaps-global-survey-results-2018-1.pdf>.
- Ion, A., and S. Creighton. 2019. "Techniques of Female Genital Cosmetic Surgery." In *Female Genital Cosmetic Surgery: Solution to What Problem?*, edited by S. Creighton and L. Liao. Cambridge, UK: Cambridge University Press.



- Jabbour, Samer, Elio Kechichian, Barbara Hersant, Philippe Levan, Lena El Hachem, Warren Noel, and Marwan Nasr. 2017. "Labia Majora Augmentation: A Systematic Review of the Literature" *Aesthetic Surgery Journal* 37(10): 1157–64. <https://doi.org/10.1093/asj/sjx056>.
- Jones, Bethany, and Camilla Nurka. 2015. "Labiaplasty and Pornography: A Preliminary Investigation" *Porn Studies* 2(1): 62–75. <https://doi.org/10.1080/23268743.2014.984940>.
- Jones, Bethany A., Kathy Griffiths, Boris Bizumic, and Camille Nurka. 2015. "Self-Objectification, Pornography Consumption, Mental Health and Genital Satisfaction in a Community Sample." Paper presented at the 16th International Mental Health Conference, August 2015, Gold Coast, Australia. <https://www.researchgate.net/publication/281103718>.
- Kaivanara, Marzieh. 2016. "Virginity Dilemma: Re-Creating Virginity through Hymenoplasty in Iran." *Culture, Health & Sex* 18(1): 71–83. <https://doi.org/10.1080/13691058.2015.1060532>.
- Kalampalikis, Andreas, and Lina Michala. 2021. "Cosmetic Labiaplasty on Minors: A Review of Current Trends and Evidence." *International Journal of Impotence Research* 35(3): 192–95. <https://doi.org/10.1038/s41443-021-00480-1>.
- Khader, Serene J. 2011. *Adaptive Preferences and Women's Empowerment*. New York: Oxford University Press.
- Kidd, Ian James, José Medina, and Gaile Pohlhaus Jr. 2017. *The Routledge Handbook of Epistemic Injustice*. New York: Routledge.
- Koning, Merel, Ingeborg A. Zeijlman, Theo K. Bouman, and Berend van der Lei. 2009. "Female Attitudes Regarding Labia Minora Appearance and Reduction with Consideration of Media Influence." *Aesthetic Surgery Journal* 29(1): 65–71. <https://doi.org/10.1016/j.asj.2008.12.003>.
- Kvalem, Ingela Lundin, Bente Træen, Bo Lewin, and Aleksandar Štulhofer. 2014. "Self-Perceived Effects of Internet Pornography Use, Genital Appearance Satisfaction, and Sexual Self-Esteem among Young Scandinavian Adults." *Cyberpsychology: Journal of Psychosocial Research on Cyberspace* 8(4): Article 4. <https://doi.org/10.5817/cp2014-4-4>.
- Laemmle-Ruff, Ingrid, Michelle Raggatt, Cassandra J. C. Wright, Elise R. Carrotte, E., Angela Davis, Rebecca Jenkinson, and Megan S. C. Lim. 2019. "Personal and Reported Partner Pornography Viewing by Australian Women, and Association with Mental Health and Body Image." *Sexual Health* 16(1): 75–79. <https://doi.org/10.1071/sh18037>.
- Lewis, Lyn. (2021). "Assimilation as False Consciousness: Higher Education Immigrant Students' Acculturation Beliefs and Experiences." *International Journal of Inter-cultural Relations* 83:30–42. <https://doi.org/10.1016/j.ijintrel.2021.04.012>.
- Lukes. S. 2011. "In Defense of False Consciousness." *University of Chicago Legal Forum* Article 3.
- Mackenzie, Jean. 2017. "Vagina Surgery Sought by Girls as Young as Nine." BBC, July 2, 2017. <https://www.bbc.com/news/health-40410459>.
- Marino, Patricia. 2022. "Sexual Use, Sexual Autonomy, and Adaptive Preferences: A Social Approach to Sexual Objectification." In *The Palgrave Handbook of Sexual Ethics*, edited by David Boonin, 111–28. Palgrave Macmillan.
- Meyerson, D. (1991). *False Consciousness*. Oxford: Clarendon Press.

- Nejadsarvari, Nasrin, Aali Ebrahimi, Azin Ebrahimi, and Haleh Hashem-Zade. 2016. "Medical Ethics in Plastic Surgery: A Mini Review." *World Journal of Plastic Surgery* 5(3): 207–12.
- Özer, Müjde, Indiana Mortimore, Elise P. Jansma, and Margriet G. Mullender. 2018. "Labiaplasty: Motivation, Techniques, and Ethics." *Nature Reviews Urology* 15: 175–89. <https://doi.org/10.1038/nrurol.2018.1>.
- Parsitau, Damaris Seleina. 2018. "How Outlawing Female Genital Mutilation in Kenya Has Driven It Underground and Led to Its Medicalization." Brookings Institution, June 19, 2018. <https://www.brookings.edu/articles/how-outlawing-female-genital-mutilation-in-kenya-has-driven-it-underground-and-led-to-its-medicalization/>.
- Pop, Meda V., and Alina S. Rusu. 2015. "The Role of Parents in Shaping and Improving the Sexual Health of Children – Lines of Developing Parental Sexuality Education Programmes." *Procedia – Social and Behavioral Sciences* 209:395–401. <https://doi.org/10.1016/j.sbspro.2015.11.210>.
- Rashidi, Fatemeh Niki, Zohreh Ghorashi, and Shayesteh Esmaeilzadeh. 2020. "How Do Some Iranian Grooms React if There Is Not Any Sign of Blood Stained Bed Sheets?" *Sexuality and Culture* 24(6): 2056–64. <https://doi.org/10.1007/s12119-020-09736-2>.
- Rodrigues, Sara. 2012. "From Vaginal Exception to Exceptional Vagina: The Biopolitics of Female Genital Cosmetic Surgery." *Sexualities* 15(7): 778–94. <https://doi.org/10.1177/1363460712454073>
- Rothman, Emily F. 2021. *Pornography and Public Health*. Oxford: Oxford University Press.
- Saharso, Sawirti. 2022. "Hymen 'Repair': Views from Feminists, Medical Professionals and the Women Involved in the Middle East, North Africa and Europe." *Ethnicities* 22(2): 196–214. <https://doi.org/10.1177/14687968211061582>.
- Saraiya, Hemant A. 2015. "Surgical Revirgination: Four Vaginal Mucosal Flaps for Reconstruction of a Hymen" *Indian Journal of Plastic Surgery* 48(2): 192–95. <https://doi.org/10.4103/0970-0358.163060>.
- Schall, Theodore E., and Jacob D. Moses. 2023. "Gender-Affirming Care for Cisgender People," *Hastings Center Report* 53(3): 15–24. <https://doi.org/10.1002/hast.1486>.
- Schick, Vanessa, Sarah K. Calabrese, Brandi N. Rima, and Alyssa N. Zucker. 2010. "Genital Appearance Dissatisfaction: Implications for Women's Genital Image Self-Consciousness, Sexual Esteem, Sexual Satisfaction, and Sexual Risk." *Psychology of Women Quarterly* 34(3): 394–404. <https://doi.org/10.1111/j.1471-6402.2010.01584.x>.
- Shai, Ayelet, Shahar Koffler, and Yael Hashiloni-Delov. 2021. "Feminism, Gender Medicine and Beyond: A Feminist Analysis of Gender Medicine." *International Journal for Equity in Health* 20: 177. <https://doi.org/10.1186/s12939-021-01511-5>.
- Sorice-Virk, Sarah, Alexander Y. Li, Francisco L. Canales, and Heather J. Furnas. 2020. "The Role of Pornography, Physical Symptoms, and Appearance in Labiaplasty Interest." *Aesthetic Surgery Journal* 40(8): 876–83. <https://doi.org/10.1093/asj/sjz254>.
- Sterodimas Aris, Henrique N. Radwanski, and Ivo Pitanguy. 2011. "Ethical Issues in Plastic and Reconstructive Surgery." *Aesthetic Plastic Surgery* 35(2): 262–67. <https://doi.org/10.1007/s00266-011-9674-3>.

- Summers, Hannah. 2022. "‘Virginity Repair’ Surgery to be Banned in Britain under New Bill." *The Guardian*, June 25, 2022. <https://www.theguardian.com/global-development/2022/jan/25/virginity-repair-surgery-to-be-banned-in-britain-under-new-bill>.
- Teven, Chad M., and Scott B. Grant. 2018. "Plastic Surgery's Contributions to Surgical Ethics." *AMA Journal of Ethics* 20(4): 349–56. <https://doi.org/10.1001/journalofethics.2018.20.4.nlit1-1804>.
- Tiefer, Leonore. 2008. "Female Genital Cosmetic Surgery: Freakish or Inevitable? Analysis from Medical Marketing, Bioethics, and Feminist Theory." *Feminism & Psychology* 18(4): 466–79. <https://doi.org/10.1177/0959353508095529>.
- Tylka, Tracy L., and Ashley M. Kroon Van Diest. (2014). "You Looking at Her ‘Hot’ Body May Not be ‘Cool’ for Me: Integrating Male Partners’ Pornography Use into Objectification Theory for Women" in *Psychology of Women Quarterly* 39(1): 67–84. <https://doi.org/10.1177/0361684314521784>.
- UK Department of Health. (2022). "UK-Wide Ban on Virginity Testing and Hymenoplasty." July 1, 2022. <https://www.health-ni.gov.uk/news/uk-wide-ban-virginity-testing-and-hymenoplasty>.
- Winter, Virginia Ramseyer, Michaella Ward, Sarah Pilgrim, Mackenzie Cook, and Alison Summers. 2019. "Want to Improve Sexual Health Education for Girls? Include Body Image." *American Journal of Sexuality Education* 14(2): 152–64. <https://doi.org/10.1080/15546128.2018.1531362>.
- Women's Wellness Institute of Dallas. n.d. "Labiaplasty Surgery in Teens: What You Should Know." <https://womenswellnessinstitute.com/labiaplasty-surgery-in-teens-what-you-should-know/> Accessed August 16, 2024.
- World Health Organization. 2018. "United Nations Agencies Call for Ban on Virginity Testing." October 17, 2018. <https://www.who.int/news/item/17-10-2018-united-nations-agencies-call-for-ban-on-virginity-testing>.
- Wynn, L. L. (2016). "Like a Virgin: Hymenoplasty and Secret Marriage in Egypt." *Medical Anthropology* 35(6): 547–59 <https://doi.org/10.1080/01459740.2016.1143822>.
- Young, Sarah. 2017. "Online Pornography Blamed as Girls as Young as Nine Seek Vaginal Cosmetic Surgery, Doctors Reveal." *Independent*, July 3, 2017. <https://www.independent.co.uk/life-style/gynaecology-girls-aged-nine-vaginal-cosmetic-surgery-pornography-social-media-naomi-crouch-paquita-de-zulueta-a7821186.html>.
- Zeplin, Philip H. 2016. "Clitoral Hood Reduction." *Aesthetic Surgery Journal* 36(7): NP231. <https://doi.org/10.1093/asj/sjw058>.

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