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For one drop of blood

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

Ayuandini, S.P.

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CHAPTER V:

DEMEDICALIZATION
OF THE ‘BROKEN’ HYMEN

5.1 Article Title

Finger Pricks and Blood Vials: How doctors medicalize ‘cultural’ solutions to demedicalize the ‘broken’ hymen in the Netherlands

5.2 Abstract

This paper provides new perspectives on the scholarship on medicalization and demedicalization, building on an ethnography of hymenoplasty consultations in the Netherlands. By looking at how doctors can play an active role in demedicalization, this paper presents novel insights into Dutch physicians’ attempt to demedicalize the ‘broken’ hymen. In their consultations, Dutch doctors persuade hymenoplasty patients to abandon the assumed medical definition of the ‘broken’ hymen and offer nonmedical solutions to patients’ problems. Drawing from unique ethnographical access from 2012 to 2015 to 70 hymenoplasty consultations in the Netherlands, this paper’s original contribution comes from closely examining how demedicalization can be achieved through the process of medicalization. It investigates how Dutch physicians go even further in their efforts to demedicalize by medicalizing ‘cultural’ solutions as an alternative course of action to surgery.

5.3 Introduction

This paper contributes to the scholarship of medicalization-demmedicalization by looking at how demmedicalization is attempted by Dutch doctors through, ironically, the process of medicalization. In the effort to demmedicalize a condition that this paper refers to as the ‘broken’ hymen, Dutch physicians negate the assumed medical definition of the condition and prescribe nonmedical treatments for patients’ problems. Literature on demmedicalization and physicians’ roles has largely focused on how doctors limit participation in addressing problems they consider needing actions outside of medical attention (Kurz 1987, Sulzer 2015, Haines 1989). The case of hymenoplasty consultations in the Netherlands provides a contrast to this norm, insofar as doctors decide to be actively involved in demmedicalization.

This paper is not intended to be evaluative nor normative. Critical analysis of the conduct of doctors are meant to advance scholarship on medicalization/demmedicalization and on hymenoplasty. The most important contribution of this paper comes from examining Dutch doctors’ idiosyncratic practice of appropriating ‘cultural’ solutions when they make medical recommendations. They even go further by devising their own culturally informed medical treatments. The case allows insights into two important lines of inquiry: (1) What distinguishes practices physicians are comfortable medicalizing from those they prefer to keep outside of the medical realm? (2) How do the geographical context and the localized normative understandings of certain practices play a role in physicians’ attempt to medicalize/demmedicalize?

Medicalization and Demmedicalization

The term medicalization was first framed by Irving Zola (1972) to further the theorizations of medical authority’s expansion into problems existing outside of strict medical realms. More recently, Peter Conrad formulated one of the more widely accepted definitions of medicalization as a process that encompasses “defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to ‘treat’ it. [Medicalization] is a sociocultural process that may or may not involve the medical profession, lead to medical social control or medical treatment, or be the result of intentional expansion by the medical profession” (1992: 211). Scholars traced the beginnings of medicalization to the late 1800s, where behaviors and attitudes that were previously conceived as sinful gradually became reinterpreted as criminal and later medical (Fox 1977).

The steady rise of medicalization since then has become attributed to various larger systems such as “medical imperialism”, social control and scientific revolution

(Illich 1976, Zola 1972, Golden 1999, Freidson 1988). Psychiatry was one of the first realms where medicalization was observed and criticized (Szasz 1963). Ever since then, medicalization has become an illustrious focus of exploration in sociology and anthropology where scholars study and examine topics such as, to name a few, childbirth (Davis-Floyd 2009, Jordan 1997), alcoholism (Schneider 1978), gambling addiction (Rosecrance 1985), sleeping disorder (Williams 2002), shyness (Scott 2006) and ADHD (Malacrida 2004). Clarke (2010) argues that the latest reincarnation of medicalization is biomedicalization, resulting from the pervasiveness of science and technology in everyday (post)modern life.

Some scholars have also explored the limit and resistance to medicalization. Strong (1979) argues for the existence of factors constraining the power of medicine and medicalization. Studies have also examined resistance to medicalization in the form of non-compliance, for example, in the case of homelessness (Lyon-Callo 2000). It is also found in the promotion of an alternative discourse to medicine, for example in the case of childbirth (Davis and Walker 2013).

Both resistance to and limitations of medicalization can lead to demedicalization. One of the more commonly used definitions of the term comes from Conrad (1992), who outlined it as “a problem [that] is no longer defined in medical terms and medical treatments are no longer deemed to be appropriate solutions” (224). Although some scholars question this definition as it asserts that demedicalization can only be achieved when both conditions are fulfilled (Davis 2006) and that demedicalization is seen as an absolute rather than a continuum (Halfmann 2012). Similarly, Sulzer (2015) argues that demedicalization and medicalization should be seen as a contested process because *de jure* and *de facto* situations might not be aligned with one another. More generally, Golden (1999) cautions that demedicalization should not be perceived as merely the opposite of medicalization but rather to be understood as a complete historical process of its own.

Even though there is not yet a definitive characterization of demedicalization, it can be seen as starting with a social movement rising from outside of medical practice to challenge the medical formulation of a certain condition, identity or activity. This has been particularly the case with homosexuality and breast feeding (Conrad and Angell 2004, Torres 2014). Demedicalization is also observed to take place when questions arise over medical efficacy, such as in the case of circumcision (Carpenter 2010). It likewise occurs when engagement in a certain ‘harmful’ behavior is increasingly seen as a result of choice, such as in the case of self-injury (Adler and Adler 2007). The erosion of medical authority to administer treatment and the availability of technology to enable self-care, such as sex therapies (Tiefer 2012) and artificial insemination (Wikler and Wikler 1991), are also seen as factors that facilitate demedicalization.

The Role of Physicians in Demedicalization

Both in the efforts to resist medicalization and in the attempt to demedicalize, social scientists have observed the role of physicians. Albeit rarely, doctors have been found to make attempts to question and even resist medicalization of a certain practice, notion or condition. Thomas-MacLean and Stoppard find that Canadian doctors acknowledge the limitations of the medicalization of depression and choose to frame the understanding of the condition outside of medical discourse. Kurz (1987) looks at the reluctance of physicians to accept the idea of a battered person 'syndrome' to be 'diagnosed'. These physicians consider battering to stem from social factors which are held to be outside of the realm of medicine. Hence battering is not a legitimate medical concern although the resulting injuries are. However, shortly after Kurz's publication, the American Medical Association (AMA) did issue guidelines on diagnosis and treatment of victims of abuse (Flitcraft 1992). In the case of Borderline Personality Disorder (BPD), Sulzer (2015) claims that clinicians have been known to deny care for patients whom they sometimes suspect 'fabricating' their symptoms. These patients are considered not truly sick and therefore untreatable medically. These two cases are seen by the authors to simultaneously demonstrate doctors' resistance to medicalization and the practice of partial demedicalization.

One of the more unique cases of physicians' refusal to medicalize was observed by Haines (1989) in the case of lethal injection as a means of capital punishment. Since the introduction of state laws in 1977 to terminate criminals' lives by lethal injection, doctors have actively resisted legislative attempts to frame the process as medical. Physicians' rejection was due to their concerns that the initiator of the idea, who were exclusively of non-medical backgrounds, had politicized agendas. The refusal of participation also stemmed from their consideration that the act violated the Hippocratic oath of *primum non nocere*—first, do no harm.

As it is evident from the collection of scholarship presented in this section, the term 'demedicalization' in relation to the role of physicians in the process is synonymous with non-participation. Doctors would rather not contribute their expertise in cases which they deem to either be unworthy, to violate medical ethics or not to have a medical basis. The contribution of this paper to this discussion lies in the uniqueness of the case of hymenoplasty consultations. In the Netherlands, doctors involved in the provision of hymenoplasty offer their service to the patients despite recognizing the absence of a medical indication of the surgery. This paper argues that providing medical advice is an integral part of the doctors' attempt to demedicalize hymenoplasty. More precisely, it is crucial in their effort to demedicalize the motivating reason for undergoing the surgery: the 'broken' hymen. The doctors then go even further in the attempt to demedicalize the 'broken' hymen by offering alternative courses of

action to their patients. These alternatives are informed by practices that originate from outside the medical realm. However, since they are offered as a part of a medical consultation using medical resources, this paper posits that doctors are actively medicalizing non-medical solutions in order to demedicalize the 'broken' hymen.

5.4 The 'Broken' Hymen: A Medical Perspective in the Case of Hymenoplasty in the Netherlands

Hymenoplasty is a medical procedure done to alter the shape of a membrane in the vaginal canal commonly known as the hymen. In its intact condition, the hymen is still widely believed to be the hallmark of a virgin (Christianson and Eriksson 2011, Steinmueller and Tan 2015). Women who are contemplating hymenoplasty often do so because they believe that their virginity will come under scrutiny, typically during the wedding night. In many societies, the presence of blood on the marital bed sheet after the first penetration by a newly wedded husband is considered to be a visual sign that the bride owned an 'intact' hymen and therefore was previously sexually untouched (Logmans et. al. 1998, Buskens 1999, Skandrani et. al. 2010, Cinthio 2015, Ghanim 2015). Women who are considering hymenoplasty often ultimately desire to bleed in order to successfully 'perform' virginity during her wedding night (Ayuandini 2017).

However, scholars and medical professionals have shown that blood loss does not always occur after the first coitus (Raveenthiran 2009, Hegazy and Al-Rukban 2012, Christianson and Eriksson 2013). Doctors and physicians also consider the link between an 'intact' hymen and an absence of sexual penetration to be weak (Ayuandini 2017, Adam, Botash and Kellogg 2004, Edgardh and Ormstad 2002, Bravender et. al. 1999). Furthermore, it is difficult to discern what an intact hymen should look like. The hymen of a virgin woman is not of one standard shape: the amount of tissue, the regularity of the edge and the width of the aperture differ from one woman to the next (Hegazy and Al-Rukban 2012, Pokorny 1987). Consequently, physicians have stated that visual examination of the hymen is not a definitive means to discern whether or not sexual penetration has occurred.

In-depth interviews as well as conversational exchanges with physicians in the Netherlands, including with gynecologists, sexologists and general practitioners, reveal that a 'broken' hymen is not seen by Dutch doctors as a condition that merits medical intervention (Ayuandini 2017). Physicians are still in disagreement about the functions of the hymen, hence none have claimed that a particular state of the hymen renders a woman to be biologically impaired (Hegazy and Al-Rukban 2012,

Hobday, Haury and Dayton 1997). The exception is in the case of an imperforate hymen, which can cause pain due to the blockage of menstrual blood (Dane et. al. 2007, Rathod et. al. 2014). In the words of one Dutch doctor interviewed about hymenoplasty, “You would not die if you [were] not operated [on].” Dutch physicians also consider a ‘broken’ hymen—a hymen that is altered in condition after sexual penetration—to be quite ‘natural.’ According to the doctors, some alterations of the shape of the hymen after the first coitus is to be expected and can be seen as ‘normal’.

In Dutch, hymenoplasty procedure is also known by its local name: *maagden-vlieshersteloperatie*, which translates to “hymen restorative surgery”. The word *maagden-vlies* itself can either be translated as maidenhead or as virgin (*maagd*) membrane (*vlies*). Due to the high improbability of knowing what each individual woman’s hymen looked like before it was ‘broken’, Dutch doctors are reluctant to see the operation as a ‘restorative’ procedure. One doctor often remarks to the patient that the operation is more of a constructive surgery rather than a reconstructive one. Two techniques of the surgery are known by Dutch physicians (Feitsma and Kagie 2004). The first involves a temporary suture of tissues. Coitus will ‘break’ the suture resulting in (minor) bleeding. The second is done by gathering different parts of the hymen tissues to form a more uniformly shaped hymen opening. Neither technique guarantees bleeding during the wedding night, adding to physicians’ reluctance in performing the operation (Ayuandini 2017, van Moorst et. al. 2012).

Since doctors perceive that there is an absence of any medical information to support the claim of a ‘broken’ hymen, there is a concomitant lack of medical necessity to ‘repair’ it. The ‘problem’ of a ‘broken’ hymen is considered to be situated outside of the medical realm. The need to ‘fix’ this membrane is also usually informed by non-medical beliefs and encouraged by non-medical practices, particularly wedding rituals. Therefore, Dutch physicians deem the ‘broken’ hymen a misconception and say that it has no place in the medical understanding of bodily integrity.

5.5 Methodology and the Context of the Study

The findings presented in this paper are based on access to unique ethnographic observations of 70 hymenoplasty consultations in the Netherlands. Data was collected between 2012-2015 from 2 main medical establishments: a public hospital in a major Dutch city and a private clinic situated about an hour train ride from the capital. Observations of doctor-patient interactions are well known qualitative research methods since the 1970s (see for example Korsch and Negrete 1972 and Pilnick and Dingwall 2011), but untried in hymenoplasty case. Hymenoplasty consultations involve

high sensitivity and require the utmost level of secrecy to protect the identity of the patients. This situation makes ethnographic access to observe exchanges between doctors and patients difficult. Studies on hymenoplasty have been hitherto largely done by medical professionals involved in the provision of the service or by soliciting views from outside of the consultation rooms (Ahmadi 2014, Cinthio 2015, Essen et. al. 2010, Juth and Lynoe 2015, Kaivanara 2016, Loeber 2015, van Moorst et. al. 2012, Wild et. al 2015). The ethnographic access obtained by this study is therefore unparalleled.

Patients were identified as they made their appointments to meet with doctors to discuss hymenoplasty. Appointments were arranged either personally by phone or through a referral from their huisarts (a general practitioner akin to a family physician). All observations of exchanges between doctors and patients were done with a full consent from both. Consent from patients to observe their conversations with doctors was obtained in person prior to the first meeting with the physicians. Separate consent was then sought for the consultation to be audio recorded. In cases where patients refused recording, extensive notes were taken. Excerpts presented in this article came both from transcribed recordings as well as from field notes, both translated from Dutch to English. All procedures were reviewed and approved in advance by Washington University and hospital institutional review and ethical boards.

To complement the observations, this study also included in-depth interviews with 14 physicians who were in one way or another involved in the provision of hymenoplasty. About half of these doctors practiced in the two main medical establishments participating in this study. The rest worked in other medical establishments throughout the Netherlands. Doctors' views are integral parts of the argument presented in this paper. To refer to the doctors in the study, I interchangeably use the word "doctors", "physicians" or specifically "Dutch doctors" or "Dutch physicians".

Analysis is done following the tradition of qualitative study and constant comparative method where immediate findings refine the progression of research (Glaser 1965, Boeije 2002). Grounded theory is used in later stages to hone in on arguments (Strauss and Corbin 1994) and computer-assisted qualitative data analysis software (CAQDAS) Atlas.ti was used to support the process.

5.6 Findings

Demystifying an 'Intact' Hymen

Doctors dedicate a significant portion of their consultation time informing patients about 'medically correct' knowledge of the hymen and virginity. The most common 'misconception' they aim to dispel is the causal link between an 'intact'

hymen and the absence of sexual intercourse. Patients contemplating hymenoplasty consider their hymen to be no longer 'intact' and are anxious about whether they will bleed on their wedding night. Some patients imagine the hymen to be similar to a wall-like structure which will 'break' and bleed when penetrated. Some others visualize the membrane as resembling a ring with a smooth and annular edge which will be disturbed in the event of coitus. Almost all participants believed that the integrity of the hymen could be observed visually.

During consultations, doctors address the patients' preconception of the hymen and its link to virginity. This is often done by highlighting how visual observation of the hymen is not a conclusive method to determine a woman's chastity. Doctors explain how the hymen is normally and naturally of different shapes and no particular shape is an indication of the absence of sexual penetration or otherwise. As a way of illustration, one doctor often points to the sleeve of the patient's sweater, drawing attention to how the flexibility of the opening resembles that of the hymen. As a hymen can stretch and bend, it is possible for sexual penetration to cause no disruption to its integrity.

Another doctor chooses to ask her patients to envision a flower. A flower has natural notches and clefts, similar to a hymen. Crevices and indentations can be present on a hymen even without a prior history of sexual penetration. Patients often consider any observable fissure on the membrane as a sign of a 'broken' hymen. The flower metaphor is then useful to underscore that even an 'intact' hymen may have breaks and openings.

Doctors also use other types of visual aids to disconnect the link between the shape of the hymen and a woman's virginity. One doctor shows patients a brochure with drawings of hymens with very little tissue or with sizeable opening. The doctor uses these pictures to address another idea patients often have about the hymen: that the membrane has a small opening. This idea explains why hymenoplasty-seeking women in the Netherlands generally believe that penetration is more difficult with a virgin.

A different doctor chooses to use computer slideshows to display hymens with small openings and annular edges; the kind of hymen that most patients consider to be those of virgin women. However, these images are photos of the hymens of women who have had sexual penetrations. One is even notably of a woman who has had a baby. The visual aids used present a contrast. The brochure shown by the first doctor is meant to illustrate that a virgin woman can have an intact hymen with a large opening. The slideshow utilized by the second doctor demonstrates the complementary situation: a woman who has had sexual intimacy can possess (or at least have the appearance to possess) a hymen with a small opening.

The Role of the Pelvic Muscles and the Absence of Bleeding

Doctors also inform the patients that the small opening of a hymen can be achieved through contracting the pelvic floor muscles. This is partly also to address the patients' understanding that a virgin woman is believed to be 'tight'. It is not uncommon for patients to think that the 'tightness' of a virgin is due to the fact that her hymen opening is small and results in less degree of ease of entry during the first coitus. Patients also frequently mention how they know men to be able to feel whether or not a woman is still a virgin by virtue of her 'tightness'. Doctors address this pre-conception by informing the patients that it is likely that the 'tightness' men claim to be able to feel as well as the difficult penetration with a virgin comes from the tensing of the pelvic muscles. A sexually inexperienced woman is more likely to feel anxious during her first coitus, hence her pelvic muscles tense up resulting in difficult penetration. Dutch Doctors also speculate that the tensing up of the muscles and the anxiety are what most likely cause the bleeding after first coitus. Friction between the penis and the unlubricated vaginal wall may create a small laceration which results in bleeding. However, doctors never rule out the possibility that the hymen can be scratched or cut as a consequence of first sexual penetration. The resulting wound may also produce blood.

To further convince patients that the 'tightness' of the vaginal canal comes from tensing up the pelvic floor musculature, Dutch doctors encourage their patients to try contracting and relaxing these muscles. Patients are also urged to observe how the 'closeness' or 'openness' of their vagina is affected with each motion. It is not uncommon that the physicians even guide their patients through this exercise, especially if it is done during the gynecological examination to discern the state of the patient's hymen. Some doctors go even further by encouraging their patients to gaze in a mirror at their own vaginal opening when doing the exercise. Dutch physicians are convinced that if patients can see how contracting the pelvic muscles results in the narrowing of the vaginal opening, they will be more likely to abandon the idea that difficult penetration with a virgin is due to an 'intact' hymen.

In the consultation, Dutch doctors also address the notion of bleeding during first intercourse. Even though not all patients are under the impression that first penetration with a virgin woman will result in blood loss, some still hold that idea to be true. When consulting with the latter type of patients, Dutch doctors bring forth statistical 'evidence' to support their claims and state that about 50% women do not bleed the first time they have sex.

Cultural References and Cultural Solutions

The variability of the shape of an ‘intact’ hymen, the role of the pelvic musculature in creating ‘tightness’ of the vaginal canal, as well as the absence of blood in half of the cases of first sexual penetration, are seen as valid grounds by Dutch physicians to decouple the notion of the ‘broken’ hymen from its assumed medical definition. This indicates an attempt of demedicalization. However, Dutch doctors also widely recognize the patients’ need to bleed during the wedding night as a potential cultural requirement. Physicians are aware of wedding practices where linens are checked for a sign of blood, which is still believed to signify the bride’s well-kept sexual purity. Although it is becoming less common, they also recognize that some women of particular ancestry are still expected to go through this wedding ‘ritual’ in one form or another (Pham 2012, Eşsizoglu et. al. 2011, van Moorst et. al. 2012).

Dutch doctors acknowledge that the immediate need of the patients to produce a blood-stained bed sheet is practical in nature. They also aspire to provide help to patients who might be in a significant social dilemma if found to be no longer sexually untouched. Therefore, Dutch physicians introduce their patients to alternative ways of producing blood during the wedding night as a part of their hymenoplasty consultation. These alternatives range from pricking one’s own finger to inserting either a capsule infused with red dye or a small sponge soaked in blood into the vaginal canal. The capsule will dissolve after about half an hour and the bloodlike red dye will stay inside the vaginal canal up to approximately three hours. The act of penetration will allow the red dye to seep out to stain the linen. The sponge would not dissolve but coitus would coax the blood out and produce the desired result. For patients who are unsure about cutting their own finger or are uncomfortable about inserting a foreign object into the vagina, there is ‘the vial’. In this practice, a phlebotomy vial of blood is taken from the patients themselves and an anticoagulant substance is added to make sure the specimen stays fluid. The vial is then kept in a freezer until the wedding day. Then it is to be taken out, thawed and at the needed moment, the blood can be spilled out onto the sheet.

What is interesting about these alternatives is the fact that most of them are inspired by practices done by women in the ancestral country of the patients. Hymenoplasty-seeking women in the Netherlands tend to come from migrant backgrounds, having at least one parent or grandparent born and raised outside of the country. The majority of women seeking hymenoplasty in this study have either Moroccan or Turkish, including Kurdish, descent. The rest come from Afghani, Iraqi, Pakistani or Armenian ancestry. Dutch doctors informed patients how in the countries of their ancestry, women shared with other women what to do in the event that a newly married woman ‘failed’ to bleed after the first penetration.

- Doctor: *"You can even just prick your finger, with a pin."*
 Patient: *"and..."*
 Doctor: *"... and you put it inside your wedding dress. And during the wedding night as he is... well..."*
 Patient: (laugh)
 Doctor: *"... when he's completely gone, you prick your finger and smear it on the cloth."*

Apart from using a pin to prick their finger or a small blade to create a little nick, some brides rather choose to carry a sack or a pouch of goat blood with them. The content of this sack is then spilled onto the linen to produce a blood stain after coitus.

By introducing the patients to these alternatives, the doctors serve two purposes: 1) They pragmatically provide the help the patients are seeking and 2) arguably more importantly, they offer 'cultural' solutions to a 'cultural' problem. The second part situates the need to 'perform' virginity and its solution outside of the medical realm. This corresponds to Conrad's second condition to demedicalization which is solving a problem without medical treatments (1992).

The fact that these alternatives are seen by the doctors to be 'cultural' solutions rather than medical solutions is made apparent in the following vignette. The doctor in this vignette is advising a Dutch Turkish woman in her early 20s.

- Doctor: *"[...] you need to devise (verzinnen) other ways to bleed."*
 Patient: *"Such as?"*
 Doctor: *"Well, this is culturally specific. Depends on where you're from. Where are you from?"*
 Patient: *"Ankara."*
 Doctor: *"Well, in Ankara, people come from many places."*
 Patient: *"Yes."*
 Doctor: *"The most chosen solution for people from Turkey is the finger prick."*

Here we can see how the doctor takes into account the ancestry of the Dutch patient he is advising. For him, it is important to know exactly where the patient's family originally came from. He will then offer the alternative solutions that, to the best of his knowledge, are tailored to the methods of creating blood stain on the bed sheet that are more commonly practiced in the area.

The doctor later also mentioned other alternatives to the patient, including practices not found in the area in question. But he gave priority to those that were, as in his own statement in the vignette above: "Well, this is culturally specific. Depends on where you're from," which highlights how alternatives are seen as more culturally informed than medical.

In the consultation, Dutch doctors inform their patients of what they consider to be ‘medically correct’ information about the hymen and virginity. They also offer alternative solutions that are ‘culturally’ informed. Through these measures, hymenoplasty providers in the Netherlands situate the need for the operation that stems from the necessity to ‘perform’ virginity during the wedding night outside of the medical realm. However, we cannot neglect the fact that hymenoplasty consultations happen in a clinical setting. The advice given and the solutions offered are not only situated in a medical environment, but they are also made available using medical resources.

Medicalizing to Demedicalize

In this context, demedicalization is ultimately achieved through the act of medicalization. Take for instance the alternative solutions to producing blood offered to the patients. These ‘culturally’ informed solutions are not applied in their ‘original’ form. After all, doctors do not hand their patients a sack of goat blood to be used on the wedding night. They do, however, recommend that the patients have their blood taken out and put into a vial to be spilled when needed. The blood vial is the medically modified version of the sack of goat blood which is only made possible by the utilization of medical resources. For a woman to have her blood in a vial, she needs to have her blood taken by a certified nurse using a sterilized syringe on an exposed skin surface that is cleansed by an alcoholic swab. The blood is then put into a vial where an anticoagulant substance is added to ensure its fluidity. The ‘cultural’ solutions the doctors offer are at the same time medical alternatives.

Medical alternatives to ‘cultural’ solutions do not stop at the blood vial. Doctors also provide a medically tailored solution to cutting one’s skin to produce blood. Instead of being handed a pin to pierce one’s finger, the patient is given what the doctors call a finger prick. This is a special short needle, sheathed in a casing where a pressure on one end will trigger the needle to jut out. This type of finger prick is commonly used to obtain blood needed for different forms of blood tests. In the case of hymenoplasty, the needle is used to ‘recreate’ the effect of pricking one’s finger with a pin. With this, Dutch doctors devise another medically modified solution to the ‘culturally’ informed alternative of producing blood during the wedding night.

Another recommended way to produce blood is by having the first penetration coincide with the menstruation period. The risk involved in this method is to know with high confidence the timing of menstruation. However, with medical assistance, the certainty of the timing can be increased. Doctors recommend their patients to take birth control pills to regulate their bleeding. They then advise their patients to stop taking the pills shortly before the wedding so they can be sure blood will be produced during penetration. Again here, producing blood during the wedding night that is con-

sidered by Dutch doctors to be a culturally informed need is accommodated and met through medical means.

Culturally Informed, Medically Manufactured

The most intriguing solution offered by doctors to their patients is arguably the suppository. A suppository is a dissolvable medical capsule containing a red dye to be inserted into the vaginal canal. In the Netherlands, the suppository was first introduced by a gynecologist practicing in Utrecht in mid 2000s. Through her practice, she recognized the need of some of her patients to produce a blood-like stain on their marital bed sheets. She regularly recommended the suppository to her hymenoplasty patients. The suppository was produced in a pharmacy and was only available through a medical prescription. It satisfied some of the women's needs although the inventor lamented that the color of the dye was somewhat more purplish than red. Later, the suppository was also offered by other doctors in the Netherlands as an alternative solution to hymenoplasty.

This suppository is undoubtedly a medical solution to what the doctors consider to be a 'cultural' problem. The formula for the suppository was invented by a medical doctor and the production was done in a medical establishment—a pharmacy—by a medical professional—a certified pharmacist. More importantly, access to it could only be gained through medical means: a medical prescription written out after a consultation in a clinical setting.

In recent years, the suppository is no longer produced and has been replaced by a gelatin capsule containing red food coloring. Inspired to find a solution to the suppository's color inaccuracy, a doctor in a private clinic successfully found a combination of substances to create the reddish color that resembles fresh blood. The capsule can be obtained for as little as 2.50 euros. This doctor is less strict about the need for a medical prescription or medical consultation to obtain the capsule. She allows the capsule to be bought by others and then given to a woman who would benefit from it. However, the availability of these capsules is still mediated through a medical setting. They are not openly available to the general public and the doctor is the only person who can create and dispense them.

The suppository and all the alternatives highlighted above are devised and made available through an extensive use of medical resources, including medical tools, establishments and expertise. The access to them is also somewhat, if not fully, restricted. This is not to mention that the entire process happens through a medical system where a woman seeking to 'perform' virginity during the wedding night is advised through stages of medical consultations. The stages might include an intake meeting, a physical examination and more often than not a counseling session. Not to forget

that the woman in question is assigned the role of a patient where she can then be medically advised on how to address her 'cultural' problem.

5.7 Discussion and Concluding Thoughts

A 'broken' hymen is thought by patients seeking hymenoplasty to be a membrane with a 'damaged' appearance. It has clefts and notches and there is not much tissue remaining as a result of sexual penetration. A 'broken' hymen is also considered to be the reason why women do not bleed after sexual intimacy which indicates that she was no longer a virgin. This is likewise the patients' explanation why the vaginal canal is no longer 'tight'. These ideas are considered by Dutch doctors to have no medical basis as their own medical experience and observations as well as their knowledge of scientific research and studies demonstrate otherwise. The notion of the 'broken' hymen for Dutch doctors has no medical definition.

Doctors' active role in the demedicalization of the 'broken' hymen starts with their attempt to instill in their patients a 'medically correct' understanding of the condition of the hymen. Medically researched facts and visual aids are used to encourage patients to decouple the link between a woman's chastity and the condition of her hymen. Gynecological examination and patients' opportunity to take a first-hand look at their own vaginal canal serve as another tool to demedicalize the 'broken' hymen. All of these attempts to demedicalize are notably done in a medical establishment by medical experts through medical processes. Seen in this light, it is clear that demedicalization of the 'broken' hymen is actually achieved through a medicalization framework.

Scholars have argued that medicalization and demedicalization should not be seen as separate processes that happen distinctly from one another (Burke 2011, Lowenberg and Davis 1994). The two are argued to exist simultaneously and in gradation rather than in absolute terms (Halfmann 2012). In her exploration of the demedicalization of breastfeeding, Torres (2014) establishes this coexistence, because lactation consultants simultaneously medicalize and demedicalize breastfeeding. There are some parallels to be drawn between Torres' observation on demedicalization of breastfeeding and the case of hymenoplasty consultations presented in this paper. One particularly relevant to this case is how the process of medicalization can precede demedicalization; the former is a means to achieve the latter. The case of hymenoplasty consultations in the Netherlands represents an important contribution to the scholarship of demedicalization. It shows that medicalization and demedicalization processes not only can coexist, but also may be causally linked to one another.

However, in the case of hymenoplasty consultations in the Netherlands, physicians take this a step further by actively medicalizing alternative courses of action being offered to patients. As these alternative 'solutions' are culturally informed, Dutch doctors' attempts to demedicalize the 'broken' hymen include the provision of nonmedical treatments to address the patients' problems. These alternative treatments are then 'medically appropriated' to be offered as medical recommendations. Demedicalization of one notion that is considered to exist outside of the medical realm—the 'broken' hymen—is achieved through medicalizing practices that equally originate from outside of the medical world—finger pricking, among others. Here, doctors are exercising their prerogative on what can and cannot be part of the medical realm.

Furthermore, the case of hymenoplasty consultation in the Netherlands is unique in that medicalization of the 'broken' hymen almost exclusively originates from outside of the medical realm. Patients are the ones who initiate medical engagement as a result of concern about potential social or physical repercussions from being found to be a non-virgin. Doctors' attempts to simultaneously provide help for patients and keep the issue outside of the medical domain cannot be divorced from their understanding of ethics. Beneficence is the ideal Dutch physicians involved in the provision of hymenoplasty often claim they are striving for (Beauchamp and Childress 2012). This explains why they are comfortable in medicalizing alternative 'solutions' but are wary of providing hymenoplasty. The alternatives are seen to be in line with the spirit of beneficence while the provision of hymenoplasty is fraught with ethical quandaries. Scholars question whether performing the surgery means physicians are agreeing with the idea of women surgically altering their body to fulfill the expectation of others (Bekker et. al. 1996, Raveenthiran 2009, Cooks and Dickens 2009). What can be seen as doctors choosing between medicalization and demedicalization can be argued to be in line with the aspired ethics of their profession. It is also important to underscore at this point that if the patient still insists on getting hymenoplasty by the end of the consultation, doctors will agree to perform the surgery. Dutch doctors respect patients' ultimate decisions regarding the procedure.

In the exploration of physicians' rejection of the medicalization of lethal injection, Haines criticizes the tendency of social studies scholarship to frame medical professionals as constantly desiring to extend their authority outside of medical practice (1989). But as in the case of legal injection, the physicians studied here are not necessarily keen on having their expertise linked to practices that can be seen to violate their ideals. This is particularly true when the basis of medicalization is also considered to be medically false and scientifically unproven, such as in the case of hymenoplasty and the 'broken' hymen. In fact, many medical professional bodies

across the globe have encouraged their members not to perform hymenoplasty, including those in Egypt, United States, Canada, New Zealand, Sweden, and England (Kandela 1996, Braun 2010, de Lora 2015, Juth et. al. 2013). In the Netherlands, the Dutch Association for Obstetric and Gynaecology (Nederlandse Vereniging voor Obstetrie en Gynaecologie-NVOG) recommends physicians not to perform hymenoplasty unless there are no other alternatives available after consulting with patients (Feitsma and Kagie 2004). Therefore, there is a nuance to Dutch physicians' involvement in the provision of hymenoplasty; one that is reflective of the NVOG's statement. The doctors are willing to consult patients contemplating the operation but they are not eager to actually perform the surgery.

As a concluding thought, the case of hymenoplasty consultations in the Netherlands brings forward the contextual and localized nature of the process of demedicalization. The efforts of Dutch physicians to demedicalize the 'broken' hymen operates within the context of the Netherlands. Ever since the sexual revolution in the 1960s, sexuality has been considered to be an integral part of Dutch society (Schnabel 1990, Ketting 1990). Where pre-marital sex is largely seen as acceptable, a 'broken' hymen, particularly before marriage, does not have a problematic contextual framing. But elsewhere, virginity before marriage is desirable if not obligatory. Patients have indicated that this ideal is still widely aspired to in countries of their ancestry. They have further stated that in such countries, physicians are more willing to offer their expertise and play an adjudicator role when a woman's chastity is in question; they do so by examining her hymen. This is not to dismiss the potential importance of a financial incentive in any individual physician's decision to conduct hymenoplasty (Wynn 2016). However, it merits further exploration of how doctors in other countries might adhere to a different set of considerations than those of Dutch physicians regarding the 'broken' hymen. It is even feasible that physicians in other countries do frame this condition as medical. Exploring this possibility can provide new insights into how medicalization/demedicalization processes are influenced by and derived from contextual, local, and normative factors that reside outside of the medical realm.

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