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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 VI:**

# ENACTING DUTCHNESS IN HYMENOPLASTY CONSULTATION

## **6.1 Article Title**

Becoming (More) Dutch as Medical Recommendations: How understandings of national identity enter the medical practice of hymenoplasty consultations

## **6.2 Abstract**

This article looks at how Dutch as a national identity enters the practical setting of a medical consultation. Extending the growing scholarships of everyday nationalism and engaging with the notion of multivocalism, this article shows how Dutchness is understood in the form of desirable personal characteristics. These characteristics are promoted by physicians to patients of migrant ancestry looking for a surgery called hymenoplasty. This article presents unique scholarly observations of a case where a particular understanding of national identity is recommended as part of medical advice. Furthermore, by closely examining exchanges between doctors and patients, this article argues that Dutchness is a state of flux where a person of migrant ancestry can simultaneously be seen by others as Dutch and non-Dutch.

### 6.3 Introduction

In recent decades in Europe and in the US, nationalist discourse is steadily on the rise (Bonikowski, 2016; van Reekum, 2012; Gingrich and Banks, 2006), prompting necessary examinations of how nationalism enters public life and national conversations anew. This paper takes the case of the Netherlands and looks at how Dutchness is understood, enacted and promoted, chiefly by physicians, in a practical setting of medical consultation. Nationalism scholarship as of late has been increasingly championing explorations of national identity as it is defined by ‘ordinary’ people rather than the ‘elites’; a theoretical leaning that is mostly referred to as everyday nationalism (Billig, 1995; Skey, 2011; Fox and Miller-Idriss, 2008). By looking at the micro-social interactions between doctors and patients, this paper extends the scholarship on banal nationhood by exploring the ambiguity of national identity in everyday lives. This focus corresponds to Kaufmann’s latest call to look at nationalism through the lens of multivocalism (2016). He offers the concept as an intervention in the debate between the national liberals and the multiculturalists over descriptions of national identity. Kaufmann argues for a more central role of individuals in the context of “crowdsourced nationalism” where various understandings of national identity can differ from one individual to the next (2017, p. 21).

In the Netherlands, where the country has witnessed a resurgence of the populist anti-immigration agenda, many politicians and public figures today have started to define what it means to be Dutch (van Reekum and Duyvendak, 2012; de Leeuw and van Wichelen, 2008). This agenda is reflected within national media debates (Prins, 2002; Eyerman, 2008) and in more tangible forms such as during civic integration courses (Suvarierol and Kirk, 2015), naturalization ceremonies (Verkaaik, 2010) and parenting classes (van den Berg and Duyvendak, 2012). Scholars claim that citizenship in the Netherlands is increasingly understood by state elites in primarily cultural terms (Verkaaik, 2010; van Reekum and Duyvendak, 2012; Shadid, 2006; van den Berg and Schinkel, 2009; Duyvendak, Geschiere, Tonkens 2016). Being Dutch is seen as a state of contrast, specifically towards those that are considered to be the cultural Other, in particular, Muslim people of migrant ancestry (de Leeuw and van Wichelen, 2008; van Reekum and Duyvendak, 2012).

What Dutchness means and what cultural norms it signifies are constantly debated. Allegedly in line with ‘Dutch liberalism’, the value of autonomy and the emphasis on individual rights are traits often claimed in national conversations and public discourse as typically Dutch (de Leeuw and van Wichelen, 2008; Duyvendak, 2011; van den Berg and Duyvendak, 2012). Acceptance of homosexuality, recognition of gender equality as well as secularism are other traits that are also valued as Dutch (Mepschen,

Duyvendak and Tonkens, 2010; de Leeuw and van Wichelen, 2008; Verkaaik, 2010). These characteristics are lumped together under the umbrella of ‘modernity’, as all political parties, including right-wing populists, define ‘modern’, progressive values – particularly in the fields of religion, gender and sexuality – as core Dutch characteristics (Mepschen, Duyvendak and Tonkens, 2010, Roggeband and Verloo, 2007). Accordingly, a person of migrant background can achieve modern-ness through ‘full’ integration by adopting the aforementioned progressive qualities (Mepschen, Duyvendak and Tonkens, 2010).

In analyzing these new ‘culturalist’ tendencies in Western Europe, one cannot overlook the pivotal role played by the rhetoric of sexual and gender progress (Uitermark, Mepschen and Duyvendak, 2014). This entails, as a consequence, policies that address the presence of people with migrant ancestry in the Netherlands - specifically in the first decade of the second millennia - mostly targeting women of migrant descent (Roggeband and Verloo, 2007, Ghorashi, 2010). One hears in public debates the assumption that integration is not complete if women of migrant descent do not enjoy the full freedom of their Dutch counterparts. Families and spouses are seen by policy makers as obstacles to autonomy (van den Berg and Schinkel, 2009; Schinkel, 2011) and the condition of migrant women is considered to be the mark of the success or the failure of people of migrant background’s integration into Dutch society.

This paper offers a complementary outlook to a more ‘top-down’ understanding of Dutchness. Through analyzing exchanges between physicians and patients in hymenoplasty consultations, we look at how individuals understand and employ the concept of Dutchness as national identity. Observations of hymenoplasty consultations in the Netherlands also provide a unique opportunity to simultaneously explore how national identity enters the realm of medicine and how values of gender and sexuality are conflated and operate within Dutchness. Hymenoplasty is a medical procedure that alters the shape of the hymen membrane, commonly done to minimize the aperture (Karasahin et. al., 2009; Renganathan, Cartwright and Cardozo, 2009; Cook and Dickens, 2009). This surgery is often requested by women who believe that they are no longer physically a virgin and will face examination of their chastity immediately following their wedding night (Ayuandini 2017a, Logmans et. al., 1998; van Moorst et. al., 2012; Wild et. al., 2015). In the Netherlands, the operation is almost exclusively sought by Dutch women of migrant ancestry with at least one parent or grandparent born in countries such as Morocco, Turkey, Afghanistan, Iraq or Pakistan (Ayuandini, 2017b).

It is important to note that physicians involved in the provision of hymenoplasty in the Netherlands nearly all come from ‘native’ Dutch backgrounds. Doctors interviewed for the purpose of this study are no exception. All the doctors being consult-

ed, except for one, have stated that their preference is to not perform hymenoplasty. Their view is a reflection of medical ethics boards, hospital departments, as well as doctors associations that often urge Dutch physicians not to perform hymenoplasty (see Dutch obstetric and gynecological association's statement in Feitsma and Kagie, 2004). They regret the fact that the desire for the operation exists. Some of these physicians nevertheless still decide to provide the surgery or at the very least, meet with women contemplating hymenoplasty. Dutch doctors have been known to meet with hymenoplasty-seeking women in order to offer them alternative solutions to surgery (Ayuandini, 2017b). In the Netherlands, the meetings are also frequently aimed to dissuade patients from getting the operation (Ayuandini, 2017a). The way this is done is in line with the doctors' understandings of the causes behind the desire for hymenoplasty as well as what they deem to be the core reasons why some women are able to reject the surgery while others cannot.

In this paper, we first and foremost look at how Dutch physicians define and employ the idea of Dutchness. We chiefly examine their rhetoric, specifically how Dutchness is understood as a set of preferred characteristics. In so doing, we provide a new angle to multivocalism, one that is not only about coexistence of different understandings of national identity, as proposed by Kaufmann (2002), but also one of tension and conflict. We highlight how Dutch doctors' understandings of Dutchness face are challenged by the patients, by other people in the patients' life and even through their own discordant behaviors on different occasions in their medical practice. It is crucial to underscore here that what it means to be Dutch is not solely present in the point of view of the Dutch doctors in the confined context of hymenoplasty consultations. Excerpts and vignettes presented in this paper will show that patients often have similar ideas. It is not uncommon for the patients to agree with the positions of the doctors even frequently preempting the physicians' remark by volunteering comparable understandings of Dutch ideals. However, this does not detract from the fact that it is the doctors who are taking active measures to promote Dutchness, notably by encouraging their patients to adopt and exercise certain qualities as an integral aspect of their expert advice to address the patients' 'medical' situation. Staying true to our data that reflects this situation, it is our deliberate choice to primarily analyze the understanding of Dutchness through the doctors' rhetoric rather than the patients'.

This article does not seek to define what it means to be Dutch. However, it does argue that in the setting of hymenoplasty consultations in the Netherlands, the idea of Dutchness and being Dutch experiences a process of translation into distinct traits that are considered desirable by the physicians providing the service. What we aim to illustrate in this paper is twofold: (1) How national identity, in this case Dutchness, is prescribed by doctors as a solution to the patients' problem and (2) How Dutchness

becomes a state of flux where a person of migrant ancestry can simultaneously be seen by others as Dutch and non-Dutch.

## 6.4 Methodology

All findings presented in this paper were collected during 20 months of research conducted between 2012 and 2015. The main means of data collection was the close observation of 70 exchanges between doctors and patients during hymenoplasty consultations. All patients involved in the study were of migrant ancestry while out of 14 doctors who participated, 1 was of non-Dutch descent. All doctors were women except for 2, however, our findings do not show meaningful correlations between doctors' gender and their approach of practice. The consultations were mostly done in two establishments: a public hospital in one of the major cities in the Netherlands and a private clinic located about an hour from the Dutch capital by train.

The ethnographic access as the basis of this study is unprecedented due to hymenoplasty being a highly sensitive medical procedure where secrecy and confidentiality of the patients' identity is of the utmost priority. Discovery of the patients' intention to undergo the surgery by people in their social circle has frequently been cited by the patients as having unintended and unwanted consequences. Patients fear social drawbacks if it is found out that they are no longer a virgin. Accordingly, to ensure patients' anonymity, any identifiable personal information is omitted from this article.

Patients' consent to have their conversations with doctors observed was obtained in person prior to their first meeting with physicians. For observations done in the public hospital, further consent was sought from patients to audio record the consultation. In cases where consent was not obtained for audio recording, as well as for every observation in the private clinic, extensive field notes were taken. Audio recordings were later transcribed and both the transcriptions as well as field notes were translated from Dutch to English for the purpose of this paper. Observations of the consultations were supplemented with direct exchanges with doctors before and after the consultations.

In line with a constant comparative methodology and following the tradition of in-depth qualitative study, initial analysis was done in an immediate and cyclical manner in order for early insights to be fed back into field research (Glaser, 1965; Boeije, 2002). In this way, the development of the research was ensured to be consistent with emerging themes and data collection was constantly refined and attuned. The grounded theory approach was utilized in later stages of the study to distinguish important findings and key concepts to be used as the foundation of main arguments

and overall analyses (Strauss and Corbin, 1994). A computer-assisted qualitative data analysis software (CAQDAS) Atlas.ti was used to support an in-depth analysis of data. This served to structure the argument and aid the writing of this article (Kelle, 2004).

## 6.5 Findings

### Patients of Migrant Background

Doctors in the Netherlands generally see a very close connection between the desire for the hymenoplasty surgery and the ethnic cultural background of the inquiring patient<sup>4</sup>. The linkages between the two is an expected line of thought, as women who are seeking hymenoplasty in the Netherlands, although being full Dutch citizens, almost exclusively come from migrant backgrounds (Ayuandini, 2017a). Data from this study demonstrates that 100% of hymenoplasty patients have non-Dutch ancestry, in which 4 out of 5 have parents with roots in Muslim majority countries. These patients are typically Dutch born citizens with at least one parent or grandparent who migrated to the Netherlands from Morocco, Turkey, Afghanistan, Iraq or Pakistan. Immigration took place either in the 1970s, for those with ancestry from Morocco and Turkey, or in the early 2000s, for those from Afghanistan, Iraq and Pakistan. A few of the women seeking the surgery moved to the Netherlands when they were younger. Conversations with more than a dozen doctors involved in the provision of hymenoplasty in the Netherlands show that it is extremely rare for a Dutch woman with no migrant ancestry to contemplate getting the surgery. With more than 100 years of experience in total, only two of the doctors could recall a patient of ‘native’ Dutch background consulting them for hymenoplasty.

### Hymenoplasty and Patients’ Ancestry

With this as the context, it is unsurprising that Dutch doctors frame the desire for hymenoplasty as related to the patients’ migrant ancestry. Some doctors attribute the request to what they consider to be a scientifically unfounded connection, often believed by people of the patients’ background, between the condition of the hymen and the absence/presence of sexual intimacy. The hymen is a membrane in the vaginal canal in which its ‘intact’ condition is still considered in many countries to be the sign of a virgin (Logmans et. al. 1998; van Moorst et. al., 2012; Wild et. al., 2015; Eich,

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<sup>4</sup> 80% of patients in this study self-identified as Muslims, with the rest being orthodox Christian or different Iraqi religious denomination. However, participating patients and doctors consistently argue for the exclusion of religious beliefs from possible connections to hymenoplasty and would rather converse about “traditions” instead. Our findings correspond with Abu-Lughods (2002) where people find it difficult to talk about religion and rather speak of ‘culture’ instead.

2010; Buskens, 1999). However, doctors consider the link between a seemingly ‘intact’ hymen and the absence of sexual intercourse to be weak (Gay-y-Blasco, 1997; Boddy, 1989; Edgardh and Ormstad, 2002). Dutch doctors regularly referred to the conviction that an ‘intact’ hymen is a hallmark of a virgin woman as the ‘myth’ of virginity. Belief in the ‘myth’ continues to be a strong driver for patients seeking hymenoplasty. Doctors regret the enduring dissemination of the ‘myth’ among people of patients’ ancestry. One physician explained to me, “From their own background they are getting all kinds of other information and they don’t believe the ‘Western’ information.”

Some other doctors consider the patients’ desire for hymenoplasty to stem from their connection with men of migrant backgrounds. These men, particularly those the patients are dating or about to marry, not infrequently allude, insinuate, or even directly require them to be virgins before marriage. In fact, in one of the very rare cases where hymenoplasty was requested by a Dutch woman of no migrant ancestry, the operation was sought for because she was marrying a Dutch man of migrant parentage who expected her to still be a virgin on their wedding night. This arguably idiosyncratic case, somewhat fortuitously, further confirms the norm: migrant ancestry is a consistent common denominator for the desire to undergo hymenoplasty.

It is worth noting here that being connected to men of migrant background, whether through blood or through marriage, is an important reason a patient would seek hymenoplasty in the eyes of Dutch doctors. Men of migrant ancestry are often seen as unfair in their expectations regarding patients’ sexual history. They tend to be portrayed as practicing a regrettable double standard (*dubbele moraal*) where they freely explore pre-marital sexual intimacy while expecting their bride to be sexually untouched before marriage.

Studies have shown that Dutch women of migrant ancestry, particularly those of Moroccan and Turkish descent, tend to marry or date men who share a similar ethnic background (van Tubergen and Maas, 2007; Hooghiemstra, 2003; Kalmijn and van Tubergen, 2006). Findings from this study correspond to this earlier scholarship and the tendency for patients’ partner to be of similar ancestry is also observed by Dutch physicians. This observation reaffirms Dutch doctors’ view that there is a strong correlation between the patients of migrant descent who desire hymenoplasty and the ‘myth’ of virginity perpetuated by the people of her similar background. Doctors also see a correlation between being of migrant descent and the tendency for patients to marry men of migrant ancestry who would expect them to be virgins on their wedding night.



### Incompatibility Between Being Dutch and Hymenoplasty

Hence, the physicians assume the inversion to be equally valid: if the patient was not of migrant ancestry, in other words, if she was (truly) Dutch, she would not have the need for hymenoplasty. During consultations, it is therefore not uncommon for doctors to establish that in the Netherlands, as well as among the Dutch and Dutch society, hymenoplasty does not belong. In one notable occasion, when a patient inquired why the operation was not readily available in the country<sup>5</sup>, the doctor's answer encapsulated this succinctly.

Patient's friend: *"Why aren't there any other places providing this [hymenoplasty]?"*

Doctor: *"Well, people tend to see it as nonsense."*

Patient's friend: *"Nonsense? But this is a real problem!"*

Doctor: *"Yes, but in Dutch culture it is not important, that's why people see it as not important."*

Not uncommonly doctors emphasize this point to the patient by indicating that even the desire for the surgery could not have come into existence in the Netherlands.

Patient: *"But I feel guilty about it [not being a virgin]. But I can't take back what has happened."*

Doctor: *"Well, yes, in the Netherlands that past is not actually a problem, right?"*

Patient: *"No, that's true."*

The patient in this short vignette was a Dutch woman of Moroccan background who was born and raised in the Netherlands. However, as evident from the excerpt, the doctor seemed to have overlooked the fact that the patient was a Dutch citizen and her virginity dilemma was in fact an integral, if unfortunate, part of her life in the Netherlands. Her dilemma marked her as being 'outside' of 'Dutch culture'. This finding is in line with other scholars' observations that Dutch people of migrant ancestry are still seen as outsiders despite being born in the Netherlands, being a full Dutch citizen and only speaking Dutch (Essed and Trienekens, 2008).

The dissimilarities between being Dutch and being of migrant descent are sometimes highlighted by physicians through pointing out the differences between groups of people. Doctors make comments on how a Dutch person who does not have migrant ancestry will consider a woman who is no longer a virgin before marriage to be appealing as a partner.

Patient's friend: *"Yeah, no. I lost my virginity to my love when I was young and he*

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<sup>5</sup> Our explorations do not show any indication of 'black market' existence of hymenoplasty providers in the Netherlands. Patients however did sometimes allude to hymenoplasty being offered in their ancestral countries.

*left me after (laugh). And then I got married to a Dutch guy. And I have..."*

Doctor: *"And he knew about it..."*

Patient's friend: *"Yeah, I told him, "This is who I am. I am no longer a virgin. [...] He said, "Oh okay." Yeah, and then there's no problem anymore."*

Doctor: *"But that was because he's a Dutch guy."*

Patient's friend: *"I think so, yeah... (to the patient) Maybe you need to be with a Dutch [guy]... (laughing without finishing her sentence)."*

This comment is complementary to Dutch doctors' view on men of migrant background, as was illustrated earlier. Here, the Dutch guy is seen to be easily accepting of the patient's past while a man of migrant ancestry is considered to be the exact opposite: he disapproves of the patient's sexual history hence he is the source of the problem in her life.

The comparison is also made between Dutch women of migrant background and those who have no migrant ancestry. A notable example of this can be found in one of the doctors' speech to patients about the possibility of bleeding after the first sexual penetration. This doctor has conducted research among young Dutch women in the Netherlands on whether or not they bleed after their first sexual encounter. The result of this study is often mentioned to hymenoplasty patients as a way to highlight that expecting a virgin woman to always bleed the first time she has sex does not correspond to medical facts. The doctor regularly remarks that based on the research, 25% of women coming from migrant backgrounds did not bleed after experiencing their first coitus. Among Dutch women with no migrant ancestry, the percentage is doubled: 50% of women did not experience bleeding after their first sexual penetration. The doctor further explains that the reason for this difference is because the women of migrant descent tend to feel very afraid when they have sex for the first time. "They don't know what will happen. So, it's easier to bleed," states the doctor, "[A Dutch girl] is ready to have sex. She is lubricated enough. But for girls from other cultures, they are sometimes scared, they even feel like they're a prostitute. So, when you're afraid and tense like that, blood can also come."

It is evident through the illustrations provided in this section that there are obvious unquestioned assumptions being put forward by the doctors. Dutch people and Dutch society, which embody the life in the Netherlands, are portrayed to be entirely open to the explorations of sexuality and, in this case, pre-marital sexual encounters. This is the reason why men of migrant background are seen to be unaccepting of women's sexual history before marriage. This is also the logic behind why Dutch women of migrant background are perceived to be sexually inexperienced and even anx-

ious before their first sexual encounter.

### Always Connected to ‘Foreign’ Roots

The image of a patient who remains connected (*blijft verbonden*) to her non-Dutch heritage is frequently apparent from the exchanges recorded during consultations where physicians often frame her as ever-linked to other people with a similar foreign background. When addressing the patient, the consulting doctor regularly brings up the patient’s ancestry and not infrequently even tailors the medical advice given accordingly. The following vignette illustrates this. Here, the doctor was about to explain to the patient alternative ways of producing blood during the wedding night.

- 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.*”

There is no fundamental reason why a certain alternative is better for a patient of a particular background. Either a finger prick, a vial of blood or a capsule containing red dye can be used to produce blood or a blood like stain. They can be used as effectively by a woman of Turkish background as by a woman of Moroccan background. Yet the patient’s ancestry seems to be an important part of the advice giving.

Because the connection between the patient and her cultural heritage is naturalized by the doctors, some Dutch physicians are at times amused that the patients they are consulting have never heard of alternatives to producing blood during the wedding night; advice which is supposedly shared by women of her ancestry. Blood after the first penetration is still widely believed to be a sure mark of a virgin, as coitus is understood to ‘break’ the hymen of a chaste woman (Logmans et. al., 1998; Buskens, 1999; Skandrani et. al., 2010; Cinthio, 2015; Ghanim, 2015). Dutch doctors label these alternatives to produce blood as ‘tricks’.

- Doctor:           “*What I find funny about all of this is that in Morocco women know about these tricks. They tell each other.*”
- Patient:           “*Well, I don’t know anything about it. Why don’t they make a documentary so people like me can watch and find things out?*”

As evident from the above conversation, Dutch doctors assume that the patient is always connected to her cultural heritage and this is not left unchallenged by the

patient. Not infrequently, it is the patient themselves who would directly remind the doctor that she is very much a Dutch woman, being born and raised in the Netherlands.

Doctor: "What do women in Afghanistan do if they don't bleed?"

Patient: *"I live here. I grew up here. I don't know about the story about what happened."*

However, the more profound challenge to the physicians' assumption that the patient is always somewhat foreign comes in instances when doctors themselves express their surprise upon observing and assessing that the patient in front of them can very well be seen as Dutch. When Oumaima, a Moroccan woman in her early twenties, mentioned she first came to the Netherlands in her late teens, the doctor exclaimed in astonishment, "How can you speak Dutch so well?" When Besjana, a woman of Eastern European descent with a Caucasian look first came for a hymenoplasty consultation, the doctor remarked, "People will think you're Dutch." Both Oumaima and Besjana are Dutch citizens. These comments made by the doctors highlight their categorizations of patients who they understand to be the Other. For many doctors in the Netherlands, there is stereotyping of women who might have a greater tendency to contemplate hymenoplasty. The line of thinking is thus (just to name a few): this woman tends not to have a Caucasian appearance; she is most likely a Muslim; and she probably does not speak Dutch that well. The more she exhibits these characteristics, the more likely she will be to desire hymenoplasty.

It is not surprising that this categorization is informed by the more common demographic characteristics of the patients to which the doctors are accustomed to through their extensive experience in the provision of hymenoplasty in the Netherlands. However, it is notable that the doctors start to expect the kind of characteristics their patients possess even before meeting them in person. This explains the physicians' amazement when the stereotypes differ in practice.

More importantly, doctors do not only have certain expectations that their patients are not entirely Dutch, but they also sometimes assess how Dutch the patients are.

Doctor: *"Did you have more relationships after your first boyfriend?"*

Patient: *"After that I had two more relationships. The last one was for five years."*

Doctor: *"So you were a typical Dutch girl then?"*

Patient: (Laugh) *"Yes, I was."*

It is not uncommon for doctors to make remarks about the Dutchness of the patient they are consulting. "She is very Dutch in that sense," or "She is Dutch that way," were just some of the comments made. In one notable occasion, after a patient of

Moroccan descent exited the room, the doctor turned and exclaimed, “She’s half Dutch already!”

The last doctor’s comment is particularly noteworthy. With this remark, the physician signals that any patient coming for hymenoplasty consultation has the potential to be more Dutch, probably even to be ‘fully’ Dutch. In fact, they are already on their way to becoming Dutch. This is an important point to highlight as this line of thoughts plays a significant role in the physicians’ objectives when meeting with a woman contemplating hymenoplasty. We will come back to this point a bit later.

### **Assumed Characteristics of Dutchness**

As has been mentioned at the start of this article, physicians involved in the provision of hymenoplasty in the Netherlands often aim to dissuade their patients from undergoing the operation. As evident in some of the vignettes presented here, one way to persuade the patient to not continue with hymenoplasty is to present alternative ways of producing blood during the wedding night, called “tricks” by physicians. Doctors hope that by knowing there are other less intrusive methods, patients will ultimately decide against getting the operation. Another of the means the doctors frequently resort to is to make sure that the patients they are consulting acquire, exhibit and perform certain characteristics that would make them less likely to undergo the operation. Dutch doctors are of the mind that there are particular traits which are incompatible with the desire for the operation. The doctors are convinced that the more a woman exhibits these characteristics, the more likely she rejects the idea of undergoing hymenoplasty.

At the same time, this paper has also demonstrated that doctors in the Netherlands consider the desire for surgery to be incompatible with being Dutch. Excerpts from doctors’ exchanges with their patients show that this is because the physicians consider Dutchness to be inconsistent with the expectation of virginity on the wedding night. Dutchness is also perceived to be incongruous with the absence of sexual exploration before marriage. Hence, in the mind of the doctors, the more Dutch a woman is, the less likely she will be under the pressure of ‘proving’ her virginity on the wedding night and the less likely she will be to contemplate getting hymenoplasty. In short, Dutch doctors are convinced that if a woman possesses the ‘right’ characteristics or if she is Dutch (enough), she will not undergo the operation. Not surprisingly, the two ultimately conflate: exhibiting certain traits that are perceived to be incompatible with the desire of hymenoplasty is also identified as a hallmark of being Dutch.

There are several ‘desirable’ traits Dutch doctors time and time again allude to in their conversations with patients. These characteristics also relate to the physicians’ idea of the core reason that leads to the patient contemplating the surgery. Since

many consider the desire for hymenoplasty to stem from the lack of understanding about the ‘medically correct’ information of the hymen and virginity, doctors perceive education to be an important factor. Hence, being an educated knowledgeable woman is one of the characteristics Dutch physicians see as preferable in their patients. An educated woman is considered to be less likely to desire hymenoplasty.

Another characteristic that many doctors deem important is what they called ‘being strong’. It is particularly applicable in cases where the patients were victims of sexual abuse. Data from this study shows that close to one out of three women who are considering hymenoplasty in the Netherlands lost their virginity as a result of sexual violation. For these women, ‘being strong’ is regularly equated with addressing their sexual trauma (which was either because of abuse, rape, or deceit). For some, this means seeking psychological help. For others, it means reporting their violators to the police. Still some choose to talk to their family or relatives about the situation. While for others, being strong might be as simple as severing ties with the man who committed the violation. For patients who were not sexually violated, talking to others about their situation and walking away from men who caused them trouble are also seen as signs of ‘being strong’. All of these steps indicate that the woman is taking more control in their life and is no longer a helpless individual whose course of life and actions are determined by other people.

Closely related to this, some of the doctors see the root cause of the desire for hymenoplasty to be the men in the social circle of the surgery-seeking women. This includes, primarily, her betrothed or (ex) boyfriend. Hence, doctors consider women who are able to stand up to these men or those who are able to break their relationships with them to be the kind of women who will decide not to undergo hymenoplasty. These are women who have the ability to be independent and self-sufficient.

It is furthermore considered to be essential that the patient is autonomous. For the doctors, the idea of autonomy is closely related to being able to go to school and/or being able to hold employment. Dutch doctors are often concerned that after marriage, their patients will stop their education—if they are marrying while in school—and they worry that patients will no longer seek a paying job. The unease the physicians have about this issue does not necessarily come from the possibility that the patients would choose to stay home rather than work. It comes more from the concern that the new husbands will prohibit the patients from seeking employment. This is observable in the following vignette.

Doctor:           *“You’re such a smart woman. I find it weird that you want this operation.”*

Patient:           *“Well (smiles) I’m still busy with my study. I’m not working yet.”*

Doctor:           *“Your fiancé is also okay with you studying and wanting to work?”*

- Patient: *“Yes, he works too. [...] So he understands. My father also said that it’s important for him that his daughter finishes her study.”*
- Doctor: *“Also after you have children? You can still work?”*
- Patient: *“Well, I don’t want to have children just yet. But yeah, on the one hand I thought it’s best for children to be raised by their own parents, on the other hand, when you work there’s also child care. So...”*
- Doctor: *“I have seen a lot of modern women after marriage simply stay at home.”*
- Patient: *“Yes, but you change after you are married. You have more responsibility.”*
- Doctor: *“Yes, but what I meant was autonomy [autonomie].”*
- Patient: *“Yes. Yes... I think. It’s still possible.”*

This excerpt shows us anew that the physicians consider the men in the patient’s life, in this case the husband in particular, to be the reason that she could not make a decision for herself. The patient is questioned about her ability to be an autonomous individual. It is however worthy to note here that the physicians conflate the ability to exercise autonomy with having or continuing employment, a tendency that has also been observed by scholars elsewhere (Roggeband and Verloo, 2007). Being a working woman is now considered to be a preferred quality which is incompatible with desiring hymenoplasty.

### **Advising, Worrying, Praising**

All of the desirable traits mentioned above are evident from the doctors’ talk with the patients during hymenoplasty consultations. The most common methods physicians use to convey the characteristics to the patients are through their advice. One doctor suggests to a patient, “You can focus on yourself first. Find a job so you can be independent. And then you can find a partner who is like that too. Then two independent people can be together.” The doctor’s advice here clearly highlights one trait: independence. But the advice also emphasizes, again, the importance of having paid employment. Both, as has been mentioned before, are traits Dutch doctors consider to be incompatible with desiring hymenoplasty.

Advice is not the only way to inform the patients of the desirable qualities. Expressions of worry are also used to convey a similar message. This is evident in the last excerpt where the doctor was questioning the patient about her autonomy, particularly her ability to continue her study and seek employment. “Your fiancé is also okay with you studying and wanting to work?” as well as “Also after you have children? You can still work?” clearly convey the doctor’s anxiety and highlight what qualities

that are considered to be preferable for the patient to possess. The patient evidently understood both the concern and the preference as she proceeded to placate the doctor's concern, "Yes, he [fiancé] works too. [...] So he understands. My father also said that it's important for him that his daughter finishes her study."

Apart from giving advice and expressing concern, doctors also use praise to emphasize the qualities they consider important. Doctors praise their patients when they are seen to possess or exhibit other 'preferable' qualities. "You're a strong woman," or "You are independent," are common praises. More frequently, the doctors also respond with a simple, "Good!" when they deem the patient to have expressed a commendable trait such as severing ties with a controlling boyfriend or, once more, having paid employment.

The vignette where the doctor stresses the importance of autonomy is also a good example of praise as a way to highlight a 'desirable' quality. At the beginning of the conversation, the physician was observed to offer a compliment to the patient, "You're such a smart woman. I find it weird that you want this operation." It is worth noting that in this statement, not only was the doctor commending the patient for a quality she possesses (being smart), but the doctor also highlights how such a trait is incompatible with desiring hymenoplasty. This vignette succinctly illustrates how Dutch doctors perceive certain qualities and characteristics to be irreconcilable with wanting the operation. The physicians then aim to inspire the patients through the consultations to embody these traits which they hope will eventually persuade the patients to decide against undergoing the surgery.

### To be Modern

Dutch doctors have a word that they often use to encapsulate all of the aforementioned 'desirable' qualities. This word is 'modern'. Going back to the vignette on autonomy, one statement by the doctor is evident of this: "I have seen a lot of modern women after marriage simply stay at home." This statement was made in the context of the doctor being concerned that an educated woman would not be able to continue working. This statement, as well as the rest of the vignette, highlights how a smart woman, a woman who is highly educated, a woman who works professionally and a woman who is independent and strong would be the type of women doctors consider modern. Being modern is seen as incompatible with desiring the surgery. It is because being modern is also equated with not demanding a woman be a virgin before marriage as well as being open to the exploration of sexuality including pre-marital explorations. The following vignette clearly illustrates this.

Doctor:            "*Okay. And your older brother is strict (streng)?*"  
 Patient:            "*No. not at all.*"



- Doctor: *“So he plays no role in this story?”*
- Patient: *“No. It’s my own life. I have my own life, my own thinking.”*
- Doctor: *“Okay but you know that in quite some culture the oldest brother is the honor.”*
- Patient: *“No no. My father also doesn’t think that way. Everyone is educated (afgestudeerd). They don’t think...”*
- Doctor: *“All modern people...”*
- Patient: *“Yes, modern.”*
- Doctor: *“Except for this thing.”*
- Patient: *“Yeah (laugh). But it is actually the culture that I’m afraid of, not my parents.”*

This “thing” the doctor refers to is the expectation put on the patient to be a virgin on her wedding night. The vignette clearly highlights how being modern is seen to be irreconcilable with this expectation. Here, it is also evident that being modern is not solely a trait the patient can aspire to. It is a quality that other people in her life can also embody through education.

Hence, whenever a patient comes in for a hymenoplasty consultation and she is deemed by the consulting doctor to possess some, if not all, the characteristics that qualify her as being modern, it is not uncommon for the physician to express amazement.

- Doctor: *“The woman who sits in front of me is a modern Dutch woman who is under a cultural pressure.”*
- Patient: *“Yeah... I’m not really pressured. But I don’t want it afterwards...”*  
(trailing off)
- Doctor: *“But now the case is you want to be operated even if you know well that blood loss is not guaranteed.”*
- Patient: *“No, that’s correct.”*

At the beginning of the vignette, the doctor made a notable comment about the patient being both modern and Dutch. Previous sections have explored how the possession of certain characteristics is being conflated with being Dutch. Since the aspired qualities are perceived by the physicians to result in being modern, it is unsurprising that being modern and being Dutch is also conflated as in this vignette.

The vignette also clearly highlights the surprise the doctors’ experience when confronted with a woman who they deem as modern but who still desires hymenoplasty. This study finds that Dutch doctors often are confronted with this self-afflicted irony. In fact, almost all patients who consider undergoing the operation can be seen as modern—according to the doctors’ own criteria. These patients are either working, currently in school or just recently completed their tertiary study. However, despite

being challenged by this paradox, Dutch doctors' conviction that a modern woman would not desire the operation prevails. To account for this, it is useful for us to go back to one of the doctor's comments highlighted previously, "She's half Dutch already!" When doctors meet a patient who they consider to be modern but who still desires hymenoplasty, instead of modifying their assumption that only non-modern women seek the operation, they adjust their assessment of the patient. Clearly, the patient is modern, but not modern enough to do away with hymenoplasty. In other words, she is only half Dutch.

### **Empowering Patients through Consultations**

Hence, Dutch doctors in this study treat their hymenoplasty consultation as more than just a provision of a medical service. They often remark, except for one doctor, that they aim to educate, framing their meeting with the patient as *voorlichting* (education). This education goes beyond just replacing the belief women hold concerning the hymen and virginity with the ones that are considered by the doctors to be 'medically correct' or 'modern'. Hymenoplasty consultation becomes an opportunity for Dutch doctors to instill the characteristics they deem to be preferable in the patients they are meeting with. All doctors, including one who does not aim to educate, see this chance as a way to empower patients to aspire and acquire the qualities they consider to be desirable.

This aim to empower is readily observable from the encouragement doctors give patients. It is also palpable in doctors' advice as well as in their concerns about the kind of woman they hope the patients can become. At the moment of the consultation, the patient might have been smart but she might still hold a 'medically incorrect' understanding of virginity. She might be a strong woman but she could trust herself more. She might be independent but she could make better decisions to make sure her life is not dictated by others. She could speak up more, stand up more and act more. In essence, the patient could become more 'modern'. Doctors view each patient to have the potential for this improvement. Fundamentally, every patient can be and is encouraged to be more 'modern' and consequently more Dutch.

### **Other People See Patients as Dutch**

However, what the doctors in the Netherlands often do not take into consideration is that the patients might have been seen by others, particularly by people of similar ancestry, to be Dutch. At the very least, the patients are frequently perceived, if not suspected, to have started to open up to or even adopt what other people in their social circles consider to be an unquestionable Dutch trait: the acceptance of exploration of sexuality, including and particularly pre-marital. Ironically, this spec-

ulation by others about the patients is not uncommonly what directly compels them to contemplate getting hymenoplasty. One patient explains, “He [my fiancé] is a bit strict. But not only him, the entire family is strict when it comes to virginity. Because I live here in the Netherlands, they are all afraid that I’m no longer a virgin.” Echoing the same sentiment, an exchange between one patient and the doctor illustrates this further.

Patient: *“Well, yes, over there it’s a bit different. Afghanistan is a strict country. You can’t even be with a man. But here, it is a free country. So, people think about what you must have done.”*

Doctor: *“So you think that in Afghanistan women are adequately preserved/protected (bewaard) ...”*

Patient: *“Yes.”*

Doctor: *“...and even if she didn’t bleed, people can still believe that she is still a virgin.”*

Patient: *“Yes.”*

Doctor: *“And this is a free country, so we must have a stronger control.”*

Patient: *“Yes.”*

Both patients in these cases are concerned that their chastity will come under close scrutiny and then they decided to entertain the possibility of undergoing hymenoplasty. Furthermore, the contrast between perceptions put on the patient by the doctors and by others in her social circle is readily observable. For the physicians, the patient is not Dutch enough which becomes the core reason, in the eyes of the doctors, why she is entertaining hymenoplasty. For people in the patient’s social circle, however, she is seen as Dutch enough to warrant an inspection of her virginity on the wedding night.

### **Responding to Dutchness**

What is also important to note here is that even if doctors do not see their patients as ‘fully’ Dutch yet, previous sections have demonstrated that they do acknowledge when their patients exhibit characteristics they consider ‘rightly’ Dutch. When the doctors are confronted with the Dutchness of their patients, they then act accordingly and are almost compelled to respect it. This explains why despite not favoring the operation, Dutch doctors still perform hymenoplasty when the patient ultimately decides to undergo the surgery. “The patient is the boss,” remarks one doctor often at the start of the consultation, “if she says “I want to be operated”, then we operate.” This is the doctors’ way of valuing the autonomy of the patient in making her own decision—a trait that the physicians consider to be preferable in a woman and when that trait is exhibited, it needs to be respected.

It is not infrequently the case that the patient's decision to continue on with the surgery is communicated to the doctors towards the end of the consultation. The patient typically has sat through 20 minutes to 45 minutes of meeting with the doctors during which medically correct knowledge about virginity and the hymen was imparted to her. Patients' decision to undergo the surgery after the consultation was then seen by the doctors as being made knowledgeably and with all the accurate and needed information. The physicians respect this 'informed' decision by performing the surgery.

## 6.6 Conclusion: Being Dutch as the State of Flux

This article has shown how Dutch national ideals and nationalism permeate everyday practices and how national identity is conveyed and promoted by Dutch citizens and 'street level bureaucrats'—in this case doctors. What we observe here is everyday nationalism chiefly taking the form of talking (Fox and Miller-Idriss, 2008) and arising when a 'native' individual (the physicians) encounters a person of migrant background (the patients). It is reminiscent of Brubaker's study that looks at how encounters between two people momentarily takes the form of an interethnic interaction (2006). What is unique in the case of hymenoplasty consultations is that the interactions take the form of evaluations by the doctors of the patients in which the perceived 'deficiencies' of the latter are attributed to a lack of national identity and therefore recommended as a solution. Dutchness becomes part of the medical advice prescribed by Dutch doctors to their hymenoplasty patients.

Many Dutch citizens prefer that immigrants accept the official discourse of religious, sexual and moral 'progressiveness' (de Koster et. al., 2014; Houtman, Aupers and de Koster, 2011). In other words, when it comes to issues of public morality and personal values, citizens in liberal countries do not necessarily favor diversity in opinions and cultural repertoires. Quite strikingly, liberal values are not defended as universal human rights but as characteristics of a national identity: Dutchness. This is where we differ slightly from Kaufmann's idea of multivocalism where he argues that differences in understandings of national identity only energize rather than detract (2017). While acknowledging that different individual understandings of national identity could exist side by side, a struggle for validity can emerge when two or more competing ideas meet. The case of hymenoplasty consultation in the Netherlands illustrates this.

Dutch physicians' idea of national identity mirrors a more general development in Dutch society in which citizenship is increasingly defined in cultural terms, in con-

trast to the cultural Other, in particular the Muslim immigrant (Duyvendak, 2011; Van Reekum and Duyvendak, 2012; Duyvendak, Geschiere, Tonkens 2016). Secularism, gender equality and the acceptance of homosexuality serve as ideological benchmarks to test whether immigrants have entered 'modernity', the singular condition according to which they are allowed to belong in Dutch society (Mepschen, Duyvendak and Tonkens, 2012). Scholars have argued elsewhere that Dutch people who are labeled *allochtoon* (coming from outside the Netherlands) are commonly seen as non-Dutch but are capable of acquiring a certain degree of Dutchness (Essed and Trienekens, 2008). Hymenoplasty consultation becomes a venue to negotiate Dutchness and what it is to be Dutch between the doctors, who are of 'native' upbringing, and the patients, who are of migrant descent. Conversations between doctors and patients in hymenoplasty consultations highlight that being Dutch is interactional and situational in nature. Patients' Dutchness is acknowledged at certain times but it is overlooked in other circumstances by others including the physicians and people in the patients' social circle. Dutchness in this context is parallel to van Reekum and van den Berg's (2015) 'dialogical Dutchness' where being Dutch is situated in an interactive network of meanings.

This paper has demonstrated that Dutch people of migrant descent are seen to permanently have a link with their non-Dutch background; hence they are perceived to be not (yet) 'entirely' Dutch. Other scholars on migration and integration in the Netherlands have reported similar observations (Roggeband and Verloo, 2007, Ghorashi, 2010). Therefore, there is a gradation of Dutchness where one can move from being less Dutch to becoming more Dutch. This scale of being is arguably not precise or linear yet it has its measurements in the form of characteristics and values that are seen as both favored and 'rightly' Dutch. The more these traits are observed in a person, the more that person is deemed (more) Dutch.

What this paper has also demonstrated is that the Dutchness of the same person might be evaluated differently by various people. In the case of hymenoplasty patients, the physicians see them as not Dutch enough while some people in their immediate social circle perceive them to be (too) Dutch. We have also witnessed how patients themselves challenge the physicians' evaluation of their Dutchness. Moreover, we have observed occasions when Dutch doctors seem to contradict their own assessment of the Dutchness of their patients: being surprised when a patient is seen to be quite Dutch and performing hymenoplasty on patients because she exhibits the Dutch characteristic of autonomy. This is where national identity exhibits its profound nature of ambiguity. Multivocalism chiefly points to how the understandings of certain national identities can be different from one individual to the next; as such we have demonstrated in the case of hymenoplasty in the Netherlands. However, more im-

portantly, we have also shown a complexity to the idea of national identity that goes beyond just varieties between individuals. There can exist inconsistencies in one's person understanding of a particular national identity; two people can have similar understanding of what a national identity entails but when that understanding is used to evaluate a third person, their assessments differ; and the same person can be considered to not exhibit enough national identity in one occasion but seen as adequate in a different one.

What this paper has made abundantly clear, assuming a particular identity, in this case being Dutch, also becomes about values and norms and not only about birth, formal citizenship or upbringing. Hence, one can always have and exhibit a degree of Dutchness, albeit perhaps very little. At the same time, one can also be perceived to be not yet entirely Dutch, even ever so slightly. Being Dutch, or not-Dutch for that matter, takes up a quality of being in a state of flux where one can simultaneously be Dutch and also not Dutch. In the context of everyday nationalism, the same individual can be deemed by others during different micro-encounters to exhibit too much national identity, too little or somewhere in between, highlighting a view of nationhood that is heavily multivocal, interactional and contextual. Exchanges between doctors and patients during hymenoplasty consultations suggest that being Dutch or not-Dutch becomes less of an absolute binary position and more of a continuum.

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