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For one drop of blood

Virginity, sexual norms and medical processes in hymenoplasty consultations in the Netherlands

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CHAPTER III:

VARIABILITY OF HYMENOPLASTY RECOMMENDATIONS

3.1 Article Title

How Variability in Hymenoplasty Recommendations Leads to Contrasting Rates of Surgery in the Netherlands: An ethnographic qualitative analysis

3.2 Abstract

Hymenoplasty is surgery to alter the shape of the hymen membrane in the vaginal canal, commonly performed to minimise the aperture. This medical operation is often requested by women who expect that their virginity will be under scrutiny, particularly during their first sexual encounter on their wedding night. Despite increasing demand for the surgery all over the globe, there is no one standard of practice in performing hymenoplasty. In the Netherlands, the manner in which medical consultations concerning the procedure take place depends heavily on the consulting physician. This paper looks at two different approaches to hymenoplasty consultation in the Netherlands: a pedagogical philosophy adopted in a public hospital and a practical approach employed by a private clinic. Each approach culminates in a contrasting result: patients in one medical establishment are twice as likely to undergo hymenoplasty than those visiting the other.

3.3 Introduction

Hymenoplasty, also known as hymenorrhaphy, is surgery to alter the shape of the hymen membrane in the vaginal canal, commonly performed to minimise the aperture (Ahmadi 2013, Renganathan, Cartwright and Cardozo 2009, Cook and Dickens 2009). In the past decade, the demand for hymenoplasty has been increasing in countries such as China, Canada, the USA and in various European countries (van Moorst et al. 2012, Amy 2008, Steinmüller and Tan 2015). In the Netherlands, the operation is often requested by Dutch women of migrant background, particularly from Morocco, Turkey, Afghanistan and Iraq. This medical procedure is frequently sought by women who consider themselves to be no longer sexually untouched, yet are facing the expectation of virginity on their wedding night (Logmans et al. 1998, van Moorst et al. 2012, Wild et al. 2015).

Despite increasing demand for the surgery all over the globe, there is no one standard way of performing hymenoplasty (Wild et al. 2015, Raveenthiran 2009, Goodman 2011). Physicians who perform this surgery rarely learned to do so in medical school and were more likely to have developed their own technique and/or acquired it from a senior practicing doctor on the job. Doctors around the world are still actively sharing the way they personally perform the surgery in medical journals (see for example Saraiya 2015, Triana and Robledo 2015, Ou et al. 2008, Prakash 2009 and Wei et al. 2015).

This lack of standards for performing hymenoplasty is partly due to the fact that the operation is a fairly new addition to the practice of medicine (Goodman 2011). In the Netherlands, this situation is compounded by the stance of medical associations, medical ethics boards and hospital departments which often discourage surgeons from performing hymenoplasty (see, for example, the Dutch obstetric and gynaecological association's statement (Feitsma and Kagie 2004)). Dutch institutional reluctance to acknowledge the surgery reflects similar position statements issued in recent years on comparable medical procedures collectively referred to as Female Genital Cosmetic Surgery (FGCS) by professional bodies in other countries, including in Egypt, the USA, Canada, Sweden, New Zealand, France, the UK and Germany (Kandela 1996, Braun 2010, de Lora 2015, Amy 2008, Juth et al. 2013).

Among doctors and medical professionals, hymenoplasty is still widely seen as a controversial topic. Physicians and midwives, as well as social scientists, are divided on the ethical nature of conducting the surgery as well as whether or not the operation is necessary to be performed (Cook and Dickens 2009, Christianson and Eriksson 2014, Cindoglu 1997, de Lora 2015). Those in support of the provision of hymenoplasty equate it with cosmetic and ritualistic surgery, favour women's autonomy in choosing

the operation, consider it a way to help patients who are often facing a precarious social dilemma, and/or view it as a form of women's empowerment (Logmans et al. 1998, Ahmadi 2015, Ross 1998, Juth and Lynöe 2015, Kaivanara 2016).

Those who are more cautious about doctors engaging in the practice cite the possible surgical exploitation of patients, reason that performing the surgery is perpetuating sexual inequality between men and women and argue that physicians may be considered to be colluding in deceit (Raphael 1998, Raveenthiran 2009, Roberts 2006). For physicians, their main objections mostly stem from the absence of medical reasons for the surgery, particularly because the link between a seemingly 'intact' hymen and the absence of sexual intercourse is considered to be weak (Adams, Botash and Kellogg 2004, Edgardh and Ormstad 2002), as well as due to the procedure's questionable efficacy (Juth et al. 2013, Raveenthiran 2009).

In the context of this controversy, hymenoplasty, perhaps somewhat ironically, is not a very difficult procedure to conduct. One gynaecologist maintained in a personal exchange that so long as one knows how to perform surgery, one should be able to figure out how to do hymenoplasty. A different doctor, who has performed hymenoplasty on a weekly basis for the last five years, claims similarly, 'As long as you know how to stitch a wound, you can do the operation.' Lack of formal acceptance of the operation and heterogeneity in the surgical method, as well as the relative simplicity of the technique, render the practice of hymenoplasty highly dependent on the doctor who is doing the surgery.

In the Netherlands, consultation concerning hymenoplasty is similarly dependent on the consulting doctor. Before the operation, the patient who desires the surgery needs first to meet with the doctor to talk about her intentions. The manner in which this consultation ensues depends heavily on the consulting physician. As hymenoplasty is a highly contested surgery, doctors' deliberations about performing or not performing this operation do not only include the biological aspects but also the social effects it may cause (Juth and Lynöe 2015, Ahmadi 2013). As a result, each hymenoplasty consultation is somewhat coloured by the stance of the consulting doctor concerning the operation.

Despite recognition of the variability of physicians' responses to requests for hymenoplasty (Essen et al. 2010, Juth and Lynoe 2015), there is an absence of a closer look at the effect of these diverse approaches on the outcomes of the consultations. Drawing on participant observations of 70 meetings between doctors and patients in the clinical setting, this paper looks at two different approaches to hymenoplasty consultations in the Netherlands: the first, provided by a team of doctors in a public hospital, the second, offered in a private clinic. The ethnographic access to hymenoplasty consultation this study employs is unprecedented as the surgery is a highly

sensitive medical procedure where secrecy and confidentiality are of the utmost concern both for the patients and the physicians, as discovery may result in unintended repercussions, including ostracisation, divorce and even death (Eich 2010, Amy 2008). Academic and scientific articles about the surgery that include a focus on the clinical setting are almost exclusively written by medical professionals involved in the provision of the service. This is to be expected as patients often desire only their physicians to know of their intention and no one else apart from them.

3.4 Methodology

A hospital and a clinic: the sites of the study

The study was conducted in two establishments that deal with hymenoplasty patients regularly throughout the year. The first is a teaching hospital, located in the southern area of a major city, the other is a private clinic situated about one hour from the capital by train. The hospital receives about 30-50 patients a year while the clinic receives double that number. Permission to carry out the study was also obtained from a third establishment, a different hospital in the same city as the first hospital. This second hospital employs closely comparable procedural stages of hymenoplasty consultation to those of the first hospital. However, the number of patients coming to this second hospital was significantly lower (no more than five a year) during this study's main data collection period. Due both to the low number of patients as well as the similarity of procedures with the first hospital, this paper will only look at the consultations conducted in the first hospital (henceforth: 'the hospital') and in the clinic, apart from one vignette taken from the third establishment. The choice of the vignette from the third establishment is considered necessary to illustrate the situation under discussion.

Data collection

The findings presented in this paper were collected through fieldwork conducted by the author over the period from 2012-2015 in the Netherlands. The main data derives from in-person observations of 70 hymenoplasty consultations. Since the 1970s, the observation of doctor-patient interaction has been viewed as a productive research method in the social study of medicine (see for example Korsch and Negrete 1972, Pilnick and Dingwall 2011 and Arora 2003), but it is hitherto unprecedented in the case of hymenoplasty due to the sensitive nature of the surgery.

In this study, patients were identified as they arranged their first hymenoplasty appointment, which was commonly done either personally by telephone or through a

referral letter from their huisarts - general practitioners akin to family doctors. During an in-person visit to each establishment and prior to their first meeting with a specialist, women were informed about the study and verbal consent was obtained for the meeting to be observed. Due to the need for high level of confidentiality, a waiver of written informed consent was approved from the ethical review board of Washington University in St. Louis to ensure the patient's real name was not associated with the surgery in any documentation. Observations took place during the gynaecological examination and the surgery once only, and specific agreement had been given by the patient involved. In the first of these observations, I was seated with no direct view of the patient's genitalia but with partial observation of the movements of doctors.

Refusing to participate in the study (11 patients) did not influence the care provided and this was made clear to each patient. Further consent was then obtained for doctor-patient exchanges to be audio recorded (11 instances). In cases where audio recording was not used, extensive note taking took place instead (59 instances). The consultation excerpts and ethnographical vignettes presented in this paper are translated versions of the transcribed audio recordings, or carefully reconstructed exchanges documented in the field notes. The research protocols received clearance from the Institutional Review Board of Washington University in St. Louis as well as from both medical ethics boards of the two studied hospitals.

Data analysis

In the spirit of qualitative study and constant comparative method, a preliminary analysis was performed immediately and cyclically whereby findings were fed back to the data collection effort in order to hone in discoveries and to develop the exploration so as to be closely in line with emerging themes from field research (Glaser 1965, Boeije 2002). Later stages of the study used a grounded theory approach to identify important concepts and key findings as the basis of the overall analysis and its main arguments (Strauss and Corbin 1994). The computer-assisted qualitative data analysis software Atlas.ti was used to support the detailed examination of data (Kelle 2004), whereby codebooks were developed both in vivo and based on commonalities to aid the process of synthesis and the writing of this article specifically.

3.5 Findings

The procedural set-up of the consultation

In the hospital as well as in the clinic, consultations are most of the time headed by one doctor. Both head doctors' philosophies of care were reflected in the hystero-

plasty consultation as performed in the medical establishment they were working in. Dr. Zeeman (a pseudonym) was the head of the hospital's sexology department. In the past decade, Dr. Zeeman, in collaboration with colleagues in two other hospitals, has established a step by step protocol for how hymenoplasty consultations should be conducted. This protocol involves the woman seeking the operation going through three different appointments. The first one is an intake meeting where Dr. Zeeman explores the reason for the request and the background of the patient, which lasts for around 45 minutes. The second visit is a meeting with the gynaecologist. Finally, the patient meets with Dr. Zeeman again for the third visit to inform the doctor of her decision to proceed or not with the surgery.

In contrast, at the clinic the patient often decides after the first visit whether or not she wants to continue with the surgery. Dr. Linden (a pseudonym), the head doctor of the clinic, meets with the patient for about 20 to 30 minutes to ascertain her reason for wanting the operation. This visit often includes Dr. Linden performing a gynaecological examination to determine whether surgery is possible to be done given the condition of the patient's hymen. The office in which Dr. Linden conducts the consultation is adjacent to an examination room, accessible by a connecting door. The physical examination rarely lasts more than five minutes. Afterwards, Dr. Linden and the patient return to the consultation room and the patient can then determine what the best course of action is going forward.

A cultural motivation for the operation

Both Dr. Zeeman and Dr. Linden see the root cause of the patient's 'problem' as one and the same thing. In October 2014, during an informal gathering of practicing sexologists in the Netherlands, held every six months or so to share knowledge and practice, Dr. Linden gave a presentation on her experience with hymenoplasty patients. A significant part of the presentation covered the description of the reasoning behind the patients' desire to have a hymenoplasty. Dr. Linden started the presentation by saying that the presentation touched on the cultural anthropological aspects of the problem. Dr. Linden then continued by detailing the different cultural expectations patients may be subject to that result in them desiring to have the surgery, including having to keep their chastity before marriage.

In a similar line of thought, Dr. Zeeman often remarks to me during our conversations that there are a lot of 'myths' about the hymen and virginity that many patients and people in general still believe in. To Dr. Zeeman, patients are not only lacking in knowledge of the hymen and virginity, they are also often in possession of erroneous beliefs about the subject. Dr. Zeeman attributes this perpetuation of incorrect understanding to the kind of stories people of the patients' background circulate among

themselves: ‘From their own background they are getting all kinds of other information and they don’t believe the “Western” information,’ Dr. Zeeman explained to me in one of our exchanges.

Philosophy of the consulting doctors

As Dr. Zeeman considers that the root cause of hymenoplasty seeking behaviour lies in patients’ misapprehension of issues related to the hymen and virginity, Dr. Zeeman views every consultation as a chance to correct the patient’s cultural misconceptions. The mistaken understandings Dr. Zeeman addresses include, among other things, widely-held beliefs that the condition of the hymen is a conclusive determinant of virginity, that a woman who is still a virgin always bleeds after first sexual penetration and that a hymenoplasty guarantees the presence of blood on the wedding night.

Coming from the position that the surgery is not a medical necessity, even calling it ‘nonsense’ on several occasions, Dr. Zeeman maintains that for the team of doctors in the hospital, success entails having the patient opt out of the procedure. However, Dr. Zeeman always affirms at the beginning of the consultation that if after the meeting the patient still desires the surgery, she will be operated on. What is important is that by the end of the consultation, the patient is in possession of what the doctor considers the ‘medically correct facts’ about the hymen and hymenoplasty. Dr. Zeeman sees a decision made by the patient after they are aware of the ‘correct’ facts and knowledge of virginity and the hymen to be more fully informed than the patient’s initial desires that are mainly driven, according to Dr. Zeeman, by incorrect beliefs.

Dr. Linden at the clinic does not share the same view as Dr. Zeeman about the surgery. While recognising there is no medical need for the surgery, Dr. Linden does not have any specific objection to performing it. In fact, Dr. Linden sees the operation simply as another ‘trick’ to ensuring there is blood on the marital bed sheet; nothing fundamentally different to using a finger prick or a vial of blood. Dr. Linden also reasons that even if the patient gains more information about virginity after the consultation, she may still face difficulties because her future husband may not have the same knowledge. For Dr. Linden, the operation is a practical and immediate solution to the patients’ dilemma concerning virginity.

The purpose of question and answer

The following is a typical exchange observed during Dr. Zeeman’s consultations.

Dr. Zeeman: *“How do people prove that you’re a virgin?”*

Patient: *“I don’t know. That’s why I’m here.”*

Dr. Zeeman: *“Do you have to show the [blood stained] sheet?”*

Patient: *“Maybe.”*

Dr. Zeeman: *“Did you bleed the first time?”*

Patient: *“Yes. A little.”*

Dr. Zeeman: *“How many women do you think do not bleed the first time?”*

Patient: *“A few?”*

Dr. Zeeman: *“A lot more than a few. Only less than half of women actually bleed.”*

Patient: *“Really?”*

Dr. Zeeman: *“How do they solve the problem if they don’t bleed?”*

Patient: *“I don’t know.”*

Dr. Zeeman then explains some of the ways other than surgery that women can ensure a blood-stained sheet.

Throughout this question and answer type of interaction, whenever the patient answers ‘wrongly’, Dr. Zeeman provides her with the ‘right’ reply; this is how Dr. Zeeman ‘corrects’ the mistaken knowledge the patient has about the hymen and virginity. This back and forth between the doctor and the patient resembles that of a teacher and student. As the hospital Dr. Zeeman is working at is a teaching hospital, it is perhaps unsurprising that the consultation also has these pedagogical undertones to it.

Dr. Linden’s consultation is in stark contrast to Dr. Zeeman’s. Dr. Linden frequently remarks that the consultation provided in the clinic is more practical in nature compared to the one in the hospital. This often means that Dr. Linden will meet with the patient to discern what the patient wants to achieve through the operation and tailor the treatment based on that. Dr. Linden’s aim is less about educating the patients and more about finding the best solution for them. In the Netherlands, women who are contemplating hymenoplasty do not all have the same goal in mind. Some hope to bleed at the wedding night, others wish for their husbands to feel that the vaginal opening is ‘tight’. Some need to convince their in-laws of their virginity, while others only need to assure the husband. A few resort to hymenoplasty to find closure on a sexual violation that lies in their past.

Dr. Linden offers different solutions to the patient based on the end goal a particular patient expects to achieve. These solutions do not always mean surgery. For those who need only to convince the husband, Dr. Linden suggests they use a capsule that is infused with a red dye. This pill is inserted into the vagina about half an hour before sex and a red liquid in a colour similar to blood will seep out after. For those who need to convince the in-laws, Dr. Linden will explain that the patient can use a finger prick to produce drops of blood on the sheet or they can resort to taking their own blood and putting it into a vial which can then be spilled during the wedding night.

The following is a typical interaction in Dr. Linden's clinic:

Dr. Linden: *"Okay, so what do you want now? Do you want a statement of virginity? Do you want to bleed? Do you want to feel tight?"*

Patient: *"All three, I think. More tight than blood."*

Dr. Linden then explains to the patient that being tight is caused by the pelvic floor muscles being contracted.

Dr. Linden: *"Are you going to bed with him the first time round in Morocco after marrying in the mosque?"*

Patient: *"Yes."*

Dr. Linden: *"Well, if you want blood, then it's a bit complicated."*

Dr. Linden continues by explaining the two types of operations that can be performed. The first one involves an elaborate technique where the hymen tissue is shaped in a particular manner. The other one, which Dr. Linden calls a temporary operation, is one where surgery is performed in the week of the wedding day in order for the suture to still be fresh. The suture is then pulled apart during vaginal penetration which results in blood.

Patient: *"I probably go there [Morocco] one month before [the wedding]. I don't have to show the sheet."*

Dr. Linden: *"Then I have a good solution for you."*

Dr. Linden then describes the red dye capsule that could be inserted into the vagina.

As is evident here, Dr. Linden takes the cue from the patient. Dr. Linden's interaction with the patient resembles more of a conversation taking place over the phone line between a customer and a technical support provider than between a teacher and student in a classroom.

Questions about bleeding after the first penetration

The most illustrative of the contrast between these two approaches was observable when looking at one question both doctors ask their patients, namely: 'Did you bleed the first time you had sex?'

Dr. Zeeman: *"Do you know how many women bleed on first penetration?"*

Patient: *"I don't know."*

Dr. Zeeman: *"50-60% all around the world. Did you bleed?"*

Patient: *"I didn't bleed."*

Dr. Zeeman: [Facing the patient's sister] *"Did you bleed?"*

Patient's sister: *"I'm still a virgin. I'm not married yet, remember?"*

Dr. Zeeman asks the question as a way to affirm the point that not all women bleed. The information Dr. Zeeman is sharing would have a stronger impact and is

potentially more easily accepted if the statement can be related to the patient's own experience, in this case, not bleeding during first penetration. Hence, this question is asked as another means of educating the patient. Dr. Linden, on the other hand, has a different reason for asking the question:

Dr. Linden: *Did you bleed the first time around?*

Patient: *A little bit... Actually, I saw nothing.*

Dr. Linden: *If the first time there was no blood, it's hard to say that from the surgery you will actually bleed. You may have a flexible hymen.*

Dr. Linden then continued by explaining how using the red dye capsule might also be a good option for the patient.

For Dr. Linden, there is a practical reason for asking that same question. When a patient does not bleed the first time she experiences penetration, Dr. Linden's view is that the chances are that the patient's hymen is flexible in nature. Hence a reshaping of the hymen, the way the more elaborate version of the operation is done, may not increase her chance of bleeding during the first night. This will be communicated to the patient if she leans towards having this type of operation performed. Additionally, by asking this question Dr. Linden has a better idea of what type of solution that might be best to offer to the patient.

The aim of the gynecological examination

Patients' second visit to the hospital which involves an examination by a gynaecologist has both pragmatic and educational purposes. Practically, it is necessary for the physician to have a look at the condition of the patient's hymen to know what can be done if the surgery is to be performed. Pedagogically, the examination is another way to impart more knowledge about the hymen and virginity to the patient. Dr. Zeeman thinks it is important for women to have a first-hand look at their own hymens as this exercise may further demystify patients concerning 'incorrect' beliefs surrounding virginity.

The following exchange illustrates what typically happens during an examination with the gynaecologist. This particular conversation took place at the second hospital which has the same protocol as the hospital where Dr. Zeeman works. There are three people in this conversation, the patient, the gynaecologist, and the head doctor whose role is comparable to Dr. Zeeman's:

Gynaecologist: *"Okay, we will do the examination now. We will see what it looks like down there."*

Head Doctor: *"And you have to see it yourself."*

Patient: [Laugh] *"Noooo, I don't want to see it. I don't want to see anything!"*

[Gynecologist performs examination on the patient]

Patient: *“Can you tell whether I’ll bleed or not?”*

Gynecologist: *“No.”*

Patient: *“I don’t want to see anything.”*

Gynecologist: *“Have you seen it yourself?”*

Patient: *“No.”*

Head Doctor: [Picking up a mirror] *“You have to look into the mirror. If not, you’d see nothing. See how it is closed? That’s your external. And that’s your internal. See how there’s no big hole? See how small it is? There, that folded thing. Do you see that? So small. It is not entirely closed, of course. Now, let’s try to contract your muscle.”*

What doctors hope a patient will see when she inspects her vaginal opening by looking through a mirror are several things. First, they hope to show that the hymen is not completely closed, as some patients imagine the hymen to resemble a wall-like structure. Second, the intention is to reveal that the opening of the hymen is more often than not smaller than the patient may have imagined. However, the most important part of this exercise of looking at your own hymen is accomplished through the dual action of contracting the pelvic muscle and seeing the effect of this at first-hand. Dr. Zeeman indicated to me that women often feel empowered when they witness this. This brings them the confidence that they themselves can make sure that the expectation of virginity put upon them on the wedding night can be met by regulating their own body by contracting the pelvic muscle to tighten the vaginal opening. This confidence may be enough to make the women decide to not to have the surgery; an end result that would be considered a successful outcome by Dr. Zeeman.

When performing the gynaecological examination, Dr. Linden never asks the patient to look into the mirror unless the patient herself asks to do so. The pelvic muscle exercise is also not performed, except when the patient indicates the need. Dr. Linden’s examination is aimed more at finding out what can or needs to be done if an operation is to take place. For example, on one occasion with a patient Dr. Linden explained after the examination that the patient would be better to opt for the temporary and not for the more elaborate surgery due to the absence of clefts on her hymen. On another occasion, a gynaecological examination was not even carried out as a result of Dr. Linden’s assessment of the situation, which the patient agreed to. Since her fiancé was aware that the patient was no longer a virgin and the couple only needed to convince the groom’s family of this by producing a blood-stained bed sheet, there was no need for the surgery and, therefore, there was no need at all for the examination.

3.6 Discussion

Similar but fundamentally different

The hymenoplasty consultations provided by Dr. Zeeman and Dr. Linden share some similarities. Both doctors impart comparable information to their patients, particularly on what they consider to be medically correct knowledge of the hymen and virginity. Imparting information on the hymen and virginity is also advocated by many scholars (Christianson and Eriksson 2013, Wild et al. 2015, Essen et al. 2010). The two doctors also introduce alternative course of actions to surgery for the patients to consider and resort to if preferred. Both too equally stress that their only desire is to provide the best help, which Dr. Zeeman reasons that it also means explaining to the patients that the operation might not always be the most useful solution. Ultimately, the two doctors emphasise that it is the patient's decision how to proceed.

However, Dr. Linden and Dr. Zeeman acknowledge that their philosophical views of hymenoplasty vastly differ. Dr. Zeeman considers the consultation a success if the patient opts out of surgery, while Dr. Linden sees the operation as just another device to fulfill expectations and has no fundamental objections to performing the procedure. These contrasting philosophies translate into the distinct ways in which consultations are done by each doctor.

For instance, Dr. Zeeman does offer alternatives to surgery - solutions that are similar to Dr. Linden's - to the patients. Yet Dr. Zeeman's explanation of doing so is not prompted by an elaboration of the specific goals each might achieve. Dr. Zeeman's aim by laying out all different alternatives the patients can resort to, is to illustrate that there are other solutions that are as, if not more, viable as surgery. This knowledge may then persuade the patient away from having the operation, a result Dr. Zeeman considers a success. Dr. Zeeman's consultation is pedagogical. The mandatory visits Dr. Zeeman's patients have to go through are arguably comparable to learning modules. It is only after going through them all that a patient is in possession of enough knowledge to make a fully informed decision as to whether or not to go through with the surgery.

On the other hand, Dr. Linden also provides the patients with 'education', for example through imparting information about virginity and the hymen. However, this information is conveyed as a part of the practical solutions Dr. Linden is offering based on the patient's individual situation. As a vignette previously illustrated, Dr. Linden may explain about the role of the pelvic muscle floor because the patient desires 'to be tight'. Similarly, Dr. Linden also explains the different shapes of the hymen and how it is not possible to determine whether or not someone is a virgin just by looking at the hymen in conjunction. Dr. Linden's treatment of patients is in a sense more tailor-made than that of Dr. Zeeman.

In short, both Dr. Zeeman and Dr. Linden provide comparable sets of information to the patients. The approach to the delivery of this information is what differentiates the two. Dr. Zeeman takes a more educational route, presenting the patient with all of the information first before the patient can then make a final decision about what to do. Dr. Linden takes a more pragmatic direction, offering alternative treatments while gradually learning what it is that the patient ultimately wants to achieve. It is important to highlight here that it is not that one doctor's approach is strictly educational while the other is purely practical but, as this paper has demonstrated, there are pedagogical aspects to Dr. Linden's consultation, just as there are pragmatic aspects to Dr. Zeeman approach. However, the philosophy of the consulting doctor, including what they consider is the root cause of the patients' problems and how best to help, determines which of the two becomes prioritised. The differing approaches then translate into a significant difference in outcome in terms of the number of patients who decide to have the surgery. Of all the patients consulting with Dr. Zeeman only around 33% decide to proceed with hymenoplasty while among those who meet with Dr. Linden, almost 60% patients decide to proceed.

Addressing the financial gain

At face value it may not be surprising that the private clinic performs more surgery compared to its public sector counterpart. After all, more operations mean more money and it is only to be expected that private establishments identify profit as one of their priorities. However, it needs to be mentioned that the price of hymenoplasty differs significantly between the two establishments, arguably uncharacteristically, with the private clinic offering a much lower price. The surgery costs around 1500 euros in the public hospital while in the private clinic it is but 150 euros - a mere 10% of the public hospital's cost. This particular private clinic is an exception to the norm as other private providers of hymenoplasty in the Netherlands and in Belgium, for instance, charge a considerably higher price for the procedure ranging from 1500 to 2200 euros.

It has to be acknowledged that despite the low price, performing more surgery does mean more income for the private establishment. However, it has also to be said that Dr. Linden has a significant say in the low price and can set the price of medical services provided in the clinic. Dr. Linden explains that the low price is made possible due to the low rent charges of the consultation room and the fact that all of the facilities and equipment needed for the surgery are available in the clinic, including an operating room that is free of charge to use: 'All I need is for the anaesthetic and some other small stuff and a bit for my time,' Dr. Linden explains. Dr. Linden considers provision of hymenoplasty a form of help to patients. The decision to keep the cost low stems from the same ideal.

Study Limitations and Future Work

This is a small-scale study involving two medical establishments and two lead consultants. This small number is due to the sensitivity and secrecy of the issue being examined and limited opportunities for ethnographic observation. Conducting similar studies in different medical establishments or different countries will allow a richer understanding and should be aspired to as a future endeavour.

Furthermore, when looking at hymenoplasty as a medical procedure, scholars should recognise that the provision of this service is a productive window through which to look at how social issues such as gender (Christianson and Eriksson 2015, Eich 2010, Wild et al 2015, Awwad 2011, Hegazy and Al-Rukban 2012) and contrasting cultural norms (Webb 1998, Loeber 2015), as well as the concept of ‘othering’ (Christianson and Eriksson 2013, Krumer-Nevo and Sidi 2012), may come into play during medical consultations. These are all topics that are undoubtedly relevant to the study and merit more in-depth exploration in future work.

3.7 Conclusion

This study contributes to the growing body of research on doctor-patient interaction (see for example Korsch and Negrete 1972, Esquibel and Borkan 2014, Menchik and Jin 2014, Emanuel and Emanuel 1992, Rubinelli 2013, Hurwicz 1995, Kayser-Jones 1995) especially the growing scholarship on communication between physicians and patients of migrant backgrounds (Dawson, Gifford and Amezquita 2000, Lechner and Solovova 2014). When it comes to the specific issue of hymenoplasty, this paper extends previous literature highlighting variabilities in the provision of the service (Essen et al. 2010, Juth and Lynoe 2015) and provides insights on how different approaches to consultation lead to contrasting outcomes. Hymenoplasty consultations, revolving around a medical intervention that is controversial and devoid of standardisation, provide opportunities for physicians to steer the direction of the medical process.

More importantly, this contrasting outcome comes within three crucial contexts: (1) the absence of regulation and standardisation of practice, (2) institutional and professional bodies’ tendency to recommend physicians against the provision of the surgery and (3) lack of publicly available knowledge about hymenoplasty, the hymen and virginity. This setting creates almost zero possibilities for patients to compare and contrast different available treatments for them to base their care decisions¹. It might be therefore high time for medical professionals and scholars alike to aspire to amend

¹ None of the patients participating in this research indicates that they have visited both medical establishments under study. Views from patients that have done so would undoubtedly be invaluable.

this situation in the hope to provide a more consistent treatment of patient and a better care in general.

3.8 Bibliography

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