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Female Genital Cosmetic Surgery: Neoliberalism, Medicalization, and the Pathologization Of Embodiment

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FEMALE GENITAL COSMETIC SURGERY: NEOLIBERALISM, MEDICALIZATION, AND THE PATHOLOGIZATION OF EMBODIMENT

A dissertation submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

HISTORY OF CONSCIOUSNESS
with an emphasis in FEMINIST STUDIES

by

Jessica Y. Neasbitt

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Vice Provost and Dean of Graduate Studies
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2018
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Abstract

Female Genital Cosmetic Surgery: Neoliberalism, Medicalization, and the Pathologization of Embodiment

Jessica Y. Neasbitt

Female Genital Cosmetic Surgery (FGCS) is a burgeoning area of developing cosmetic surgery in the U.S., Britain, and Australia. Hotly debated, the procedure is caught up in cultural discourses of medicalization, on the one hand (arguing for the necessity of such procedures to correct a “defect” in female anatomy), and, on the other, condemnations of the practice as yet another market invention to capitalize on women’s traditional anxieties regarding beauty, especially with regard to genital anatomy. This dissertation situates FGCS historically and culturally within practices of neoliberal capitalism, new surgical technologies, changes in U.S. healthcare systems, increased bodily surveillance and advances in media technology, and a tradition of the development and use of standardized systems of classification within practices of Western medicine. It then illustrates how these factors work in concert to produce “defective” bodies and the technologies marketed as necessary to fix them.
Acknowledgements

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Finally, there is a group of women to whom I owe more than can be articulated here (which doesn’t mean that I won’t at least try). To Dr. Christina Rincon and Dr. Elise Hughes, thank you for insisting that I follow up on my own health, which quite literally saved my life and provided me with the treatment that enabled me to continue this work. To Michelle Michaels, the woman who helped facilitate that treatment, I cannot begin to thank you enough for making one of the most difficult periods of my life that much easier. This dissertation quite literally wouldn’t exist without the thoughtful care and advocacy you provided, and I am eternally grateful to you all.
Dedication

For Irene, who completed her journey before I could complete this one. For so many reasons, this only exists because you did—and you are missed and loved every day.
Introduction

Ten years ago, I left a fifteen-year medical career to finish a long-delayed degree at UC Berkeley. I did this with no intention of studying the field that I had just left, or anything related to it. In fact, my plan was to obtain a degree in U.S. history in preparation for a career teaching at the secondary level. The plan was not to change my major, write not one—but two—theses on female genital cosmetic surgery (FGCS), apply to graduate school, and pursue a Ph.D. The plan was not to become someone whom a conference attendee would one day address as “the vagina lady” after forgetting my name, the plan was never about that moniker sticking to me for years afterward, and the plan was most certainly not about spending the next nine years immersed in studying the wide variety of ways that a surgeon can cosmetically alter female genitalia.

Plans change, however, and this brings me to one of the most common questions that I am asked by people when they hear the topic of my research: How did you come to know about, much less study, female genital cosmetic surgery? The answer is easy because, unlike anything else caught up in the tangle of interactions surrounding FGCS, it involves one person, and a simple recounting of facts from that person—and no more. There are no factions or sides, no overlapping interests or conflicts, no theoretical claims or accusations of conflicts of interest to be investigated. Instead, there is just me, recalling a day like any other at UC Berkeley; there is me, poring over piles of resource materials for a paper I was writing on problematic Western responses to practices of female genital cutting (FGC) in
African countries, and finding one sentence in one source that mentioned vaginal plastic surgery in Western nations. Before that day in 2009, I had never heard of FGCS. I had no idea what vaginal plastic surgery could entail, but I immediately went online in order to find out—and the more I read, the more intrigued I became. I, like most of the people that ask me about my work, had many questions—and thus, in the course of reviewing one source for a paper, events were set in motion that ultimately led to me changing my major, and the focus of my scholarship at Berkeley and beyond.

Which leads, somewhat indirectly, to the second most common question I am asked when speaking about FGCS: What, exactly, are these surgeries? The question is complicated, because, like many aspects of FGCS it is contested. This question captures FGCS, in a sense, because to answer it is already to declare one’s alignment with or against the procedures, people, and industry surrounding FGCS and its representations. What is included, and what is elided, in one’s conceptualization of the procedures is already a political act. This was my first indication that the research that I hoped to examine—non-partisan research that critically explored all aspects of FGCS, especially in relation to discourses of choice, bodily “improvement,” and pathologization —would be a very difficult tightrope to walk.

Eventually, what I came to realize was that I needed to think—and write—a larger story than could be informed by any one discipline. While they all had useful tools, none held all of the necessary equipment within their well-defined institutional borders to do justice to the array of specializations—sociology, medical
anthropology, history, science and technology studies, feminist theory—required to address FGCS. I found an interdisciplinary graduate program that welcomed my research, and set about continuing and expanding my research in order to integrate knowledge and methodologies from a range of disciplines. I did this because a satisfactorily diligent accounting of the various factors and actors involved in FGCS include traditions of pathologizing and/or categorizing bodies (especially female bodies); discourses of individual responsibility in neoliberal capitalism; the gendering of particular emergent technologies and medical advancements; and the interaction of biopower with ideals of normative female embodiment.

In undertaking this accounting, I turn first to history. Not the history of FGCS, per se, but to a history that paves the way for its existence: the pathologization of female bodies in Western cultures. A genealogy of this pathologization (and the medicalization that is inextricably linked to it) allows for a consideration of the historical practices that have paved the way for the emergence of FGCS. Following Foucault, Chapter one—“The Tangled Path to Pathologization”—uses a genealogical method to illustrate three key events in this history of the pathologization of female bodies in Western cultures: 1) the practice of holy anatomies in mid-thirteenth to late-sixteenth-century Western Europe, 2) the nineteenth-century European study, display, and eventual dissection (and re-display) of Saartje Bartmann, a black African woman, and 3) the experimental surgeries conducted on enslaved black women that are recognized as constituting the birth of “American gynecology.”
Using genealogy as a method for this chapter allows me to examine the chance encounters and surprising aspects of this history, and to move beyond current narratives of FGCS that propose that the root of this pathologization can be found in the growing medicalization of various forms of embodiment. Additionally, I briefly examine how critics of FGCS and other scholars define this medicalization, and illustrate what is possible if we consider it not as the root, but as one aspect of a much more complicated path toward it. Moving beyond accounts of medicalization and pathologization emerging from medicine alone, a more complex tradition emerges, where the access to female bodies that is a vital aspect of medicalization and pathologization is the result of a wide variety of social, religious, judicial, scientific, and medical forces and edicts. This, in turn, illuminates the contradictions and ethical dilemmas posed by processes of pathologization and its critiques. Additionally, exposing the varied and sometimes unexpected aspects of the history of the pathologization of female bodies in Western cultures has the potential to offer new avenues for formulating future scholarship and critiques of one of the most controversial products of female medicine’s newest subspecialty: FGCS.

In Chapter two, “Lips Unsealed: Narratives of FGCS,” I examine some of the marketing and critiques of FGCS, and divide these narratives into three major categories: choice narratives, medicalization narratives, and nature narratives. I find these groupings to be a useful tool for analyzing the discourses of FGCS, even as I acknowledge a good deal of overlap between them, and a certain lack of precision that always comes with general classificatory schemes. Despite this, these
classifications help build upon the processes of pathologization discussed in Chapter one and reveal the places where the underlying frameworks of narratives of FGCS overlap, fall short, and conflict.

These narratives occupy various positions regarding these surgeries, and the most prevalent belong to one of two groups: those in favor of the procedures, often generated by FGCS surgeons and patients happy with the procedures, and those opposed to or critical of them, most commonly generated by academics, feminists, and members of more traditional (Western) medical establishments. The forms these narratives take are wide-ranging, from surgeon websites to beauty magazine articles, from YouTube parodies to photography books, and from academic scholarship to online petitions and senate testimony. Choice narratives seek to inform potential FGCS patients and create more savvy consumers in the hope of facilitating a more knowledgeable approach to deciding whether or not to undergo FGCS. Among these, choice narratives produced by FGCS surgeons that present genital cosmetic surgery as empowering—a step in a woman’s transformational journey, self-management, and self-care—are the most common. Medicalization narratives are most often generated by activists and scholars opposed to a broader medicalization of sex that they see as including FGCS and technologies like it; however, medicalization narratives can also include FGCS industry use of the implied authority of medical professionals to correctly interpret when a body is in need of a medical or surgical “correction” such as FGCS. Nature narratives vary according to their origin, but can roughly be divided into two general groups. The first set of narratives argues for an
expansive view of bodily variations, and generally emanates from those who oppose FGCS on the grounds that the industry contributes to the homogenization of women’s genitals. The second group includes narratives most often produced to encourage potential patients to have the surgeries in order to return to a more “natural” state or reverse the damage wrought by processes such as childbirth and aging.

As activist, critical, and industry narratives of FGCS proliferate, so does the importance of non-partisan examinations, which have the power to provide insight into not only what methods are being employed, but also by whom and to what end. This chapter seeks to provide such an examination, which I argue reveals places where the originators of the narratives in question produce scholarship that is problematic relative to their stated purpose. For example: While many of the most prominent producers of anti-FGCS scholarship and activism base their objections to the surgeries on an opposition to the medicalization of sex, they nevertheless counter this medicalization by deploying medical arguments as supporting evidence. Also problematic are narratives concerned with genital “norms,” which—by pointing out the lack of medical consensus about normative genital morphology—run the risk of reproducing the narrowing of genital aesthetics they purport to oppose by suggesting that such a standard might exist.

The contradictions arising in even this cursory examination support the need for more expansive scholarly engagements with FGCS to better understand the phenomenon beyond the poles of pro- or anti-FGCS. These examples offer another important reason for examining these narratives; namely, to see how FGCS represents
a case study of issues relevant beyond the procedure itself. By separating FGCS
narratives into three main types—choice narratives, medicalization narratives, and
nature narratives—and then examining their framing, we are better able to view the
complex nature of the theoretical and representational work they are called upon to
do. The resulting engagements are seldom simple, and have the power to interrupt
and resist, producing projects with the potential for a more generative engagement
with this group of increasingly popular and controversial surgical procedures.

In Chapter three, “On Neoliberal Markets and Designer Vaginas,” I look more
closely at a very particular aspect of narratives of FGCS—the role of neoliberal
practices in medical marketing and processes of pathologization—to understand some
of the mechanisms that have propelled FGCS to the forefront of particular Western
elective medical practices. FGCS can illuminate how and where power is at work,
who is exerting it (and who—if anyone—it is being exerted upon), whether and how
various actors are responding, and how future engagements might use this
information in addressing the marketing and dissemination of this procedure.

The interaction of pro- and anti-FGCS groups with neoliberal markets marks
the site of a major convergence of the various narratives of FGCS. Chapter three
illustrates how groups opposed to the practices, on the one hand, often address the
supply of FGCS as a response to marketing, while those groups who support FGCS
tend to position themselves as providing a service to satisfy consumer demand. At
first glance, it might appear that these factions adopt extremely different arguments;
however, when analyzing these approaches in relation to neoliberal and free market
rhetoric, the reality is more complex, and sometimes finds these two camps
addressing FGCS and its relation to neoliberalism in ways that overlap. In order to
better analyze this entanglement, I use David Harvey’s work on neoliberal theory and
practice in consumer capitalist societies. I also examine the meteoric rise in
popularity of Viagra—and the consequent widening of the definition of erectile
dysfunction (ED), the diagnosis it was marketed to treat—as a case study that
illustrates how neoliberal markets contribute to changes in social ideals of appropriate
embodiment and mandates of health requiring the use of medical and pharmaceutical
technologies.

This chapter also explores the power of physicians (backed by the perceived
authority granted them as a result of their medical and scientific knowledge) to
“create and define new categories of illness to match new drugs coming on the
market,” like the insurance companies Harvey discusses in his work (80). In the case
of FGCS, if we substitute “surgeries” for “drugs,” the question of consent versus
coercion is worth considering in relation to FGCS. As the case of Viagra
demonstrates, these surgeries can be viewed as one of the technological innovations
that lead to the invention of a corresponding illness to guarantee consumer demand
that is a hallmark of the neoliberal state; this is also one of the defining features of
many anti-FGCS critiques (Harvey 69).

This, however, is only the academic “how” and “why” of my current
endeavor. Just as important are the social attitudes toward FGCS that have convinced
me of the necessity for a deeper, non-partisan engagement. Among these, the single
most common reaction is horror. Horror that the procedures exist, that any woman would willingly undergo them, and horrified fascination about what the procedures entail. This horror became a driving force for me, and convinced me of the need for work that could move beyond horror toward more generative engagements.

In the beginning, the general lack of public knowledge surrounding FGCS, and the shock and horror with which people spoke about my work, convinced me that I was doing the right thing. After all, knowledge is important, and shock limits the conversation. Shock might get people to react, but it generally doesn’t guarantee that they will do so in an informed manner. Shock, for lack of a more elegant way to phrase it, doesn’t have what it takes to go the distance, when it comes to informed critical engagements and inquiries of complex issues like FGCS. Rather, it runs the risk of contributing more to what is problematic about current engagements with FGCS than to a rigorous analysis of them.

When one reads particular critiques or listens to certain questions, what emerges is a vision of surgeons that is difficult to separate from the world of caricature. It is cartoon-like, and—in this cartoon—FGCS surgeons are depicted as standing over a tray of scalpels and surgical implements with dollar signs for eyes, evilly rubbing their hands together and cackling maniacally. In this imagining, the woman is always already tied to an operating table, awaiting a hero to ride to her rescue, loosen her bonds, and carry her away to safety before the scalpel descends upon her. Women, in this formulation, are always unwitting accomplices in their own bondage, and can never escape without the help of a stronger, better informed, savior.
Cartoons are, by necessity, gross oversimplifications. They disseminate information using stereotypes, caricatures, and other representations that obscure the complexity of the underlying relations, interactions, and other contributing factors that lead to what they are attempting to portray. As a result, there are no gray areas—situations exist in a world of black-and-white, good-or-evil, a clarity that, for all intents and purposes, cannot be found in most lived experiences. Without complexity, there is no way to imagine an operating table without restraints, and it is impossible to account for women who might choose to walk through a surgeon’s doors of their own volition. Choice and agency, in the stark world of either/or that FGCS is often imagined as inhabiting, are strictly limited to surgeons and those individuals who choose not to undergo FGCS. There is no accounting, in this formulation, for the possibility that some women might choose, of their own volition, to undergo the procedures—and might find some strength or solace in doing so. Accepting such a possibility requires moving beyond polarized models and static representations of unquestioning damsel-in-distress patients and money-hungry, power-mad surgeons in order to understand the complexities and constraints of agency and choice under neoliberalism.

My decision to conduct this research in an interdisciplinary manner has allowed me to understand the complexity of the interrelations and interactions that inform the practices of FGCS and the people involved in these practices. This project, then, not only seeks a more deeply informed engagement with FGCS, but also a broader engagement within and between the disciplines that inform it. It challenges
science and medicine to consider the history of the categories that they have created and continue to use—categories such as “normal” and “pathological”—and the effects of their daily implementation. It is also research that asks feminist critics of FGCS to move beyond a model that downplays or invisibilizes women’s agency. Finally, this project also urges political economists to consider how the terms of citizenship change alongside the development of emergent technologies and the social and medical practices that accompany public access to these technologies.

Moving beyond horror, and into a more non-partisan interaction, is what this project seeks to do; producing research that has the power to move discussions of FGCS out of caricature and into the “real world,” where the procedures, the surgeons who perform them, and women who do—or do not—choose to undergo them reside. The “real world” applications of this research go beyond FGCS. Interdisciplinary research has much to contribute to the growing field of bioethics, especially as regards projects of body modification and enhancement. Working with theories from Feminist Studies, Cultural Studies, Disability Studies, the History of Science and Medicine, and Science and Technology Studies presents opportunities to go beyond historicizing the development and application of different modes of classification and governance, and sets the stage for an expanded, and hopefully more ethical, engagement with them. Working between disciplines sets the stage for changing the parameters of the discussion entirely. Imagine a discussion that takes the answer to why particular bodies are/were pathologized and uses it to answer the following question: Should medical and scientific classificatory schemes continue to use
“pathology” in discourses of diagnosis? What is the function of such classificatory schemes—and when and how might they be deemed unnecessary? Research such as this has the potential to contribute richer, more complex considerations of the intricate systems being analyzed, and to advance expanded possibilities for ways of living and being more attuned to the complexities—especially for subjects marked by gender and racial “difference” from normative models—of navigating modern neoliberal capitalist constraints.
Chapter 1: The Tangled Path to Pathologization

I. Introduction

The recent ascendancy of female genital cosmetic surgery (FGCS)\(^1\) in the U.S. has been accompanied by an increase in scholarship critical of the surgeries. Much of this critical scholarship originates from feminist academics and activists and claims that FGCS is used less as a means of meeting the medical needs of patients than as a way for surgeons to capitalize on the increasing medicalization of sex or on the long tradition of pathologizing of female bodies in Western cultures.\(^2\) Thus, scholars who engage in critiques of FGCS stress that its current popularity is dependent upon the medicalization of sex in Western cultures and the pathologization of biological diversity that is often found intertwined with this medicalization.\(^3\) The most common

\[\text{1 Female Genital Cosmetic Surgery, or FGCS, is the commonly used terminology for a suite of surgical procedures. My use of the term most closely matches that of FGCS critic Dr. Virginia Braun, who defines FGCS as follows: “Labiaplasty/labiplasty (labia minora reductions), labia majora ‘augmentations’ (tissue removal, fat injections), liposuction (mons pubis, labia majora), vaginal tightening (fat injections, surgical tightening), clitoral hood reductions, clitoral repositioning, G-spot ‘amplification’ (collagen injected into ‘G-spot,’ which swells it significantly), and hymen reconstruction (to restore the appearance of ‘virginity’).” Like Dr. Braun, I do not include the following as FGCS procedures: sexual reassignment surgeries (for transsexual people), sexual assignment surgeries for intersex infants (or non-consenting intersex individuals of any age), or any of the suite of practices termed “female genital cutting” (FGC)/“female genital mutilation” (FGM) (Braun, “In Search of” 407). Additionally, I exclude from the category of FGCS any genital surgery performed for damage repair or trauma related reconstruction, as opposed to for purely cosmetic reasons. While there are arguably women for whom FGCS would not be considered a purely cosmetic endeavor (for reasons of psychological and/or social distress, etc.), these cases would require a more in-depth examination than is within the scope of this chapter.}

\[\text{2 For the purposes of this chapter, I use the term “Western cultures” to refer to the United States and Western Europe. While there is a growing amount of scholarship critical of FGCS coming out of Australia, where the surgeries are also increasing in popularity, the genealogical examination I am undertaking here is focused on Western Europe and the U.S., and, given the colonial history of Australia, the examination can, in many ways, still be applied.}

\[\text{3 For examples of these critiques, see the work of Virginia Braun (“In Search of”), Virginia Braun and Leonore Tiefer, (“Designer Vaginas”), the New View Campaign (“Manifesto”), Leonore Tiefer (“Beyond the Medical,” “The Designer Vagina,” and “FGCS”); and Simone Weil-Davis “Loose Lips”) [full titles and citations in Works Cited].} \]
formulation of critiques thus argues that: 1) FGCS is growing in popularity in particular (mostly Western) societies because those societies have medicalized sex, which has led, in turn, to physicians having an ever-expanding authority over bodies, and 2) Working in concert with this medicalization is a processes of pathologizing the naturally occurring diversity of female genitalia. These critics posit FGCS as a logical outgrowth of these processes, the latest in a long line of technological advancements marketed to address what many consider a “created worry”: that of a female genital aesthetic that falls within the realm of the pathological and/or abnormal (Braun and Tiefer, “The Designer Vagina”; Weil-Davis 8).

Worries regarding the female body—especially relative to its appearance—are hardly novel, nor is the marketing of products claiming to alleviate these worries. Critics claim that the successful marketing of these technologies is due, in large part, to the fact that the female body is always already available for the mapping of pathologies upon it that these technologies are then marketed to “fix” or “cure.” Many critics of FGCS, like many cultural critics who write about the female body, cite

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4 Medicalization (as discussed in this dissertation) is a “major social and intellectual trend whereby medicine, with its distinctive ways of thinking, its models, metaphors, values, agents, and institutions, comes to exercise practical and theoretical authority over particular areas of life” (Tiefer, “Beyond the Medical” 3). For more on medicalization—including specific examples of its application—see Section II of this chapter, or Leonore Tiefer’s “Beyond the medical model of women’s sexual problems: a campaign to resist the promotion of ‘female sexual dysfunction’” in Sexual and Relationship Therapy.

5 This is not to say that critics of FGCS exist as a single, homogenous bloc, or that they all subscribe to the same opinions on various aspects of the surgeries. Instead, this is merely the distillation of two of the most common aspects of critiques of FGCS. It is also important to note that it is not my claim that any or all critics of FGCS subscribe to a theory that female genital aesthetics can never be within the realm of the abnormal/pathological, but rather that most FGCS critics attribute these diagnoses as overdetermined, and within the realm of social construction.

6 For introductory works on the female body in Western Culture, see Susan Bordo’s Twilight Zones: The Hidden Life of Cultural Images from Plato to O.J. and Unbearable Weight: Feminism, Western Culture, and the Body.
accounts that detail a long history of medical access to, and narrowing acceptable aesthetics for, female bodies in Western cultures.\footnote{See note 4.} As such, I forward that a genealogy of the pathologization of female bodies in Western cultures (and the medicalization that is inextricably linked to it) allows for a consideration of the wide array of historical practices and other contributing factors that have paved the way for the emergence of FGCS.

An excellent example of such a genealogy can be found in Michel Foucault’s \textit{Herculine Barbin}, which explores the life of the title character, designated female at birth (1838), then later judicially designated male (in 1860) after physicians examined and authenticated her genitalia as indicative of a body belonging to the masculine sex.\footnote{The full title of Foucault’s work is \textit{Herculine Barbin: Being the Recently Discovered Memoirs of a Nineteenth-Century French Hermaphrodite}.} Drawing from judicial records, physician reports, news clippings, popular fiction, correspondence regarding Herculine’s case, autopsy reports, and Herculine’s diaries, Foucault presents a deeper, more nuanced view of a historical tradition wherein bodies were expected to be classifiable into one of two distinct sexes based on genital appearance. The determination of this distinction was the province of medical professionals and select members of the state.\footnote{This is evidenced in Herculine’s required change of civil status (from female to male), the impetus of which was the testimony of the physicians tasked with finding Herculine’s “true” sex. There was great importance attached to this task, according to Foucault, as “the years from around 1860 to 1870 were precisely one of those periods when investigations of sexual identity were carried out with the most intensity, in an attempt not only to establish the true sex of hermaphrodites but also to identify, classify, and characterize the different types of perversions. In short, these investigations dealt with the problem of sexual anomalies in the individual and the race (Foucault, \textit{Herculine Barbin xi-xii}).” As such, the various legal, religious, medical and social edicts and input that contributed to the outcome of Herculine’s story were indicative of a larger social project, in which particular genital appearances, as verified by physicians, determined an individual’s sexual identity and civil status.}
this use of genealogy as a method, which provides an exploration of the variety of ideologies that informed the historical processes evident in Herculine’s story.

Following Foucault (and including his work), I approach FGCS using a genealogy of the pathologization of female bodies, and access to those bodies, that form the basis of many narratives of the procedures. By moving beyond accounts of medicalization and pathologization rooted only in medicine, a more complex tradition emerges—one in which the access to female bodies that is a vital aspect of medicalization and pathologization is the result of a wide variety of social, religious, judicial, scientific, and medical forces and edicts. This, in turn, illuminates the investments of contributing factors and actors in, and possible ethical dilemmas and contradictions posed by, the processes of pathologization that have contributed to both the ascendancy and successful marketing of FGCS, and to its critiques. 10

I undertake this genealogical account of the pathologization of female bodies in Western cultures with an exploration of author accounts of three formative events that are especially relevant to questions of pathologization in narratives of FGCS: Katherine Park’s account of “holy anatomies,” Sander Gilman’s and Anne Fausto Sterling’s writings on Saartje Bartmann, and various accounts of the development and practice of gynecology in the United States.

Katherine Park’s examination of changes in physician access to female bodies in mid-thirteenth to late-sixteenth century Western Europe is the first event that I

10 For more on the benefits of genealogy in the project at hand, see Section III of this chapter, “Why Genealogy?”
explore in this genealogy. Park’s text examines the role of changing religious, funerary, social, and medical conventions in the shifting purposes and practices of cadaver dissections during this time period. Park’s research demonstrates the complex web of social relations and acceptable post-mortem practices in “holy anatomies” and highlights the role of non-medical anatomical dissections in a time of shifting post-mortem traditions. For the purposes of this genealogy, the most significant aspects of this shift are those that resulted in greater access to female bodies for the purposes of post-mortem dissections. Section IV of this chapter details the shifts in post-mortem practices that paved the way for these dissections, as well as the dissections themselves, and examines how both signaled significant changes in the medical governmentality of female bodies. As a result, female bodies became more accessible to medical doctors and attained a status wherein the female body necessitated professional male interpretation. These changes are key to the history of the pathologization of female bodies that is such an oft-cited aspect of FGCS.

The changes in access to, and need for interpretation of, female bodies that I discuss in relation to Park’s work lay the groundwork for another important event in the genealogy at hand: the nineteenth-century European study, display, and eventual dissection (and re-display) of Saartje Bartmann. Sander Gilman’s chronicle of the cultural significance of these events links them to a larger process of medicalization

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11 The full title of Park’s work is *Secrets of Women: Gender, Generation, and the Origins of Human Dissection.*
12 The term “holy anatomies” refers to the non-medical dissections of potential saints, generally performed by members of the deceased’s church order in search of markings or implanted evidence of the divine within the body of the deceased. For more on these dissections, see Katherine Park’s *Secrets of Women: Gender, Generation, and the Origins of Human Dissection.*
and pathologization within which categorization takes on a more expanded role, including not only gender but also race. Gilman details how different female bodies came to be categorized as more or less accessible to medical inspection than others as a result of the influence of the era’s dueling theories of monogeny vs. polygeny, the continuation of a long tradition of European colonial projects, and the rise of the authority given to the claims of practitioners of science and medicine. Gilman examines how these claims were utilized in the creation and upkeep of categories of female embodiment. At the heart of his work is the growing investment in categorizing race and appropriate womanhood, both of which projects were served by the categories created as a result of processes of pathologization. In addition, both Gilman’s and Anne Fausto-Sterling’s research on Bartmann detail the pathologization of the female body as rooted in particular parts of the body, including—and, in the case of Bartmann, specifically—the genitals and the gluteal region. This pathologization of female genitals falling outside of the created category of “normal” is, therefore, an important part of a genealogy of pathologization of female bodies that includes current narratives of FGCS—especially those narratives in which FGCS marketing suggests that the normativizing of genital variation is a goal to be achieved.

Three decades after Bartmann’s exhibition and dissection, the experimental surgeries that would later be referenced as the basis for the birth of “American gynecology” were being performed on enslaved African women in a backyard clinic.

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13 Monogeny and polygeny were dueling theories of race popular in nineteenth century discourse. Monogeny was the contention that all humans came from a single creation, whereas polygeny stated that the races were actually separate species (Fausto-Sterling, “The Comparative Anatomy” 27-28).
in rural Alabama. Dr. J. Marion Sims’s early surgical experiments are important to examine as a moment when the medicalization, pathologization, and racialization of female bodies become directly entwined with gynecological surgery in the early United States. The birth of U.S. gynecology as a medical discipline in the mid-nineteenth century offers valuable insight into specific aspects of how the long tradition of the pathologization of female bodies in Western cultures moves within the medical field. Examining the genesis of this medical discipline also illustrates how flexible pathology is in its attachment to female bodies, and how the pathological attaches differently to female bodies—perhaps most notably when the race of those bodies is taken into consideration. As such, the birth of U.S. gynecology occupies an important position within this genealogy of the pathologization of women’s bodies in Western cultures, especially as it relates to the advent of cosmetogynecology—and the FGCS procedures that are a key aspect of this new discipline’s practice.

While Dr. Sims is frequently referred to as both the “father of modern gynecology” and the “father of American gynecology” in historical and biographical accounts, these titles reflect how he was referenced by the press and his contemporaries during his lifetime, and have been carried on by enthusiastic supporters through the years, despite growing controversy over the role of human experimentation in Sims’s most famous surgical innovations. As the United States is but one country belonging to one of two American continents, I refer to Sims as “the father of U.S. gynecology” in order to acknowledge that 1) he is still seen—and referred to—as such by many medical associations and practitioners (in many countries), and 2) Sims’s work in “America” was limited to the United States of America.

The International Society of Cosmetogynecology was formed in 2004, with the mission of promoting “the advancement of knowledge, skill, and excellence in female cosmetic medicine and surgery through education, training, and fellowship...The society was founded to fill an academic void in the field of women’s healthcare in a milieu of changing social opinions towards cosmetic surgery and medicine and a nontraditional shift in the practice of many gynecologists” (ISCGN 2014; emphasis mine). For more information on the ISCGN and its members, mission, and practices—including specific cosmetic procedures offered (such as FGCS)—see the group’s website at: http://www.iscgyn.com.

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II. Medicalization and Pathologization

“Because medical knowledge is always also cultural knowledge, it carries the burdens of its contexts, often reproducing expectations of difference. Medical professionals conceive new orderings to the world and thereby produce forms of life that are healthy and unhealthy, orderly and disorderly, but are always indebted to the cultural situations in which medical knowledge is produced and applied.” (Wolf-Meyer 9)

The creation of categories is an important aspect of medicalization, and categories such as “normal/abnormal” or “healthy/diseased” are a means of pathologizing. In the Western cultures I discuss in this chapter, the medicalization of bodies and their various functions and activities open them to categorization through medicalization and the proclamations of scientific professionals. This is perhaps most succinctly explained by theorist and sexologist Leonore Tiefer: “Medicalization is a major social and intellectual trend whereby medicine, with its distinctive ways of thinking, its models, metaphors, values, agents, and institutions, comes to exercise practical and theoretical authority over particular areas of life. Medicalization relocates activities or experiences (e.g. crimes, habits, or changes in physical or intellectual ability) from categories such as social deviance or ordinary aging to categories of medical expertise and dominion” (“Beyond the Medical” 3).16 As evidenced by Tiefer, and by Matthew Wolf-Meyer in the epigraph to this section, the diagnoses that are inextricably connected to medicalization carry within them the sociocultural values of their social context (Foucault, The History; Tiefer, “Beyond the Medical”; Wolf-Meyer 9). Tiefer points out, “Think drunkenness and alcoholism;

16 Tiefer credits the work of Conrad and Schneider in this formulation of medicalization. For more information, see their 1980 work Deviance and Medicalization: From Badness to Sickness, or Conrad’s 1992 article “Medicalization and Social Control” in the Annual Review of Sociology.
think moodiness around menstruation and premenstrual syndrome [PMS]; think children’s school misbehavior and conduct disorder or attention deficit disorder [ADD]; think shyness and social phobia. In the case of sexuality, medicalization currently focuses on genital function and sexual behavior. Deviant levels of interest in sex, in orgasm experience, or in patterns of genital response have been labeled ‘dysfunctions’ and industries of expert assessment and treatment have developed” (“Beyond the Medical” 128).

In Tiefer’s model, medicalization brings bodies and their various functions under the jurisdiction of medical professionals. The authority conferred on these professionals is evident in many Western cultures, and one need only open a periodical or turn on a network news broadcast to see examples of it. In its simplest articulation, it is the pervasive attitude that, in matters of the human body, doctors know best.17 Medicalization, then, grants access, most commonly to members of the medical profession: access to bodies, and access to the power of diagnosing these bodies in accordance with the medical model. Within this model, “doing medicine centers around diagnosis” (Atkinson in Tiefer, “Beyond the Medical” 11), and diagnosis “is both a process of assigning a disease label and the label itself” (Blaxter in Tiefer, “Beyond the Medical” 11). Thus, the power of diagnosing human bodies and behaviors is the power of categorization; in the case of medicine, this is also often the power of pathologization.

17 For a more detailed explanation of the power granted science and medicine in Western cultures (especially power over the body and its functions), Michel Foucault’s The History of Sexuality trilogy, especially Volume 1, is an excellent starting point.
Diagnoses often coincide with pathologization because of the role of “norms” and assumed “natural” functions of the body in Western medicine. As put by Mishler [in Tiefer] “Diagnostics searches for abnormalities; assessment technology calibrates deflections from standard values; benign variation from a health norm is a contradiction in terms” (“Beyond the Medical” 15). Wolf-Meyer’s *The Slumbering Masses: Sleep, Medicine, and Modern American Life* provides an excellent recent example of the role of assessment technologies, diagnostics, and health norms in processes of pathologization. Wolf-Meyer’s work is an in-depth look at how the medicalization of sleep, and the resultant pathologization of insomnia, coincide with the development of various cultural norms and the treatment technologies to achieve them in sleep research in the U.S., with the result that “what was once considered natural, as in the case of periodic and self-resolving insomnia” becomes something that is now “being treated as a medical disorder” (14). Similar critiques of the role of assessment and treatment technologies have been made by FGCS critics who forward that the adoption of the Masters and Johnson “Human Sexual Response Cycle” as the basis for classification and nomenclature of sexual dysfunction by the American Psychiatric Association laid some of the foundations of female genital pathology that is present in narratives of FGCS. Indeed, in some literature, it is even referred to as the “natural’ sexual response cycle” (Marshall 133). As a result of its acceptance as the measure of normative, or natural, sexual response, the study became the standard by which the medical establishment measured all sexual responses, physiologies, behaviors, etc., and those whose sexual experiences fall outside of the cycle risk
being labeled non-normative or unnatural. Thus, Masters and Johnson became a
diagnostic tool that led to the pathologization of entire groups of bodies, practices,
and people that did not fit within the “normative” standards that it defined.

The powers attributed to the medical and scientific professions—to make
bodies accessible and to make categories that define the status of those bodies—are
the corner-posts of many FGCS critiques; they are also an important aspect of the
genealogy of the pathologization of female bodies in Western cultures that I
undertake here. The value of a genealogical approach is that it provides an analysis of
the ideologies that inform historical processes, and thus has the power to illustrate
contributing factors involved in these processes, including the investments, intent,
and possible ethical dilemmas that exist both within, and as the result of, the
processes of pathologization. In the case of FGCS, such a methodology offers up the
ideological kernels behind these procedures that help broaden future critiques by
making more visible the complexity of the processes and interchanges that contribute
to their existence and popularity.

III. Why Genealogy?

“In contrast to some of the initial press and professional reaction, FGCS is not some
freakish development. It arises from the same sources as sexuopharmaceuticals: the
perfectionist body project, insufficiently regulated markets, lack of appreciation for
diversity, and gendered techno-medicine. FGCS and sexuopharmaceuticals are more
than new technologies; they are labyrinthine psychological, ethical, and commercial
domains.” (Tiefer, “Female Genital” 475)

“We want historians to confirm our belief that this present rests upon profound
intentions and immutable necessities. But the true historical sense confirms our
existence among countless lost events, without a landmark or a point of reference.”
(Foucault, “Nietzsche” 155)

Using genealogy as a method to explore the long history of the attachment of pathologization to female bodies in Western medicine has certain advantages. In this examination of FGCS, it is more useful than conducting a search for the pathologization of female bodies as the inevitable outcome of an uninterrupted continuity of historical events. As Foucault writes in this section’s second epigraph, a genealogy focuses on how the role of the seemingly small moments and accidents of history show that the present is not necessarily the inevitable outcome of the past. Michel Foucault, in “Nietzsche, Genealogy, History,” which articulates genealogy as an analytical method, notes that “we should avoid thinking of emergence as the final term of an historical development…these developments may appear as a culmination, but they are merely the current episodes in a series of subjugations” (148). Thus, critiques of FGCS that portray the surgeries as the inevitable outcome of a long, traceable history of medicine in which female bodies were always already conflated with the pathological oversimplify the historical relations that lead to the present situation. Such relations are often complex, and examining them using a genealogical framework can denaturalize this inevitability by exposing more diverse knowledge regarding the conditions, responses, and meanings that surround—and attach to—a phenomenon like FGCS.

The implication of inevitability can also result in the appearance of a teleology in which FGCS is a logical, even inescapable, result of the pathologization of female
bodies. Such teleological conclusions are unsupported by a more careful examination of this history. However, they are wholly avoidable if we instead employ genealogy as a method of examination, since “genealogy does not pretend to go back in time to restore an unbroken continuity that operates beyond the dispersion of forgotten things…it’s duty is not to demonstrate that the past actively exists in the present, that it continues secretly to animate the present, having imposed a predetermined form to all its vicissitudes…genealogy does not resemble the evolution of a species and does not map the destiny of a people” (Foucault, “Nietzsche” 146). A genealogical methodology, then, eschews both the search for the singular origin and the teleological movement toward an inevitable outcome, and instead “must record the singularity of events outside of any monotonous finality; it must seek them in the most unpromising places, in what we tend to feel is without history” (Foucault, “Nietzsche” 139).

One of the places relative to FGCS that is often treated as though it is “without history”—or at least without a history that precedes the nineteenth century—are the practices of medicine that paved the way for the attachment of pathology to the female body. For example, many critics of FGCS argue that the pathologization of women’s reproductive systems and external genitalia coincides with popular nineteenth-century medical discourses of hypertrophy, especially of the labia minora and clitoris (Braun and Tiefer, “The Designer Vagina” 3-5). As will be discussed in Section V of this chapter, it is true that such discourses were used in category making—most notably, to shore up the historically unstable category of
racial difference by providing scientific “proof” of difference between white and black female bodies. When it comes to female bodies, however, the use of an anatomical proof of difference enjoys a much longer and more complex historical development than is referenced in critiques based solely upon the knowledge production and practices of nineteenth-century Western medicine.

Racialization as pathologization is a major component of the historical pathologization of female bodies in Western cultures. Sander Gilman and Anne Fausto-Sterling examine one of the more famous instances of this co-articulation of racialization and pathologization—the story of Saartje Bartmann. Their work illustrates the variety of contributing factors, from institutional to individual, that resulted in the pathologization of race and a contraction of the category of acceptable female genital aesthetics. Additionally, accounts of Bartmann offer us insight into one of the most overlooked of the purposes served by the pathologization of women’s bodies: a “difference making” that focused not only on gender, and the appropriate aesthetic properties thereof, but that also contributed to categorizations of race. Bartmann’s place within this genealogy raises important questions for current critiques of FGCS that neglect to explore differences among pathologized female

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18 This particular use of pathologization is rarely explored in depth within critiques of FGCS. Instead, these critiques emphasize gendered differences, and narrowly-defined aesthetic differences within gender groups: female genitalia is pathologized because it is female (and not male), and further pathologization happens within the category of female via the creation of an acceptable genital aesthetic among these bodies against which individual female bodies are judged. What remains unexamined, in this formulation, is the variety of sources from which these aesthetics are drawn, and one—perhaps the primary—of these is a long tradition of science and medicine using the bodies of black women in the creation of racial categories and other categories of difference.
bodies—specifically, which bodies are positioned as pathological, and which are positioned as the “norm” against which this pathology is gauged.

This positioning of bodies was a key factor when, thirty years after Bartmann’s death, a rural Alabama doctor by the name of J. Marion Sims began a series of experimental surgeries in the hopes of finding a cure for the condition known as vesicovaginal fistula. These surgeries were performed on enslaved African women in a makeshift clinic behind his home without anesthetic over a four-year period, and are widely accepted as the origin of U.S. gynecology as a medical specialty (Harris 372; Kapsalis 31-32; Kuhn-McGregor 6; Washington 66).

Gynecology is a medical specialty that is intimately intertwined with the surgical repair of the female genitalia and/or reproductive system, and its beginnings shed light on the ways the pathologization of female bodies proceeded within the U.S. medical context. While some historians posit a narrative wherein gynecology is born of the medicalization of previously non-medicalized conditions and events (such as pregnancy and childbirth), I contend that close examination of the early practice of U.S. gynecology illustrates that the genesis of this specialty lies at the nexus of this medicalization and ideals of gendered/racial embodiment, political economy, surgical and technical innovation, and the practice of chattel slavery in the antebellum south.

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19 Vesicovaginal fistulas are defined by health educator and author Terri Kapsalis as “small tears that form between the vagina and urinary tract or bladder which cause urine to leak uncontrollably” (31).

20 Prior to Sims’s development of a successful vesicovaginal repair surgery and his (later) role in the creation of the first U.S. women’s hospital (in New York), gynecological concerns in the U.S. (and much of Western Europe) were lumped in with obstetrics in training treatises and manuals, and were the purview of general practitioners and midwives (when they were addressed at all). For more on the history of gynecology before Sims, I recommend the work of Deborah Kuhn McGregor, especially From Midwives to Medicine: The Birth of American Gynecology.
Additionally, the story of Sims and early practices of U.S. gynecology offer us a view of the flexibility of pathologization as it is applied to different female bodies—especially to bodies already categorized (and often pathologized) based on perceived racial difference.

In order to classify particular female bodies (such as Bartmann’s and the enslaved women Sims experimented on) as pathological, physicians (and/or scientists) needed access to those bodies to inspect the physical characteristics upon which such classification depended. It is this access that helped to ease the way for the attachment of the pathological to particular bodies—and, later, to entire groups of people. However, this access is tied to a much longer historical tradition, and requires an examination of certain aspects of the pathologization of female bodies in Western culture that pre-date Saartje Bartmann by centuries. Katherine Park’s work demonstrates the relationship of pathologization to certain pre-medical anatomical practices. By focusing on medicalization as taking root within the medical profession, many critiques have obscured the fact that access to female bodies is the result of a wide array of factors that fall both within and outside of the practice and/or instruction of medicine. Park posits that, in Western cultures, these factors include changes in the medical governmentality of female bodies that are related to a tradition of pre-medical anatomical dissections which can be traced to infrequent occurrences in the late twelfth century, and which, “beginning around 1300…developed quickly and spontaneously out of a set of ad hoc cultural practices that had nothing to do with medical instruction” (15). These “ad hoc cultural practices” complicate the traditional
view of medicalization developing within the field of medicine itself. Indeed, any
discussion of the relation of pre-medical anatomical dissections to current processes
of medicalization and pathologization “disturbs what was previously considered
immobile; it fragments what was thought unified; it shows the heterogeneity of what
was imagined consistent with itself” (Foucault, “Nietzsche” 147)—in short, it
contributes to the work of genealogy, making visible the accidental as well as the
intentional, and illuminates the investments, inconsistencies, and discontinuities that a
traditional historical account can obscure.

IV. Holy Anatomies: Pre-Medical Anatomical Dissections
and Medical Access

“By treating all these practices together rather than looking at academic
dissection in isolation, I aim to restore their cultural coherence. This is a
fundamental point: assuming anachronistically that opening the human body is in
the first instance a medical procedure, historians have ignored the broader
phenomenon of which it was a part—or reduced these other, related procedures to
the status of ‘background’ or ‘cultural context’. In contrast, I consider the opening
of the human body as a whole…its variants…are like a set of angled mirrors: each
illuminates and reflects others.” (Park 18)

A useful text for exploring the role of pre-medical anatomical dissections in
processes of medicalization and pathologization is Park’s book Secrets of Women:
Gender, Generation, and the Origins of Human Dissection. Park details changes in
how women’s bodies were viewed and understood in Europe between the late-
medieval period and the Renaissance. She traces these changes to the dissection of
female cadavers, and the search for the hidden reproductive truths of women’s bodies.
Specifically, Park tracks a shift in the sixteenth century from the belief that these
truths lay within previously published texts that enjoyed canonical status to the belief that they could be uncovered within the body itself through the growing practice of anatomical dissections. These dissections were not performed for academic or purely medical purposes, however, and their widening acceptance and occurrence was the result of changing funerary, religious, medical, and political practices that Park traces in late-medieval (late-twelfth century) to Renaissance (mid-sixteenth century) Italy. Accompanying this evolution were changing views of women’s bodies and increased access to the same. This access, in turn, led to an increase in public and academic anatomical dissections by medical practitioners, in which women existed as objects that could offer anatomical truths and be “known” through dissection and display. According to Park, this “knowing” was contingent on anatomical knowledge, and women were reduced to and explained by corporeal means, with special attention given to newly discovered differences of internal anatomy.

Park’s account, then, provides a revealing look into a time when medical practitioners’ access to women’s bodies was not yet a common occurrence, or as acceptable an aspect of medical practice as it is today. By moving beyond the assumption of naturalized access, Park reveals the complexity of a historical tradition of medical practitioners’ access to female bodies that comes into being as the result of a wide variety of events, customs, and influences that included—but were not limited to—the study and practice of medicine. In contrast to traditional accounts of anatomical practices popular within the region and era, Park contends that the focus on anatomical dissections performed at universities, primarily as a tool for medical
instruction, is misleading. Citing the lack of available cadavers and the lax application of dissection requirements for medical trainees in late fourteenth- and fifteenth-century Italy, Park looks beyond the burgeoning medical field to other traditions of cadaver dissection, for a more well rounded account of the development of the practice (14-15). She details other reasons for the post-mortem opening of female bodies, the most common of which were relative to women’s powers of reproduction and/or the related belief of women’s “porousness,” which rendered them more susceptible to implantation of various kinds. The belief in this porousness is evidenced in the practice of “holy anatomies,” performed on potential saints in order to discover and have church specialists verify internal markings and items believed to be of divine origin. Other cases of female dissection included caesarian sections performed after a mother’s death during childbirth to save the baby or to remove it for the purposes of baptism before burial (if it did not survive). Indeed, Park’s research reveals numerous, often simultaneous practices that contributed to the rise of

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21 One of Park’s most vocal and well-known critics is historian Thomas Laqueur, and the two have engaged in several written debates regarding their divergent claims regarding sex and gender, and the historical importance of the anatomical dissections at the heart of Park’s research to these categories. Perhaps the most notable difference between Park and Laqueur is the latter’s claim that the instances cited by Park as proof of the growing popularity of a model that contained two distinct, biological sexes were not commonplace incidents, and thus not representative of the social climate or practices of Western cultures during the time periods Park’s account focuses on. Instead, Laqueur argues for the widespread domination of the one-sex/gender model, wherein women’s reproductive systems were (nearly) anatomically identical to men’s, save that they were internal. Laqueur maintains that this was the dominant model before the eighteenth century, and that the two-sex/gender model came into common usage via a more gradual move, due to changing political structures that necessitated a new basis of differentiation to protect gendered (i.e. male) power structures already in place. For more on Laqueur’s theory, see his book Making Sex: Body and Gender from the Greeks to Freud. (Note: While outside of the scope of the current project, a more comprehensive overview of Laqueur’s and Park’s theories and critiques, as well as the ways in which these both contribute to and complicate discussions of the pathologization of female bodies, would be a valuable addition to any future, expanded projects to come out of this chapter.)
anatomical dissections. This allows her to elaborate upon the gendered differences produced by, and evident in the varied practice of, these same dissections—and how the production of these differences were inextricably tied to social and cultural practices and beliefs of the era and region.

One such cultural practice that figures in the tradition of anatomical dissection of women was the Catholic Church’s cult of saints and relics. Park argues that the practice of “holy anatomies,” which she posits found their origin in post-mortem practices reserved for potential saints, was “far more central to the early history of dissection than many other histories of anatomy would lead one to believe,” contrary to popular tales of the hostility of the Church to such activities [of dissection] (21).22 One reason for the centrality of “holy anatomies” to the early history of dissection was how the human body was understood in relation to existing Italian cultural structures and institutions from the mid-thirteenth to the mid-sixteenth century.23 Park’s research suggests that the men and women who inhabited northern Italian cities during this time understood their bodies “primarily in terms of family and kinship, on the one hand, and religion, on the other” (23). She suggests that understanding the body in terms of medical models, such as those that dominate

22 The nature of these tales—and their tenacious hold on the popular imaginary—is another place where Park illuminates deep-seated Western ideas regarding the scientific origins of modernity. I would forward that these tales, which most often seem to feature brave, intellectual giants of the Renaissance such as da Vinci, Michelangelo, and Vesalius conducting secret dissections in hidden basements, always in mortal danger as a result of the Church’s certain wrath were they to be discovered, also have a good deal to teach us regarding the role of gender within this oral tradition (no matter its truth) of secrecy, discovery, and the intellectual foundations of science and modernity. As such, a more in-depth exploration of their role will be included in any post-dissertation expansions of this chapter. For more on this subject, see Park, page 21.
23 Unless otherwise noted, Park’s references to Italy—and thus mine—are to northern Italian cities.
bodily comprehension in current Western cultures, came in a distant third—even in areas of Italy known for their “highly developed medical institutions and practices” (Ibid). As a result of this privileging of specific bodily/institutional relations, the primacy of familial and religious concerns shaped how female bodies were understood and treated in life as well as in death, and were interwoven aspects of early female anatomical dissections—especially those dissections that occurred in relation to the cult of saints and martyrs.

This was due largely to the fact that, in terms of their relation to familial structures, female bodies were associated with the maternal. The answers to the mystery of women’s reproductive capabilities were thought to be found inside the female body—specifically, inside the womb, which led to an implicit link between the female body and its interior (Park 24-26). This link, when coupled with Christian beliefs regarding the cult of relics and the possibility of the divine leaving marks upon the bodies of the devout, paved the way for the recorded openings of several bodies of holy women who were believed bound for sainthood. The “cult of relics—in the form of fragments or even entire corpses—as well as funerary practices that involved disembowelling [sic], dismembering, and mutilating dead bodies,” was “enthusiastically embraced” by late medieval Italians (Park 24).24 These practices reflected a strong belief amongst medieval Italians in the body as “one of the principal elements connecting the natural and the supernatural worlds” (Park and Daston; Park 24). As a result, bodies—especially those of the extremely devout—

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24 The cult of relics was also popular with Christians all over Europe during this time period; however, practices “differed significantly according to region and class”—including within Italy (Park 24).
were considered a “conduit for divine grace” (Park 24). This belief, in combination with the understanding of female bodies that placed heavy emphasis on their relation to familial and maternal roles, contributed to the opening of the bodies of extremely devout females believed bound for sainthood in what Park calls “holy anatomies” (39).

These dissections, according to Park, were also tied to embalming practices, as the nuns handling the bodies after death began by eviscerating them in preparation for embalming, which provided a rationale for further internal inspection (Park 49). As potential saints, the bodies of these women were embalmed for purposes of public viewing and visitation, as well as for their status as potential relics (Park 39). While embalming was the probable impetus for the initial opening of their bodies, the further dissection and opening of women’s internal organs was an inspection for marks or other implanted evidence of the divine. Women were, of course, largely equated with their organs of generation, and “the bodies of mothers and holy women were understood in analogous terms.” Since women were considered more porous and open to implantation than men, extremely pious and devout women were often described as being “holy vessels,” which, when combined with their femaleness, made them more susceptible to receiving the gifts of the divine. These gifts ran the gamut from the spiritual to the physical—both internal and external.

The practice of holy anatomies thus demonstrates that gender was a major determinant in adjudicating whom among the devout was most suited to receive

25 Park details the dissection of two holy women in particular in her book: Chiara of Montefalco, who died in 1308, and Margherita of Cortona, who died in 1297.
internal markings of a divine nature. While not common, the records of the
dissections of holy women that Park details in her text date back to the late-thirteenth
century. However, she did not find a “single case of the internal inspection of the
body of a holy man before the middle of the sixteenth century,” at which time
changes due to the Counter-Reformation led to the practice being extended—albeit in
a less systematic way—to holy men potentially bound for sainthood (Park 50).
Gender, then, played a role at multiple sites that contributed to the practice of “holy
anatomies,” with the longer history of their practice on potential female saints located
less within the realm of physician access to female bodies and more within an
ideological framework of how the gendered body was understood. Female bodies
were not necessarily more available or more sought out for dissection due to their
gender; rather, in the case of “holy anatomies,” their anatomy, which was inextricably
tied to the mysteries of generation, was believed to be more suited to the implantation
of divine gifts.

There are, however, factors besides this anatomical “othering” that tie these
holy anatomies to a genealogy of access to the female body. Such factors also place
these pre-medical anatomical dissections within a larger medico-judiciary tradition
that introduces the necessity of authentication in matters of the female body. Park
notes that the holy anatomies she details, which were performed at the end of the
thirteenth and during the early years of the fourteenth century, coincided with the
“first appearance of what we might call judicial anatomy” (52). Institutionalized in
the secular context, a “judicial anatomy” was essentially a judicially ordered autopsy,
performed by government-appointed doctors with the intent of determining responsibility for individual deaths. Initially, these autopsies were based solely on external inspections; however, beginning around the early fourteenth century, doctors increasingly turned to internal dissections to determine cause of death (Park 52-53). Thus, “holy anatomies” and “judicial anatomies” were contemporaneous. We can also see the influence of the secular practice of “judicial anatomy” in the authentication practices that followed the “holy anatomies” of the two potential female saints at the heart of Park’s research.

As a result of their contemporaneous development, there is overlap in some of the procedures developed for the execution of both “holy anatomies” and “judicial anatomies.” For instance, official authentication of the physical evidence found in these anatomies was generally required (Park 52-59). This was especially the case of “holy anatomies” performed on female bodies in the era and region in which Chiara of Montefalco’s “holy anatomy” took place, due to the Catholic Church’s concern regarding a growing female religious movement and the “doubly suspect” nature of the women involved in this movement (Ibid).²⁶ This is perhaps best exemplified in the canonization procedure surrounding Chiara of Montefalco, the “apostolic” phase of which lasted 11 months (from September 1318 to July 1319), and “involved the

²⁶ Park details the challenge posed to Church authorities by the “feminization of the penitential ideal in the late thirteenth century,” especially as regards the exploration of “new ways of life in more open communities” of women focused on “autonomous and sometimes highly visible penitential lives” (Park 54). Adding to this concern was the charismatic nature of some of these women—including Chiara—whose understanding of their piety as the result of inhabitation or possession by supernatural forces led to Church suspicion of their “mistaking inhabitation by demons for inhabitation by God,” and “faking the visions and physical behavior that lent them such authority” (Park 56).
testimony of 486 witnesses on 315 interrogatory articles.” The juridical influence is apparent in this process, as the “interrogatory articles” referenced included the “notarized testimony of witnesses, taken both in person and by deposition, in response to an officially established series of questions” (Park 54). It was not uncommon for formal canonization proceedings of this period to be conducted according to the legal and bureaucratic structure of a trial, with doctors being called upon to testify. However, Park argues that the proceedings surrounding Chiara’s proposed sainthood were the first in church history in which the “physical evidence—in the form of signs found inside a potential saint’s body”—occupied such a decisive position in the authentication of her sanctity (Park 53-54). Among the underlying factors that contributed to this necessity for outside authentication—especially as verified by the knowledge and testimony of doctors—was an understanding of the female anatomy’s porousness, which was understood as leaving women’s bodies open to implantation by forces both divine and evil (Park 56, 59). Additional anxiety over the provenance of any items found within the bodies of potential saints during their dissection was a result of gendered religious conventions, such as the enclosure practiced by certain nuns. This anxiety, in turn, contributed to increasing

27 Park describes the “large scale”—or “apostolic phase”—as one of two phases that comprise the canonization procedures used to determine the suitability of an individual for sainthood. After a preliminary inquiry, a papal bull was required to authorize the “apostolic phase” of proceedings. During this phase, “an officially established series of questions (‘the interrogatory articles’)” generated “mountains of written documentation, including local records, duly authenticated,” as well as the “notarized testimony of witnesses, taken both in person and by deposition.” Also included were a “formal account of the saint’s life, or vita; and a summary assessment of the case by three cardinals” (Park 53-54). For a detailed description of canonization procedures, I recommend the "Canonization of Saints (History and Procedure)," available online in the New Catholic Encyclopedia.
requirements of authentication of the findings of “holy anatomies.” Also around this time, emerging practices of dissection in nearby medical institutions led to the privileging of medical expertise, evident in the use of state-appointed physicians in the concurrent practice of “judicial anatomies.” As a result, a shift occurred relative to the authentication required during “holy anatomies,” a task increasingly assigned to physicians, as opposed to the nuns who would previously have conducted “holy anatomies” on the bodies of potential female saints. Inextricably intertwined, these practices contributed to the intense scrutiny of physical evidence in Chiara’s canonization proceedings, and the strenuous demands for authentication of this evidence signals an important shift in access to female bodies, as well as a shift in whose access to female bodies produced more legitimate claims regarding those bodies.

In Chiara’s case, questions of authentication were highly gendered. This was due, in part, to her practice of enclosure, which meant that Chiara never appeared outside of the convent. Her modesty was legendary, and on the days that it was her turn to go out begging (before she embraced strict enclosure) “she wrapped herself in her cloak in such a way as to make her face and body unrecognizable,” and “as she went, she shielded herself from the sight of men so as not to see any of them and not to be seen by any (Beranger’s vita in Park 71).” As a result, the only witnesses to some of the claims regarding her pious and/or miraculous acts were her fellow nuns. While these nuns were indirect witnesses to the “private elevations and ecstasies” that comprised the majority of Chiara’s living “saintly” acts, as the facilitators and
conductors of her postmortem dissection, they were direct witnesses to the bodily signs of her piousness (Park 56). The Church, however, considered Chiara’s fellow nuns biased, motivated to provide physical evidence that would assure her canonization in a system in which “the identification of women with the body demand[ed] that their sanctification occur in and through that body” (Hollywood in Park 59).

The Church required strict male verification of the nuns’ testimony due both to their gender and their assumed bias in favor of Chiara’s canonization. This increased the difficulty of proving cases like Chiara’s, since male verification of the living acts and physical state of a nun practicing enclosure would have been nearly impossible to obtain due to the very nature of enclosure (Park 56). Park details a rare exception to Chiara’s practice of enclosure, in which doctors were called to inspect her body before her death in an attempt to “verify her sanctity medically” in response to rumors of miraculous acts connected with Chiara (Ibid). This active solicitation of medical authentication of Chiara’s body and the signs of piety associated with it signifies an important change in who was granted both access to female bodies—and for what reasons. Park’s account details the variety of factors that contributed to this change, and pays particular attention to the fact that the field of medicine was but one

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28 According to the testimony given by a nun present during Chiara’s holy anatomy, these bodily signs included “a cross, or the image of the crucified Christ” as well as “something that looked like the scourge with which he had been beaten during the passion,” both of which were found inside of Chiara’s heart. In addition to this, three small stones were found in Chiara’s gallbladder, which a male physician assigned to the convent informed the nuns there “was no natural explanation for”; these stones, in turn, were taken to be a physical reference to the Holy Trinity. The nuns’ belief in the “miraculous nature of these structures” was further confirmed when “Chiara’s heart began almost immediately to perform wonders,” such as healing the injured (Park 41-42).
of many forces contributing to this shift. Further, because this shift drew from and occurred within the context of highly institutionalized proceedings, the resulting changes in access and powers of authentication (especially as relates to the female body) appeared much more naturalized than was actually the case.

Medicine is one discipline in which this naturalization of access and classification all too often remains uninterrogated in any rigorous or substantial way. What Park accomplishes, with her accounts of holy anatomies like Chiara’s, is an interrogation that moves beyond most contemporary critiques of the medicalization and pathologization of female bodies, which tend to focus on the complicity of Western medicine with these processes. Many of these critiques take the access and diagnostic powers of medical doctors as their starting point, tracing a teleological development of an increase in access to female bodies from the nineteenth century to the present day. In these accounts, vestiges of particular nineteenth-century medical practices are often clearly visible in the present day medical practices—such as FGCS—that are being critiqued. But such accounts obscure the complex historical convergences that undergird these practices, as well as the multiple intentionalities that contribute to their institutionalization. By examining the pre-medical aspects of access to female bodies and their categorization alongside a variety of concurrent traditions, medical, and cultural practices and beliefs, Park offers a more in-depth view of just how complex and tangled the historical tradition of medical access to female bodies truly is. Understanding the complexity of this history and the ideologies that inform it creates new opportunities for engaging with FGCS; it also
offers insight that encourages new ways of viewing the procedures relative to a longer, more complicated genealogy of access to female bodies than is currently accounted for in most narratives of FGCS. In detailing the non-medical histories of processes now associated with the practice of medicine, Park’s work illustrates how a wider inquiry might uncover contributing factors to these processes that have been largely overlooked and unremarked upon in previous critiques and scholarship. In doing so, she demonstrates changes in access to female bodies as the complex culmination of changing institutional, ecclesiastic, social, and medical practices, and offers both contrast to—and possible new bases for—the critique of narratives of FGCS that focus on this increased access as rooted in the medicalization of female bodies in Western cultures.

V. Using Access to Authenticate Difference: Saartje Bartmann, Race, and Pathologization in Nineteenth-Century Europe

“Medicine uses its categories to structure an image of the diversity of mankind; it is as much at the mercy of the needs of any age to comprehend this infinite diversity as any other system which organizes our perception of the world. The power of medicine, at least in the nineteenth century, lies in the rise of the status of science. The conventions of medicine infiltrate other seemingly closed iconographic systems precisely because of this status in examining conventions of medicine employed in other areas, we must not forget this power.” (Gilman, “Black Bodies”, 205-206)

In nineteenth-century Europe, medical access to female bodies and the powers of authentication increasingly granted to physicians discussed in the previous section were two very important aspects of a growing project of “difference making”—namely, the search for medical and scientific proof of racial difference. This project
depended upon historical access to female bodies, beliefs that the female body was more connected to the “natural” world, anatomical dissections, colonialism, the powers of authentication granted to practitioners of Western medicine, and a burgeoning interest (and growing belief) in the power of science and its tools to reveal the (previously hidden) truths of nature, including those connected to the human body. Vanita Seth contends that the racial theories that arose from this project were also dependent on an epistemic shift from the time period in which the “holy anatomies” that Park details took place. This shift was related to a “fixity” of the body that was not present in the late-medieval/Renaissance period, when—in much of Western Europe—women were considered “porous,” and all bodies were open to the impress and implantation of the supernatural. According to Seth, “specifically, nineteenth-century racial theories rested on an epistemological edifice that both recognized the body as an object and represented that object as transparent, intransigent, and measureable. It was precisely the rendering of the body as an immutable, passive object that transformed it into a site of discourse and accorded it significance it had hitherto lacked” (174).

Fixing the body made it measureable and knowable in ways that it had not previously been. As a result, the classificatory systems used by nineteenth-century anatomists and anthropologists became especially relevant and increasingly accepted as tools that had the power to reveal various “truths” of the body. These systems most often relied upon measurements of bodily diversity visible to the naked eye, and their increased acceptance was directly tied to both the privileged status of the scientists
and physicians who developed and used them and the authority of the discipline, individual, and/or institution from which they originated. As a result of their increased social acceptance, these classificatory systems were called on in the early nineteenth century to authenticate the existence of a scientific physical difference between black and white races. This project came at a time when older justifications of said differences—namely, those based upon travel accounts and cultural iconography—were being dismissed as “unscientific by the radical empiricists of late eighteenth- and early nineteenth-century Europe” (Gilman, “Black Bodies” 28-35).

In order to meet the scientific standards of these empiricists, a new paradigm was needed, and “this paradigm would have to be rooted in some type of unique and observable physical difference” if it was going to be able to uphold the binary placement of black and white races. The answer to this need came in the distinction drawn “between the pathological and the normal in the medical model” (Gilman, “Black Bodies” 35). In their use of the medical model (and bolstered by the privilege enjoyed by this model detailed in this section’s epigraph), the anatomical studies called upon to offer up proof of racial difference also contributed to a pathologization of bodily diversity. Perhaps the most well known example of this pathologization of bodily diversity is the early nineteenth-century public exhibition,

29 In Difference and Pathology, Gilman discusses how previous (c. eighteenth century and earlier) pseudoscientific “labeling of the black female as more primitive, and therefore more sexually intensive” based on travel accounts “would have been dismissed as unscientific by the radical empiricists of late eighteenth- and early nineteenth-century Europe.” Gilman contends that these empiricists “would not have accepted generalizations but would have demanded the examination of specific, detailed case studies to evolve a ‘scientific’ paradigm” that “had to be rooted in some type of unique and observable physical difference.” According to Gilman, “such a criterion was found in the distinction drawn between the pathological and the healthy in the medical model” (83).
dissection, and re-exhibition of Saartje Bartmann, a black African woman whose genitalia and buttocks were presented as proof that the black female body was the pathological “other” to white European womanhood. The pathologization of Bartmann was thus both raced and gendered, and introduced an important foothold for the new paradigm of racialization by pathologization detailed in Gilman’s “Black Bodies, White Bodies: Toward an Iconography of Female Sexuality in Late Nineteenth-Century Art, Medicine, and Literature.” While there are many accounts of the use of Bartmann in the nineteenth-century search for proof of racial categories, an exploration of two by Gilman and Anne Fausto-Sterling illustrate how these racial projects called upon processes of pathologization in order to ensure their success.

The fact that the anatomical difference most important in this pathologization of Bartmann was related to her genitalia and buttocks makes her case an important aspect of a genealogy of the pathologization of female bodies, and an especially relevant one in any study and/or critique of FGCS. This relevance is apparent when examining many of the critiques of FGCS whose focus is the pathologization of

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30 Bartmann is referred to in various historical projects as Saartje, Saatje, Saartjie, and Sarah. While there is no record of her given name, Saartje is the Dutch name given to her, presumably by the family for whom she worked as a servant, and the one by which I have most often seen her referred. Sarah was the name bestowed upon her as part of her European baptism, and, while it is the one Gilman refers to her by, I follow Anne Fausto-Sterling and use Saartje, the name with which I am most familiar (Gilman, “Black Bodies”; Fausto-Sterling, “The Comparative Anatomy”).

31 Gilman’s article also details the pathologization of “deviant sexualities,” most notably with his discussion of the anthropological studies of prostitutes compiled by Parent-Duchatelet and Tarnowsky. These studies ranged from descriptive (Parent-Duchatelet) to detailed physiognomies (Tarnowsky) of the bodies of prostitutes, and they are significant in that their result was the pathologization of particular body types and parts. While hypertrophic labia and clitorises were among these, the most famous was the so-called “Darwin’s ear,” which served as an outward sign of the pathological sexuality of any woman who bore it.

32 The two accounts can be found in Gilman’s “Black Bodies, White Bodies: Toward an Iconography of Female Sexuality in Late Nineteenth-Century Art, Medicine, and Literature” and Fausto-Sterling’s “The Comparative Anatomy of ‘Hottentot’ Women in Europe, 1815-1817.”
diversity in female genitalia that the procedures then aim to “fix” or “cure.” These critiques often stress the role of medicalization, and the access to the classification of bodies that is an integral part of it, in the labeling of labia (and, to a lesser extent, clitorises) as “hypertrophic”—the very term used to reference Bartmann’s genitals. The pathologization of Bartmann’s genitals was specific to their size and shape, and contributed to the formation of a norm of acceptable genital aesthetics for all female bodies, while concurrently separating some of those same bodies for a different type of pathologization as racially “other.” This history is lost within many critiques of FGCS, where questions of race are often either focused entirely upon contemporary African cultural practices, or altogether absent. Great benefit can come, then, from a close examination of some of the key aspects of the use of Bartmann in the development of processes of pathologization, and the raced and gendered categorizations that arose from these processes.

33 For examples of such critiques, see the work of Virginia Braun and Leonore Tiefer ("The Designer Vagina"); the New View Campaign; Katherine Pauly Morgan ("Women and the Knife"); Leonore Tiefer ("Female Genital"); and Simone Weil-Davis ("Loose Lips") [full titles and citations in Works Cited].

34 Commonly understood as excessive growth or accumulation, hypertrophy is rarely understood as benign in medical discourses; indeed, some non-medical dictionaries go so far as to define it as “abnormal enlargement of a part or organ; excessive growth” (Dictionary.com).

35 The most common mention of race and practices of pathologization is coincidental, at best, as it focuses entirely upon an assumption that a pathologization of hypertrophic external genitalia is at the root of the set of Eastern Mediterranean and African practices known collectively as female genital mutilation (FGM) or female genital cutting (FGC). While these practices can be found only in particular areas of the aforementioned regions, and are by no means homogenous in their execution, they are rarely referenced with any attention to their heterogeneity. In addition to being presented as a unified, continental practice (associated with Africa), these practices are often used in comparisons with FGCS, wherein both are equated with needless butchering of female genitalia in the name of conformity or as a mechanism used to remedy the pathologization of individual genitalia that fall outside of a culturally or medically created “norm.” In establishing FGM/C as a barbaric practice that FGCS enjoys close parallels with, such comparisons contribute to a project identical to that which they purport to be resisting: namely, one of “difference-making” or “othering.”
How Bartmann came to reside in Europe and be publicly exhibited and examined while there, is, in itself, indicative of the complicated history at work in questions of racial pathologization. Bartmann was a black African woman whose claim to fame depended upon the writings of the white European men who studied her and the press and court proceedings that mentioned her; what we know of her is thus a highly mediated account that exists largely through and in the service of the racial project of nineteenth-century European science. Some accounts claim that she was descended from the African Khoikhoi and worked—or was indentured—as the servant of a family of Dutch settler-colonials before her arrival in England; most accounts list her as a “Hottentot” female, a term Europeans used interchangeably with the word “Bushman” in the eighteenth and nineteenth centuries (Fausto-Sterling, “The Comparative Anatomy” 22-25; Gilman, “Black Bodies” 213). These labels mark Bartmann as always already “other” to the white Europeans who displayed her, and the access to her that they enjoyed—from her time as a servant in her homeland to her time as a circus and museum curiosity in Europe—was the direct result of European colonial expansion.

Bartmann’s time in London, where she arrived in 1810, further illustrates the involvement of colonialism in her tale, as she was put on exhibition in the Egyptian Hall of Piccadilly Circus, where she “appeared on a platform raised two feet off the ground.” During her “performances,” a ‘keeper’ “ordered her to walk, sit, and stand, and when she sometimes refused to obey him, he threatened her” (Fausto-Sterling, “The Comparative Anatomy” 28). According to Fausto-Sterling, “the London (and in
fact European) show scene during the nineteenth century became a vehicle for creating visions of the nonwhite world” which served to strengthen Britain’s “civilizing colonial mission.” As such, Europe’s access to Bartmann’s body became the very vehicle through which Europeans sought to justify and expand their colonial projects, ostensibly in order to protect those races who were seen as unable to protect themselves or act in their own best interest (“The Comparative Anatomy” 30).36

As a result of her Piccadilly “performances,” Bartmann became a highly exoticized figure of the “other” that served to reinforce whiteness as the definition of “normal” (Ibid). Public access to Bartmann’s body during these displays helped to reinforce European beliefs in anatomical differences between races; in Bartmann’s case, the difference most publicly discussed and portrayed within the media was the shape and size of her buttocks. This fascination continued after her arrival in Paris, and it was there—both before and after her death—that “Bartmann entered into the scientific accounting of race and gender” through the use of her bodily measurements and descriptions as a measure of the pathological in classificatory systems (Fausto-Sterling, “The Comparative Anatomy” 33). Bartmann’s entrance into this accounting was effected through pre- and post-mortem examinations of her body conducted by famed anatomists/pathologists Georges Cuvier and Henri de Blainville.

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36 At the time of Bartmann’s arrival in Europe, England had minimal colonial holdings, and a few occupied territories, in Africa. They also had colonial holdings in other areas populated by “non-white” peoples, including: several Caribbean islands, some islands in both the Atlantic and Indian Oceans, and portions of both Australia and New Zealand. While it is outside of the scope of the current chapter, I hope in future works to explore the relation of these colonial projects to the discussion of Bartmann in more detail by using the work of Anne McClintock (Imperial Leather) and Ann Stoler (Race and the Education of Desire).
While travel tales of genital differences between the races (particularly between white European and black African women) had been circulating in various forms for centuries, proving them true was not the only motivation behind Bartmann’s post-mortem dissection and display. In fact, Gilman insists “it is important to note that Sarah Bartmann was exhibited not to show her genitalia but rather to present another anomaly which the European audience (and pathologists such as de Blainville and Cuvier) found riveting. This was the steatopygia, or protruding buttocks, the other physical characteristic of the Hottentot female that captured the eye of early European travelers. Thus the figure of Sarah Bartmann was reduced to her parts,” which were made available for public viewing after her dissection (Gilman, “Black Bodies” 213). Viewed in the privileged context of the museum, with all of its attendant scientific authority, this reduction of Bartmann to her genitals and buttocks came to signify not only what made her “other” than European, but also what made her “other” than female. The power of such a display cannot be underestimated, since “when a specimen was to be preserved for an anatomical museum, more often than not the specimen was seen as a pathological summary of the entire individual” (Gilman, “Black Bodies” 216). As a result, “Sarah Bartmann’s genitalia and buttocks summarized her essence for the nineteenth century observer,” and the pathology attached to these body parts via the authenticating power of scientific writings became conflated with Bartmann’s gender and race, as well (Ibid).
This display of Bartmann’s genitalia followed Cuvier’s post-mortem dissection of Bartmann, after which he prepared various parts of her body for display in Paris’s famed Musée de l’homme (Gilman, “Black Bodies” 216). According to Fausto-Sterling, Cuvier’s first order of business upon receiving permission to dissect Bartmann was to “find and describe her hidden vaginal appendages” in order to compare them to previous oral, written, and artistic accounts of the significant anatomical differences of African genitalia from those of European women (“The Comparative Anatomy” 37). While both de Blainville and Cuvier produced reports of the results of Cuvier’s dissection of Bartmann, de Blainville’s text provides reasons for the project of determining racial difference by way of genital pathologization. These reasons were to provide “‘a detailed comparison of this woman [Sarah Bartman-sic] with the lowest race of monkeys, the orangutan’” and “‘the most complete account possible of the anomaly of her reproductive organs’” (de Blainville in Fausto-Sterling, “The Comparative Anatomy” 33). The aspects of this account featured within Fausto-Sterling’s work suggest that de Blainville was more invested in the former rather than the latter, or at least that the former is where he was able to best engage in a project of racial “difference-making.” This is in part due to repeated references to Bartmann as different from [European] “Negroes,” and as possessing various bodily structures more similar, in his view, to those of the orangutan (Fausto-Sterling, “The Comparative Anatomy” 33).

While such comparisons might seem shocking now, this was not an isolated mode of comparison in de Blainville’s time. In fact, the work of Cuvier and de
Blainville was referenced as scientific proof of the non-unity of the races for decades after Bartmann’s death, not only within the disciplines of medicine and science, but also in politics, art, and literature, among others (Gilman, “Black Bodies” 216-22). The intent, in almost all of these cases, was perhaps best described by the editor of the *Journal of Anatomy and Physiology* in his opening remarks regarding anatomical dissections of “Hottentot or Bushman women” in the journal’s inaugural volume. According to the editor, “he wished to provide data ‘relating to the unity or plurality of mankind’”; after his description of a dissection, he reported that the “the remarkable development of labia minora [sic], or nymphae, which is so general a characteristic of the Hottentot and Bushman race…were sufficiently well marked to distinguish these parts at once from those of any of the ordinary varieties of the human species” (Gilman, “Black Bodies” 216). Differences in the dissected genitalia and buttocks of Bartmann and other non-white women not only marked these individual women as pathological other to white Europeans; by positioning these bodily differences as pathological, they marked the black, African female body as pathological other to white, European womanhood. The history of such processes of pathologization is significant, as “it is this borderline between normal and abnormal that Bartmann’s presentation helped to define for the Euro-American woman” (Fausto-Sterling, “The Comparative Anatomy” 30).

The privileging of a particular genital aesthetic as “normal,” as appropriate, and as more human than other genital variations is one aspect of Bartmann’s story that informs modern modes of pathologization, and thus, the pathologization of
female bodies in Western cultures. The processes of pathologization at work in the events surrounding Bartmann were part of a larger project of knowledge production and “difference-making.” Within this project, bodies were reduced to the status of their parts and raced and gendered according to nineteenth-century medical and scientific constructions of the “normal” and the “pathological.” The use of Bartmann’s body by European scientists to aid in the construction and support of these categories complicates historical accounts of pathologization that trace the pathologization of the diversity of female genitalia as originating solely within the practice of medicine. Such accounts obscure the role of nineteenth-century racial projects, colonial legacies, and the highly varied access to differently situated female bodies that also contributed to the complex history of pathologization. In this history, processes of pathologization were overwhelmingly called upon to provide evidence of recognizable difference and used to prove that not all humans were equal. Indeed, some were considered barely human at all, and what Bartmann illustrates is that, when one body part—and then one person—is called upon to represent the whole, the highly complex workings of categorization and pathologization easily become obscured in the process.

VI. Using Difference to Authenticate Access: Dr. J. Marion Sims and The Birth of U.S. Gynecology

“…the institution of slavery served medicine in providing subjects for experimentation. The gynecological patients’ position as slaves defined their status as medical subjects, situating them as institutionally powerless and therefore as fitting props for the experimenting white physician-turned-master-
showman, who revealed, probed, and operated on their vaginas. Slavery enabled the foundation of gynecology and in the process helped define the proper object of medical experimentation.” (Kapsalis 32)

“The designation of these women as hospital patients placed them in a lower class and/or race, women on whom doctors could experiment. Even though the Women’s Hospital of the State of New York also had patients of high social standing, they fell into a separate category and were less often the subject of untried surgeries.” (Kuhn McGregor 3)

The birth of U.S. gynecology as a discrete medical specialty in the mid-nineteenth century exemplifies similar modes of medicalization and pathologization as those detailed in the previous discussion of Saartje Baartman. This historical event offers valuable insight into the process by which a condition that was previously viewed as one of many possible outcomes of childbirth became recognized as pathological, and led to the establishment of the medical specialty now known as gynecology. Thus, the beginning of U.S. gynecology exemplifies a historical shift wherein changes to female genitalia previously considered the result of natural processes were pathologized; also relevant to the specialty’s formation were a number of other factors such as the practice of chattel slavery, race, class, and cultural expectations of gendered behavior and embodiment. Examining this historical shift offers further examples of the work of difference-making explored in earlier sections of this chapter, and how this work depends upon—and often bolsters—the right of medical and scientific professionals to access female bodies (especially those deemed pathological) in the course of medical experimentation and innovation. As such, careful examination of the experimental surgeries widely identified as the genesis of
U.S. gynecology allows for an analysis in which gynecology is not just accepted as a given specialty, or viewed as without history, but rather analyzed in relation to a wide range of actors and factors involved in this formative event in the history of what is often referred to as “women’s medicine”—a history FGCS draws from today.

According to Deborah Kuhn McGregor, the denotation “gynecology” first appeared in Europe in 1847 to describe “a medical department treating diseases and disorders peculiar to women” (48). Kuhn McGregor traces the technological advances that allowed for this split from the field of obstetrics to innovations in medical equipment by Récamier in France in the 1820s (Ibid). However, the limited communication between U.S. and European medical professionals meant that, for many U.S. physicians, such innovations often went unnoticed by all but the most privileged of students and practitioners. The provincial nature of the practice of U.S. medicine at the time was indicative of a young country that—outside of a few larger cities—was comprised of a population spread over large, rural areas where communication of novel technological and medical advancements traveled haphazardly, if at all. This was especially the case during the formative years of U.S. gynecology, the origin of which is generally traced to a series of experimental surgeries conducted without anesthesia on enslaved women between 1845 and 1849 in the backyard hospital of an Alabama surgeon by the name of J. Marion Sims. Sims, a native of South Carolina, is widely referred to as the “father of modern gynecology,” and the “father of American gynecology” for his surgical advances in the treatment of vesicovaginal fistulas (Harris 372; Kapsalis 31).
Sims, however, was perhaps as unlikely a candidate as could be imagined to be at the forefront of a new medical specialty whose focus was the female genitals and reproductive organs. In 1845, he was a young country doctor who had but recently decided that surgery was to be his chosen milieu. He is described, both in his biography and in his own writings, as being openly opposed to plying his trade on female bodies before this, having routinely turned away gynecological referrals as “out of his line” of practice, telling prospective patients he knew “practically nothing” about female medicine (Harris 82-83; Sims 226). Indeed, according to his biographer, Sims showed a “violent distaste”—and shared his instructors’ “marked disdain”—for the few lectures in obstetrics and “women’s problems” included in the “three month course of lectures” that comprised his medical education at the brand new Medical College of South Carolina (Harris 26-28).

Aside from a seemingly casual misogyny not unusual in medical writings of the time, Sims’s attitude reflects a climate wherein specialization within the medical community—especially as regarded women and childbirth—was uncommon. Kuhn McGregor contends that specialization was a gradual process, and followed upon the professionalization of medicine—a shift that did not begin until later in Sims’s career (7). She posits that the move towards U.S. gynecology occurred as “physicians came into cultural authority as representing science and the social structure of the larger political and economic system when they began to supervise childbirth” (122), which had previously been the purview of midwives. In the nineteenth century, physicians—who were previously called upon only in cases of difficult/problem births that
midwives could not resolve—began competing with midwives to “supervise childbirth” (Kuhn McGregor 35-37). This coincides with a shift toward a more clinical practice of medicine due to exposure to more empirical methods based on the recent rise in the popularity of statistics and bodily measurement/quantification in Europe (and the U.S.). This shift, when combined with the recent invention of the forceps used by physicians to aid in the delivery of infants during difficult labor, lent an air of authority to male physicians, and made it easier for them to begin to displace midwives as preferred birth attendants (Kuhn McGregor 13, 37).

The change in Sims’s practice began just this way in the summer of 1845, when Sims was summoned to assist with a seventeen-year-old enslaved woman on a nearby plantation whose childbirth had stalled after three grueling days of labor (Harris 83, Kapsalis 35, Kuhn McGregor 45, Sims 226-27). Sims was able to deliver the child using forceps, and went on his way, only to be recalled to the plantation five days later when Anarcha (the young mother) began showing signs of a serious vesicovaginal fistula (Ibid). After some research, Sims—who had next to no experience with obstetrics and gynecology, and had never before seen a vesicovaginal fistula—told Anarcha’s “…master that the girl was doomed to permanent invalidism, that she never could work again as a servant, and that there was nothing which he or any doctor could do about it” (Harris 83). For months, Sims remained resolute in his refusal to operate on vesicovaginal fistulas, regardless of continued pleas from the plantation owner who engaged his services to care for Anarcha and at least two other

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37 Vesicovaginal fistulas are defined by health educator and author Terri Kapsalis as “small tears that form between the vagina and urinary tract or bladder which cause urine to leak uncontrollably” (31).
plantation owners who sent prospective (enslaved) patients Lucy and Betsey to Sims’s makeshift hospital in search of a cure for their vesico-vaginal fistulas (Harris 83-84, Kapsalis 36, Sims 228-30). In the end, however, Sims’s ability to utilize his own technical innovations in order to effect a surgical fix to a problem that—to his knowledge—no surgeon before him had been able to adequately address proved more tantalizing than his distaste for operating on female genitals, and, utilizing a speculum and silver sutures of his own design, Sims set out to cure what he referred to as “suffering womanhood” from the “veritable living death” of the accidents of childbirth (Harris 83).

Kuhn McGregor details a historical shift wherein a condition that was previously viewed as one of many possible physical outcomes of childbirth became the focus of a burgeoning medical specialty and a pathology described by physicians as a “disgusting infirmity,” “disgusting disease,” and a “loathsome and disgusting” condition whose result was a life defined by “incapacity, the mortification, the veritable living death” of vesico-vaginal fistula (Harris 83; Kapsalis 35-36, 43; Kuhn McGregor 67; Sims 240). The severity of the language used to describe a previously unnamed (although known and remarked upon) condition is important, and points to the ways in which “vesico-vaginal fistula’ gained meaning through the relations between male physicians and their women patients”—patients who were now being described with euphemisms like “suffering womanhood”:

Despite the fact that, for hundreds of years, the symptoms of vesico-vaginal fistula appeared as a female disorder in medical texts, only in the mid-nineteenth century did medicine name the affliction. Vesico-vaginal fistula meant something unique at this time. Although parturient women throughout
much of history faced the possibility of incurring vaginal tears from childbirth and subsequent incontinence, and many still do today, when medicine became clinical and began to concentrate on female diseases vesico-vaginal fistulas became a focus...The nineteenth-century perception of vesico-vaginal fistulas also arose from a cultural context and from definitions of masculinity and femininity, situated in a class structure (Kuhn McGregor 33-34).

Thus, in Kuhn McGregor’s estimation, Sims’s description of his patients and their condition speak to a pathologization of vesico-vaginal fistula that marked both a change in perception of the condition and the genesis of physician specialization in the medical discipline that would later become known as gynecology.

In the case of the enslaved women Sims experimented on, the pathology of vesico-vaginal fistula was often framed in terms of economic loss (of labor—both reproductive and physical—as well as loss of sexual availability), while for white middle- to upper-class women, the pathology of the condition was often presented in terms of how it disrupted the most revered female role of the time: that of wife and mother (Kapsalis 32, 35, 43; Kuhn McGregor 34, 40, 54; Washington 63). Vesico-vaginal fistulas, then, as well as the medical specialty born of their treatment, offer an historical space wherein we see that the oft referred to universal woman was a heterogeneous group whose experience of this condition and its treatment was greatly varied. Kuhn McGregor clarifies:

A patient’s treatment…was based on his or her social status determined by perceived differences based on cultural perceptions of race, class, and/or ethnicity. Because vesico-vaginal fistulas were a relatively minor condition, medical practitioners experimented with different therapies. Patients considered to be of lower social status became likely targets of these practices. (35)
That gynecology begins at the hands of a surgeon is important; that it begins on the bodies of enslaved women no longer able to fulfill the duties expected of them by their “owners” is perhaps even more so. These women were considered pathological on multiple levels: removed from the capital functions of the plantation system they had previously been a part of, vesicovaginal fistulas were the result of prolonged, difficult births that had rendered their bodies no longer “productive” in ways that were legible to the economic and social expectations of the geographic region and the era. They were outside of their expected role of laborers in every sense. No longer able to conduct physical work, appear in public, bear children, or be sexually available, they existed in a limbo that managed to reverse the dominant system of the time: their existence was one that demanded the support of their white “owners,” with no hope of any of the usual economic, reproductive, or other returns slavery generally netted. We see an example of this in Sims’s diagnosis of Anarcha when he reports that, “She will not die, but will never get well, and all you have to do is to take good care of her as long as she lives” (Sims 227).

Sims’s access to the various female bodies he experimented on and treated was dependent on multiple aspects of their pathologization, and—while his position as a physician allowed him more access to female bodies than most men of the era—his position as a white male physician in the antebellum South offered him exponentially more (and more invasive) access to female bodies classified as non-
white or non-citizen, most notably the bodies of enslaved black women.\(^{38}\) This access provided Sims with what journalist Harriet Washington refers to as the “clinical material” upon which he could experiment and develop surgical instruments and techniques that might one day cure vesico-vaginal fistulas in women of all races: “Physicians were also dependent on slavery, both for economic security and for the enslaved ‘clinical material’ that fed the American medical research and medical training that bolstered physicians’ professional advancement” (26). As evidenced by Sims’s and other physicians’ work—and in the epigraph to this section—only particular female bodies were seen as appropriate subjects for experimentation and the public display that often accompanied it (reminiscent, in many ways, of Bartmann’s treatment in Europe). Enslaved women, by the very nature of their status as non-citizen and their classification as “other” to white women (discussed in Section V of this chapter) did not require the same considerations as Sims and other physicians gave their white, middle- to upper-class female patients—considerations such as anesthesia, modesty covers/clothing, and privacy (both from being the subject

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\(^{38}\) Later in his career, and after he had relocated to New York (where chattel slavery was not legal) and established the first women’s hospital in the country, Sims and his assistant would turn to Irish immigrant women as his primary research subjects as he continued to refine his vesico-vaginal repair surgeries (and develop other new procedures and medical instruments) (Kuhn McGregor 105-113). Terri Kapsalis has written about Sims’s use of immigrant patients at the Woman’s Hospital of New York, which she forwards he used “as his own private experimentation theater,” in which Sims operated in front of increasingly larger crowds of physicians and students, perfecting technology of his own design on women whose perceived class or race did not allow them the same rights of refusal as those enjoyed by middle- and upper-class white women of the time. These middle- and upper-class white women would later benefit from the instruments and techniques Sims developed, tested, and perfected on enslaved and immigrant women—and they would pay Sims handsomely for the privilege (Kapsalis 45-47; 58).
of large surgical audiences and scientific publications) (Kapsalis 58; Kuhn McGregor 47, 50-51, 124; Washington 64-65).

While Sims’s enslaved patients might have shared some experiences with white women of the time, whose bodies were also made pathological by the occurrence of vesico-vaginal fistulas, this pathologization differed in key aspects. Since the bodies of white women in mid-nineteenth century Alabama were not expected to labor in any way similar to those of enslaved black women, the pathologies read onto white female bodies by early gynecology required a shift of sorts. As such, they were often framed relative to a different form of production: childbirth and the anchoring of domestic units (Harris 179-81; Kuhn McGregor 85-86). The writings of Sims and his contemporaries confirm that a significant marker of pathology—the root of the tragedy of vesicovaginal fistula for white women—was the resulting removal from society (and even the space of the family) of women who suffered from this injury. The literature is rife with stories of shame, of women whose exile from public and family life (both self- and outwardly imposed), even of suicide (Harris 87; Kuhn McGregor 34; Sims 236).

Such extreme ostracism is presented as the unfortunate—but perfectly understandable (and, in some cases, necessary)—result of being afflicted with this condition. In the literature and oratory produced in the course of pushing for the creation of a new Women’s Hospital to treat vesico-vaginal fistulas in mid-1850s New York, there is discussion of the tie between untreated gynecological ailments and mental illness in women; according to Kuhn McGregor, it echoed “a major thread
in mid- and late nineteenth-century attitudes toward women,” namely that “the physical and mental well-being of a woman was diagnosed as almost completely bound up in her womb and its associated organs” (Kuhn McGregor 71; Rosenberg and Smith-Rosenberg 12-27). Such thinking was espoused not only by physicians, but also by key social reformers within the charity and asylum movements of mid-nineteenth century America. For instance, well-known philanthropists, women’s charity groups, and then New York City Health Inspector John Griscom all supported Sims’s 1855 bid to build the nation’s first hospital specializing in gynecological surgery, with the latter basing his support on the “fact” that “a large percentage of the cases of insanity in our insane asylums is due to the neglected diseases of females” (Harris 141-42; Sims quoting Griscom in Kuhn-McGregor, 71). For the white women gynecology was now focused on treating, pathologies of the body could easily travel and spread, infecting the minds of women left to suffer gynecological infirmities for too great a period of time. While I am in no way suggesting that vesicovaginal fistulas are not a medical issue that caused very real suffering, I am suggesting that their role in the birth of U.S. gynecology offers a case study of how the pathologization of female bodies can exceed the realm of the physical. Pathologization in this case was factored not only by medical assessment of appropriate embodiment, but also encompassed the relation of that embodiment to race, ideal gender roles, ability, and capitalism.

As discussed in earlier sections of this chapter regarding holy anatomies and the display and dissection of Saartje Bartmann, the construction of gender roles is key
to the development and understanding of pathologization. When it comes to the practice of U.S. gynecology and its later influence on cosmetogynecology, the role of women as producers of offspring and laborers to support (mostly) white, heteronormative, nuclear familial units is intimately entwined with how this pathologization is measured. This is evidenced by the pleading of plantation owners for a return on their human “investment,” the appeals of white nineteenth century women and their families for a return to domestic wholeness, and in advertisements for FGCS that promise a return to a more youthful, pre-childbirth state (Laser Vaginal, Pelosi; Laser Vaginal 2006, 2010, 2014, 2017). In marketing campaigns that stress the medical authority of FGCS surgeons we are privy to the workings of a relatively new medical specialty: cosmetogynecology. This specialty marks a shift wherein the health and maintenance of the female genitals and reproductive system—the purview of gynecology—takes a backseat to genital aesthetics and sexual function. As such, we see cosmetogynecology marketing that stresses the possibility and importance of returning the vagina to adolescent or pre-childbirth aesthetics with the stated goal of enhancing the experience of penetrative (presumably heterosexual) sex (Ibid). Thus FGCS marketing, like the discourses surrounding the vesico-vaginal fistula repair surgeries that signaled the birth of U.S. gynecology, relies on a pathologization of female bodies that is both flexibly applied and lies at the nexus of many factors, both within the medical field and outside of it.

The birth of U.S. gynecology illustrates an historical instance in which physician access to female bodies was dependent on cultural ideals of female
embodiment that were highly classed and raced. At the time, this access was neither understood as related only the practice of medicine or applicable to all female bodies; instead, its application was selectively applied and directly related to other factors, such as a woman’s race, nationality, familial and social status. Additionally, this account explores how the pathologization of vesico-vaginal fistulas that resulted from this access can be understood as a shift both in how women interacted with a burgeoning medical field and how that field classified the bodily variations of the women it sought to “treat.” The complexity of this account of the birth of U.S. gynecology and the myriad chance factors that contributed to it stands in contrast to current narratives of FGCS that focus on the pathologization of women’s bodies as a phenomenon originating solely within the practice of Western medicine, and following an uncomplicated historical trajectory to the present moment. By exposing the varied and sometimes unexpected aspects of the history of pathologization of female bodies in U.S. gynecology, this expanded engagement offers new avenues for formulating future scholarship and critiques of one of the most controversial products of its newest subspecialty: FGCS.

VII. Conclusion

One benefit of a genealogical approach is that it is better situated to make visible some of the complexities of these processes, as well as the wide variance found within their application, both of which might otherwise remain concealed in a traditional historical account. By resisting a search for origins or “truth,” it is easier to
remain open to the chance moments, the accidents, and other myriad events that commingle in a historical tradition like the pathologization of female bodies in Western cultures (Foucault, “Nietzsche” 143-44). Furthermore, resisting the search for the origins of such networks leads us away from teleological explanations, whose march toward an inevitable endpoint visible in present-day practices almost always occurs down corridors far too narrow to offer us an intricate view of the factors that worked to advance these practices.

When considering prevalent narratives of the role of processes of pathologization in FGCS, one finds that the most common narratives are those contained in critiques of the procedures. These narratives often follow this formula: 1) FGCS is growing in popularity in particular (mostly Western) societies because those societies have medicalized sex, which has led, in turn, to an expansion of the authority traditionally granted to physicians over bodies, and 2) Working in concert with this medicalization are processes of pathologization; more specifically, the pathologization of the naturally occurring diversity of female genitalia. In this logic, FGCS becomes the latest in a long line of technological advancements marketed to address what many critics consider a “created worry”: the creation of a normative female genital aesthetic and concomitantly, a domain of the pathological or abnormal (Braun and Tiefer, “The Designer Vagina”; Weil-Davis, 8). By locating the origin of medicalization within Western medicine and/or the medical model, the authors of these critiques have rendered other contributing factors and actors invisible, and
therefore effectively limited the possibilities of their interactions with, and interventions of, the practices at the heart of their critiques.

What a genealogy of the attendant processes of pathologization of female bodies offers, then, is a space in which to formulate a more expanded interaction with these processes. The potential to do so is based upon several tenets of the genealogy, but one of the most notable is regarding the naturalization of processes and institutions that occurs as a result of traditional historical accounts. In its refusal to accept a natural, or inevitable, outcome, a genealogy records “the singularity of events outside of any monotonous finality”, and seeks them “in the most unpromising of places, in what we tend to feel is without history” (Foucault, “Nietzsche” 139). In doing so, we make visible a wider web, a complex tangle of the mundane and the magnificent, all coming together in ways from the most unexpected to the predictable, and all adding up to practices and processes a traditional historical account would have presented as an inevitable, even natural, endpoint. Resisting this naturalization, and exposing the complexity that it obscures, presents us with an opportunity for a more generative engagement with our object(s) of study, and a genealogy is just the tool to facilitate this resistance.

What we can learn, from this genealogy of the pathologization of female bodies in Western cultures, lies within the walls of thirteenth-century convents and the hearts of its resident nuns just as much as within the practice of anatomical dissections used to bolster the credibility of nineteenth-century racial science and the birth of new medical specialties focused on female genital surgeries. These are the
spaces—both unlikely and expected—where access to female bodies and the pathologization of those bodies emerge. What we find in the canonization proceedings of Chiara de Montefalco is every bit as relevant to processes of pathologization and narratives of FGCS as the display and dissection of Saartje Bartmann and the surgical experimentation of Dr. J. Marion Sims, and examining these introduces spaces of potential engagement with—and interruption of—these present-day surgeries. These accounts illustrate that the pathologization at the heart of current narratives of FGCS did not arrive via an uncomplicated, “straight” historical trajectory, but instead exists as the culmination of a tangled path with many branches originating from various (and not always related) spaces within this history. Expanding our search to include history’s accidents as well as its intended actions illuminates the heterogeneous ways in which humans experience and are understood in their world, thus offering multiple entry points for future inquiries and critiques of FGCS. The work of pathologization is the work of “difference-making,” and critiques of FGCS that neglect careful examinations of this aspect of pathologization limit their own potential by representing these differences as experienced and understood similarly among women and throughout time. In doing so, these critiques risk succumbing to the very projects of naturalization and obfuscation that they purport to oppose, and close out engagements with this “difference-making” of a more expansive, productive—and perhaps even revolutionary—type.
Chapter 2: Lips Unsealed: Narratives of FGCS

“Our mission is to empower women with knowledge, choice, and alternatives. We encourage patients to participate in their healthcare and surgical design. In one of our patient surveys, women were asked, do women want to be loose or relaxed or do women want to be tight? Women answered 100% of women want to be tight. LVR [Laser Vaginal Rejuvenation] can accomplish what ever (sic) you desire.” (Laser Vaginal, Pelosi)

“Following the labiaplasty he [the surgeon] comments: ‘She is like a 16 year old now’, a phrase he repeats in many videos and one that is also used by other FGCS39 surgeons.”

(Tiefer, “Female Genital” 469)

“FGCS should ultimately be analysed (sic) together with other controversial genital surgeries: infant intersex operations, infant male circumcision, and traditional female genital cutting.” (Tiefer, “FGCS”)

I. Introduction

In the previous chapter, I employed a genealogy of the pathologization of female bodies in order to explore the limits of FGCS narratives that posit medicalization and pathologization as contributing factors of FGCS rooted solely in the realm of the medical. I examined the role of various social, religious, judicial, scientific, and medical forces in the accounts of three formative events within this genealogy in order to call attention to the increased access to—and pathologization of—female bodies in Western cultures as a phenomenon with multiple contributing factors.

39 Female Genital Cosmetic Surgery, or FGCS, is the commonly used terminology for a suite of surgical procedures. My use of the term most closely matches that of FGCS critic Dr. Virginia Braun, who defines FGCS as follows: “Labiaplasty/labiplasty (labia minora reductions), labia majora ‘augmentations’ (tissue removal, fat injections), liposuction (mons pubis, labia majora), vaginal tightening (fat injections, surgical tightening), clitoral hood reductions, clitoral repositioning, G-spot ‘amplification’ (collagen injected into ‘G-spot,’ which swells it significantly), and hymen reconstruction (to restore the appearance of ‘virginity’).” Like Dr. Braun, I do not include the following as FGCS procedures: gender confirmation/sexual reassignment surgeries (for people who identify as transsexual), sexual assignment surgeries for intersex infants (or non-consenting intersex individuals of any age), or any of the suite of practices termed “female genital cutting” (FGC)/“female genital mutilation” (FGM) (Braun, “In Search of” 407). Additionally, I exclude from the category of FGCS any genital surgery performed for damage repair or trauma related reconstruction, as opposed to for purely cosmetic reasons. While there are arguably women for whom FGCS would not be considered a purely cosmetic endeavor (for reasons of psychological or social distress, etc.), these cases would require a more in-depth examination than is within the scope of this dissertation.
factors, which hail from both within and outside of the practice of medicine. Such an examination illuminates the history of pathologization as a longer, more complex tradition than is visible when considered only within the context of the practice of Western medicine, thus complicating narratives of FGCS that fail to take into account the influence of other factors that contribute to this pathologization.

As such, Chapter one’s discussion of these factors and their role in the pathologization of female bodies has laid the groundwork for this chapter’s more in depth exploration of particular narratives of FGCS. While these narratives are varied and have diverse origins, many can be classified as belonging to three main groups: choice narratives, medicalization narratives, and nature narratives. I have found these groupings to be a useful tool for analyzing the discourses of FGCS, even as I acknowledge a good deal of overlap among them, and a certain lack of precision that always comes with general classificatory schemes. Nevertheless, these classifications offer insight into various narratives of FGCS in a way that builds upon the process of pathologization discussed in Chapter one, and open up new discussions of where the underlying frameworks of the featured narratives of FGCS overlap, fall short, and come into conflict. Before diving into these narratives, however, it is useful to quickly review some basics about FGCS.

Surgical procedures focused on the aesthetics of female genitalia have a long and well-recorded history worldwide (Braun, “In Search of” 408; Green, “Erasing Genital”; Tiefer, “Female Genital” 467; Weil-Davis, 16-18). While surgeons who practice female genital cosmetic surgery (FGCS) claim decades of experience
administering the procedures (Laser Vaginal, 2014; Laser Vaginal, Pelosi), FGCS has enjoyed a noticeable increase in popularity since the media blitz that accompanied Los Angeles surgeons Drs. Alter and Matlock’s 1998 publicity campaign highlighting various FGCS procedures offered at their Beverly Hills clinic (Tiefer, “FGCS”). With this increased visibility came an increase in criticism of these procedures, from both the academic and medical communities. This criticism stood in stark contrast to the claims of better sex and happy patients featured in surgeon interviews, and the glowing testimonials published on surgeon websites, as is evidenced by the narrative examples in this chapter’s epigraph.

The years since the 1998 media blitz have seen a swell in narratives of FGCS, and these narratives occupy various positions regarding these surgeries. The most prevalent belong to one of two groups: those in favor of the procedures, often generated by FGCS surgeons or patients happy with the procedures, and those opposed to or critical of them, most commonly generated by academics, feminists, and more traditional (Western) medical establishments. Whether favorable or critical, most FGCS narratives fall into the following categories: choice narratives, medicalization narratives, and nature narratives. Choice narratives seek to inform potential FGCS patients and create more savvy consumers in the hope of facilitating a more knowledgeable (and, depending on the origin of the narrative, a more critical)

40 There is a fourth type of narrative, which is often less accessible to the general public, as it is situated more within the realm of calls for more medical/empirical evidence of FGCS outcomes. The narratives which fit into this category, which include professional sanctions from medical associations, medical journal articles, and other related medical and scientific disciplinary works, are outside the scope of this chapter, the focus of which is the narratives most accessible to the general (i.e. non-medical professional) public.
approach to deciding whether or not to undergo FGCS. Among these, choice narratives produced by FGCS surgeons that present genital cosmetic surgery as empowering—a step in a woman’s transformational journey, self-management, or self-care—are the most common. Medicalization narratives are most often generated by activists and scholars opposed to a broader medicalization of sex that they see as including FGCS and technologies like it; however, medicalization narratives can also include FGCS industry use of the implied authority of medical professionals—in this case, FGCS surgeons—to correctly interpret when a body is in need of a surgical intervention. Nature narratives vary according to their origin, but can roughly be divided into two general groups. The first set champions a more expansive and inclusive engagement with bodily variations. Narratives that fall within this category are most commonly produced by groups or individuals who oppose FGCS on the grounds that the industry increases the pressure to attain homogenized genital aesthetics. The second group includes narratives most often produced to encourage potential FGCS patients to have the surgeries in order to return to a more natural state or reverse the damage wrought by processes such as childbirth and aging.

The forms these narratives take are wide-ranging, from surgeon websites to beauty magazine articles, from YouTube parodies to photography books, and from academic scholarship to online petitions and senate testimony; they include counter-

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41 Many of these narratives also claim that these homogenizing aesthetics being advertised by FGCS surgeons are unattainable without undergoing FGCS.

42 My goal is to more deeply examine this second type of nature narrative in my future work.
conferences, sidewalk protests, and other formats, as well.\textsuperscript{43} However, in a time where so much business occurs online, members of the FGCS industry and their critics have increasingly attempted to attain more of an online presence for the narratives that they produce. This growing internet presence can be viewed as a direct response to the increase in both medical business and activism conducted online. In light of the tremendous amount of advertising and consulting conducted by FGCS practitioners via the world wide web, the New View Campaign (NVC), in particular, has expressed the need to bring opposition to surgeons’ places of business—not only via sidewalk and clinic protests, but also in the form of an increased internet presence for the organization’s campaign against FGCS (New View Campaign, 2010).\textsuperscript{44}

As activist, critical, and industry narratives of FGCS exponentially increase, so does the importance of non-partisan examinations of the procedures. Such projects have the power to provide insight not only into what methods are being employed, but also by whom, and to what end. These examinations reveal places where the originators of the narratives in question engage in behavior or scholarship that is

\textsuperscript{43} On “counter-conference”: In September of 2010, the New View Campaign (NVC- see note 44) planned what they termed a “counter-conference”, to be held in Las Vegas on the same weekend as FGCS surgeons were holding their annual meeting at a Las Vegas luxury hotel. The stated purpose for organizing the event was the belief that it “could create the ideal intellectual and activist event,” by gathering like-minded scholars and activists in such close proximity to so many FGCS surgeons (“New View Campaign”).

\textsuperscript{44} The New View Campaign (NVC) is a working group comprised mainly of academics and practicing therapists whose 2000 manifesto expressed concern for the growing acceptance and usage of a “medical model of sexuality” and the increasing use of frameworks that reduce “sexual problems to disorders of physiological function” (“New View Manifesto”). The initial focus of the “New View Campaign Challenging the Medicalization of Sex” was the growing market for, and prescribing of, pharmaceuticals advertised as treatments for sexual dysfunction and the expanding categorizations of this dysfunction, which the NVC forwards as directly linked to the increased availability of drugs marketed to treat it (Ibid). With the rise in marketing for FGCS as a treatment for various sexual dysfunctions, however, the NVC expanded their campaign to include a challenge not only to FGCS, but also against the medicalization of sex in general.
problematic relative to their stated purpose. For example: While many of the most prominent producers of anti-FGCS scholarship and activism base their objections to the surgeries on an opposition to the medicalization of sex, the narratives produced by these scholars also use sanctioned medical knowledge or the official opinions of professional medical organizations as supporting evidence. Also problematic are narratives concerned with genital “norms,” which—by pointing out the lack of medically sanctioned normative measurements for female genitalia—run the risk of reproducing the narrowing of the genital aesthetics they purport to oppose, if such normative measurements were to be instituted.

Both of these examples are indicative of the ease with which FGCS discourses on either side of the divide overlap. The contradictions arising in even this cursory examination support the need for more expansive scholarly engagements with the various narratives of FGCS in order to better illuminate those that have been largely represented as occupying one of only two recognized positions: pro- or anti-FGCS. Additionally, these examples offer another important aspect of a thorough and non-partisan exploration of the various narratives of FGCS; namely, that such an exploration can illuminate the places where they—no matter the politics of their authors—might also contribute to narratives (harmful and otherwise) in the wider sphere of women’s medicine. For instance, many feminist critiques of FGCS produce narratives that position women who choose to undergo the procedures as being pressured by an industry claiming the procedures as a way for women to achieve more appropriate genital aesthetics (and the rewards associated with them). This
formulation is problematic, however, in that it suggests that women are duped into major, surgical modification without considering the ways in which these women’s decisions factor into questions of female agency.

In addition to examining these narratives, this chapter seeks to move the discussion beyond the limits of who is for, and who is against, these surgeries, and to explore narratives that might move beyond this oppositional positioning. In it, I use the work of Lauren Berlant and Kathy Davis to examine alternative ways of thinking about the decisions women make regarding FGCS. By engaging in an intersectional feminist analysis of popular narratives of FGCS, I seek to move the conversation past the limiting framework in which it is currently couched, and to illustrate the places where that framework may be more illusion than stable ground. Doing so will improve future scholarship of FGCS even as it offers a more ethical engagement with all involved parties, especially those women who have undergone the procedures while negotiating complex modes of agency that have generally gone unacknowledged.

II. Choice Narratives

“We developed the LVR [Laser Vaginal Rejuvenation] program by listening and caring about the needs of women in this area of sexual gratification...Women of the world inspired all of the surgical designs. For this, we as well as present and future patients thank the ‘true pioneers’ and inspirational forces that made Laser Vaginal Rejuvenation a reality...WOMEN.” (Laser Vaginal, Pelosi)

“We have learned a tremendous amount from listening to women we have treated from over 35 states and 20 countries. Women come to us because they want knowledge, choice, and alternatives.” (Laser Vaginal, Pelosi)
One of the most common themes found in FGCS promotional materials is that FGCS is an empowering choice and is available because women demand it. Consider the quotes above, taken from a surgeon website: In the first, women are hailed as the very force behind the existence of FGCS, with the surgeries created to address women’s desires, providing them with a choice that was ultimately their idea. The same is implied in the second example, which takes the idea one step further. In addition to suggesting that FGCS surgeons offer the choices women want, such narratives also infer that surgeons possess a greater knowledge of women’s genitalia than (many) women do and can thus offer alternatives to address their “needs” through FGCS clinics. Often, choice in FGCS promotional narratives is framed as an act of empowerment, of women taking control of bodies, which, through no fault of their own, are unruly and outside the genital aesthetic that these narratives deem acceptable or desirable.

Among the choice narratives designed to resist this line of argument, the most common situate female choice as being highly constrained by the narrowing of available options produced by the FGCS industry (Braun, “In Search Of” 418; Tiefer, “A New View” 98). Narratives that focus on limited choice fall into multiple categories, some of which overlap with other types of narratives. For instance, those who claim that FGCS results in a homogenization of acceptable genital aesthetics, thus decreasing a woman’s choice if she wants to be viewed as attractive—or even normal—to sexual partners, often invoke narratives that resemble nature narratives. This resemblance is most noticeable in relation to narratives that promote a particular
aesthetics as more “natural,” or offer FGCS as a method of returning to a more “natural” state after the “damage” wrought by processes such as childbirth and aging (Laser Vaginal 2009, 2010; Laser Vaginal, Pelosi). For example, the Laser Vaginal Rejuvenation website states: “Women who have had children want a solution to rejuvenate the vagina and achieve the best sexual experience possible” (Laser Vaginal 2014). Aside from exhibiting clear overlap with narratives focused on “natural” genital aesthetics, this narrative also makes a typical consumer capitalist move, producing a problem to which it then offers a solution. This places it within the realm of choice narratives that many anti-FGCS critics charge with constraining women’s choices, in this case by contributing to the narrowing of acceptable genital aesthetics and offering one solution: FGCS.

Choice narratives also occasionally overlap with medicalization narratives, typically narratives that focus on the medicalization of bodily diversity in relation to expanding treatment markets. The resulting medical marketing models—like neoliberal markets more generally—engage in a system of rewarding certain consumer behaviors. These behaviors, when backed by the power of media and the capitalist imperative of consumption, often become habits rewarded—and thus striven for—by the majority of society. This type of reward system can also be found within many choice narratives of FGCS, and one example of this is the celebration of the “early adopters”: these were the women who were willing to take a chance and have the procedures before FGCS was more publicized and socially accepted. In discourses of neoliberalism, such “early adopters” are lauded as cutting edge, brave, and
“empowered consumers” (Tiefer, “FGCS”). Consequently, these women are held up as exemplars of agency and power, savvy consumers who used new technologies to assert control over their unruly bodies, the highly advertised result of which was praise, an ideal aesthetic, and a claim of better and more sex. These women can be found in the “testimonials” section and photography galleries on surgeon websites (Laser Vaginal, 2009, 2010 and 2014), where they are celebrated for taking control and exercising the power of personal choice to correct bodily imperfections. Some of these women have also appeared on video segments for surgeons’ websites and on television as part of doctors’ reality shows, like “Dr. 90210” and “Plastic Wives” (Ibid). Consider the role of choice in the testimonials below:\footnote{45 A note on the uncertainty of online testimonials: While impossible to verify their veracity or origin, these testimonials are nevertheless useful when examining narratives of FGCS. This is due to the fact that they exist in the public domain as popular narratives of the procedures, and are common additions to many surgeon websites and marketing campaigns. Thus, prospective patients and others who conduct online research regarding FGCS are likely to encounter these testimonials, and many prospective patients seek them out in more interactive forums, such as those found on the information sharing sites discussed in Chapter three of this dissertation.}

\textbf{Testimonial #1}

I still tell my friends about my wonderful surgery that Dr. Matlock performed on me in 2002. Fabulous! Wish I could do more, really. I wish more women would take control and do these sorts of procedures for themselves, as I did. What a difference!
–DZ (Laser Vaginal, 2014)

In DZ’s testimonial, happiness with the results of FGCS is followed immediately by her wish that other women would make the same choice—and thus attain the same happiness—for themselves. The sincerity of her appeal “wish I could do more, really,” conveys (with a feeling of some angst) a desire to be helpful, and creates an
impression of real concern for women who would not choose to avail themselves of the obvious benefits of the procedure. DZ’s additional wish, that “more women would take control and do these sorts of procedures for themselves,” as she did, carries with it the implication of responsibility on multiple levels. For one, there is the obvious nod to an individual’s responsibility for her own well-being and happiness; perhaps more interesting, however, is the suggestion of individual responsibility for self-improvement through the use of emergent technologies. These implied responsibilities can be directly related to Western practices of neoliberalism, wherein bodily perfection becomes just one of the many aspects of life (health, financial stability, emotional well-being, etc.) that are deemed the responsibility of the individual (Harvey 76, Tiefer “FGCS”). This individuation of responsibility is often repackaged as patient choice on surgeon websites, in their marketing materials, and in the testimonials they choose to publish.

A popular critique of this individuation of responsibility for bodily perfection, however, is that it assumes an even playing field among potential consumers of FGCS. One result of this assumption is the flattening out of the very real economic obstacles—and the possible dangers masked by the fetishization of emergent technologies—that might also be legitimate reasons for women to choose not to undergo FGCS (Harvey 66, Tiefer, “Female Genital” 474). Indeed, there is a long history in which the fetishization of, and rush to use, emergent technologies (many of which were at first marketed as devices to better women’s lives) created more harm than good. This has been especially true of products and services that lie at the
intersection of the cosmetic and the medical. Considering the privileging of
technology and medicine in our society, which often contributes to greater consumer
trust than in commercial enterprises (you would not necessarily buy a new car
recommended by an auto salesman as quickly as you would try a new medication
recommended by your physician), the association of these products and services with
the medical field often results in them enjoying the authority associated with that
field. When factored together with the privileging of innovation, the result is often a
rush to attain the newest, and assumedly best, product to hit the market.
Unfortunately, this fetishization of technological “fixes” includes a long list of
products and services that ultimately did more damage than good to the women who
used them. Some examples are silicone breast implants (many of which leaked,
leading to a variety of health problems); Phen-phen diet pills (pulled from the market
after causing numerous deaths); 1960s-era IUDs (pulled from the market after
causi ng numerous gynecological infections and problems); and the morning sickness
remedy Thalidomide (pulled from the market after causing numerous, severe birth
defects and deaths). While not necessarily mentioned by name, these are the specters
at the heart of FGCS discourses that reference the possible dangers of emergent
technologies. Critics of “consumer choice” hold that the individuation of
responsibility in projects of medical and cosmetic betterment serve to effectively

46 For more on the privileging of medicine and science in Western societies, see Michel Foucault’s
History of Sexuality, Volume 1.
mask potential dangers and instead position women who choose not to have FGCS as less than ideal citizens rejecting available technology for self-improvement.

**Testimonial #2**

Dr. Matlock has given me a whole new perspective on life. About a year ago, I underwent lipo-sculpturing [removal and/or replacement of adipose tissue on the body—including genitals—in order to attain desired shape] on most of my body. What a miracle it has been. I am sooo happy and feel very confident and satisfied with the procedure…I was so thrilled with the results that I decided to go back a 2nd time for a second procedure. I had the Brazilian Butt Lift a few months after my 1st procedure. I was a little scared, but I knew Dr. Matlock would work his magic on me. From having a small behind to a nice behind, WOW, what a difference. I have gotten so many compliments with how natural my body and butt look!! I am much more confident now and excited for the new ME! I owe this all to Dr. Matlock…I can't wait to go back again!

–Leeza (Laser Vaginal, 2014)

Leeza’s testimonial, while also a choice narrative, initially appears to differ from DZ’s in at least one notable way. The focus of Leeza’s narrative is, at first glance, on transformation, as opposed to individual responsibility and choice. When we look closer, however, we can see that the overarching theme is similar to that of DZ’s testimonial: Choosing FGCS (or related procedures like the Brazilian Butt Lift [BBL] offered by some FGCS surgeons) is a step on the path to happiness. In this formulation, transformation is required in order to attain happiness, and this rejoins the two narratives: To be happy, an individual must change her appearance, and the responsibility for attaining this happiness rests solely with that individual, and can include undergoing the knife (or laser) in order to best (and most quickly) effect said transformation. This theme is echoed in other Matlock marketing materials, such as
the pamphlet for G-Shot procedures that urges women to: “Empower yourself. 
Women have claimed to experience a peak in their sex drive and reach new heights of ecstasy [after undergoing the $1,850 G-Shot]” (Radakovich 91). This rationale is similar to the capitalization on “transformational ‘makeover’ language” discussed by Leonore Tiefer, a leading critic of FGCS: “Their appeal to a fantasy body fix is the same as for the new sex drugs. Change the body to change the (sex) life, goes the story, underscoring beliefs that the body is the prime factor limiting initiative, connection, and happiness. The focus is on instant success (“Female Genital” 469).”

**Testimonial #3**

After the 6 weeks of healing took place I felt as good as new, having this procedure was the best decision I had made regarding my health. I felt confident and vibrant again. And my love life was back on track. Having no problem reaching sexual gratification. Even my husband noticed the difference and was very pleased. I would recommend this procedure to anyone who is suffering from this discomfort…It gave me a whole new outlook on things, it was a motivational experience that took place. I soon lost unwanted weight, cut my hair, and made more personal improvements physically since then. It was just what I needed to get things going again. I am now 35 years old and planning to have another child next year, and if the same situation arises from this child, I will not hesitate to have this procedure performed again...

—Anonymous (Laser Vaginal, 2014)

In this testimonial, Anonymous delivers a narrative that, like Leeza’s, trades on the tropes of choice and transformation. While Leeza speaks more of the instant transformation that is discussed by Tiefer, using words like “miracle” and “magic,”

47 The discomfort referred to in the full testimonial is different sexual sensation after the birth of a child.
Anonymous describes a post-FGCS transformation that is both gradual and involves the whole body. Anonymous’s choice to undergo FGCS results in a transformation that also arguably extends to the mind, as is evidenced by her use of terms like “new outlook” and “motivational experience.” Her descriptions of a love life now “back on track” suggest that the results of such transformations necessarily lead to a happier, more fulfilling life. It is this usage of Tiefer’s “transformational ‘makeover’ language” that places Anonymous’ testimonial alongside other narratives of choice. By changing the body, it suggests that one can lift perceived limits on initiative, connection, and happiness (Tiefer, “Female Genital” 469).

Such transformations, however, are not always a one-time necessity. Instead, women are encouraged to be vigilant of the possible need for additional aesthetic work, including the need for repairs or touch-ups on areas of the body previously transformed via cosmetic procedures. This is illustrated in Anonymous’s testimonial: “I soon lost unwanted weight, cut my hair, and made more personal improvements physically since then,” and “I am now 35 years old and planning to have another child next year, and if the same situation arises from this child, I will not hesitate to have this procedure performed again” (Laser Vaginal, 2014). While Anonymous claims that the choice to undergo FGCS helped her to gain control of—and improve—her life, the path to doing so appears to involve a constant self-surveillance, the purpose of which is to keep up with the need for additional improvements in order to maintain what seems to be an elusive state of ideal female beauty.
Consumer choice, cruel optimism, and breathing room

One common critique of FGCS involves the role of marketing of surgeries designed to deliver these ideal female aesthetics, particularly using narratives such as those featured above, in the creation of pathologies whose only solution is FGCS. Women, framed as empowered consumers, play a crucial role in the framework of expanding neoliberal markets. In these markets, the creation of new pathologies interpellates subjects as in need of these new technologies. The result is an increasing demand for technological “solutions” from a growing consumer base.

As a general rule, when medical and pharmaceutical establishments refer to patients as consumers, they are referring to the 20th-century popular use of the word as a synonym for any purchaser/buyer of goods (McGill 78-79). There is an added benefit in this utilization of the term for the corporations and institutions employing it. The use of the word consumer gives the appearance of autonomy; as such, it can lend subjects a feeling of control over a market situation that is actually designed to control or influence their actions (Ibid). This can be especially true in the case of FGCS in the current culture of the “sexual imperative” (Braun, “In Search of” 414; Tiefer, “FGCS”), imposed by the self-regulating that is a demand of the neoliberal market (Harvey 76-77, Williams 152). This imperative is similar to the catch-22

48 This “sexual imperative” is referenced by several critics of FGCS, and describes the “mandate of good sex” (Tiefer, “FGCS”) that is often considered the “obligatory pursuit for the ‘liberated’ (sexual) subject” (Braun, “In Search of” 414). The “sexual imperative” and “mandate of good sex” are generally cultural expectations associated with liberal Western cultures, especially those of the United States, Great Britain, and Australia, and can loosely be explained as the expectation that—as subjects of governments or societies who “allow” for the pursuit of individual sexual enjoyment, expression, and practice—citizens are expected to pursue a sexual lifestyle that adheres to a socially understood ideal of “good sex.” This “mandate” extends into public and private manifestations of sexuality and its
introduced by other technologies, often presented as responsibilities that individuals assume: To have such technologies available and not use them indicates pathology, but to use them indicates a need based on a pathology as well. While it would appear to be a conundrum, the allusion to autonomy in the marketing of these technologies often sweetens the deal, leading consumers to acknowledge pathology but then gain strength and autonomy through the consumption of the “cure” for the pathology in question (Braun, “Straight”).

This formulation, then, offers one possible explanation for women who choose to undergo FGCS as just such a “cure” for genitalia that have been deemed pathological. This explanation contrasts with critiques of FGCS that portray women who choose to undergo the procedures as uninformed consumers who have unwittingly fallen victim to the savvy marketing techniques of FGCS surgeons. Things are rarely this simple, and the portrayal of such consumers as unquestioning can be problematic in its own right. To present consumers as subjects led, through false consciousness, by market and media manipulation creates the disturbing effect of further chipping away at the possibilities for female choice and agency within these interactions. By positing neoliberalism as paving the way for FGCS to become a requirement of female existence, some activists are in danger of obscuring the

practice; physical representations that signal sexual expression are not immune. Not wanting to adhere to the “mandate,” or adhering to other modes of governmentality (especially religion) that might contradict such an expectation, is often viewed with suspicion or outright derision; such cases are also often cited as instances of repression (such as the observance of religious modesty rules) or ignorance (such as the denial of “asexual” as a legitimate sexual identity).
complicated dynamics contributing to the situation, and the agency women exercise within these dynamics.

In Cruel Optimism, Lauren Berlant explains the hazards of such an engagement:

I suggested that critics interested in the ways structural forces materialize locally often turn the heuristic “neoliberalism” into a world-homogenizing sovereign with coherent intentions that produces subjects who serve its interests, such that their singular actions only seem personal, effective, and freely intentional, while really being effects of powerful, impersonal forces. Yet, at the same time, they posit a singularity so radical that, if persons are not fully sovereign, they are nonetheless caught up in navigating and reconstructing the world that cannot fully saturate them. This dialectical description does not describe well the messy dynamics of attachment, self-continuity, and the reproduction of life that are the material scenes of living on in the present, though, and this is where conceptualizing affectivity works illuminatingly. (15)

Berlant’s call to conceptualize affectivity provides a means of understanding the agential potential for the consumer subject who is engaged with what Berlant calls “cruel optimism…the condition of maintaining an attachment to a significantly problematic object” (24) than would be allowed by the more flattened narratives of control described earlier. If we consider that “…where cruel optimism operates, the very vitalizing or animating potency of an object/scene of desire contributes to the attrition of the very thriving that is supposed to be made possible in the work of attachment in the first place” (Berlant 24-25), then we can see that it could be useful to consider FGCS as a scene of cruel optimism, where the marketing promises used to convince consumers of its necessity for their sexual and psychological empowerment, health, and well-being are countered by the threat that these procedures can pose.
Berlant suggests that, rather than consumers of FGCS taking part in these scenes because they were manipulated and followed blindly along, there is another possibility:

I am not asking to replace a notion of cognitive will with a notion of involuntary or unconscious activity. In the model I am articulating here, the body and a life are not only projects, but also sites of episodic intermission from personality, the burden of whose reproduction is part of the drag of practical sovereignty, of the obligation to be reliable. Most of what we do, after all, involves not being purposive but inhabiting agency differently in small vacations from the will itself, which is so often spent from the pressures of coordinating one’s pacing with the working day, including preparation and recovery from it. These pleasures can be seen as interrupting the liberal and capitalist subject called to consciousness, intentionality, and effective will.

…

In this scene, activity toward reproducing life is neither identical to making it or oneself better nor a mimetic response to the structural conditions of a collective failure to thrive, nor just a mini-vacation from being responsible—such activity is also directed toward making a less-bad experience. It’s a relief, a reprieve, not a repair (Berlant 116-17).

It is possible, within this formulation, that consumers of FGCS are engaging in a sort of lateral move outside of the demands of our capitalist society, a “floating sideways” towards “small pleasures” that can lead to a reprieve from the constant demands of chasing a good life that remains increasingly out of reach (Ibid). In Berlant’s model, these demands are tied to capitalism, and to expectations of appropriate self-management that are an important aspect of the “practical sovereignty” she ascribes to the capitalist project. Under such circumstances, perhaps FGCS, like Berlant’s example of overeating, “…adds up to something, many things: maybe the good life, but usually a sense of well being that spreads out for a
moment…” (Berlant 117). In this moment, the subject effects an interruption of expectations of self-management and improvement; there is the possibility, no matter how brief, of breathing room—of a break from the expectations of reliability and what would be considered responsible citizenship. While it may not be what would be considered a healthy pursuit, it is not necessarily one that indicates a powerless subject, either; in fact, the situation may be read as quite the contrary, according to Berlant.49 FGCS, in such a formulation, may be about attaining a small break from the demands and responsibilities of living the “good life” Berlant describes: By choosing to undergo FGCS, some women can—for small and temporary amounts of time—meet the social demands and expectations of appropriate female aesthetics and sexual function that are an understood requirement of that “good life.”

III. Medicalization Narratives

Social expectations of particular sexual aesthetics and function are one place where choice narratives necessarily overlap with medicalization narratives. This overlap is the direct result of a particular type of marketing that suggests that any

49 I am referring, in this instance, to the common usage of the word “healthy” in the context of the United States, which draws largely from edicts of Western medicine and popular media. Berlant’s example of overeating, for example, is a behavior commonly accepted as unhealthy in the U.S., due in large part to its association with obesity. While this association is being increasingly contested by groups of activists and medical professionals, current pathologization of obesity lends such strong stigma to the association that overeating is frequently viewed as an unhealthy activity. In regards to FGCS, it is not necessarily that the surgeries are any more or less healthy than other cosmetic procedures, or any surgery in general, for that matter. Rather, the point is that undergoing cosmetic surgery in order to attain the reprieve and breathing room suggested by Berlant’s model is a behavior that might be viewed as unhealthy by some people.
body that does not meet these expectations is “abnormal.” FGCS surgeons, using their medical authority, strive to persuade by listing their numerous medical affiliations and training backgrounds on their websites (Laser Vaginal 2009, 2010, 2014; Laser Vaginal, Pelosi). In response, some of the most common medicalization narratives produced by anti-FGCS activists and scholars position themselves in opposition to the implied authority of medical professionals to correctly interpret when a body is in need of surgical interventions like FGCS. In addition to these more specific anti-FGCS narratives, which focus on medical authority over bodies, there are also narratives produced by activists and scholars that oppose a broader medicalization of sex.

Medicalization narratives can take a wide variety of forms. One entertaining example of activism that touches upon all three types of narratives (choice, medicalization, and nature)—but is best located within the category of the medicalization narrative—is the parody video made by a New View member, endorsed by the NVC, entitled “Dr. Vajayjay’s! Privatize Those Privates!” The video, which mimics a teaching tool for any surgeon looking to “expand your market-and your wallet,” consists of Dr. Vajayjay outlining his four-stage approach to “privati$e those private$,,” and thus increase both the scope of surgeons’ authority over women’s bodies and surgeons’ profit margins (Dr. Vajayjay!).

Stage one of this approach, “Plant that Seed (of Discontent),” is a how-to guide for creating self-doubt in women regarding the appearance of their external genitalia by utilizing pornography as “reference material for women” (Ibid). In the
The video, Dr. Vajayjay’s on-screen student, “Steve,” is reproached for raising questions regarding the already altered state of many of the female genitals featured in mainstream pornography:

Steve: “The labia are airbrushed out of porn, so, really, we’re not seeing what’s normal at all…”

Dr. Vajayjay (with dismissive shrug): “Can Dr. Vajayjay help it if this is what women ask for?” (Ibid).

While Steve may have questioned the validity of the suggested “reference materials,” however, the woman who plays Steve’s wife obligingly views the centerfolds she’s given, and flatly replies “I understand,” apparently having embraced the aesthetics of the glossy centerfolds before her as the expected female genital norm (Ibid).50

The video’s references to Playboy as a guide for women to view correct aesthetics and the nameplate on Dr. Vajayjay’s desk (which lists his degrees as M.D., M.B.A) are clear nods to Dr. David Matlock, self-described “Picasso of Vaginas” (Radakovich 91), one of the most highly visible practitioners of FGCS and a commonly mentioned surgeon in NVC literature. Dr. Matlock, an M.D. who also possesses an M.B.A., was featured in a video on his website in 2009 in which he recommended that patients consult Playboy for ideas of the most aesthetically

50 The female role in the video never seems to be more than one of generic accessory; a necessary addition to Dr. Vajayjay’s informational video whose main purpose is to be either A) potential patient to be convinced of her need to undergo FGCS, thus proving the doctor’s methods as successful, or B) potential foil to claims of sexism, via satisfied testimonials or just mere presence in FGCS practices (since women can “never be sexist”) (Dr. Vajayjay’s!).
pleasing vulvas. Dr. Matlock’s practice is in Beverly Hills, but he is world famous for his role on reality television (Dr. 90210, Plastic Wives) and for being the surgeon who developed Laser Vaginal Rejuvenation (LVR), a technique he trademarked and now sells the franchise rights to surgeons who attend (and, of course, pay for) his three-day training seminars (Innogyn). Matlock’s “medicine as business” practice is clearly the model for Dr. Vajayjay’s “The Business of Medicine” seminar, and his creation and trademarking of new surgical techniques and terms—such as “Laser Vaginal Rejuvenation” (LVR) and “Designer Laser Vaginoplasty” (DLV) (Laser Vaginal 2006; Laser Vaginal 2011)—is spoofed in Dr. Vajayjay! in stage three of the “private$e those private$” plan. Stage three—entitled “Make It Science”—contains instructions on utilizing medical terminology to further legitimize the practice of FGCS in the following scene:

Dr. Vajayjay: Points to a list of medical terminology for various aspects of FGCS that is written on a whiteboard. The list includes the following: Cutting, stitching, and burning vagina; amputation of labia; amputation of clitoral hood; suck out flesh from pubic mound; stick collagen into vagina.

Dr. Vajayjay: “This is how not to talk about—or ‘market’—what we do.”

Steve: “Isn’t that called FGM?”

While I have been unable to locate this video after the 2011 redesign of his website, I have found the same suggestion on one of Dr. Matlock’s franchisee’s website: “Many people have asked us for an example of the aesthetically pleasing vulva. We went to our patients for the answer and they said the playmates of Playboy” (Laser Vaginal, Pelosi).

In this instance, I use the term FGM (a commonly used acronym for “Female Genital Mutilation”) while discussing an author’s work that refers to the practices as such. In any personal references to this complicated set of practices within my work, I prefer (and thus will use) the term “Female Genital Cutting” (FGC). While both terms are problematic, I feel as though FGC attaches less stigma to both
Dr. Vajayjay: “FGCS, yes…otherwise known as ‘Cosmetogynecology’…It’s important to wrap your privates [sic] practice in (mimes finger quotes) ‘medical terminology,’ making what we do scientific…giving us legitimacy. It also helps to differentiate what we do ‘down there’ to what they do ‘down there’ (points to a map of Africa as tribal drums beat in the background) …You can also throw in the words ‘laser,’ ‘designer,’ and ‘expert’ to make things hot, hot, hot!”

This use of medical and scientific terminology in order to legitimize surgeon claims is a key component of medicalization narratives and of medicalization in general. Tiefer draws on Peter Conrad and Joseph Schneider to define medicalization as “a complex process of transforming a social situation or personal experience, especially one that is culturally abnormal or ‘deviant,’ into a medical problem that requires treatment by medical experts” (Tiefer, “Beyond the Medical” 128).

the act and its survivors, and is thus (hopefully) less inflammatory and, ultimately, more useful in addressing a practice which many women worldwide are attempting to eradicate. 53 Narratives of medicalization are possibly the most common narratives of FGCS that touch upon issues of race. This is directly related to the long history of the use of race in both various processes of pathologization and in the creation of difference between groups of humans. In medicalization narratives of FGCS, race is most commonly referenced when FGCS surgeons attempt to distance themselves from the practices of FGC, especially as is performed in rituals in Africa, the “Middle East,” and some Eastern European communities. The basis of differentiation in these narratives is sometimes technological, but is most often one of empowered choice vs. misogynistic cultural practice. In other words, FGCS is something that (Western, often white) women choose to do to make their lives better, whereas FGC is something that (non-Western, and often non-white) women have done to them in order to either take power from them, give the men in their lives power over them, or both. This is, of course, a gross over-simplification of an extremely complex issue—one that is deserving of a more detailed examination of the role of race in narratives of FGCS, which would be best conducted as a separate, future project.

For more information regarding the role of race in processes of pathologization and the creation of difference between humans, I recommend the work of Sander Gilman; for information regarding the role of FGC/M in narratives of FGCS, I recommend the work of Fiona Green (see ‘Works Cited’ for titles).
Similarly, Matthew Wolf-Meyer borrows from Peter Conrad when defining medicalization as a process that takes “what was once considered natural, as in the case of periodic and self-resolving insomnia” and turns it into something that is now “being treated as a medical disorder” (14). Tiefer elaborates: “Think drunkenness and alcoholism; think moodiness around menstruation and premenstrual syndrome [PMS]; think children’s school misbehavior and conduct disorder or attention deficit disorder [ADD]; think shyness and social phobia. In the case of sexuality, medicalization currently focuses on genital function and sexual behavior. Deviant levels of interest in sex, in orgasm experience, or in patterns of genital response have been labeled ‘dysfunctions’ and industries of expert assessment and treatment have developed” (“Beyond the Medical” 128). Many surgeon-produced narratives of FGCS are criticized as attempting to boost profits via the medicalization of these “deviant levels of interest or patterns of genital response.” They have also been criticized for the medicalization of genital appearance that deviates from social expectations of appropriate female genitalia. Often, scientific and medical terminology is used in these narratives to link “deviant” aesthetics to “deviant levels of interest or patterns of genital response,” resulting in a medicalization that confluates dissatisfaction with one’s bodily morphology and sex life with an aesthetic norm for which the only remedy is FGCS.

Dr. Vajayjay’s instruction in the use of scientific and medical terminology to medicalize female genital aesthetics finds its inspiration in many FGCS surgeon webpages and YouTube videos. For instance, Dr. Marco A. Pelosi III uploaded the
power point presentation that accompanied an address he gave at the 2013 International Society of Cosmetogynecology’s (ISCG) 6th World Congress to YouTube (Pelosi III). The slides contained in this presentation feature photographs of various female genitalia, both pre- and post-FGCS, and often pictured in the popular “before-and-after” style favored by many practitioners. The slideshow is accompanied by music, and, while there is written text in the form of inter-titles and short slide descriptions, there is no voiceover to elaborate on the medical legitimacy of terms that often read as diagnoses of the pictured genitalia. The most common labels for these pictures are “elongation” and “hypertrophy,” and the two are often used interchangeably, appearing in slides as follows: Elongation (Hypertrophy) (Ibid). One or both terms also appear in combination with other terms on some of the slides, resulting in a double pathologization of the genitalia pictured next to terms like

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54 The International Society of Cosmetogynecology (ISCG) was founded by Drs. Marco A. Pelosi II and Marco A. Pelosi III and “has over 700 members in over 30 countries.” “The ISCG is the world’s first and largest association of gynecologic specialists in female cosmetic medicine and surgery. The mission of the ISCG is to promote the advancement of knowledge, skill and excellence in female cosmetic medicine and surgery through education, training and fellowship…” (ISCG).

55 This “before-and-after” style of advertisement and presentation of results is a common staple of many cosmetic industries, including (but not limited to): Cosmetic surgery, various beauty industries (such as hair and make-up artistry), weight loss, dermatology, and esthetician-related practices. It can also be argued that this style extends to aesthetics beyond those associated with the human body—consider advertisements for auto body repair, house painting, and interior decorating, to name but a few instances of this.
“Asymmetric Unilateral Elongation,”56 “Bilateral Asymmetric Elongation,”57 and “Circumferential Elongation (Hypertrophy),”58 to name a few (Pelosi III).

While the high production values and title slide listing Dr. Pelosi’s credentials and extensive medical affiliations lend an air of medical authority to the video, the language used in the slides is an example of the process of medicalization discussed by Tiefer and Wolf-Meyer and detailed by Dr. Vajayjay in the “Make it Science” portion of his video. This is especially the case with a term like “hypertrophy,” which is commonly used in medicine to describe an “excessive development” or an “exaggerated growth or complexity” of an organ or part (Merriam-Webster, “Hypertrophy”). References to hypertrophy in medicine often carry with them the

56 Photographs with this designation are of cases where one side of the patient’s labia minora is longer than the other; as far as the designation of ‘hypertrophy/elongation’ goes, I did not see any labia minora—in any of the presentation’s slides—that protruded further than ¼-½ inch past the patient’s labia majora.

57 Photographs with this designation are of cases where both sides of the patient’s labia minora protrude past the labia majora, and are not symmetrical.

58 Photographs with this designation appear in a section of the presentation subtitled “Ritual vs. Physiological Stretching,” the purpose of which seems to be the differentiation of labial tissues stretched due to culturally specific rituals and those stretched as a result of physiological causes, the most referenced of which (in FGCS literature) are aging and childbirth. It is difficult to ascertain, from the photographs of labia that have sustained ‘physiological stretching,’ the length that these labia protrude, and this is primarily due to the staging of the labial tissue within the photographs. While all of the other photographs that are mentioned above were framed to feature the area between right below the navel to the upper thigh of standing female patients, those featuring labia stretched by physiological processes are framed to feature the genitalia of patients lying down in the operating room, already marked with cut lines, and often spread too wide for me to ascertain their actual dimensions (although none appear to be longer than ½ - ¾ of an inch when spread).

This section is one of the two most racially charged of the presentation, with the title slide featuring the words “Ritual vs. Physiological Stretching” above what appears to be a grainy, black and white artist’s rendering of a black female from below the navel to the mid-thigh. The woman’s labia (the picture is too grainy to determine if it is the labia majora or the labia minora) hang to her mid-thigh area, and the staging is reminiscent of nineteenth-century anthropological renderings. The upper left-hand corner of the slide features a map of Africa, with a large red arrow pointing towards the subcontinental region, where FGC/M—the genital practice most often referenced in narratives of FGCS—is most commonly practiced. All slides of stretching due to physiological processes also feature the genitalia of black women, as do all of the slides but one in the “Hyperpigmentation” section. See footnote 53 for further information regarding the role of race in narratives of FGCS and plans for further examination of this role in future papers.
implication of abnormality or pathology, especially as they are commonly used in reference to “excessive development” or “exaggerated growth” that results in an “increase in bulk (as by thickening of muscle fibers) without multiplication of parts” (Ibid). Traditional medical usage, then, describes a condition that is the result of an underlying disease state or bodily process gone awry, necessitating correction—or at least interpretation and supervision—by medical professionals.

The frequent use of the term hypertrophy by FGCS surgeons most often occurs in regards to the length of the labia or clitoris, and there is no universally agreed upon medically-accepted standard for the length of either of these body parts (Dr. Vajayjay’s!; Laser Vaginal 2009, 2010; Laser Vaginal, Pelosi; Tiefer, “FGCS”). Appending the term “hypertrophy” to photographs of female genitalia that have not undergone FGCS implies that the genitalia in these photographs are abnormal.59 This results in a twofold effect: the naturally occurring diversity of female genitalia is medicalized, and FGCS is presented as the only legitimate solution.

Critiques of FGCS that make claims based upon the lack of medically sanctioned, standardized normative measurements of labial and clitoral lengths risk couching their arguments in the very terms of medicalization that they oppose in FGCS narratives. By suggesting the illegitimacy of surgeons’ labeling of various labial and clitoral lengths as “hypertrophic” (since no official medical standard exists for a “normative” labial or clitoral length), these critiques also implicitly suggest that a standard, medical “norm” might prevent such arguments. This is not to say that anti-

59 For more on the history of pathologizing female genitals labeled as “hypertrophic,” see the discussion of Saartje Bartmann in Chapter one (especially Section V).
FGCS critics are calling for medical “norms” to be established; their critiques of the medicalization of sex by a variety of medical actors and markets indicates that they are, in all likelihood, opposed to the very idea. The activism of prominent scholars and groups, especially the NVC, supports this, in that their anti-medicalization projects and narratives often focus on themes of the naturally occurring diversity of the human body, and the celebration of this diversity as a mode of educating the public and opposing technologies and industries that contribute to bodily homogenization.60 However, by referencing a lack of normative medical standards as evidence of false diagnoses in FGCS marketing, some of these critiques become necessarily tangled up in the very system of “norms” they are arguing against. The result is a critical engagement limited by the very terms it seeks to challenge, and this limitation leaves many anti-FGCS narratives of medicalization in need of new framework(s) to challenge the medicalization of sex.

The labeling of non-conforming individuals (and their bodies) as “abnormal” or “pathological” is a hallmark of medicalization, a process that “raises questions of the generic versus the particular” (Braun, “In Search of” 419) for many critics, including those who frequently challenge the validity of the marketing methods and motives of FGCS surgeons. Marketing materials often feature the homogenized results of post-FGCS clients, which in turn, critics argue, proposes this

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60 For examples of the activism described here, see the Petals Project in Part IV of this chapter, Dr. Debby Herbenick’s “What Do You Like About Your Vulva and Vagina?” project, or the Vulvagraphics project (both detailed on the New View Campaign website).
homogenization as aesthetic norm. These aesthetic norms then become the responsibility of the individual to attain. The shifting of social expectations to the realm of individual responsibility contributes to the “unfortunate consequence of the individualism of medical model thinking,” which “stigmatizes the individual” who does not meet these expectations (Tiefer, “Beyond the Medical” 130). As a result, critics contend that many women who seek out FGCS and other cosmetic surgeries may be doing so because they find that “individual change can often be ‘easier’ than social change” in such situations (Braun, “In Search of” 419).

In pursuit of this “individual change,” “people appeal increasingly to the powers of medicine, not solely for the alleviation of symptoms, but as a form of citizenship, a form of belonging, mediated by a desire for normalcy” (Wolf-Meyer, 15). Consequently, “for those who are outside the masses, outside the normal, medical treatment is one means to render them part of the masses, integral to society” (Ibid). These narratives thus demonstrate the broader medicalization of sex and emblematize the industry’s use of the implied authority of surgeons to achieve this medicalization while it offers procedures to address it. This helps illustrate the thought process at the heart of many critiques of FGCS, namely that members of the FGCS industry are implicated in both the supply and demand sides of the procedures. This is also the critique motivating Dr. Vajayjay!, which, although an obvious parody, is a particularly potent medicalization narrative in its ability to outline so many of the existing academic critiques of FGCS. By using humor and recognizable references to

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61 This is most commonly in reference to genitalia such as those featured in the “after” photographs found on surgeon websites, in promotional materials, and in presentations like Dr. Pelosi’s slide show.
particular surgeons and practices—all on a platform easily available to the general public—Dr. Vajayjay! addresses the processes involved in medicalization, how they function within the FGCS industry, and how diverse the forms of resistance to medicalization and the FGCS industry can be.

IV. Nature Narratives

The overall implication of the Dr. Vajayjay! video is that, by turning aesthetics into medicine into business, Drs. Vajayjay and Matlock (and other surgeons like them) stand to profit handsomely from the pathologization of the naturally occurring diversity of female genitalia. This pathologization of diversity is one of the most frequent themes of nature narratives of FGCS. Less common are a subset of nature narratives that focus on returning female genitalia to a more “natural”—and thus, less “pathological” state—usually by repairing damage done by “natural” processes like birth and aging. There is necessarily an overlap, then, between medicalization and nature narratives, in that the pathologization of genital diversity lies at the root of multiple types of nature narratives. In the narratives I examine below, medicalization lays the foundation for nature narratives that depend on attaching pathology to genital diversity, both in narratives that promote FGCS and those that advocate a wider acceptance of female genital diversity.

Critics of FGCS argue that the naturally occurring diversity of female genitalia is effaced by the visibility of highly altered, “cookie cutter” genitals (Braun,
“In Search of” 413) featured not only in pornography (Braun and Tiefer, “The ‘Designer Vagina’” 7; Tiefer, “FGCS”), but also in multiply mediated FGCS industry narratives (Laser Vaginal, 2006, 2010 and 2014; OCBODY; Pelosi Medical; San Francisco). 62 According to these critics, the expanded exposure and access to these images can be directly traced to the advent of the Internet, which is a major factor in the increased mainstream availability of pornography. 63 The result of this increased availability and acceptance, according to Fiona Green, is women’s exposure to more vaginas (“From Clitoridectomies” 174). While such exposure often leads to comparison, in the vast majority of these cases, what women are viewing as ideal genitalia is a body already altered, either via surgery, Photoshop, or both (Green, “From Clitoridectomies” 174; Weil-Davis 11-12).

Critics of FGCS contend that these alterations are not disclosed to patients who present pornographic images as models during consultations with FGCS surgeons, and point out that several FCGS surgeons recommend consulting pornography when considering whether or not to undergo FGCS. Take, for example,

62 Most of the pornography referenced within these critiques is of the mainstream, heterosexual variety, and mainly consists of genres that are composed of products with high production value, such as Playboy and Penthouse. While there are certainly tremendous amounts of pornographic materials that fall outside of this designation, I have limited this discussion to the genre that most often appears in anti-FGCS critiques. It is worth considering that the advent of the internet has increased the availability of pornography available at no charge, which is quite possibly viewed more often than the higher-end, pay publications listed above. It is also possible that this pornography—which does not necessarily use the high production values of larger mainstream production companies—features more diverse representations of female genitalia, which complicates the anti-FGCS critique of porn as a site of limited representation.

63 As mentioned previously, all references to pornography in this chapter are to heterosexual, mainstream pornography with high-end production values, as this is the type of pornography both recommended by FGCS surgeons as “reference materials” for prospective patients, and is also the type of pornography that surgeons claim is most often presented to them by prospective patients as exemplifying “ideal” female genital aesthetics.
Dr. Alter, a surgeon who performs FGCS and suggests that the genital ideal that informs his clients comes from heterosexual pornography, a phenomenon he has termed the “Penthouse effect” (Green, “From Clitoridectomies” 174). Further ethical complications arise when Dr. Matlock, who is considered a pioneer in the field of FGCS, suggests pornography to his prospective patients as a sort of catalogue in which to “shop” for an ideal post-operative goal (Laser Vaginal 2006). Both Drs. Matlock and Alter acknowledge that pornographic images are often the template patients bring with them to consultations, and, in the case of Dr. Matlock’s online suggestions, patients are encouraged to consult particular pornographic publications as potential templates—publications that have featured Dr. Matlock and his practice in several issues over the years (dating as far back as 2001, in the case of Playboy) (“After Hours”; LVRI, 2017). However, the encouragement to consult these pornographic materials does not address the production processes behind the images. With limited access to what occurs in individual patient consultations, it is difficult to say whether prospective patients are informed of this media manipulation, or whether they rely entirely upon the professional suggestions of FGCS surgeons. These surgeons’ suggestions often carry the authority of scientific discourse, as is evidenced in surgeon statements like the one found on the website of Dr. Pelosi III, a trainee of Dr. Matlock: “Many people have asked us for an example of the aesthetically pleasing vulva. We went to our patients for the answer and they said the playmates of Playboy” (Laser Vaginal, Pelosi). In such cases, then, women are being advised to
consult reference materials in which the most “natural,” attractive, and aesthetically ideal genitalia are the result of surgery or other image modifications.

However, assuming that women are unaware of these alterations, as FGCS critic Green does, is a dangerous move for a purportedly feminist critic. While it appears that surgeons are not disclosing the various alterations (surgical or photographic) that genitalia featured in pornography undergo, it is unreasonable to think that women are unaware of such media conventions in this day and age. These modes of image manipulation are not only common knowledge, they are common practice, as evidenced by the fact that just about anyone with a digital camera and a few minutes on their hands has the power to produce significantly altered photographs. Even for individuals who lack access to these editing tools, awareness of their existence and use has become commonplace in marketing campaigns (the Dove soap campaigns are perhaps the most well-known of these), photo shoots of famous actors and actresses (wherein the entire editing process is documented), and popular song lyrics. Consider the following, taken from what was arguably one of the biggest pop songs of the late summer/early fall of 2014: “I see them magazines/working that Photoshop/we know that shit ain’t real/come on, now, make it stop” (Trainor). With such high availability of editing technology, and the widespread acknowledgement of its use, it is difficult to imagine that women are as

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64 Expensive editing software suites, which used to be required for the manipulation of (non-film) images, are no longer necessary to the editing process. Most digital cameras, laptops, desktop computers, and even some printers come with basic editing suites on board, and cell phone cameras are no exception to this: not only do most include basic editing software, the number of additional downloadable applications available—many of which are free—is beyond count.
unaware of these practices as Green suggests. The suggestion limits her critique, which comes across not only as resting on a highly unlikely conceit, but also as condescending in its assumption of female consumers’ ignorance.

There is, however, another aspect of image manipulation in nature narratives of FGCS that should be examined: the editing of medical photography featured on surgeon websites. Many women first come into contact with FGCS and examples of particular surgeons’ work online. Thus, how that work is presented has the potential to influence a prospective patient’s decision whether or not to undergo the procedure. What patients understand about the production of these photographs is an important part of any thorough assessment of the role of photographic representations of female genitalia in nature narratives. For example: The post-surgical (or “after”) photographs on FGCS surgeon websites most often feature well lit, fully healed, and highly homogenous genitalia. Photo galleries contain multiple rows of these photographs, which use the same soft lighting as mainstream pornography. Like the photographs found in this pornography, the “after” photographs also feature genitalia that are hairless or near hairless, highly groomed, smooth, and with no visible inner labia. This suggests that not only are these “after” photographs taken under ideal circumstances and after the bruising, incisions, bleeding, and swelling of surgery have subsided (which would take a few months, minimum), but also that these “after” photographs are airbrushed, in much the same way they are in the pornography that serves as their model. These photographs, however, that are presented in surgeon marketing and informational materials as the genital aesthetic that women should
most closely resemble—row upon row of artfully lit, perfectly composed, highly homogenous genitalia presented in their “natural” state—are a highly mediated aesthetic ideal designed to masquerade as the “natural” state that only FGCS can help a woman attain.

In stark contrast to these idealistic “after” photos, FGCS “before” photos are generally poorly lit, often not white balanced (which gives them a sickly, yellowed appearance), and depict genitalia that are commonly stretched and spread out on an operating drape. Some of the featured genitalia have visible surgical guide marks drawn onto the skin; many of the “before” photographs also include a drain and/or catheter already inserted into the vagina or urethra (CosmeticSurgeryTruth; Laser Vaginal 2006 and 2011; OCBody; Pelosi Medical; San Francisco). When combined with the fact that these photographs are obviously taken in a surgical suite or surgeon’s examination room, the proximity of the featured genitalia to surgical

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65 “White balance” is a camera setting that accounts for the type of light available to a photographer when they are photographing a subject. Due to the various temperatures of different light sources, they emit different colored light; the result is noticeable in both film and digital photographs if the camera is not programmed for the correct light source before photographs are taken.
equipment and medical paraphernalia offers a powerful suggestion that these genitals require medical intervention. Staging these “before” photographs in such clinical surroundings places them in an environment that most women associate with illness or disease, which results in a powerful suggestion of the genitalia in question occupying a less “natural” state than those in the more polished and familiarly staged “after” photographs.

Figure 2: Sample “before” photos taken from surgeon website (*Laser Vaginal 2017*)

One example of activism that is focused on disrupting such photographic narratives is the Petals Project. Initially conceived of by sexologist Dr. Nick Karras, who is now joined in his work by partner Dr. Sayaka Adachi, the project communicates the natural diversity of female genitals in order to combat social (and medical) narratives of non-acceptance (Karras, et al. “Photography”; Karras, *Petals* website). Initially formulated as a response to a lover’s insecurity about the appearance of her genitals, Karras—who is also a professional photographer—set out to capture their beauty, which at the time was a beauty he could not convince her that she possessed. Dozens of photographs and months later, Karras finally produced a
photograph that his lover liked. Karras claims that this process led him to realize that the odds were extremely high that his lover was not the only woman who viewed her genitalia as abnormal or unattractive, and his desire to interrupt such narratives of self-loathing spawned the Petals Project (Karras, et al. “Photography”).

The Petals Project offers a direct challenge to the pathologization implied by the before and after photographs available on surgeon websites. Certainly, a careful comparison of the two reveals a good deal about the intended use of the photographs and the feelings that they are designed to provoke in both those who pose for and those who view them. Similar to the surgeons’ “before-and-after” photographs described above (and easily accessed online), Petals—the book that came out of the Petals Project—and its follow-up, I Love My Petals, feature close-ups of women’s labia and vulvas. In contrast to surgeons’ “before” photographs, the genitalia represented in both Petals and I Love My Petals are all professionally photographed, with high production values, soft lighting, and appropriate white balancing/coloring [see Fig. 3] (Karras, Petals; Karras and Adachi). Only the labia and vulva are visible, and—unlike the obviously clinical setting of FGCS “after” photographs—there is nothing in the pictures that medicalizes them.
The images of Petals and I Love My Petals are cropped tighter than those on surgeons’ websites, and the result suggests not only a concentration on the unique composition of each woman’s anatomy, but also a studious avoidance of the traditional “beaver shot” featured in mainstream heterosexual pornography. This avoidance, however, can be seen in both camps: neither surgeon-generated media nor the books produced as part of the Petals Project contain photographs that include visible positioning of the labia, which would be seen as suggestive of manual stimulation. Terri Kapsalis discusses similar restrictions placed upon anatomical drawings featured in medical textbooks, and the avoidance of anything that might resemble mainstream pornography (106-07). In addition to avoiding references to

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66 While I have found some rare instances of surgeons’ hands in “before” photographs, these are always gloved, and the photographs tend to be part of “how to” or informative videos detailing FGCS methods. However, even surgeons who include such photographs/slides in their presentations often only do so when the staging clearly indicates a surgical—and thus medical—setting, and, even in such a setting, surgeons often resort to separating and pulling labia for purposes of demonstration by using medical instruments like retractors and clamps (or, in at least one instance, a run-of-the-mill Q-tip).
pornographic tropes, there are other reasons for not including visible, manual positioning of the female genitalia in the photographs. In the case of FGCS surgeons, this could indicate an attempt to eradicate any visual cues that suggest the procedures are performed for any reason outside of the medical (thus calling into question surgeons’ access to all of the privilege and authority the practice of medicine entails). This is especially concerning to surgeons as critics of the procedures continue to urge that FGCS be classified as purely cosmetic. In Karras’s case, this framing is indicative of his stated purpose regarding the original goal of his project, which was to produce a fine art book featuring the beauty and natural diversity of female genitalia:

*Petals* is a book of vulvas, their exquisite beauty and wondrous variety. The photography unfolding here is a candid presentation of the most essential part of the female anatomy, an unyielding mystery shrouded in cultural taboos. The subtle black and white photographs, accented by light and shadow, display the delicate shapes and textures of female genitals, inspiring a profound sense of wonder and awe. (Karras, *Petals* website)

Karras’ decision to create an art book highlighting genital diversity among women was not necessarily an easy one, nor was it initially received the way he intended. Indeed, both Karras and his partner (and *I Love My Petals* co-author) Dr. Sayaka Adachi have spoken about the struggle to find a publisher for the initial project, and about initial criticisms regarding lack of diversity and the desire to have a second book featuring color photographs (Karras, et. Al, “Using Photography”). Karras and Adachi produced a second book—*I Love My Petals*—in response to criticisms and to requests from clinicians using the books as aids in their urology, gynecology, and counseling practices; his work is now featured prominently in photo
therapy sessions for survivors of trauma, as well as in empowerment training, couples’ therapy, and as educational aides for a variety of groups and institutions (Karras, et. Al. “Using Photography”; Karras, Petals website). In this second Petals book, Drs. Karras and Adachi continue to produce images of the wide variety of women’s genitals with the stated goal of accentuating the beauty and diversity of these variations:

We believe that nature created us all to be unique and beautiful. Yet many of us get stuck trying to achieve a standard of beauty that is unrealistic. In a world filled with new and improved beauty and cosmetic surgery techniques, the vulva might have been the last place you thought about in terms of beauty…Yet, labiaplasty (cutting off the labia minora), and designer vaginas (including, but not limited to, vaginal tightening and G-spot enhancements) are fast becoming one of the most popular plastic surgeries in Australia, the UK, the United States, and possibly beyond. (Adachi and Karras, 65)

With this statement, I Love My Petals interacts directly with narratives of FGCS, as Adachi and Karras call attention to the procedures and their relation to “a standard of beauty that is unrealistic” in the face of the naturally occurring and widely diverse world of female genital aesthetics (Ibid). I Love My Petals delves deeply into this theme, moving beyond the black and white photographs that comprised Petals and including full color photographs, sections on the anatomy, physiology, and recommended care of female genitals, suggestions for talking to teens about their genitals and how they may change over time, and assurances about the wide variety

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67 For more information regarding Nick Karras or his work, I recommend Petals-Journey into Self Discovery (documentary), or the Petals website: https://www.nickkarras.com/Home_Page.html.
of genital embodiment experienced by women as natural. Consider this passage from the “Anatomy and Physiology” section of the book:

Then, puberty hits, breasts start budding, hair starts growing, the menstrual cycle starts, all of which girls tend to be prepared for. But the inner labia also starts blossoming! Now that’s an unexpected event most girls are never prepared for.

Many carry the shock with them for a long time, and if a sexual partner ever makes an unflattering comment, these girls often feel that there is something terribly wrong with their labia minora. They may look around to see if they are normal, but vulva images that are available are not good representations of normal, healthy vulvas. Just as smaller breasts are rarely seen on TV and in magazines, larger labia are rarely shown. As our vulva models reveal, labia minora that protrude to the outer labia are very common and perfectly normal. The next time you discuss the “birds and bees” with your daughters, please include this information to spare them from panic (and future labiaplasty)! (Adachi and Karras, 70)

…and this one, from the book’s Introduction:

This book was not meant to represent “all” vulva types and shapes. If you don’t find one that looks like yours, don’t worry. Vulvas are like faces. We are all unique, no two are alike.

It is our sincere hope that you will find these images empowering and that you will love your own vulva. We call them Petals, as they are just like flower petals, each with distinct beauty and characteristic scents, and we want to honor each one. (Adachi and Karras, 1)

It is within the context of this project and speaking engagements (including at NVC sponsored conferences), that Karras and the Petals Project enter the realm of nature narratives of FGCS (Karras, et. al. “Photography”; Tiefer, “FGCS”). While later aspects of the project directly address—and encourage resistance to—FGCS, overall, the Petals Project is focused on the naturalness of diverse female genital embodiment. Presenting an alternative to narratives that contribute to narrowing acceptable female genital aesthetics, the Petals Project has been utilized by physicians and counselors as
a resource that highlights and celebrates the naturally occurring diversity of female genitalia.

V. Conclusion (Moving Forward)

The homogenizing effects of FGCS that are at the heart of the nature narratives of FGCS discussed in this chapter also illustrate one place where nature narratives and medicalization narratives overlap. Such overlaps are not only common among narratives of FGCS, but necessary at times: The frameworks of certain choice narratives depend upon narrowing the ideal genital aesthetics that are the result of particular medical and nature narratives and the authority enjoyed by FGCS surgeons that is the lynchpin of other medical narratives. Many nature narratives would not exist without the effort to pathologize genital diversity. These overlaps suggest entanglements that are rarely addressed by the various factions that deploy FGCS discourses; additionally, they illustrate the fact that many narratives—regardless of who produces them, or for what function—cannot be entirely separated from other narratives produced and used by factions that frequently claim to be in direct opposition to each other.

While an examination of the narratives of FGCS does reveal the existence of two outspoken factions that are often represented as occupying directly oppositional positions (pro- and anti-FGCS), it also reveals the complex interactions among the surgeries, the surgeons that provide them, current and prospective patients, and other involved parties, that are obscured by such oppositional framing. For instance: Critics
of FGCS regularly condemn a narrowly defined genital aesthetic that they claim is presented as empowered choice in FGCS industry narratives. The critique goes something like this: the FGCS industry presents a highly mediated, homogenized ideal as the most desirable, “natural” genital aesthetic (nature narrative); any genitalia that do not conform to this ideal are implicated as pathological (medicalization narrative); and choosing to remedy such a pathology with FGCS—and thus return your genitals to a more “natural” state—is presented as an empowered exercise of self-care and responsible citizenship (choice narrative). While there is some truth in particular aspects of this formulation, there are far more complexities than are accounted for within it. Consider, for example, how it is complicated by Berlant’s theory of “cruel optimism,” which illustrates the possibility that women who choose to undergo FGCS are not necessarily being duped or pressured into doing so by industry narratives, but might instead be using FGCS in order to find a small amount of (temporary) relief from the demands of a capitalist, consumer culture (116-17).

Following Berlant’s formulation requires that we consider that these women might make an informed decision to choose to undergo FGCS for their own purposes, and that—unlike the claims of anti-FGCS critics—this decision might be a way for these women to exercise agency.

One feminist scholar who explores the possibility of this agency and its tension with feminist critiques of cosmetic surgery is Kathy Davis. In Reshaping the Female Body: The Dilemma of Cosmetic Surgery, Davis calls for a challenge to feminist critiques of women who choose cosmetic surgery that render these women
“cultural dopes” (64) who have unquestioningly acquiesced to the oppression of societal beauty standards and the medicalization of bodily morphologies. Indeed, Davis seeks to draw “upon feminist perspectives on femininity, power, and the cultural norms and practices of the beauty system” in order to “attempt an analysis of cosmetic surgery which is critical without undermining the women who have it” (Ibid). For Davis, this means theorizing “cosmetic” surgery as being about identity, rather than beauty. Within this formulation, women are able to utilize “cosmetic” surgery to “renegotiate identity” through the body, and exercise “power under conditions which are not of one’s own making” in order to address feelings of being “trapped in a body which does not fit her sense of who she is” (163).

While Davis does not call for an unproblematic view of “cosmetic” surgery, she does call for an approach that takes seriously the choices of women to undergo “cosmetic” surgery. Like Berlant, Davis asks that we imagine what is to be gained by engaging in activities that could be construed as unhealthy, (potentially) dangerous, or even medically contraindicated. Both authors illustrate the importance of a more complex, nuanced mode of inquiry when it comes to questions of embodiment, personal choice, and the reach of the social and medical “mandates” of good health; both also challenge theorists that posit current social structures as precluding agency altogether. While neither Berlant nor Davis specifically addresses FGCS in her work, both offer valuable alternatives to the various scholarship and activism surrounding the procedures whose portrayal of FGCS patients (and prospective patients) can be best described by cribbing Davis’s term, “cultural dope.”
The women Davis interviews come across as anything but unwitting dupes who are victims of money-hungry surgeons preying upon female insecurities directly caused by oppressive beauty standards. In fact, they “explained that they did not have cosmetic surgery because they wanted to be more beautiful”; indeed, “it was not about beauty, but about wanting to become ordinary, normal, or just like everyone else (161).” We can see here that the subjects of Davis’s interviews move within all three narratives discussed in this chapter: Moved by various reasons to feel as though their body was not “normal” (medicalization narratives), these women sought ways to “renegotiate” their relationships with their bodies “to the world around them” (nature narratives) (Ibid). As reported by Davis, however, their consideration of “cosmetic” surgery as a solution to their discomfort—while it can be viewed as a form of choice narrative—differs considerably from the narratives discussed by many feminist critics of cosmetic surgery. Davis’s interviewees recall their choices as anything but coerced or forced by social standards; in fact, Davis reports that the women she spoke with were “adamant about their right to be allowed to make an informed decision—as competent decision makers who are able to weigh the risks against the possible benefits of the surgery” (162). These women approached the decision to have “cosmetic” surgery as “morally problematic for them,” as something that “had to be

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68 Davis interviewed women who underwent a wide variety of “cosmetic” surgeries, “everything from a relatively simple ear correction or breast augmentation to—in the most extreme case—having the whole face reconstructed” (7).
69 Davis is especially critical of the work of Kathryn Pauly Morgan, a vocal and widely read critic of cosmetic surgery who has theorized against genuine choice as a possibility in the case of women who choose to undergo cosmetic surgery. Chapter seven of Davis’s book contains a rich engagement with—and rebuttal of—Morgan’s theory.
justified”; in fact, Davis reports that they were, overall, “highly critical of the beauty norms which compelled them to take such a drastic step,” and “invariably skeptical about cosmetic surgery as a general remedy for women’s dissatisfaction with their appearance” (Ibid). For these women, “cosmetic” surgery—far from being a panacea for their bodily dissatisfaction—was one option among many, or, as Davis puts it, “the lesser of two evils rather than an answer to all of their problems” (162).

While the focus of Davis’s book is women who have undergone various “cosmetic” surgeries, the similarity between these narratives and those of FGCS makes her work a valuable addition to this discussion. Davis’s interviews reveal that narratives of FGCS are potentially complex in nature. By separating FGCS narratives into three main types—choice narratives, medicalization narratives, and nature narratives—and then closely examining their framing, we are better able to view their complexities and the theoretical and representational work they are called upon to do. The results are seldom simple; rather, they are more likely to open up avenues of interruption, spaces of resistance, and scholarly projects that have the potential for a more generative and informative engagement with these controversial and increasingly popular procedures. The work of Davis and Berlant suggest ways an expanded engagement might be possible, while at the same time allowing for a less reductive view of the women at the heart of these narratives, and their agency within them.
Chapter 3: On Neoliberal Markets and Designer Vaginas

I. Introduction

In Chapter 2, I explored various discourses of FGCS and illustrated how these discourses both depend upon and contribute to the pathologization of female bodies in Western cultures detailed in Chapter 1. I separated these discourses into three main categories: choice, medicalization, and nature narratives, and illustrated some of the limits of the oppositional frameworks these narratives engage in, as well as the workings and limits of the narratives themselves. By looking more closely at a very particular aspect of these workings—namely, the role of neoliberal governance in medical marketing and processes of pathologization—we can gain further insight into the mechanisms that support and help to popularize FGCS. This insight into the mechanisms of FGCS, can, in turn, illuminate how and where power is at work and how various actors are responding. This information, in turn, can fuel future engagements that address the procedures, their marketing, and those who perform and undergo them in deeper and more generative ways.

One major convergence of the various discourses of FGCS can be found within the interaction of pro- and anti-FGCS groups with neoliberal markets. Groups opposed to the surgeries, on the one hand, often address the supply of FGCS as the result of a complex web of market and legal forces, while those who support FGCS tend to position surgeons as providing a service in order to satisfy consumer demand. At first glance, it might appear that these factions are approaching their respective engagements with FGCS using different arguments; however, when analyzing these
approaches in relation to neoliberal and free market rhetoric, the reality is more complex, and sometimes finds these two camps addressing FGCS and its relation to neoliberalism in ways that overlap.

As discussed in Chapter 2, supporters of the practice claim that FGCS surgeons provide a service that meets female demand for genitals that conform to a certain aesthetic or increase sexual pleasure. For instance, consider Beverly Hills surgeon Dr. Sheila Nazarian’s claim that “once we perform this procedure for them it is like we are setting them free” (Nazarian 2016). Female demand is defined as agency, with surgeons enabling women’s exercise of individualism and empowerment (Braun, “Straight”; Laser Vaginal 2009, 2010). Considering this in light of David Harvey’s discussion of neoliberalism, as governance under which personal choice in the realm of health care is not readily separable from the personal responsibility to maintain certain governmental or societal expectations of one’s health, raises questions about the legitimacy around questions of consent and choice discussed in Chapter 2. For example, it is one thing to claim that the supply of these procedures occurs in response to consumer demand, but it is quite another if that demand is the direct result of pressure by a supplier that can effectively create the demand in question—a point at the heart of many critiques of the procedures (especially those formulated by the New View Campaign). Supporters of FGCS, then, are.

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70 Dr. Braun’s extensive research and publications make her one of the foremost scholars engaged in the examination and critique of FGCS; she is joined in this distinction by Dr. Lenore Tiefer, founder of the New View Group (NVG) of scholars, who issued their challenge to the growing medicalization of sex (which would later become the cornerstone of the New View Campaign, or NVC) in the year 2000. Both Drs. Braun and Tiefer have published extensive scholarship, together and separately, addressing FGCS, all of which has greatly informed my own research.
base their claim to address consumer demand on the theory of the neoliberal state in which, “All agents acting in the market are generally presumed to have access to the same information. There are presumed to be no asymmetries of power or of information that interfere with the capacity of individuals to make rational economic decisions in their own interests” (Harvey 68). Theory, however, is seldom practiced in such a pure state, and Harvey’s formulation can be used to support the claims of groups opposed to FGCS as, for example, when he adds, “This condition is rarely, if ever, approximated in practice, and there are significant consequences” (Ibid).

One of these consequences is the power of physicians to “create and define new categories of illness to match new drugs coming on the market,” similar to the insurance companies that Harvey discusses (80). In the case of FGCS, we can substitute “surgeries” for “drugs” in the previous example, and the question of consent versus coercion becomes one worth considering in pro-FGCS discourses. These surgeries can be viewed as one of the technological innovations that are a hallmark of the neoliberal state: the invention of an illness to assure consumer demand (Harvey 69). Indeed, the creation of such pathologies as a response to the availability of new medical technologies designed to “cure” them is also one of the defining features of many anti-FGCS critiques. As such, it is useful to examine the ways in which the development of illnesses and pathologies is related to technological and medical innovation, and what it might mean to better understand this framework when formulating future critiques of the procedures.
II. The Medical Marketing Model: Purchasing Power as Agency for Sale?

Under current neoliberal practices and conditions, the market has moved beyond the basic supply and demand model. It now anticipates demand that is in turn created by the market, which simultaneously provides the supply for this (created) demand (McGill 79; Ashcroft, et al. 149). For example: Some of the leading feminist critics of FGCS—including Dr. Leonore Tiefer, one of the foremost and well known critics of the procedures—cite the creation of a genital pathology that presents as being remedied by undergoing FGCS.\(^7\) This pathology, part of a larger overall move toward what the NVC refers to as the “growing medicalization of sex” (New View Manifesto), can be directly tied to a pair of legal decisions whose major effect has been the entry of health and medical sciences into the realm of media, and hence into the market as well (Tiefer, “Female Genital” 468).

These two decisions were the 1982 Supreme Court case that ruled that doctors could advertise their services and the 1997 removal of FDA prohibitions against the direct advertisement of pharmaceutical companies’ products (Ibid). Both decisions were the result of the “market-friendly” governments of the time and illustrative of the “hands-off” approach of neoliberal markets in general, in which any intrusion into the running of the market is viewed as detrimental (Ashcroft, et al. 148; Harvey 64-71).

\(^7\) See previous chapters for more information regarding Dr. Tiefer and her work.
While varied consumer groups were reported as favoring the new laws because they seemed to provide an incentive for companies to be competitive within the newly expanded market, many medical professionals felt that the new legislation created a conflict of interest (Tiefer, “Female Genital” 468). This conflict was attributed to cosmetic surgeons and drug companies inundating the public with advertisements for their products and services, while utilizing the same advertisements to create a perceived medical need—and very real demand—for these same products and services (Tiefer, “FGCS”; Marshall 137).

Many researchers have proposed that these legislative changes have resulted in a profound reorganization of how medicine works in (Western) nations like the United States. Adele Clark and coauthors examine these changes in their work on biomedicalization, which describes medicalization as: “The processes through which aspects of life previously outside the jurisdiction of medicine come to be construed as medical problems,” adding that medicalization is “one of the most potent social transformations of the last half of the twentieth century in the West” (Clarke et. al 47). Clarke et al. go on to discuss the ways the 1997 removal of FDA prohibitions

72 Harvey has written of the inherent contradictions of neoliberalism’s push for no government intrusion into markets even as it seeks to reap the benefits of governmental protections, specifically detailing the push for deregulation while still desiring the benefits of government subsidies and other programs designed to help businesses (A Brief History, 67-70; 79-81).

73 Medicalization is discussed in detail in Chapter 2 of this dissertation. For more on biomedicalization theory, I recommend the collection Biomedicalization: Technoscience, Health, and Illness in the U.S. The authors of this collection offer: “The crux of this theory is that biomedicine broadly conceived is today being transformed from the inside out through old and new social arrangements that implement biomedical, computer, and information sciences and technologies to intervene in health, illness, healing, the organization of medical care, and how we think about and live ‘life itself.’ Medicalization practices typically emphasize exercising control over medical phenomena—diseases, illnesses, injuries, and bodily malfunctions. In contrast, biomedicalization practices emphasize transformations of such medical phenomena and of bodies, largely through sooner-rather-than-later technoscientific
against the direct advertisement of pharmaceutical companies’ products led to a “profound shift in social policy on the proper relation between the public and biomedical knowledge” (74). Whereas before this decision, physicians would diagnose and then prescribe treatments and medications for their patients based on an in-person examination, the 1997 court case dramatically re-ordered such interactions. After this case, pharmaceutical companies encouraged “potential consumers to first acquire drug information and then proactively ask their providers about the drugs by brand name” (Ibid).

Clarke offers evidence to substantiate this assessment: In 2001, the pharmaceutical “industry spent about $2.5 billion on consumer advertising”; in the same year, a Kaiser Family Foundation survey reported that “30 percent of Americans surveyed who viewed direct-to-consumer advertising said that they talked to their doctor about a specific medication they saw advertised, and 44 percent of those reported that their doctors provided them with the prescription medicine they asked about” (Clarke et al. 74). While the 1997 court decision to relax direct-to-consumer (DTC) advertising of pharmaceuticals may have democratized the practice of medicine in some ways (such as educating the public on available treatments), the reported profits of the industry over the next two years speak to the overwhelming benefits the legislation visited upon the pharmaceutical industry: “Prescriptions for interventions not only for treatment but also increasingly for enhancement” (Clarke et al. 2; emphasis authors’). It is important to note that the authors of this theory do not call for biomedicalization as a “radical break” from medicalization, but contend that the processes that precede biomedicalization—of which medicalization is one—can be considered bleeding into (or working in conjunction with) biomedicalization, in a formulation one author describes as “medicalization and” (Fishman 289; emphasis author’s).
the top twenty-five drugs directly marketed to consumers rose by 34 percent from 1998 to 1999, compared with a 5.1 percent increase for other prescription drugs” (Charatan in Clarke et al. 74).

Perhaps no drug from this period has been more remarked upon than Viagra, the erectile dysfunction (ED) drug released by Pfizer in April of 1998. While it is now difficult to imagine a time when pharmaceutical advertisements were not so omnipresent, Viagra entered the market in the first year after the 1997 court decision. When combined with the fact that Viagra was the first prescription drug manufactured and advertised to the public specifically for the condition known as erectile dysfunction (which in turn spurred wide public discussion of the condition), the circumstances surrounding this event offer a good case study for the effects of loosening advertising regulations in the medical and pharmaceutical realms—especially those products and services marketed for sexual health.

The story of Viagra is also useful for illustrating the ways that medicalization, pathologization, and neoliberal practices contribute to each others’ workings even as they participate in shifting Western medical practices. However, its value as a case study that draws exact parallels to FGCS is limited in ways that are not always made clear by FGCS critics who use Viagra to draw comparisons to the workings of the FGCS industry. Both Viagra and FGCS offer insight into how gendered innovations in medical technologies benefit from and contribute to the medicalization of sex, and both illustrate how this medicalization, in conjunction with the medical marketing of these innovations, can result in the narrowing of “appropriate” embodiment and
expression of sexual health. There is, however, a big difference between expanding diagnoses of sexual dysfunction that require a pill as treatment (ED), versus diagnoses whose “cure” is expensive genital surgery—especially when that pill is sanctioned by mainstream medical disciplines and covered by insurance. Neither of these latter conditions applies to FGCS. There are also differences in how both pathologies are presented in the marketing materials for both products, with more attention paid to easing the worry of potential male consumers of ED medications than is generally seen in marketing for FGCS (ED commercials often go out of their way to address the “naturalness” and “common occurrence” of the condition).

However, both FGCS and Viagra illustrate how ideas of “appropriate” sexual health have shifted as a result of the medicalization of sex and the availability and marketing of gendered medical innovations that offer a way to regain control of “unruly” bodies. Thus, it is valuable to examine what the case of Viagra might offer those studying FGCS, as well as the limitations of Viagra as a case study that parallels the rise of FGCS and related procedures and practices promising improved sex and the return of consumers’ bodies to a more “natural” sexual state.

III. Viagra as Case Study

Viagra’s role as a social catalyst…and its influence transcends the drug itself. In the future, its appearance may well be remembered as the cutting-edge force that created a whole new public attitude about the sexual problems that are so prevalent in modern society and about the entire subject of sex in general …

—Melchiodi and Sloan in Marshall (131)
Those old enough to remember Viagra’s introduction to the market undoubtedly remember the extensive media coverage of the drug. Advertisements ran on network television and were featured in print and online campaigns too numerous to count (one of which featured former presidential hopeful and United States Senator Bob Dole), and late night hosts, news programs, and comedians were all talking about the “little blue pill.” Perhaps unsurprisingly, by July 10 of 1997—almost exactly four months after Viagra’s release—Pfizer announced that its second quarter profits had risen 38 percent (“Viagra Helps”). Not only did Viagra power staggering profits; it also contributed to the restructuring of its parent corporation, when Pfizer confirmed that—a month before the quarter profit announcement—the company had sold off its medical devices unit for $2.1 billion in order to focus “on its more profitable drug-making business” (Ibid).

Barbara Marshall has written about how the profitability of particular medical advancements can result in a shift in medical markets. In the case of Viagra, Marshall offers insight into the process whereby “impotence” became the more clinical diagnosis of “erectile dysfunction” (ED) in the early 1990s—a “simple mechanical problem” to which a “mechanical solution” (Viagra) could be applied (138). This formulation removed from the discussion a variety of other factors that contribute to sexual satisfaction, as Marshall notes in her analysis of this diagnostic shift.74 Marshall cites the Massachusetts Male Aging Study—the pivotal 1994 study that is “considered to have established ‘levels of impotence,’ rather than treating impotence

74 These include—but are not limited to—social, institutional, physical, and psychological factors.
as an all or nothing condition”—as the study “most frequently cited in support of the ‘epidemic’ of erectile dysfunction” in both popular and scientific literature (137).

This shift is important for a variety of reasons; it changed how ED was viewed by the public, divorcing it “from the psychological stigma of previous eras” and treating it as a widely experienced physiological condition (which now had a definitive, pharmaceutical cure), while simultaneously pathologizing wider swaths of men as suffering from ED than had previously been the case (Fishman 304; Marshall 136-40).

This pathologization is similar to that brought to bear on women’s reproductive and sexual health, as discussed in earlier chapters of this dissertation. Thus, Viagra is a useful case study in tracking how advances in pharmaceuticals and medical technologies interact with neoliberal practices in Western societies like the United States. Marshall describes how the profitability of Viagra and the definitional shifts in descriptions of ED affected the practice of female medicine in the U.S.: “A new subspecialty is developing in urology which focuses on ‘female sexual arousal disorders,’ with a great deal of research” (140). Marshall details how this research quickly became big business for more than diagnosing physicians, as pharmaceutical companies anxious to cash in on the next Viagra began funneling massive amounts of capital into the research and development of new or existing drugs that would address the newly defined “female sexual dysfunction” (FSD). Given the stunning success of Viagra, “It was no surprise to learn,” Marshall writes,

that pharmaceutical companies are a major source of research funding—in research directed at defining problems as well as research directed at their
solutions. Of the 19 scientists convened for the ‘International Consensus Development Conference on Female Sexual Dysfunction’, all but one acknowledged their association with a pharmaceutical company. (142)

This was a situation that Tiefer, one of the founders of the New View Campaign (NVC) and a noted researcher and therapist, warned of in her early writing. In 1995, Tiefer predicted that “the medicalization of women’s sexuality could likely follow the pattern of the medicalization of men’s sexuality…should some new physiological discovery about the genitalia emerge that could be developed into an industry and a clinical practice” (Sex is Not, 200). Marshall, however, questions whether such a discovery would even be necessary for those seeking to further capitalize on women’s sexuality:

It does not seem as if such a new physiological discovery is required as a prerequisite. It appears more and more like research on female sexual dysfunction is directed at ‘discovering’ the problem for which lucrative remedies already exist. As with the expansion of the disease-model of erectile dysfunction to reflect the success of the available therapy, there is no simple lateral move from an objectively defined disease state to ‘discovery’ of a cure—rather the ‘cure’ often appears to define the disorder. (142)

This “expansion of the disease-model” as answer to existing, “lucrative remedies” is something that critics of FGCS have long concerned themselves with; indeed, it is one of the cornerstones of the NVC itself, which was formed with the express goal of exposing “the deceptions and consequences of industry involvement in sex research, professional sex education, and sexual treatments, and to generate conceptual and practical alternatives to the prevailing medical model of sexuality” (New View Campaign). One of the New View’s first and longest lasting projects was to “monitor the drug industry's activities as regards new drugs for women's sexuality,” which they
anticipated in their manifesto: “In recent years, publicity about new treatments for men's erection problems has focused attention on women's sexuality and provoked a competitive commercial hunt for ‘the female Viagra’” (New View Campaign). The group did not have to wait long for their first candidate: In 2004—just two years after Marshall’s warning of the impending expansion of the diagnosis of sexual dysfunction and the rush to invent new drugs to treat the condition—the NVC proved instrumental in the FDA’s vote against approving Intrinsa™, the first drug proposed as a treatment for the hotly contested diagnosis known as “female sexual dysfunction” (FSD) (Ibid).

This expanded engagement of medical and pharmaceutical industries with treatments focused on sexual performance is only one aspect of the fallout of Viagra’s massive success. New and expanded diagnoses are also a key aspect of both the success and critiques of innovations in the treatment of so-called sexual dysfunctions (of any gender). For instance, Marshall demonstrates how the Massachusetts Male Aging Study simultaneously acknowledged the connection of ED to other human processes, such as aging and various disease states, even as it contributed to shifts in the scientific literature that represented it as a “progressive condition,” thus increasing the “responsibilization and individualization of risk,” as well as the “increased reliance on scientific expertise and consumption,” of any man concerned with his erectile performance and health (137-39). Marshall further illustrates some of the

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75 The NVC has given expert testimony to the FDA on multiple occasions regarding multiple drugs designed as treatments for FSD; for more information regarding this testimony, I recommend the NVC website: http://www.newviewcampaign.org/default.asp.
forces that are expanding this pathologization, arguing that “the efficacy of Viagra in producing erections regardless of the etiology, not to mention the huge profitability of expanding the market, has considerably broadened the clinical framing of ED as well as the way the user is being ‘configured’” (139; emphasis author’s). In other words, the existence of a “highly successful and well-tolerated treatment” is credited with revealing the “true incidence of ED” among men that—before such treatment was available—is assumed to have been under diagnosed (Ibid). Such reasoning allows for a much more expansive application of the diagnosis of ED, which includes not only men who are “unable to keep an erection most of the time” due to physiological issues, but also “all those whose erections could be ‘improved’,” allowing for a circumstance in which men might be technically diagnosed with ED without knowing—or feeling—that they are suffering from erectile dysfunction (Marshall 139). Consider this doctor’s statement: “Should a man take the pill to improve erections if he doesn’t think he has ED? The issue can be side-stepped by saying that if a man takes the pill and his erections improve, then he had ED after all” (Lamm and Cusens in Marshall, 139). In this formulation, men who might feel perfectly satisfied with their sexual performance are encouraged to consider whether or not they might actually be suffering from ED, while at the same time being encouraged to exercise responsibility for undergoing possibly unnecessary treatment, in the name of finding out (and of being attentive to their personal responsibility to be healthy).
In their work on health, risk, and surveillance, Clarke and coauthors examine how the expectation of such responsibility contributes to “health as a moral obligation” in commodity cultures:

Specifically, health becomes an individual goal, a social and moral responsibility, and a site for routine biomedical intervention. Increasingly, what is being articulated is the individual and moral responsibility to be and remain healthy or to properly manage one’s chronic illness(es), rather than merely attempt to recover from illness or disease when it ‘strikes.’ (“Technoscientific Transformations,” 63)

The focus thus shifts from “illness, disability, and disease as matters of fate” to a focus on health as “a matter of ongoing moral transformation” (Ibid).

This emphasis on individual risk and responsibility in neoliberal societies and those that practice Western medicine work as contributing factors in the expansion of diagnoses and narrowing of acceptable embodiment that many critics of FGCS have cited as a major concern. These critics—along with critics of medicalization in general—suggest that this expansion directly increases the groups of people that fall into categories to whom new pharmaceuticals and medical procedures are marketed. Such marketing offers the promise of individual benefit to prospective patients, as well as the possibility of greater profitability for the physicians, scientists, and corporations marketing new pharmaceutical and surgical cures designed to bring the body back to acceptable/normative standards. That the creation of these standards is produced by these same industries and physicians is a large part of many critiques of the medicalization of sex in general, and, more particularly, FGCS.

Such shifts in the practice of medicine—and how they play out in relation to the growing FGCS industry—have not gone unnoticed by the media. In 2011, The
Atlantic published a piece by Myong-Ok Lee that examined the role of profit motive and medical marketing in the FGCS industry and its relation to changes occurring in the practice of medicine in Western nations in general, and the United States in particular. Consider Lee’s assessments of one of the driving forces behind the rapid growth in popularity of FGCS in the United States:

But for all the talk at the [surgeon] conference about ‘giving patients what they want,’ it was clear that patients aren’t the only—or necessarily the primary—driving force behind the cosmetic-gyn boom. Many of the conference’s OB-GYNs groused that even after they’ve amassed hundreds of thousands of dollars in medical-training debt, their insurance reimbursements are lousy. One doctor said he receives just $1,700 in fees for prenatal care and delivery, and a mere $800 for a hysterectomy. By contrast, a labiaplasty can be done in just a few hours, in-office, for a fee upwards of $5,000 and no “income socialism” to spread the proceeds among hospitals, insurers, and group-practice partners. Underscoring just what this can mean, one conference presenter left his computer’s wallpaper—rotating images of him with his red Porsche 911—up in the background during his PowerPoint lecture. The message was tough to miss: practice cosmetic-gyn, and you too can live the life of a plastic surgeon. (“Perverse Incentives”)

The assessment brings to mind Virginia Braun’s report to the NVC after attending the 2011 meeting of the International Society of Cosmetogynecology (ISCG), during which she recalled one FGCS surgeon defensively exclaiming, in response to criticism, “What is wrong with making money?” while practicing medicine (Braun, “Straight”).

Critiques of the role of money in FGCS marketing continued, however, and a 2015 Alternet article that questioned the role of potential profits in the surge of popularity of FGCS also noted that the procedures were “incredibly profitable” when compared to other medical procedures:
While many medical procedures require tremendous amounts of time and offer diminishing returns in insurance reimbursements, doctors can consistently expect healthy profits from labia reduction and other forms of vaginal rejuvenation…In other words, cosmetic labiaplasty – and the whole suite of “designer vagina” surgeries – can be performed in-office and isn’t covered by health insurance. For practitioners, time investment is minimal, anesthesia is applied locally, and profits from the surgery go straight into the pockets of the doctors who perform them. This has led the industry to attract all kinds of doctors, including those with no previous surgical expertise. A development which has, predictably, resulted in a few problems. (Holloway, “The Labiaplasty”)

Moving beyond concerns about profit motive as a driving force in FGCS marketing, the article goes on to explore safety concerns stemming from lack of industry oversight of this rapidly growing medical practice:

Labiaplasty requires no special certification requirements, a consequence of the fact that “cosmetic gynecology” remains unrecognized by the very accrediting bodies which would determine those requirements. In 2007, The American Congress of Obstetricians and Gynecologists released an opinion essentially stating its opposition to all forms of vaginal rejuvenation. “[T]he appearance of the external genitalia varies significantly from woman to woman,” the opinion offered, and the “safety and effectiveness of these procedures have not been documented” due to lack of “adequate studies.” Similarly, The American Board of Obstetrics and Gynecology has thus far refused to designate cosmetic gynecology a legitimate subspecialty. Though there are many training programs for doctors hoping to earn the skills to enter the field, with none actually legally mandated, botched surgeries are not unheard of. In fact, corrective labiaplasty surgery has virtually become a specialty area unto itself. (Holloway, “The Labiaplasty”)

For critics of FGCS, then, how—and to whom—these procedures are marketed, as well as who is performing them, and on which bodies, all call for more governmental oversight than takes place within the neoliberal frameworks of the United States. However, in the current political environment, this may not be easily attained, considering the Trump administration’s push toward greater deregulation and unhindered markets. In many ways, it might seem that the discussion has remained
very close to where it started; however, as the years roll by, the available data adds up—and that data offers us additional insight for new, more informed discussions, moving forward.

Today, the bulk of Pfizer’s profits come from its internal medicine drugs and its vaccine line (Speights, “How Pfizer”). This situation, however, is not necessarily indicative of lower demand for Viagra; in fact, the drug is still heavily featured in print, television, and online advertisements, including in new formulations (such as single and travel packs) most likely developed to remain competitive after the entry into the market of similar erectile dysfunction drugs, such as Cialis and Levitra. Advertised with scenes of happy, heterosexual couples enjoying the promise of penetrative sexual intercourse, these drugs continue to be major moneymakers for their parent companies. Consider the 2014 data from the Pentagon’s healthcare system, the Defense Health Agency, which reported that $84.2 million had been spent on erectile dysfunction drugs that year, with 1.18 million prescriptions being filled, most of which were for Viagra (“Why Does”). Additionally, the agency revealed that $294 million “had been spent on Viagra, Cialis and other such medications since 2011,” which works out to an average expenditure of $98 million a year spent on ED drugs over the three-year period in question (Ibid).

This data is for only one major insurer in the United States, and it is not difficult to see the quick rise in popularity and use of these drugs (the promise of more or better sex sells quite well, it would seem). Indeed, Tiefer recognizes the 1998 release of Viagra, and the subsequent advertising deluge that accompanied the drug’s
debut, as the watershed moment in the creation of the “medical marketing model” (especially as applied to the realm of sex) that the New View Campaign (NVC) was organized to combat (Tiefer, “FGCS”). This model leans heavily on both neoliberal market conditions and the rhetoric of neoliberalism, which emphasizes personal responsibility and self-improvement, thus giving rise to self-surveillance to ensure adherence to these conditions while aiding in the fulfillment of the sexual and health mandates that are integral to neoliberal citizenship (i.e., if the technology exists, use of it to improve one’s body and the function thereof is a mark of good citizenship) (Harvey 77). In a sense, the resulting self-surveillance bears a striking resemblance to Foucault’s discussion of Bentham’s *Panopticon*, in that it “assures the automatic functioning of power” by being “permanent in its effects, even if it is discontinuous in its action” (Foucault, *Discipline* 201). Thus, the market need not police citizens if they are policing themselves.

Marshall’s work on Viagra presents the story of Viagra as “a complex history of the manner in which sexual dysfunction has been constructed and reconstructed in relation to a range of distinctly ‘modern’ phenomena—including the rationalization and medicalization of sexuality, the increased importance of expert systems and knowledges in managing everyday life, and the expansion of consumer culture” (132). Suggesting that “drugs are social products and…much capital, both economic and cultural...is vested to move the products on to the market and to construct robust

76 For more on the NVC, see Chapter 2 or visit their website at newviewcampaign.org. It should be noted that the group’s initial focus was on combatting the “medicalization of sex” generally, with FGCS being one aspect of that campaign (and an aspect that was introduced later, as the initial campaign focused more on sexuo-pharmaceuticals).
beliefs that these products are needed for the good life,” Marshall’s analysis—and the story of Viagra itself—are of great value in discussions of emergent technologies in the realm of sexual health, such as FGCS (Ibid). Indeed, similar tactics are deployed in the marketing of FGCS, and often play upon the assumed responsibility of individuals under neoliberalism to harness emergent technologies to better meet expectations of appropriate embodiment—one of the key areas of focus for critiques of medicalization.

IV. Pathologizing for Pay

As discussed in Chapter 2, anti-FGCS critics argue that surgeons and others who stand to gain from the proliferation of the procedures use a sophisticated mix of advertisement, television appearances, online presence, and other forms of communication to establish very particular ideals of appropriate female genital aesthetics. These aesthetics are, according to critics of the procedures, contributing to an unnecessary narrowing of acceptable female genital embodiment, as well as a medically unsupported pathologization of female genitalia that fall outside of those “norms.” Certainly, cosmetic surgery in general is not new to the establishment of previously unrecognized pathologies in order to create demand for newly developed procedures. As illustrated in Braun and Tiefer’s discussion of the creation of
“hypomastia” in response to the advent of augmentation mammoplasty (now more commonly referred to as a “boob job,” or “breast implants”), this change is generally the result of a discursive shift that considers the naturally occurring bodily variations of humans to be a pathological difference necessitating medical intervention (3). Thus, despite over two centuries’ worth of medical documentation to the contrary (Fausto-Sterling, “The Comparative Anatomy” 37), these variations are presented as abnormal; when combined with the industry advertising and general media attention garnered by FGCS, this helps to create a “brand new worry [of an abnormal genital appearance]” (Braun and Tiefer 6). Thus, the media producing the concern—hence producing a demand—are the same media offering what will eradicate that concern. FGCS proposes to do this by fashioning the consumer’s body into a more “normal” or “natural” (i.e. non-pathological) feminine state.

A highly contested term, “nature” is a word commonly deployed in various discourses of FGCS. As discussed in Chapter 2, the multiple meanings of nature can rarely be separated from each other and form messy, indiscrete categories (Williams 219-24). In discourses of FGCS, nature serves distinct, and, at times, contradictory purposes for various speakers on all sides of the issue, but both sides of the FGCS

77 Defined by the Merriam-Webster Online Dictionary as an “abnormal smallness of the mammary glands,” hypomastia is notable in the context of this research due to the contention of many within the medical establishment that the creation of hypomastia as a medical condition coincided with the creation of the augmentation mammoplasty procedures that purport to “cure” the condition. Similar claims can be found within anti-FGCS discourses, some of which posit the marketing of FGCS procedures as a “cure” for naturally occurring genital variations labeled by FGCS practitioners as “abnormal.”
debate utilize nature and the normative in order to shore up their discussions of pathology. Supporters of FGCS often eschew the word, instead relying on variations of “normative” often defined by medical or scientific communities when pathologizing what falls outside of this category. Many of the groups who have positioned themselves in opposition to FGCS, however, rely on terminology focused on variations of the term “nature.” These groups are especially invested in educating women about the naturalness of bodily variation, and their aim seems more to make such variation visible as non-pathological than it is to demonize various forms of bodily alteration. This is readily apparent in groups like the NVC, who are open to a wide variety of bodily alterations and who do not espouse a preferred norm of a “natural” vagina that would exclude from this category either trans individuals or women who undergo FGCS.

In the case of the surgeons, pharmaceutical companies, and their marketing teams, nature is commonly inferred when the term “normative” is invoked. To be “natural” or “normative” in this sense refers to the generalization of a common quality (Williams 220-21) —or a “norm.” As a result of the presumed neutrality of scientific discourse, which adds weight to proclamations of the medical world, these common qualities are frequently able to transition into “medical norms” (Foucault, History 53; Terry and Urla 6). Genitalia that do not conform to these “norms” are often pathologized in marketing materials and media, and many surgeons’ websites
contain galleries of before and after photographs of labia and vaginas that are posed and photographed in such a way as to imply their need for medical intervention.\textsuperscript{78}

An oft-cited example of the process of pathologization in FGCS discourses is the adoption of the Masters and Johnson “Human Sexual Response Cycle” as the basis for classification and nomenclature of sexual dysfunction by the American Psychiatric Association (Tiefer, “Sex Therapy” 361). As a result of its acceptance as the measure of normative, or natural, sexual response, this tool became the one against which the medical establishment measures all sexual responses, physiologies, behaviors, etc., and those who fall outside of the cycle risk being labeled non-normative.\textsuperscript{79} There is a sense, when reviewing the medical literature regarding sexual dysfunction, of a studious avoidance of most derivations of the term “natural,” which would theoretically allow for more diversity than a normative model.\textsuperscript{80} While many

\textsuperscript{78} Chapter 2 of this dissertation explores how both surgeons and critics of FGCS mobilize the concepts of “natural” and “normative” in various discourses of FGCS, including via the use of photography, in more detail.

\textsuperscript{79} In her article “Sex therapy as humanistic enterprise,” Leonore Tiefer details how the adoption of the Masters and Johnson “human sexual response cycle” became the basis for sexual dysfunction nomenclature. Tiefer’s assessment forwards that the 1980 adoption of the cycle by the American Psychiatric Association (APA) gave the cycle “a social legitimacy that has become the basis of American health insurance reimbursement for treatment.” Tiefer adds that, in the wake of this sanctioning, the cycle was also “adopted by international classification systems around the world and thoroughly saturates clinical sex research, both psychological or, increasingly, pharmacological” (361).

\textsuperscript{80} An excellent example of the avoidance of terminology such as “natural” and the alternate embracing of a normative model within medical literature can be found in Anne Fausto-Sterling’s \textit{Sexing the Body}, specifically in the section “Of Gender and Genitals.” In her review of the medical literature of surgeons’ responses to children born with ambiguous genitalia, she cites many instances of doctors’ unwillingness to address any “natural” variations of genitalia, as well as a pattern of eschewing adherence to the (at best) loosely followed, established “normative” measurements for acceptable genitalia. These measurements essentially determine what sex/gender a child will be assigned, based on surgeons’ judgments of the acceptability of the size or appearance of an infant’s genitals (57-60); thus, instead of documenting the natural variation of sizes or appearances of genitalia that occur in humans, the medical literature contains discussions of penises that “feel” or “perform” normally, “ideal” penises, and penises which fall within observed “normal distributions…of meatal positions” (57), to cite but a few examples.
scientists and physicians throughout the centuries have been aware of such diversity, they have rarely viewed such variations as benign; in fact, it is within these variations where we find “recurring slippages between concepts of 'difference', 'deviance', and 'pathology'” (Terry and Urla 9). FGCS, in this context, becomes an answer to this deviance and pathology, which thrive under the twin protections of a relaxed, neoliberal market and the medicalization of sexuality (Tiefer, “FGCS”). One result of this process is the subsequent increase of pathologies mapped onto the female body as an answer to the supply of cosmetic procedures, and the normalization of these cosmetic surgeries as a tool to excise said deviance/pathology (Pauly-Morgan 28).

V. Pathologization as Payday—FGCS by the Numbers

Since financial motives (especially as they relate to the role of neoliberalism in medical marketing) are such a large part of anti-FGCS discourses, it is useful to review FGCS “by the numbers.” Just how popular are the procedures, and is that popularity increasing as FGCS becomes more widely marketed, available, and noticed in popular culture? How many women are undergoing the procedures—and what are they paying to do so? Is FGCS, as some critics have estimated, the next “boob job”—or is it merely one more among a seemingly endlessly expanding list of ways to surgically modify the body?

In the early days of its existence, tracking the popularity of FGCS was extremely difficult. Not only were the procedures new, they were also a highly
private affair, and paid for almost completely out of pocket. As such, tracking how many women had undergone FGCS posed significant problems for researchers and others interested in studying the procedures. In recent years, labiaplasties have begun to appear in the yearly statistical analyses of some professional groups comprised of cosmetic surgeons. While each group’s statistics are based on the self-reporting of its own members, these studies offer valuable insight into what has been—until very recently—a very private corner of the surgical world. Since these procedures are considered purely “cosmetic” for the purposes of billing, medical insurance companies, who seldom cover the expense, generally do not track them. Most patients pay out-of-pocket for FGCS, and as a result their general practitioners, gynecologists, and insurers may never be aware that they have undergone the procedure.81

Of the various professional groups of cosmetic surgeons, two in particular have begun collecting statistics on FGCS: the American Society of Plastic Surgeons (ASPS) and the American Society for Aesthetic Plastic Surgery (ASAPS). While these professional groups have only lately begun tracking FGCS, their results offer a picture of a fairly recent innovation coming into its own, as evidenced by the

81 In both my research and in speaking with several (non-FGCS) physicians and surgeons, I have come across two general exceptions to this, neither of which were mentioned as being common occurrences: 1) Instances wherein patients have attempted to argue for insurance coverage for FGCS due to physical or psychological issues suffered as a result of labial size, and 2) Gynecologists who have collected some anecdotal data not as a result of willing patient disclosure, but instead as the result of FGCS patients seeking medical advice for botched surgeries or postoperative difficulties, such as infection. In the first case, I have little anecdotal confirmation of this type of insurance claim working in the United States; however, the National Health Service (NHS) of the United Kingdom has recently offered two-tiered statistics that indicate that the NHS is starting to cover some labiaplasties, while others are obtained as out-of-pocket expenditures. As such, I have heard some talk at conferences that the use of narratives similar to those utilized in order to obtain gender confirmation surgeries may be one way to strategically attempt to obtain insurance coverage for FGCS.
significant increase in patients undergoing perhaps the most popular form of FGCS—labiaplasty.

Both groups tracked labiaplasties performed by member surgeons in 2015 and 2016, compiling data such as age and gender of patients, as well as cost and location of the surgeries performed.\(^8^2\) This data was used to track the growth in popularity of the surgeries among various populations, as well as average out-of-pocket costs for patients. It is important to note that the listed average cost of each procedure accounts for surgeon time and labor only, and does not include any other fees that accumulate as a result of surgery, including (but not limited to) fees for surgical facility use, anesthesia and an administering anesthesiologist, laboratory and medical tests, medications, special garments, travel, lost wages/time off from work, clinic fees for follow up visits, and any other charges incurred in the course of the procedure and patient recovery.

So, what did women in the U.S. spend on labiaplasty surgeons during the 2015-2016 tracking period? According to ASAPS, the total expenditure for surgeon fees for the procedure was $32,507,357, which works out to an average of $3,017 in surgeon fees per labiaplasty (“2016 Cosmetic Surgery” 21). The numbers from ASPS were similar, with a total expenditure of $34,576,180 and an average surgeon fee of

\(^8^2\) While it would be useful to this project to have demographic data that included the race of labiaplasty patients, neither the ASPS nor ASAPS provide detailed breakdowns of the race of patients relative to individual procedures. Instead, both groups provide one statistic regarding the race of their patients—the percentage of total procedures performed according to race. The ASPS lists this under “Cosmetic Plastic Surgery Demographic Trends” on their report, and the available racial categories are “Caucasians, Hispanics, African Americans, and Asian Americans” (“2016 Cosmetic Surgery” 6). The ASAPS lists this information under “Demographics: Economic, Regional and Ethnic Information,” and the available categories are “Caucasian, Hispanics, African-American, Asians, and Other” (“Plastic Surgery” 23).
$2,730 ("Plastic Surgery" 22). To get a sense of how this compares and contributes to industry totals, the ASAPS reports that over $15 billion was spent on cosmetic procedures in 2016; of that, 56% (or $8.6 billion) was spent on surgical procedures ("2016 Cosmetic Surgery" 21). The ASPS reports similar totals, with $16.4 billion spent on 17.1 million cosmetic procedures in the U.S. during the tracking period, of which 1.7 million were surgical procedures ("Plastic Surgery" 5-6).

While it may seem to be a small number when compared to the overall totals, it is important to remember that this is the first time that either the ASPS or the ASAPS has gathered data for labiaplasties, and the data reveals something significant enough to merit special mention in both groups’ reports—namely, a statistically significant increase in the number of labiaplasties performed from one year to the next. In fact, the ASPS report includes a section on “Cosmetic surgical procedures, not among the Top 5, with notable gains in 2016,” which include three procedures commonly offered by FGCS surgeons: buttock augmentation with fat grafting was up 25% from the previous year, lower body lifts were up 34%, and labiaplasties were up 39% ("Plastic Surgery" 5). ASAPS also reported a significant increase in labiaplasties, which climbed 23.2% in one year ("2016 Cosmetic Surgery" 11).

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83 Both the ASPS and the ASAPS collect data not only on total cosmetic procedures, but also further analyze this data based on whether the procedures are cosmetic surgical procedures or cosmetic minimally invasive procedures, both of which categories are then also analyzed for statistics on particular procedures. While cosmetic surgical procedures are generally well-understood as any procedure that involves undergoing surgery, cosmetic minimally invasive procedures—which make up an overwhelming number of the overall total cosmetic procedures performed—are numerous, and include (but are not limited to) procedures such as: Botulinum toxin injections (Botox), laser hair removal, microdermabrasion, and soft-tissue fillers.
The ASAPS report broke down their data further, providing the age ranges of women who underwent labiaplasty procedures during the reported upon time period, and found that the majority of labiaplasties were performed on women aged 19-34 (51%) and 35-50 (37%), with no other age category accounting for over 6.2% of the surgeries (“2016 Cosmetic Surgery” 16). This puts the overwhelming majority (88%) of women who chose to undergo labiaplasty in the U.S. between the ages of nineteen and fifty—a noticeably large range and one worth considering alongside other statistics released (in the same study) by the ASPS, namely the percentage of patients undergoing multiple or repeat procedures. In 2015 and 2016 respectively, the percentage of patients undergoing cosmetic procedures that were repeat patients was 47% and 46%, respectively, and those undergoing multiple procedures in one visit remained steady at 41% for both years (“Plastic Surgery” 23).

These statistics offer new insight into the growing popularity of FGCS in the United States while simultaneously confirming some key claims of its critics; notably, the reports give us concrete indications of the profitability of an industry dedicated to bodily modification in a commodity culture wherein good (sexual) health is not only a mandate, but also increasingly associated with the performance of responsible citizenship.
VI. Conclusion: On Shifts in Consumers and Markets

Aside from the part it plays in the shifting role of consumers, the continued evolution of neoliberal market practices is involved in various discourses of FGCS. Consider, for example, how dramatically the place of commerce has changed in recent history: We are no longer dependent on a market with an actual, physical location, which in the past would have been dedicated mostly to the sale of perishable food (McGill 149). With the advent of telephone and online shopping, which are facilitated by television advertisements and infomercials, neoliberal practices have turned the “air” itself into a marketplace. With this market transformation, a comparable shift in the supplied goods is also occurring as we move closer to Adam Smith’s initial ideals of liberalism: The possession of “a bunch of ‘objects’ as litmus test” for civilization (Ashcroft, et al. 149). The growing demand for luxury goods and services bears this out, and it is arguable that FGCS, with its lack of sanction within most of the medical academy due to its cosmetic nature (Tiefer, “Female Genital” 469), and its out of pocket costs due to a similar lack of sanction within the insurance community (Green, “Erasing”), is such a luxury good or service. In a capitalist, consumer culture such as the U.S., the ability to purchase a luxury good or service, when framed within neoliberal imperatives, is seen as a liberated exercise of personal freedom and betterment, and the highly homogenous “designer vagina” becomes a mark of independence whose irony is made invisible.
If we understand the neoliberal forces at work in markets discussed in this chapter as a “technology of government” and as a “profoundly active way of rationalizing governing and self-governing in order to ‘optimize’,” then we can begin to comprehend what is at stake (Ong 3). The “optimization” and self-governing discussed by Aihwa Ong are requirements in the attainment of Foucault’s “normalization” process (*Discipline*, 182-83). In a society that prizes neoliberalism and the ability of its attendant technologies to define those who do not belong within the privileged sphere of appropriate citizenship, the use of products (such as FGCS) that aid in this “normalization” become stepping stones to a more highly regarded state of citizenship and belonging. In such circumstances, the luxury and autonomy represented by undergoing FGCS are equated with just such responsibility and self-policing, via the “mandate of good health” that is one of the main components of “good” citizenship in neoliberal markets (Tiefer, “FGCS”). On the other hand, women who resist these procedures risk this choice defining them as less than ideal members of society, a dangerous place to reside given that “the domain of the non-conforming is punishable” (Foucault, *Discipline* 178-79).

Ong posits this self-governmentality as part of a shift away from a disciplinary society; however, her claim is based on the shift of the mechanisms of control to a more “democratic” form, “distributed throughout the brains and bodies of its citizens,” as opposed to operating within a “society of control” (20). Posited thus, we see that the neoliberal influences that reside within the discourses of FGCS are still about control at their most basic. It is only *who* exerts this control that is being
questioned and contested within all sites of FGCS discourse. That this control is so closely linked to ideas of normative sex, gender, and appropriate citizenship is evident in the ruptures, fissures, and overlaps within these discourses. As with most concepts in this world, it is more messy and complicated than either side would care to admit.

Ong articulates another reason careful attention should be paid to issues like FGCS in *Neoliberalism as Exception: Mutations in Citizenship and Sovereignty*, where she acknowledges “since the 1970s, ‘American neoliberalism’ has become a global phenomenon that has been variously received…overseas” (3). Taking into account the full import of this statement, it can be inferred that Ong is not only speaking of the rhetoric and market practices of neoliberalism, but of the social practices that result from them. Is it not wise, then, to consider what this nation is exporting in the way of gendered expectations and concepts of abridged citizenship?

In 2010, FGCS was already being practiced in almost thirty countries worldwide by one doctor’s franchisees alone (Laser Vaginal 2010); by 2017, that same surgeon had trained over four hundred and fifty surgeons in over forty-six countries and had personally treated patients from all fifty states and over seventy countries (Laser Vaginal 2017). As these procedures travel to other cultures, what will the fallout be? Are these discourses paving the way for more human bodies to enter Foucault’s “machinery of power,” only to be explored, broken down, and rearranged as a homogenized ideal (*Discipline* 138)? Or will others (as some have in the resistance to FGCS in our society) find that, when examined, these discourses are the “specific
technologies of governing and self-governing [that] produce a variety of meanings and room for maneuver, negotiation, and ethical doubt” (Ong 27)?

One way to consider these questions is to consult patient testimonials and online commentary—especially those written by FGCS patients who hail from outside of the United States. While an imperfect tool due to the nature of how these commentaries are gathered (they are self-reported) and presented (in the case of surgeon websites, they are selected and presented by the surgeons’ marketing team and web designers), they still offer insight into FGCS patients’ experiences and feelings regarding the procedures. Consider the testimonial of this patient:

I have been a client of Dr. David Matlock for the last two years.

I travel 14 hours from Sydney to Los Angeles to be looked after by Dr. Matlock, I would travel 36 hours if I had to, even though there are many options in Australia to improve my wellbeing and appearance I have never second guessed my options and always stick to Dr. Matlock, his service, his follow up, is second to none. (Laser Vaginal 2017; punctuation author’s)

On the one hand, this testimonial speaks to the powerful and far-reaching nature of Dr. Matlock’s marketing. This particular patient not only found information on Dr. Matlock’s Beverly Hills practice and made the decision to undergo the advertised procedures, they also decided that no other physician would be able to offer them the result they desired—even though, as they acknowledge, there are many local options in Australia from which they might choose. Initially, this could be construed as an instance of a patient feeling so pressured by marketing focused on the narrow range of acceptable embodiment featured on a surgeon website that they flew thousands of miles in order to have that particular surgeon attend to their “wellbeing and
appearance” (Ibid). Upon closer inspection, however, it is also possible to interpret this testimonial as an exercise in agency and choice—the potential patient may have already made up their mind regarding the procedures they wanted, then went on to do the research and made an informed, intentional decision to have these surgeries performed by the carefully selected surgeon of their choice, regardless of location.

This example illustrates the complexity of narratives of FGCS, and many critics would forward that it is difficult to imagine any patient’s choice to undergo FGCS as existing outside of neoliberal practices that attach value to choosing to use innovative and controversial medical technologies in order to bring a body perceived as “abnormal” back into the realm of “acceptable” embodiment. There are other online narratives, however, that suggest that women do share stories of labiaplasties that they are unhappy with, and the existence of these narratives illustrates that physicians are engaging in marketing that also acknowledges the possibility that undergoing FGCS might fail at bringing some women’s genitalia into the domain of the “acceptable.” The website RealSelf provides a forum for prospective cosmetic surgery patients to search procedures, see other patient ratings for particular procedures and surgeons, search for cosmetic surgeons, or get answers to surgical questions from featured surgeons. While the page is obviously a marketing tool for the surgeons, it also acts as an information sharing center for prospective and current surgical patients, and the discussion forums and testimonials appear much more conversational—and much less mediated—than those on FGCS surgeon websites.
The result of this is that patients engage in detailed discussions of their overall experiences with FGCS, often documenting their post-operative experiences on a daily or every-other-day basis. Just as on FGCS surgeon testimonial pages, they share their successes; however, they also share the difficulties, the pain, and (when applicable) the failure of their individual surgical experiences. That the pain and failures are left on the message boards for any visitor to see conflicts with critical narratives of FGCS that focus on the persuasive power of highly curated before and after photo galleries on surgeon websites. Such galleries, accompanied by glowing testimonials, may be the norm in most cases, but clearly there are surgeons who choose to market their services in a more expansive way. It is important, however, to note that there is a potential marketing advantage to this more inclusive marketing strategy: namely, surgeons often address patients who come to the forum unhappy with the results of their previous surgery with offers of “revisions” (“Labiaplasty”). However, sometimes the consultations are more complicated, and the marketing more nuanced, such as in the case of a user whose header read “Can I fix my ugly vagina?”:

In the first photo, all the vaginas are mine. You can tell from earlier years, my vagina was decent looking. Years later, it gets larger, so big it would get swollen after sex, as you can see in the photo; it was miserable. So I got labiaplasty. As you can tell, still not very good! I have 6 month & 1 year post op pictures posted. The second set of photos is my desired look. Is this possible or am I being unrealistic. I am going to get fat transferred into the labia majora to plump it up too. (Ibid, punctuation author’s)

This patient comes across as more savvy than FGCS critics often allow for, and expresses a nuanced understanding of the fact that the photographs they have chosen as a target for post-operative aesthetics may or may not be possible to achieve
with FGCS. Additionally, the patient has engaged in enough research to know that additional procedures (such as the fat transfer they mention) may be required in order to meet their ultimate post-operative goal—and, even then, the writer does not assume success, but asks for surgeon input on the prospect of meeting their aesthetic goal. This interaction is very different from critical representations of FGCS that posit prospective patients as at the mercy of surgeons marketing their services as “one-size-fits-all” solutions to any bodily variation that might be troubling you. Not only is the patient well informed and taking active part in their care, but the physicians who responded to the query were equally nuanced in their engagement:

A: fix ugly vagina

Based on your pictures, you still have redundant tissue. Since your labia tend to get engorged after sex, your tissues may be more prone to stretching. You are certainly a candidate for a revision. An exam is required to determine the extent of the revision so that the most appropriate technique is used. Fat transfer to the labia is fine depending on the look you are going for and what matches your overall physique. However, if you are a thin person, having really plump labia majora can look mismatched.

A: Revision labiaplasty

I am often asked about revisions of unsatisfactory labiaplasty, and there is no one answer. Undesired results are "all over the map," and the proper procedure to "repair and restore" is entirely dependent on both your anatomy and the skill of the revision surgeon. As one who performs revisions (by the way, I just won the award for the "Best Revision Labiaplasty of 2018" from the International Society of Cosmetic Gynecologists at their Annual Meeting last week in Las Vegas...), there are many different procedures. The one very important thing is to see only a surgeon who SPECIALIZES in revision, and has performed > 100 labiaplasties. As for fat transfer, the same thing: only choose experience! You might look into a fat/stem cell/ PRP transfer-probably better than fat alone...

Best wishes, (and, by the way, you are NOT ugly!)
("Labiaplasty")
While both of the surgeons who responded to this query are offering services for sale, their interactions with the prospective patient are complex, and suggest more choice than is often represented in critiques of FGCS and the surgeons who provide it. Both are marketing surgical “revision” services, and both agree that this patient is a candidate for these services. That having been said, both are also quite candid about the fact that these services—along with others that they offer—may or may not work for the individual patient. Far from narratives of surgeons marketing a quick and sure-fire fix to pathological genitalia that promises to line their own pockets in the process, these surgeons go so far as to warn the patient that results of the procedures vary depending not only on the surgeon—but also on the patient’s body type. Given the chance to sell not only a revision surgery, but also a fat transfer, both surgeons offer the patient advice that includes the possibility that either, both, or neither might be appropriate for the situation; one even closes by seeking to dispel the patient’s belief that her genitalia are “ugly.”

This is not to say that marketing is not at work in these forums, or that every interaction is as complex as this one; instead, I offer this as a surprising alternative to those critiques of FGCS that tend to oversimplify the interactions happening within medical marketing. Interactions like this one offer the possibility that there is more complexity happening within some medical marketing than is being accounted for in current critiques of the practice. This is not to say that such marketing should be assumed to be benign, or that it is without ethical complication; rather, as an ever-evolving aspect of how medicine engages with neoliberal practices, it merits
continual re-evaluation and consideration on a case-by-case basis. Examinations and critiques that do anything less run the risk of reducing patients and surgeons to gross caricatures, and reproduce troubling narratives wherein the agency of the former is all but negated by the cunning and unethical marketing machinations of the latter.

Without access to personal interviews with prospective and former FGCS patients, it is impossible to fully examine patient testimonials and account for a patient’s decision-making process, and, thus, their agency. That having been said, the testimonials in this chapter illustrate that it would be irresponsible to attribute all of the power involved in these interactions to FGCS surgeons and their marketing techniques. While I argue that a better, more detailed interaction with the procedures and those who consider or undergo them is needed, I also accept that the controversial nature of the procedures and United States medical privacy laws make such an interaction a complicated prospect at the current time. It is possible that, with time, FGCS may come to be spoken of in less combative terms, but—as long as the majority of narratives of the procedures position themselves as either for or against them—that time may be further down the road than is useful for women currently considering undergoing FGCS. It is my sincere hope that this dissertation might begin to open up the conversations happening around these surgeries in ways that acknowledge these women, their agency, and the complex narratives that they are trying to navigate, even as they find themselves—willing or not—already implicated in them.
Coda

“That is really what we’re up against, you know—the blurry line between medicine and markets. That means our research, our markets, everything, is shaped by [pharmaceutical] industry influences.”
(Meika Loe in *New View Campaign, Capstone*)

In the course of researching and writing this dissertation, many changes have come to pass in the realm of FGCS. As discussed in Chapter three, the number of women choosing to undergo the procedures continues to increase exponentially, as have the number and locations of surgeons offering the procedures. One change that should be discussed further, however, and did not make it into the main body of the dissertation due to its relatively recent occurrence, is the end of the New View Campaign (NVC). In October of 2016, I traveled to Bloomington, Indiana, to attend the fifth and final conference put on by the group. Billed as a capstone conference, its stated purpose was to end the campaign “with intention,” thus allowing the New View to “declare victory and have a major celebration” rather than “peter out” or “limp along” like “so many other feminist projects” (Tiefer in *New View Campaign Capstone*).

In many ways, the conference was structured like others that I have attended in the course of this research: there were panel and paper presentations, activist and art workshops, keynote speakers, and networking. There were also, however, exhibits of New View materials being prepared for archiving at Indiana University’s Kinsey Institute, videographers interviewing New View members and documenting the closing of the campaign, and a gala held on the final night that included a ceremonial
group dance and extinguishing of the New View flame (candles were handed out to all attendees).

Having spent the past nine years working with materials published by the New View Campaign and its members (and writing about them), I was shocked when I received an invitation to what would be the end of the campaign. Even after the capstone conference, I continue to ponder what the purpose of ending—even “with intention”—at this point in time might be. The New View Campaign, after all, brought together an international community of scholars and activists working against the medicalization of sex. For the better part of seventeen years, the members of the group worked to bring their cause beyond the “bubble” of scholarly engagement, and to stress the importance of incorporating activism into scholarship (New View Campaign Capstone). The group organized street theatre outside of FGCS surgeons’ offices, filmed parody videos, and put on conferences; its members testified in FDA hearings regarding the approval of controversial medications marketed for “female sexual dysfunction,” wrote journal articles and op-eds, and were interviewed by members of the media on many occasions. Small but vocal (their email list serve reached several hundred people) they were well enough known to be expected at industry hearings and directly addressed by pharmaceutical companies and FGCS surgeons alike, and it is difficult at this time to assess what the demise of the campaign might mean to future discussions. If the presence of engaged junior scholars and graduate students at the capstone conference is any indication, interest in the issues that the New View Campaign was founded to address may actually be
increasing, and I continue to wonder why—with so much interest still evident, and the issues that the group was organized far from settled—did the New View choose to extinguish their light, rather than pass the torch?

While beyond the scope of the current project, the question is worth considering, especially in light of the discussions of medical marketing in Chapter three. The last line of the New View Manifesto reads: “We call for research and services driven not by commercial interests, but by women's own needs and sexual realities” (New View Campaign). Seventeen years is a long time, and a tremendous amount of labor—especially when the industry one is up against is a multi-billion dollar, worldwide juggernaut. Perhaps one lesson to consider here is in setting the terms of engagement, and in doing so, providing a blueprint for future scholars. As it stands, the New View has committed to leaving its website (and all of the information it contains) up indefinitely; the group has also archived all of the materials produced in the course of its campaign at the Kinsey Institute, located at Indiana University in Bloomington. For those who wish to continue on the New View path and “reclaim feminist critique(s)” while finding “ways to intervene and make change”—especially with regard to the medicalization of sex—the work the group produced in the service of this goal and the tools they employed will be available for the foreseeable future (Barb Marshall and Leonore Tiefer, New View Campaign Capstone). In the end, the capstone conference seemed hopeful that this would pave the way for some of the junior scholars in attendance, and leave a blueprint of sorts with which they might
meaningfully oppose the increasingly narrow dictates and definitions of sexual health defined by “Big Pharma” and “Big Medicine” (New View Campaign Capstone).

Whether groups take up the cause remains to be seen, but the New View Campaign has made it possible for critiques of FGCS that take entirely new directions and use different theoretical frameworks as their starting point. As illustrated in Chapter two of this dissertation, there are several places where the framework of critiques of FGCS—including those produced by the New View—run the risk of reproducing the narrowing of genital aesthetics that they purport to oppose. Additionally, Chapter one demonstrates the history of the pathologization of female bodies as the result of complex, varied historical practices and institutions, as opposed to being solely rooted in medicalization, which many New View anti-FGCS critiques posited as its origin. I would like to propose that the end of the New View Campaign offers the possibility of producing scholarship and activism that moves beyond the limits of current frameworks and generates more expansive interactions with the procedures, their consumers, and all involved stakeholders.

II. Moving Forward

“I’d like to see the death of norms.” (Hugh Herr in Fixed)

In considering what this expanded engagement might look like, I think that the field of Disability Studies has much to offer feminist critiques of FGCS and its narrowing of the parameters of appropriate embodiment. It has been surprising to me, in conducting this research, to have seen so little engagement with the work of
disability scholars in these critiques, as these scholars have produced theory and frameworks that have the power to expand the discussions happening around FGCS, and open up new avenues for interactions with the procedures. In introducing this dissertation, I outlined questions that I hoped this research would touch upon, while also making a meaningful contribution toward expanding the current environment of discussions of FGCS. I asked readers to imagine a discussion that incorporates these chapters in the history of pathologization and pose these questions: Should medical and scientific classificatory schemes continue to use pathologization to measure and diagnose various conditions? Considering the blunt nature of these tools, are they still the best ones for the job? What is the function of these classificatory schemes—and is this function necessarily useful? I wanted to consider these questions, in the hopes of encouraging people to begin their engagement with FGCS thinking “bigger” than the frameworks currently determining narratives of these procedures.

In retrospect, perhaps it would have been useful to suggest other questions, as well; particularly, “Why are so many narratives of FGCS locked into a pro-/anti-framework?” and “What are ways to move outside of this framework, and take the conversation forward in a manner that better recognizes and valorizes female agency?” While I do not have the answers, I have found, in the course of my research, avenues worth considering as we work to take the conversation in new directions. Perhaps the most notable of these avenues, in my opinion, lies within works in Disability Theory—especially those relative to the creation and use of “norms.”
In particular, I am interested in how the work of Lennard Davis might change current critiques of FGCS, especially as relates to the narrowing of appropriate bodily aesthetics. Davis’s book, *Enforcing Normalcy: Disability, Deafness and the Body*, is a movement through Deafness in order to theorize on the discourse of disability. While not specifically applicable to the case of FGCS, it has much to offer more general aspects of thinking about embodiment and normativity, especially Davis’s contention “that the body is not only—or even primarily—a physical object,” but “is in fact a way of organizing through the realm of the senses the variations and modalities of physical existence as they are embodied into being through a larger social/political matrix” (14). Davis, then, encourages us to think through classificatory schemes while attending to the “fact that the disabled body is not a discrete object, but rather a set of social relations” and “a complex focus for competing power structures” (11). His work offers a corrective to thinking about bodies as given, discrete objects that fall neatly into particular categories of classificatory schemes—a useful theoretical framework when considering narratives of FGCS that trade upon discourses of bodies coded as “natural” or “normative” (11).  

Also worth considering is Davis’s discussion of the concept of the “ideal,” which he theorizes as preceding the concept of the “norm” commonly utilized in discussions of medicine and aesthetics. Davis argues that the ideal body—as

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84 Davis’s work posits the deconstruction of the continuum of human embodiment as the basis for disability.
85 Davis contends that the concept of the “ideal” dates back to the seventeenth century in the Western (mostly European) civilizations he is discussing, and that the concept precedes that of the “norm,” which Davis posits as entering the English language in 1840, and being adopted in “the modern sense” around 1855 (Davis 24).
“exemplified in the tradition of nude Venuses, for example”—was understood by society at large to be aspirational (24). Linked to the divine, this ideal body “is not attainable by a human;” indeed, an ideal “as visualized in art or imagination must be composed from the ideal parts of living models,” and—as such—“these models individually can never embody the ideal since an ideal, by definition, can never be found in this world” (Davis 25).

This is quite different from how Virginia Blum posits the “ideal” in Western civilizations of comparable time periods. In *Flesh Wounds: The Culture of Cosmetic Surgery*, Blum contrasts the permanence of these ideals—quite literally carved, as they were, in stone—with the impermanence of current “ideal images” of physical beauty (40). While Blum’s intention is to suggest that the ideal images of “traditional societies of the past” were longer lasting, given the effect of a notion of beauty literally carved in stone (Ibid), Davis explains these same ideals as aspirational goals without expectation of total attainment. Davis contends that the societies that produced such works of art understood them to be representative of an idealized form that did not exist in nature. This is not to say that people did not strive to match these idealized forms. Instead, Davis suggests that the “falling short” of this standard was both expected and met with more acceptance than occurs in present day beauty culture, and that, “there [was] in such societies no demand that populations have bodies that conform to the ideal” (25). In effect, Davis portrays the ideal as aspirational, but without the disciplinary mechanisms of normativity that govern the beauty culture of which cosmetic surgery is a part. What might future narratives of
FGCS—or cosmetic surgery more generally—look like if we were to exchange “norms” for “ideals”? What would our critiques of the industry look like if this were generally accepted? I’m not suggesting that unseating centuries’ old classificatory schemes is entirely feasible, nor do I think it could change the entire landscape of medicalization and pathologization, but it is worth considering what sorts of interruptions might be facilitated through the adoption of alternative frameworks for thinking about embodiment.

Disability studies scholar Rosemarie Garland Thomson’s work is also useful here, as it can add to discussions of medicalization in current narratives of FGCS. Her work on shifting views of disability in an increasingly secular society—specifically a shift from disability being termed “evil or immoral” to “pathological”—is indicative of how disability has been almost entirely subsumed in twentieth-century America under a medical model that pathologizes disability. Although medical interpretation rescues disability from its earlier associations with evil, pathologized difference is fraught with assumptions of deviance, patronizing relationships, and issues of control. (37)

There are real parallels that deserve further exploration between the medicalization of sex and the medicalization of bodily difference at the heart of Garland Thomson’s work. Current discourses of FGCS focused on medicalization and pathologization (such as those discussed in Chapters two and three of this dissertation) could benefit from the use of Garland Thomson’s work to consider the ways pathologization has come to be attached to—and affect—other medicalized groups (such as those classified “disabled”).
Finally, the recently established field of Ability Studies suggests interesting possibilities of engagement in relation to narratives of FGCS.\(^{86}\) Ability Studies, according to Gregor Wolbring, is “really about looking into how ability expectations, hierarchies, and preferences come to pass and the impact of such hierarchies and preferences on human-human, human-animal, and human-nature relationships” (Wolbring, *The Promise*). What is fascinating about Wolbring’s work is his insight into how advances in technology and bodily modification lead to what he terms “the new impaired,” in that the possibilities for bodily “enhancement” through the use of these technologies comes hand-in-hand with changes to “who is seen as medical, and who is not” (Ibid). Wolbring’s contention is that these innovations do not “get rid of impairment,” which they were ostensibly created to address, primarily because “tech can never fix social problems,” or “get rid of the social discrimination and/or disablement” of people who inhabit bodies classified as disabled (Ibid).

Wolbring, then—and Ability Studies more broadly—suggests a fine line between innovations in technology marketed to “fix” human bodies classified as impaired, disabled, or abnormal, and the marketing of technology in ways that have the potential to greatly expand those classifications. This is reminiscent of narratives of FGCS discussed in Chapters two and three that detail the creation of genital pathologies based upon the existence of technologies that offer cures for the pathology in question, and it would be interesting to consider what bringing

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\(^{86}\) Ability Studies was established as a field of scholarly inquiry in 2008 by Gregor Wolbring and colleagues as a way to look “beyond the dynamics of ability expectation into the governance of it” (Wolbring, *The Promise*).
Wolbring’s work to these narratives of FGCS might add to the discussion. Ability studies also has much to say regarding the use of these technologies as enhancements (rather than “cures”), and this is an arena I find relevant to FGCS and cosmetic surgery in general. Future critiques could benefit from moving away from the language of pathologization and toward a consideration of cosmetic surgery—and its attendant technologies—as enhancements, rather than medical treatments designed to address body parts deemed “pathological.” This would allow for more rigorous introspection regarding the financial aspects of the procedures, which are rarely discussed in narratives of FGCS: the socioeconomic factors affecting access to the surgeries, and how the uneven access to supposedly democratizing medical technologies and procedures contributes to the ability of prospective patients to attain the social mandates of appropriate embodiment.

While these frameworks have much to add to future discussions of FGCS, they promise to be just as messy and complicated as their predecessors. Ultimately, there are no easy answers to questions of “appropriate” embodiment; there is no real way to move outside of the histories, innovations, cultural beliefs, and systems that have contributed to the invention and growth of the FGCS industry. What I hope, instead, is that there are tools we have yet to use to address these procedures and the narratives that surround them. Thus, even as the New View Campaign dissolves and the number of women choosing to undergo FGCS continues to rise, we may find new and more inclusive ways to produce scholarship focused on the procedures and the larger issues they exemplify. This is especially important in any arena where
questions of “appropriate” embodiment are involved, and these are questions that, at one time or another, will touch all of us. None of us are immune to age, disease, or the accidents that might radically and instantly alter our current embodied state. As such, it is imperative that we engage in debates surrounding that embodiment—especially those debates that contribute to what is considered acceptable, and what is not. After all, the “technologies that bring people up to normal are used to bring people beyond normal” (Gregor Wolbring in Fixed)—raising the very real possibility that what was once considered normal may, one day soon, no longer be acceptable. In such cases, we are all only an innovation away from abnormality—and all the consequences it entails.
Works Cited


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