The Perfect Vulva? Investigating Labiaplasty in South Africa

By

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Abstract

Labiaplasty, also referred to as labial reduction, is the partial surgical removal of the labia minora in order to shorten the length that is external to the outer lips of the vulva. The conversation about labial length over the past ten years has become an important part of public debates around women's sexual and gynaecological health. In these debates, a demand for what has become popularised as the 'Barbie Vagina' has become part of the conversation. Labiaplasty is a female genital cosmetic surgery designed to make this 'Barbie vagina' look possible, in order to achieve vulvas that are 'neat' and 'tucked'. South Africa, with its complex political economy of a small number of very wealthy households and a much poorer majority, has been part of global aesthetic patterns for much of the last century and has experience a growing demand for labiaplasty procedures. To explore labiaplasty in South Africa I conduct an ethnography among plastic surgeons, aesthetic gynaecologists and clinical sexologists to understand how popular labiaplasty has become in South Africa. However, it was clear early on that knowledge about labiaplasty in South Africa was not easily accessible and by pushing my search for this knowledge I discovered firstly: the historical perpetuations of the body beautiful in plastic surgery in South Africa enveloped in ideas of race and beauty, and secondly complicated turf wars among specialisations of medicine fighting for legitimacy to perform labiaplasty.

Key words: labiaplasty, vulva, plastic surgery, aesthetic medicine, beauty, symmetry

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“We’re going to talk about vaginas”

I pulled up my handbrake as high as it would go as I parked on the steep pavement at Dr Milburn’s sexual health clinic. I sat in my car for a moment, took two deep breaths and practised the words: ‘vagina…vagina…’ quietly under my breath. I wanted to sound confident about this weighted word, in anticipation of my impending conversation with Dr Milburn. As I started walking up the driveway, I glanced back to check on my car, never before having doubted the effectiveness of my handbrake. I entered the clinic into a very ordinary waiting room, with an entry table overflowing with business cards and flyers that immediately grabbed my attention. These piles of paper ranged from adverts for nipple tattooists and gynaecologists to educational material on STI/STDs and abortion. Fascinated by the content on the table, I had not noticed the sliver of the receptionist’s head peaking up from behind a high counter. She coughed to get my attention.

‘Oh sorry, I’m here to see Dr Milburn. I’m the master’s student.’ And with a simple nod, the receptionist disappeared down a passage and soon appeared again with a voluptuous, blonde woman talking loudly to the air behind her. Before I had time to introduce myself, I was embraced with a hug and a ‘Hello darling! I am so excited about what you are doing! Come, let’s talk’. Dr Milburn ushered me down the same passage from which she had appeared to her consultation room. As she followed me down the passage, muttering away, she stopped suddenly and threw her hands in the air. ‘Oh, I must call Virginia…’ and then let out a yell down the passage: ‘Come Virginia! We talking about vaginas!’.

So began my journey, spending time with medical professionals who knew a lot about female genitals, aesthetics and talking about the ‘unsayable’ (Ensler, 2000) vagina and vaginal discourse, or as I later learned to reframe, the vulva.

Introduction

The conversation about labial length over the past ten years has become an important part of public debates around women's sexual and gynaecological health (Schick, et al., 2011). This intensification has not come about only because of gynaecologists starting the conversation, or instances of female circumcision and alteration/mutilation, but also, as I started to find in my fieldwork, because patients were having concerns about the appearance of their vulva. The deep concern about aesthetic vulval appearance and its remedies has become a hot topic since the early 2000s, and experts such as Braun (2010) attribute a major role to pornography and images of slim sleek vulvas that women and men are exposed to in the media (Bramwell, 2002). Thus, a demand for what has become popularised as the 'Barbie Vagina' (Le Roux, 2017; Urla & Swedlund, 1995; Schick et al., 2011) has increased in many parts of the world, such as Australia, the United Kingdom, Lebanon (Economist, 2018) and the United States. The idea of a reconstructed and rejuvenated vulva to represent that of a Barbie's involves several procedures to attain, which range from Botox injections inside the vagina to surgical alterations to the labia majora and minora a popular procedure being labiaplasty. Labiaplasty, also referred to as "labial reduction", is the partial surgical removal of the labia minora in order to shorten the length that is external to the outer lips of the vulva (Green, 2005; Goodman, 2011; Braun, 2010). This form of genital alteration is performed by a plastic surgeon and in some cases a gynaecologist (Braun, 2010). Clear surgical procedure for labiaplasty is vague and can vary from surgeon to surgeon.[1] However, in most reported cases, the procedure is performed under local anaesthetic, the labia are marked to the "desired length" and then cut with a scalpel or scissors. Thereafter, the wound is sutured, and the labia heals completely within four to six weeks (Furnas, 2017; Joseph, 2019).

Labiaplasty and other procedures to *improve the appearance of the vulva* fall under the umbrella term FGCS: Female Genital Cosmetic Surgery. Of these FGCS procedures, labiaplasty has recorded the largest increase in popularity worldwide since the early 2000s. The statistics

[1] In 2013, there was an attempt by The Royal College of Obstetrics and Gynaecologists (RCOG Ethics Committee, 2013) to create a framework for the ethics of Female Genital Cosmetic Surgery (FGCS). An Ethical Opinion Paper with reference to FGCS was published that confronted ethical and practical issues that needed to be clarified. However, major gaps still existed, and a call that emphasised the importance of patient consent and clear communication of the lack of evidence for such procedures was repeated numerous times in the paper.

collected by the International Society of Aesthetic and Plastic Surgery (ISAPS) show that although the figures are not always consistent, there has been a considerable increase in reported cosmetic labiaplasty surgeries every year, especially in countries such as the United States, United Kingdom and Australia (International Society of Aesthetic Plastic Surgery, 2016). However, the popularity of labiaplasty is not limited to the West, as recent publications form The Journal of Obstetrics and Gynaecology of India also show a peaking number of labiaplasty surgeries over the past five years in India (Desai & Dixit, 2018). There was an increase of 25% in cosmetic labiaplasty procedures worldwide between the years 2014 and 2018 (International Society of Aesthtic Plastic Surgery, 2018).

Research has shown that South Africa, with its complex political economy of a small number of very wealthy households and a much poorer majority, has been part of global aesthetic patterns for much of the last century, as Lynn Thomas has shown in her work on skin lightening (Thomas, 2008; Thomas, 2020). In relation to aesthetic surgery and related treatment trends, South Africa has been no exception. Statistics documenting FGCS for the world and South Africa are erratic and unreliable, as there is in most countries (with the exception of the National Health Service in the United Kingdom) no obligation for plastic surgeons or gynaecologists in private practice to report such surgeries. South Africa appeared in the ISAPS data in 2016 reporting on the year 2015, of which 216 labiaplasty procedures took place amongst 175 plastic surgeons (International Society of Aesthetic Plastic Surgery, 2016). I did not know at the start of my research that these numbers were wildly misrepresentative of the truth about labiaplasty in South Africa. How I came to find out why and from whom is surprising, but more on that later in Chapter 2.

To understand why and how labiaplasty has become such a popular genital cosmetic surgery, it was vital for me to consider the historically informed ideologies about the vulva, communicated via biomedicine and popular culture, that have shaped how the vulva is viewed today. These ideas, perpetuated from the Renaissance period to the Victorian era and expeditions in Africa, centre the vulva as something that should be clean, healthy, hygienic and *white* (Laqueur, 1990; Nurka & Jones, 2013). Thinking through this history has led me to consider what has been popularised as the 'Barbie Vagina' and its most common attribute: a procedure of cosmetic labiaplasty. Already a popular cosmetic surgery in the West, labiaplasty's increasing trend currently has its place in metropolitan cities of South Africa too.

This dissertation serves as an exploration, scratching the surface, into the cosmetic alteration of the vulva in South Africa. I have selected highly regarded medical professionals in the areas of plastic surgery and clinical sexology to study their evolving standpoints and investments in this area of medical aesthetic surgery.

My research initially was simply centred on investigating the popularity of labiaplasty in South Africa and how this popularity may be connected to the manner in which bio-medical narratives frame this surgery and the "body beautiful"[2] (Gilman, 1999). Literature on the body beautiful in the disciplines of history, philosophy, psychology and feminist theory are vast, however, little anthropological attention has been given specifically to the practices of surgeons performing cosmetic labiaplasty surgery. The answer to how popular labiaplasty is in South Africa could not be answered directly and simply with quantitative data and corresponding interpretations of such data as there was no reliable data available. The fact that there is little data to answer this part of the question was not futile as asking questions about data revealed a web of complex issues within private practices of cosmetic surgery, such as ideas of beauty and symmetry, regulation of labiaplasty, and discussions of body politics. The ethnography and analysis contained in this dissertation has leaned more towards answering the second part of the question: how the popularity of labiaplasty may be connected to how medical narratives have come to frame labiaplasty, the vulva and the "body beautiful". Although a lot of my analysis will come from historical and sociological works, the questions I pose throughout this research are of anthropological concern.

"The doctor will see you now…"

Before starting fieldwork in 2019, I had decided to interview medical professionals who performed labiaplasty in South Africa. I turned to Nader's 1972 advised methodology of 'Studying Up' (Nader, 1999) as a useful methodological approach for this project. Nader (1999) outlines this method as studying the 'colonizers rather than the colonized', and encourages anthropologists to study the powerful members of society. Gusterson (1997) revisits Nader's (1999) work twenty-five years later on studying up and confirms it to be a valuable method for anthropology that provides a portal to study the elite. Nader (1999) and Gusterson (1997) agree that ethnography does not travel well up social strata, and therefore

[2] To borrow this term from Gilman (1999) the "body beautiful" is a culturally informed aesthetic ideal achieved through a process of turning to medicine to make "us over".

encourage all the more reason for anthropologists to attempt to collect data from these spaces. However, there is a drawback to studying up that both Nader (1999) and Gusterson (1997) recognise, which is that true participant observation to which anthropology clings tightly is not always possible. Gusterson puts this dilemma in the following words: 'it may be that anthropologists who study up will have to abandon, or at least subordinate, the research technique that has defined anthropology as a discipline and served as our own parochial rite of passage into maturity since Malinowski' (Gusterson, 1997, p. 116).

I found myself in this position; instead of true participant observation, I had to rely on other methods, which concentrated on formal interviews with all my participants. I conducted a series of three interviews with each participant over the space of seven months of fieldwork. It was only on one occasion where I attended a book launch, as you will see in Chapter 4, that I was a participant observer. I was wary of obvious and complex ethical issues and needed to carefully consider an appropriate methodology of ethnography that would be able to explore the deep complexity of labiaplasty, and at the same time would be a guide to approaching medical professionals of higher social strata with the appropriate sensitivity. Hence, studying up, even without participant observation, was an appropriate technique. I was inspired by this method as it would allow me to extract valuable data that may not have been accessible via other pathways. Recently, and quite effectively, this method has also been used by medical anthropology scholars such as Renée van der Wiel in conducting fieldwork among doctors at the Wits School of Clinical Medicine, conducting an ethnography with medical doctors who produce clinical research from their patient practice. Van de Weil (2019) takes a look at the relationship between clinical practice and knowledge production among doctors at a resource-scarce public academic hospital, while the demanding institutions of the university and the state compete over their skills and research outputs (van der Weil, 2019).

With a solid methodology to work from, I continued in my fieldwork to interview three groups of participants, divided into three distinct fields of medicine, of which my ethnographic experiences with each group are represented by the chapters that follow: plastic surgeons, aesthetic gynaecologists and clinical sexologists. By interviewing these participants, I intended to answer the following questions: How has the practice of labiaplasty and labiaplasty itself come to be framed by medical professionals in South Africa, and how has this influenced the popularity of labiaplasty? How is labiaplasty advertised and marketed, and

what narratives do these advertisements reflect? To what extent is labiaplasty prevalent in South Africa today, and how has this changed over the last decade? Are there public sector surgical records for this or is this information confined to the private sector? Do opposing perspectives about labiaplasty exist from different medical practitioners?

The interviews I conducted were, except in the case of Dr Gillies, audio recorded. I also took notes during these interviews, and combined transcriptions of the interviews and my notes for reflection a few days after interviews took place. Finally, it must be said that the medical professionals I interviewed were willing to tackle these complex questions head on with me.

Doctor Patient confidentiality

I was aware of the ethical complexity of the topic and protection of the participants involved throughout my fieldwork. And so, to ensure that ethical principles were upheld throughout my fieldwork and in the writing of this dissertation, I adhered to the American Anthropological Association's Code of Ethics (American Anthropological Association, 2012) and Anthropology Southern Africa's Ethical Guidelines and Principles of Conduct for Anthropologists (Anthropology Southern Africa , 2014). The following ethical principles were upheld:

- Anonymity: The names of places and participants have been changed, and participants have been given pseudonyms.
- Voluntariness: A participant's involvement in the research was completely voluntary, and they had the freedom to withdraw at any stage, after which the information they had provided would not be used.
- Confidentiality: All sensitive information that is not relevant to the research report has been omitted and kept confidential.
- Consent: In the case of interviews, participants signed an informed consent form.
- Permission: The permission to audiotape an interview was granted by all participants except one.
- Privacy: Copies of recorded interviews have been kept in a password-protected folder, and original copies of the recordings have been deleted off the recording device used.

- Transparency: Findings of my final research report will be available to all participants should they wish to have access to the findings.

To showcase the fieldwork and contributing arguments, this dissertation is broken down into four chapters, the first dealing with a brief history and the three proceeding chapters introducing and discussing interviews with plastic surgeons, aesthetic gynaecologists and clinical sexologists. *Chapter 1: Literature Review and Historical Context* takes a historical journey through time, starting in the Renaissance period to the present day, in an attempt to paint a picture of how, possibly, narratives of female genitals, health and beauty were shaped and communicated over time, and how they have contributed to the way in which female genitals were not only represented by medicine, but also interpreted by wider society. It is also in this chapter that I have shown how anthropologists have looked at examples of cosmetic surgery and raised important questions worthy of anthropological attention when it comes to cosmetic surgery.

In *Chapter 2: Any umbrellas to mend?,* I introduce my first group of participants: Dr Gillies and Dr Joseph, both reconstructive and plastic surgeons based in Johannesburg. Both surgeons were helpful in clarifying important technicalities about labiaplasty surgery and had established themselves and the discipline of plastic surgery as the authoritative voice of labiaplasty in South Africa. Dr Gillies, the head of a prominent plastic surgery association, shared valuable insights about the recording of procedure data, "beauty" and symmetry, patient management, rules of advertising cosmetic procedures, and a deep concern about doctors outside the field of plastic surgery performing cosmetic labiaplasty. Alternatively, Dr Joseph had explained to me how his treatment of patients was a guided experience and that his patients know what they want by the time they get to him. I consider the data from these two surgeons within discussions of 'passing' presented by historian Sander Gilman in the 1990s on Jewish noses, work done by Alexander Edmonds covering plastic surgery in Brazil, and critical sociology looking at the lucrative business of Botox.

In *Chapter 3: 'The long and the short of it',* I present interviews from aesthetic gynaecologists Dr Masters and Dr Johnston, and carefully consider the experience of these two qualified gynaecologists who have both recently branched out into "aesthetics". "Aesthetic gynaecology" is a new and currently developing field in South Africa competing for legitimacy

to perform cosmetic genital procedures such as labiaplasty. In this chapter, similar to in Chapter 2, ideas of beauty are important but complicated, enveloped in themes of agency and female empowerment. Furthermore, a deeper discussion about psychology and plastic surgery is presented in Chapter 3, as both Dr Masters and Dr Johnson send their patients for psychological counselling before surgery. Dr Masters also reveals a very interesting set of patients, who in traditional practices have participated in labia elongation and, after moving to metropolitan areas then request labiaplasty. It is here for Dr Masters where psychological counselling is most important, as these women face extreme cultural conflict. I continue my conversation with Gilman and Edmonds' work in this chapter to tease out complexities of a very unique South African context, where, firstly, cosmetic procedures of labiaplasty are not regulated (nor is who can perform them) and are not reported, and secondly, there is a co-occurrence of labia elongation and labiaplasty.

In *Chapter 4: Why mend any umbrellas if it is not raining?,* I turn away from practising surgeons to present my encounters with Dr Milburn and Dr Wiley, both clinical sexologists, and Dr Effiong, a medical doctor and sexual health advocate. This group of doctors has dealt with patients who have suffered from sexual health issues, and are strongly against the cosmetic alteration and mutilation of the vulva. For this group of medical professionals, the vulva is naturally a diverse organ and it is important to them that women are educated about their anatomy. Counter to Dr Masters' view of labiaplasty being something empowering, Dr Effiong questions how a procedure that minimises the area of sexual pleasure on the genitals could be empowering. In this chapter, I start to consider the representation and knowledge of the female body in medicine – what is known, and what is not known. Furthermore, I investigate how dangerous a lack of regulation of FGCS procedures and sexual health education can become. Thus, for these discussions, I return to Virginia Braun's work on a deeper level.

By interviewing a diverse group of medical professionals, I was able to ascertain that labiaplasty was becoming increasingly popular in South Africa, but there was no concrete data to show for it as cosmetic labiaplasty is confined to the private sector with no obligation of record keeping. Dr Gillies, Dr Joseph, Dr Masters and Dr Johnson had openly spoken about the difficulties they faced in terms of strict laws that regulated their cosmetic surgery advertising, and the loopholes to circumvent these rules. It was also interesting that the

clinical sexologists I interviewed did not support cosmetic labiaplasty and grew increasingly critical of the influences of global media, consumption practices, localised interpretations of the ideas of beauty, race and medicine that have contributed to the demand for cosmetic surgery.

Chapter 1: Literature review and historical context

> Standing behind the podium on the stage of Mooredale High's school hall during assembly, Jean begins to speak slowly and awkwardly, addressing the high schoolers. "Hello, my name is Dr Milburn, and I am here to start an open conversation about S.E.X…and so I'd like you to tell me what you would like on your sex education curriculum. Take control." The microphone echoes and is followed by an awkward silence…"Perhaps you would like to know about the female orgasm…or mutual masturbation… or maybe you've always wondered, 'is my labia a normal length?"
>
> *Dr Jean Milburn, Sex Education, Season 2: Episode 2.*

The vulva over time

When considering history in the Renaissance period, the female genitalia was perceived as something not distinctly female, but rather as the inversion of the male genitalia. The ovaries and vaginal canal were considered nothing more than the scrotum and the penis inverted. This was known as the one-sex model, one which persisted to early enlightenment (Laqueur, 1990). Female genitals came to be defined in this way due to the dominant thought that the male form is the measure of all things and that 'woman' does not exist as an ontologically distinct category. Thus, during this period, to be female was to be an inverted version of the male form. However, Thomas Laqueur (1990) argued that this ideology was dependent on the 'cultural politics of representation and illusions, not on evidence about organs'. Furthermore, he stated that 'the history of the representation of the anatomical difference between man and woman is thus extraordinarily independent on the cultural structures of these organs or of what was known about them. Ideology, not accuracy of observation, determined how they were seen, and which differences would matter' (Laqueur, 1990, p. 88).

In the seventeenth and eighteenth centuries, science and biomedicine gained ground, and new ways of studying biological sex agreed that male and female were now categories that were in opposition and uncommon to each other. With this line of thought, the female form was no longer a lesser version of the male form, but rather an 'altogether different creature' (Laqueur, 1990, p. 48). Sex organs became the foundation for measurable difference between male and female: 'structures that had been thought common to man and woman… were differentiated as to correspond to the cultural male and female' (Laqueur, 1990, pp. 149-150).

These ideologies of science and medical science did not only use sexual anatomy to distinguish between male and female, but in the nineteenth and twentieth centuries also between races (Laqueur, 1990; Nurka, 2019). Moreover, as Fiona Green (2005) shows, this

was used to reinforce Victorian moral standards and appropriate femininity as well. By documenting difference, biology could justify for a differential status of race and gender based on 'natural fact'. Hence, problematic claims about anatomical difference and race being used to explain the inferiority of some races and cultures were popular narratives of the time (Laqueur, 1990; Gilman, 1999).

The classification of women by their race, morals, roles, and identity based on sexual anatomy was an interesting point in history, as nineteenth century Victorian attitudes towards genital organs, especially those of women, had developed characteristics of something polluted and dangerous. Fiona Green (2005) writes about Victorian-era practices of medical clitoridectomy to curb young women's practices of masturbation, to which, at the time, was attributable to the cause of other social ills (such as unemployment) and was considered a deeply unfeminine behaviour. Green (2005) states that for women to fit into a mould of authentic femininity, they needed to demonstrate socially approved standards of femininity; alternatively, deviant expressions of sexuality were pathologised, diagnosed and then treated by medicine through clitorectomy.

A vast scholarship on the Victorian Science of women's genitalia has emerged since the 1960s. While the ramifications of European and Victorian ideas about female genitals were felt deeply in Western societies, they also shaped the way imperial powers viewed and described the genital practices of colonised communities (Matus, 1995). Early ethnographies of African female genitals, and the alteration thereof, were deployed as a way of constructing boundaries and divisions between civilisation and barbarism, and as a basis for racist anatomical arguments (Nurka & Jones, 2013). Descriptions given by early anthropologists that were accepted as scientific fact about the KhoiSan and Bushmen (Nurka & Jones, 2013) described the genitals as protruding, as labia elongation was a traditional practice amongst these groups. Gilman (1999) also contributed to this scholarship, mentioning how at this time the buttocks, taken as the second most important sexual characteristic (the first being the breasts), were reflective of the size and shape of the pelvis. In line with the colonial scholarship at the time, describing the buttocks became a way to describe and classify races, and the more prominent the buttocks, the more primitive the woman. As Gilman argues: 'This is a continuation of the cultural presupposition that "primitive" races have a "primitive" sexuality. Which is represented in their bodies by physical

signs of their “true” nature’ (Gilman, 1999, p. 212). Therefore, KhoiSan women were represented in this way by their prominent buttocks and labia.

Following this point, theory from Mary Douglas, in her book Purity and Danger, shows how ideas of hygiene and the association of primitive peoples with ‘an impure condition’ (Douglas, 1966, p. 1) as an interesting way to understand how primitive groups were seen to be separate them from other (white) people and institutions of the world. There is a connection between ideas of primitive and pollution that can be drawn out from the already stated history in this Chapter and taking a look at these ideas through how the African vulva came to framed as something dirty, long, dark, and primitive shows how ideas of pollution and cleanliness can be reflective of a set of social beliefs at a particular time (Douglas, 1966; Hodes, 2018).

Scholars have shown the mutually constitutive process that unfolded: European discourses about African bodies and related race narratives in the nineteenth century, which documented ‘the African Pubis’ and ‘primitive sexuality’, further informed ideas of whiteness, cleanliness and the idea of ‘the perfect vagina’ and its associated reserved sexuality (Nurka & Jones, 2013). The ideal Victorian and beautifully illustrated genitals of the Renaissance period differed greatly to the anatomy of the African genitals found in Africa and informed the displacements of racial abjection onto the genitals. The scientific study of the most famous genitals of the time belonged to Sara Baartman, which provided evidence for the racist classification of human beings, and at the same time informed the appropriate appearance of the colonialist vulva.

Nurka and Jones (2013) argued that the origin of support for and the ‘production of desire in contemporary CLS (cosmetic labiaplasty surgery)’ discourses can be traced back to ‘colonial anthropological Western representations of black female sexuality’ (Nurka & Jones, 2013, p. 417). Continuing this thought, Nurka and Jones (2013) stated that a narrative of ‘fear of abnormality’ and the ‘displacement of racial abjection onto the genitals’ (Nurka & Jones, 2013, p. 417) have caused labiaplasty to become increasingly popular. Hence, through such a procedure, the desire for ‘whiteness’ can be actualised in order to curb or subdue racist discourses that have shaped and informed the social meaning of the labia in the past. Aesthetic surgery relieves an individual of the concern of being placed into an unfavourable category and allows them to ‘imagine oneself as a stereotype’ (Gilman, 1999, p. 331).

Throughout their argument, Nurka and Jones (2013) observed the popularity of labiaplasty through a "Western lens" of understanding Africa. While they trace a 'logical' linear progression, there are factual errors that fault their argument in significant ways. Key to their argument is the idea that the construction of racial difference is a crucial historical element that has influenced modern-day labiaplasty (Nurka & Jones 2013). Fausto-Sterling (1995) agrees that colonial expansions of the eighteenth and nineteenth centuries definitely shaped European science and the scientific study of the most famous genitals of the time, belonging to Sara Baartman, which both provided evidence for racist classification of human beings and informed the appropriate appearance of the colonialist vulva (Fausto-Sterling, 1995; Matus, 1995). However, there is too much confusion and conflicting evidence surrounding early ethnographic accounts of African genitals, which would make such a rigid progression from labia elongation to labiaplasty highly problematic – and would contribute to the same 'scientific' errors of the eighteenth and nineteenth centuries (Fausto-Sterling, 1995). Fausto-Sterling (1995) uses her writing to critique 'narrowly constructed histograph[ies] of science' and aims for a more inclusive approach to expose the intersections of this argument with race and gender. Following in the footsteps of the feminist project to situate practices of female genital cosmetic surgery, Nurka's (2019) book is an extension of the aforementioned article published in 2013. By tracing historical instances that link the medical policing of the vulva to social and cultural conditions of normal and abnormal genitals, Nurka (2019) argued that the pursuit of the perfect vulva lies in a linear history that has come to define normal and abnormal genitals within gendered, raced and class reflections of power. Although, while the book received positive comment by Virginia Braun, and I myself found the book insightful at times, but lacking evidence for generalised claims and with no clear framework that allowed for coherence throughout the book.

Classical art and the "body beautiful"

To understand where the idea of the 'perfect' vulva comes from, an extensive look at the history of body alteration and what has constituted a beautiful body over time is required. As discussed earlier, historical perpetuations of the body beautiful communicated by medicine over the years have definitely had a role to play, but from where did medicine get its ideas of the body beautiful? Gilman (1999), in his frustration that an extensive history of cosmetic surgery did not exist, wrote one focused on the surgical alteration of the nose starting in the

1700s through the 1940s. He brilliantly traced a flow of ideas through time and how these ideas came to penetrate medical thought and practice. In the nineteenth century, famous Jewish plastic surgeon Jacques Joseph earnestly sought models to improve his art as a surgeon by turning to classical models of the body, akin to those used by a Viennese anatomist and anatomy lecturer at Berlin Academy of Arts, Ernst Brűcke. Brűcke published a handbook in 1891 on the anatomical beauty of the body, which displayed a normative body based on classical aesthetics. His inspiration was drawn from Michelangelo's sculptures of the female breast to mould his idea of the perfect breast, as well as classical Greek sculptures. Brűcke's creations drew on Kantian conceptions of 'classical perfection' (Gilman, 1999, p. 145), but he also brought in his own flair of reflection to show the values of his current society. High art had an impression on Brűcke's creations, and according to him, 'The aesthetics of high art were…rooted in an idea of art as imitation' (Gilman, 1999, p. 145). His creation of the ideal body was that of a Greek sculpture – a body that was symmetrical, healthy and good.

Based on Brűcke's search, Joseph then, too, based his idea of the ideal body on the belief that 'the beautiful is the symmetrical, the regular, and the proportioned' (Gilman, 1999, p. 145). Gilman excellently traced surgeons that followed on from the legacy and scholarship of Joseph, and how this ideal body came to be continually ingrained and reinforced in medical thought. It became clear that the philosophy which defined the beautiful body as symmetrical and healthy was embraced by post-enlightenment aesthetics. Gilman (1999) did contest this thought saying that as much as art does provide idealisations of what one could be, in this part of history, this body is made from mathematical and structural calculations, 'perhaps better suited to architecture than to aesthetic surgery' (Gilman, 1999, p. 151). Themes of beauty, health and symmetry increase in importance in the following chapters of this dissertation, as beauty becomes symmetry, and beauty becomes healthy.

"What the experts say"

The fields of obstetrics and gynaecology have much to contribute to the ongoing study of cosmetic labiaplasty. Although predominately technical knowledge, this contribution offers a glimpse into the concerns of medicine itself, as cosmetic genital procedures start to take stage in the respective field. Two major issues are apparent: firstly, a lack of representative data and a push for accurate surgical technique; and secondly, physical post-operative outcomes on the patient, both physically and emotionally. In 2013, the Royal College of Obstetrics and

Gynaecologists (RCOG) published an ethical opinion paper clarifying ethical issues and guidelines for the clinical practice of FGCS (RCOG Ethics Committee, 2013). The views in this paper communicated that education, support and advice should be at the forefront of clinical practice, as it considers the rampant bodily insecurities circulating in Western society. The paper makes it clear that the demand for FGCS must not be seen as an 'unproblematic lifestyle choice' (RCOG Ethics Committee, 2013, p. 1), as such a view would ignore the need for women to know and understand the medical necessity and unknown efficacy of FGCS techniques.

As ethical matters arose, concerns of cosmetic labiaplasty began to unfold in gynaecology journals from the early 2000s. This inspired gynaecologists to explore variations in genital appearance given the growing concern of unrepresentative descriptions of genital appearance in the field (Lloyd, et al., 2004; Crouch, et al., 2011). In the early stages of such discourse, there was the recognition of a gap in knowledge, and an admittance that accurate detailed representations and descriptions of female genitals were rare, and that modern medical science is not immune to fluctuations of historical and cultural influences.

This raised concern for Lloyd et al. (2004), because the idea of what a 'normal' vulva should perhaps look like is vital to both the surgeon and the patient to plan and assess the positive outcome of surgery. To bridge this gap, the search and documentation of what is normal then began.[3] Lloyd et al. (2004) set out to collect and compare the measurements of the labia of fifty women in London. The data astounded them as they found much greater variations in labia length, colour and shape than initially expected. Although being scientific measurements, this data has far-reaching implications. The lack of informative data about the variation of the female genitalia and no clear representation of this variance leaves the idea of a 'normal' vulva, which a surgeon has to construct, up to subjective interpretation.

[3] This literature review is narrow, as the focus is predominately on women. However, there is scholarship debating 'the normal penis' in South Africa too. Bordo (1999) writes that when it comes to genital appearance and insecurity, men and women are not far removed from each other. Bordo (1999) cites a study from 1996 where men in college were extremely likely to underestimate their penis size as being too small, no matter what their actual dimensions. It is ironic that men here see their penis size as too small, and women with their labia too long. In a local context, Mkize (2012) and Ndlovu and Kadenge (2013) explore the thriving business of penis enlargements in Johannesburg. They consider ideas of why a bigger penis is of great value to men, and by paying attention to a demand for penis enlargements, bring sharp attention to the male body for a change and the organ that defines manhood. Images in popular media and comparison with well-endowed men (who make up a very small percentage of the population, and whose attributes are exaggerated by pornography), as with the female vulva, emphasise the idea of what 'a normal penis' is, which becomes distorted and ignites deep genital insecurity.

According to Lloyd, et al. (2004, p. 645), 'it is therefore surprising that surgeons feel confident that surgery has the potential to achieve a "normal" female genital appearance'.

Soon after, a discussion on the evidence of efficacy entered the conversation. In 2008, Cartwright and Cardozo (2008) attempted to highlight the controversies of labiaplasty in the hopes that surgeons would be cautious when dealing with labiaplasty cases even more so considering the point made by Lloyd et al. (2004). Cartwright and Cordozo (2008) explain that currently no evidence existed to prove that there are any benefits to sexual function or improvements to psychological well-being. Furthermore, to Cartwright and Cardozo (2008), this was problematic, as in most cases patients presented debilitating psychological misery, believing their labia were significantly irregular in size or shape. Patients may have emphasised the sexual discomfort they experienced as a way of legitimising their reason to seek treatment. However, due to the private and concealed nature of the vulva, women were generally unaware of the natural variance in the appearance of the genitals and as it turns out, due to the lack of accurate representation of the vulva in medicine, so were doctors (Puppo, 2013; Puppo & Puppo, 2015; Wahlquist, 2020).

Eventually, in gynaecological circles it became more accepted that female genital variance is the norm (Haim, et al., 2016; Cain, et al., 2013); however, with an ever-growing number of women presenting complaints of physical discomfort caused by the labia, the gap in understanding why women request cosmetic labiaplasty and how to achieve positive results became an urgent matter. Gynaecological journals were flooded with reports and opinions on techniques and surgical outcomes of female genital cosmetic surgery. Goodman (2011), when leading an intensive study on cosmetic labiaplasty, had highlighted key techniques most often used, provided a useful guideline for surgeons, and emphasised the benefits to psychological health that patients reported. The majority of these medical publications highlighted that women predominantly sought labiaplasty for aesthetic and not functional concerns and that patients already had labia within a normal range. Furthermore, these publications pressed the urgency for reliable and representative data on FGCS procedures, and emphasised that the narrative of psychological relief is important for successful treatment outcomes (Ozer, et al., 2018).

However, as much as there is to learn about labiaplasty itself and how it is done from these works, medical literature only goes so far. This is where the discipline of psychology has

attempted to determine why labiaplasty has become so popular and why women seek out FGCS. Psychology has recognised that the psychological issues and the narrative of 'treatment' when it comes to aesthetic surgery cannot be ignored. Psychology has had a lot to contribute to this conversation, and as a discipline has provided rationales for the popularity of labiaplasty and has covered connections between beauty and the psyche, and the pathologising of such, for the longest time (Braun , 2005). It is also from this scholarship that many other recent works depart from – a front-runner being psychologist Virginia Braun, who critically discusses FGCS within a feminist social constructivist framework. I will return to Braun's (2005) work in Chapters 2 and 4 in discussing more deeply the ethical problems of FGCS given the insufficient current knowledge and the rhetoric of choice, sexual pleasure and agency in FGCS.

The worldwide medical expertise of surgeons and psychologists provides great insight into models that attempt to understand and document cosmetic labiaplasty. These also demonstrate and reinforce the link between psychology and beauty ideals. However, these models cannot be taken to have universal application, especially in terms of race or sexuality. Also, the link between beauty and psychology is far more complicated than initially thought. Upon reflection on this literature, I move forward into this chapter to the work done in the humanities by medical anthropologist Alexander Edmonds and historian Sander Gilman to truly tease out the complexities of plastic surgery and consider some possible frameworks for my investigation of labiaplasty in South Africa.

Cosmetic surgery in the Humanities

For decades, labia elongation or female circumcision[4] has been at the forefront of the anthropological study of female genital alteration. Not many anthropologists have dealt with

[4] Medical Anthropologist Nolwazi Mkhwanazi (2016) appeals to other anthropologists when writing about medicine not to cover a single narrative that pays no attention to other issues that are also important in debates of medicine and health, and to be especially mindful of these issues. It is in this vein that I do not intend to ignore a discussion on FGM in Africa (or the above ideas of male genital mutilation/genital aesthetics) and the surrounding controversy, and by not focusing on it in this paper do not intend to diminish the importance of such debates. There is an obvious double standard, documented by many scholars, that exists in the concurrent instances of FGM and FGCS – both framed in widely different and discriminating ways (Bader, 2019; Mason, 2001). In spite of global and local efforts to eradicate male and female genital mutilation, traditional practices have continued in many parts of the world. Justifications for the continuation of genital mutilation practices include cultural rites of passage, hygiene and religious reasons. In terms of male circumcision, practices have been tied up with discussions of health and disease prevention, such as HIV/AIDS, which for Hellsten is a 'slippery slope that ultimately leads to it being culturally required that FGM is practiced for the same purpose' (Hellsten, 2004, p. 251) and 'even a medical rationalisation may cover up other hidden purposes' (Hellsten, 2004, p. 251). FGM has been practised in Western history as a treatment for insanity and masturbation; however, due to male circumcision and female circumcision in the West being practised in clinical environments by qualified medical staff, these instances did not raise the controversy that 'brutal, primitive' examples (Hellsten, 2004, p. 252) found in Africa did. Hellsten (2004) continues by saying: 'This shows that science

the cosmetic alteration of genitals, and have instead considered either plastic surgery in general or a specific cosmetic procedure elsewhere on the body. Anthropologists such as Alexander Edmonds (2010), Brigette Bagnol (Pérez, et al., 2015) and Lynn Thomas (Weinbaum, et al., 2008) have appealed that the incredible variation in practices of body alteration must be understood as practices that have roots in a web of social forces. Furthermore, context is important to understanding these instances, and when considered as strange practices of mutilation or as simple practices of beautifying, the meanings and logic behind these practices are lost or misinterpreted.

Alexander Edmonds, in a paper titled 'The poor have the right to be beautiful' (2007), dives deep into fieldwork conducted in Brazil, and discussed conversations and observations with patients (either waiting to have or who have had plastic surgery, mostly working-class women) and plastic surgeons in public hospitals, teasing out the deep complexity of plastic surgery in Brazil. Edmonds (2007) argued that Brazil's complex socio-economic and political uncertainty is internalised by working-class women, and then reveald itself as the aesthetic insecurities of Brazilian women, which are then diagnosed and treated by beauty and medicine. This argument emphasises that plastic surgery is not purely a void, vain, aesthetic decision or a practice that only treats the aesthetic insecurity of the psyche. Rather, this perceived aesthetic fault in Brazil is socio-somatic – an effect from interlinking forces of mind, body and society. This diagnosis and treatment of aesthetic faults made treatable by plastic surgery was possible by the recognition of psychological issues as legitimate medical concerns in the twentieth century (Gilman, 1998; Gilman, 1999). As cosmetic surgery attempted to distinguish itself as a valid discipline of medicine in the nineteenth and twentieth centuries, it faced a difficulty in finding the definite band of illness it had set out to treat, and overcame this thanks to the dawn of popular psychology, more importantly psychoanalysis, and the acceptance that outward appearance was absolutely linked to the psyche and the health thereof (Gilman, 1999; Edmonds, 2007).

Cosmetic surgery in Brazil in the 2000s now had a therapeutic motive, and was justified in treating women with aesthetic concerns, as these aesthetic insecurities affected their state

can be a double-edged sword that readily lends itself as an alibi for strongly held preferences and cultural biases' (Hellsten, 2004, p. 252). Agency and personal choice are the basic distinguishing factor in the distinction between FGM and FGCS (Essén & Johnsdotter, 2004).

of mental health. Aesthetic pressures applied on women to look beautiful were most obvious to Edmonds (2007) in the service work industry, in which many lower-class women worked. Emphasis in these scenarios was placed on appearance and 'whiteness', which created a breeding ground for insecurities about race and appearance for working-class women. Edmonds (2007) commented that this case – in conjunction with capitalist consumption being a central symbol of economic participation (and public socio-eco recognition) for women, even when they cannot afford it – created a space where cosmetic surgery in public hospitals (where these procedures are often free) could ensure both a change in appearance and a *seemingly* active *participation* in a first-world consumer culture.

The collision of global media, consumption, localised ideas of beauty and race, and medicine in Brazil has incited the demand for the services of cosmetic surgery. Cosmetic surgeons heeding the call for improved appearance in treating patients stated in Edmonds' (2007) work that they are solely attending to the requests of their patients. By taking this a step further, Edmonds (2007) argued that the desires of patients are 'mobilized… not only by the beauty myth… but also by the mystique of modern medicine, new expansive notions of health, and broad changes in sexual and social relationships' (Edmonds, 2007, p. 374).

Gilman (1999) provides a framework for what Edmonds is describing, and through his history of the cosmetic alteration of the nose, he traces a logic that frames the work of cosmetic surgery and the cosmetic surgeon as a tactic used to achieve what he terms '*passing*'. According to this logic, people who suffer from a deformity (perceived or otherwise) can attempt, by means of cosmetic surgery, to transcend themselves from one category or identity to another which they desire to belong. As we see in Edmonds' (2007) fieldwork, young working-class Brazilian women desire to 'pass' as a woman that is 'whiter' and involved in active capitalist consumerism. Gilman (1999) uses the case of the reconstruction of the syphilitic nose to illustrate this argument of how a syphilitic may go about hiding the social ills of their parents through advances in cosmetic surgery and pass as normal. The idea of passing is important to Gilman's (1999) history, but in order to know what one needs to be to 'pass', one needs to know what they need to 'pass' as. Therefore, Gilman (1999) considers medical pioneers and a history of the discipline of cosmetic surgery to see how over time the body beautiful has been constructed and what procedures have existed in order to allow people to 'pass'. To Edmonds (2007), cosmetic surgery is not a solitary 'isolated' service, but an

extension of a developing field called ‘aesthetic medicine’ – ‘that offers an array of medical therapeutic and cosmetic tools for the pursuit of on expansive notion of health’ (Edmonds, 2007, p. 375). I deal with this issue of aesthetic medicine in Chapter 3 when considering the rise and popularity of aesthetic gynaecology attempting to establish legitimacy.

This work led Edmonds (2008) to consider deeper arguments about beauty and health, and the way these discussions had been looked at by anthropology, feminism and psychology. Edmonds (2008), in a seminal paper, asked how beauty can be understood by medical anthropology. Moreover, he suggested that anthropologists need an original and novel framework to understand beauty and health that departs from the constructivist views of psychology, and imagines beauty and health as a distinct sphere of social experience. Edmonds (2008) starts off by stating that it is assumed that anthropology will do its duty to describe natural and cultural variation in human beauty practices. It is well known that the anthropological record of body modification for the purpose of aesthetics is vast; however, in this work of anthropology, to document such diversity, anthropologists have neglected to consider the impulse and rationales humans seem to have to improve the human form. (I do assume here that he is speaking of the more culturally inclined discipline of American anthropology versus British social anthropology.) Furthermore, Edmonds (2008) described how anthropologists have tried to understand beauty and health in intertwining ways of thought, from anthropology and feminism, and psychology. By talking through these areas of scholarship, Edmonds does not construct a framework for anthropologists to work with, but rather shows why aesthetic health importantly needs to be considered by anthropology.

As stated above, Edmonds was critical of anthropology, because in his view anthropologists have theorised little about considering beauty as a distinct sphere of social experience, and so his first consideration of scholarship looked to theoretical feminism. This perspective, as we know from Wolf’s (1991) work, theorises a connection between the dominating powers of patriarchy and beauty. Using this scholarship to understand health and beauty shows that beauty and medical beauty practices may pretend to offer women choice, and perhaps treat their psychological (ill)health, but concurrently reinforced ideals of gender and race onto the body. Although logical, Edmonds (2008) pointed out, among others, a problem of reductionism within this scholarship. He argued that yes, it may be the case that beauty and its associated practices are instituted to reproduce inequality, but ‘this leaves unanswered

the question of why in the domain of beauty, and why during particular historical periods?' (Edmonds, 2008, p. 152) and additionally the question of how can we understand the specificity of beauty ideals in different groups and historical times?

In so far as feminist theory is a useful way to begin to understand any social phenomena involving women and beauty or aesthetics, I found that the critiques that came up against feminist theory, as a framework through which to view my data, distracted from the complexity of my data. I am aware of work concerning plastic surgery and feminist theory by prominent scholars such as Kathy Davis (1995), Cressida Heyes and Meredith Jones (2009); however, I did not want my data or this dissertation to reflect a feminist theory critique, but rather wished to show, as Edmonds demanded (2013), the urgent need for frameworks that can be useful to anthropology to study issues of health in conjunction with socially constructed phenomena such as beauty.

As an alternative, Edmonds (2008) then considers evolutionary psychology and the human biology of beauty, which intends to demonstrate that like in any other species, evolutionary sexual selection has taken place over time to shape the human form and continue with a line of inherited favoured aesthetic traits. Even though variation exists, there is a general agreement of sexual ideals according to various geographies and cultures. However, and understandably so, social scientists and anthropologists have (of late) protested this view (Bordo, 1999). Evidence has contradicted these claims and the fact that they are over-exaggerated. Reflecting on these two scholarships, Edmonds (2008) concludes that aesthetic ideals may be constructed in some way, but these scholarships do not provide a useful way of understanding the complex social effects of aesthetics. Considering aesthetics as an isolated category and product of domination does not allow space to dig into historical change and offers no explanation as to why when societies are exposed to forces of global capitalism (Weinbaum, et al., 2008; Edmonds, 2007), female beauty seems to become more important.

After considering popular explanations for aesthetic health in conjunction with these scholarships, Edmonds (2008) explains that the developing field and ideas of aesthetic health should not be reduced to a cause of marketing by plastic surgeons, or as a reflection of a narcissistic consumer culture, but rather aesthetic health is based in global and significant shifting narratives of health and looks of the modern human. This idea asks big questions, paying attention to not only aesthetic practices of biomedicine, but the fluid value of beauty

and health – questions that anthropology can perhaps appropriately address. Edmonds (2008) states that aesthetic medicine deserves the approach taken by anthropologists in their inquiry, and would be incredibly useful to understand not only how aesthetic medicine depends on innovation in medicine and marketing, but also larger meanings of health, beauty and modernity.

However, in order to start anthropologically considering these issues, it is important to clarify how medicine is aesthetic, and that aesthetic medicine is not illegitimate, but in this scenario, ideas of health and beauty are complex in a way that medicine or anthropology are only beginning to explore. Edmonds (2013) looks at the entanglement of health and aesthetics, again through fieldwork in Brazil. Aesthetic medicine, as the name suggests, is the blend of health and medicine, but slyly implies an idea that healthy is beautiful and ugliness is a disease, and raises contentious issues about the authentic use of medical interventions. Edmonds (2013) is very critical of the fields of cosmetic surgery and aesthetic medicine, and I will address his arguments more closely in Chapters 2 and 3, also in conversation with Gilman (1999), when considering the legitimate claim of these fields to perform labiaplasty and ideas of health and illness as beauty or ugliness. In short, for the purposes of this review, Edmonds' (2013) criticism lies in the fact that practices of plastic surgery reinforce the field as a legitimate medical treatment for psychological social-culturally informed insecurities.

Historical considerations and contexts are incredibly important to building a narrative to the complexity of how the vulva is understood and represented today, and why some women seek out FGCS procedures such as labiaplasty. As this chapter has demonstrated, it has not only been medical or scientific inquiry that has created an accurate representation of the vulva, but rather ideologies, and the changing thereof, over time. Perhaps in late seventeenth- and eighteenth-century medical developments, representations of anatomical drawings became more accurate, but such artefacts were still influenced by ideologies that made distinctions between races. Ideals of a *white, clean and sexually reserved* vulva have been constructed over time. Although these ideas may not have been universally impactful, a misrepresentation of genital diversity is still a prominent problem in popular culture and medicine today.

Chapter 2: Any umbrellas to mend?

Toodle-luma-luma
Toodle-luma-luma
Toodle-aye-ay
Any um-ber-rellas, any um-ber-rellas to mend today?

Bring your parasol
It may be small
It may be big
He repairs them all
With what you call a thingamajig

Pitter patter patter, pitter patter patter
Here comes the rain
Let it pitter patter, let it pitter patter
Don't mind the rain

He'll mend your umbrella
Then go on his way singing
Toodle-luma-luma-toodle-ay
Toodle-luma-luma-toodle-ay
Any um-ber-rellas to mend today?

When there's a lull
And things are dull
I sharpen knives
For all the wives
In the neighbourhood
And I'm very good

I'll darn a sock
I'll mend a clock
An apple cart
A broken heart
I mend anything
But he'd rather sing

Toodle-luma-luma
Toodle-luma-luma
Toodle-aye-ay
Any um-ber-rellas, any um-ber-rellas to mend today?

He'll patch up your troubles
Then go on his way singing
Toodle-luma-luma-toodle-ay
Toodle-luma-luma-toodle-ay
Any um-ber-rellas to mend today?

The Umbrella Man, Flanagan and Allen

Growing up, I did not know what my labia was, and even though uneducated about my own anatomy, upon reflection, I did not have labia worth noticing. I was fortunate growing up, and even more fortunate now (in light of what I have learned through this project), to have small

labia – that do not hang out of a swimming costume, cause discomfort, succumb to teasing, or cause embarrassment. Despite my experiences, I am drawn to and empathetic to many women who have come to feel some significant shame and embarrassment in public and private settings about a part of their body that society, and the Foucauldian powers that be, have dictated is incredibly private – *their 'long' labia*.

Portrayals of the human body have changed significantly throughout our history (Laqueur, 1990), and it is interesting to count the alteration of the labia as a part of the fluidity of the human body's appearance over time. I hope to explore how medicine has come to frame procedures of labiaplasty, and if this narrative has in any way come to influence its growing popularity. I start the ethnographic sections of this dissertation with fieldwork conducted with two prominent plastic surgeons who practice in northern Johannesburg and the East Rand respectively. Although my fieldwork did not begin with these surgeons, I begin here as plastic surgery presents itself as the forefront authority on labiaplasty, and the surgeons' expertise laid down a foundation through which I could interpret, complicate and question everything else I had learned and documented in Chapters 3 and 4.

I made contact with Dr Gillies via the suggestion of Dr Milburn,[5] who always bluntly told me when I had prompted her for technical knowledge: 'Ag, I don't know… Talk to Harold.' They had a distant but professional relationship, as she sometimes referred patients to him for reconstructive work.[6] I reached out via email, and Dr Gillies[7] replied to me directly and prompted his receptionist to get into contact with me to make an appointment. It became clear from early on that he was a very busy man, with a schedule that had little room for negotiation. Our consultations were limited to fifteen or thirty minutes each session. These sessions where formal interviews accompanied by furious note-taking. I am not sure if it was on purpose, but whenever I booked an appointment, I was his first consultation of the day,

[5] Dr Milburn was fundamental in connecting me with most of my participants. Through her recommendation, I had gotten into contact with Dr Gillies as she had referred patients of hers to him in the past. I had initially thought finding willing participants would be incredibly difficult, but Dr Gillies and Dr Milburn's hunger for research like this opened quite a few doors. I only had one or two surgeons who did not agree to speak with me.

[6] Dr Milburn runs a sexual health clinic in Johannesburg, and often deals with patients who have suffered female genital mutilation.

[7] I needed to know the technicalities, the jargon and medical expertise, and data to tease through a lot of what I was gathering. Dr Gillies was instrumental in navigating me through these issues. I am forever grateful to his and Dr Milburn's dedication to and enthusiasm for this project.

except for one occasion, in which we had run over time by half an hour, and I walked out of the consultation room through a waiting room of many eyes trolling over me as I left.

In this chapter accompanying the ethnographic data, I hope to construct a picture of plastic surgery in South Africa and its place (implicit or direct) in the creation of the body beautiful through labiaplasty, by looking at plastic surgery, considering theory about Botox, and work from Gilman and Edmonds. Furthermore, I hope to see if this in any way influences the popularity of labiaplasty. As seen in the predominantly American, British and European literature, there is a lot of information about why women seek labiaplasty and how patients may feel about having labiaplasty. However, I would like to know more about surgeons who perform labiaplasty. How do they feel about it? What is their experience? By focusing on these two plastic surgeons in affluent metropolitan areas in South Africa, I aim to consider the close context in answering the questions above, and in the spirit of Edmonds' work, will try to understand labiaplasty as a practice grounded in a local context of meaning (Edmonds, 2009). These plastic surgeons have been given the pseudonyms of two famous and influential plastic surgeons of their day, Dr Harold Delf Gillies and Dr Jacques Joseph.

After confirming my first meeting with Dr Gillies' receptionist, I arrived at nine a.m. at the private hospital at which he consulted and operated. I was fifteen minutes early for the appointment and felt nervous. I spent the first five minutes walking around the hospital finding his rooms, making sure I would not find myself lost when the time of our meeting came. I found it on the second floor, with a brilliant bulging bronze plaque next to his door engraved with italic lettering showing his membership to and position in a plastic surgery association. Dr Gillies held a high position in the association, and the weight of who I was about to speak to started to sink in. It dawned on me that I had no idea what he looked like, aggravating my nervousness. Would a surgeon of his expertise have time for an anthropology student? I decided that not looking obviously out of place, standing awkwardly in the middle of the passage, was a good tactic, and headed to the hospital café. When seated, I began to Google Dr Gillies, hoping to find a picture of him. I found one on his website and felt foolish for not finding it before. The picture presented a tall broad-shouldered man, standing in front

of a painting of a voluptuous woman,[8] with a broad smile on his face, wearing a smart suit with a blue and white striped tie. This photo eased my nerves and made me feel more relieved. I made my way to his consultation room. I rang the bell next to the bronze plaque, and a friendly receptionist greeted me and asked me to sit down while she called Dr Gillies. I had a few minutes to take in the room around me. It was just like any other doctors waiting room: yellowish walls, hard chairs and a few family photos, but instead of the *YOU* magazine or *Country Life* to pick up and read while waiting, there were piles of the *Aesthetic Medicine Magazine*. I sat on a chair next to a pile of about eight copies, picked up one from the top of the pile and started flicking through it, and then the next one, and the next. In my moments of waiting in my other visits, it became a fascinating five minutes I always came to look forward to while waiting on Gillies, snooping though the waiting room magazines, hoping to find an article on labiaplasty.

Halfway through my third magazine, Dr Gillies appeared in the waiting room and called out to me: 'Hayls…Please, come through' (I thought this odd – no one whom I have never met before called me 'Hayls'). He motioned me to a plush-looking leather chair opposite another larger elegant leather swing chair, and hanging on the wall in all its glory: a picture of *La Bella Rafeala*. One thing I was not prepared for was the sheer amount of silicone implants scattered around his consultation room – Dr Gillies' speciality was breast augmentation. He had a loud deep voice that thundered around the room. I readied my notebook, and before I could utter anything or introduce myself, he sat back in his chair crossed one leg over the other, twirling a pen in one hand, and asked intriguingly: 'So tell me, what exactly is anthropology?'.

This was an unexpected but interesting place to start, and as I explained anthropology and why I was studying labiaplasty, his face progressively curdled with concentration. He found what I described interesting; however, he was curious to know why I was not studying different groups of doctors and the hierarchy that organises them instead. For Dr Gillies, there is a definite hierarchy that existed amongst different doctors and specialisations of medicine, and this was fascinating to him and worth knowing more about. He motioned with his hand in the air saying that 'cardiovascular surgeons are like up here and we [plastic surgeons] are

[8] I later came to learn that this painting was [a reproduction of] *La Bella Rafaela* by Tamara Lempicka (1927). Lempika (1898 – 1980) was a polish painter who was well known for her art deco pieces of American aristocrats, often depicting desire and seduction through the posing of nudes (VaginaMuseum, 2020).

a little more funny.' He revealed in a later interview that 'plastic surgery chooses you, not the other way around. It's a very closed group. You are exposed to a lot, and most of it at first is all reconstructive, so you have to have a specific mind-set for being a plastic surgeon'. Dr Gillies was charismatic, confident, engaging, eager to discuss the alteration of the vulva without any reservation, and clearly an expert in his field.

At the conclusion of each of our interviews, which had my head in a whirlwind, I sat in my car, which was often my place of ethnographic reflection, and found myself sitting there taking voice notes and jotting things down furiously for at least an hour after each meeting with Gillies. Firstly, he had requested our interviews not be audio-recorded, so I needed to write down all I could remember before I forgot it, and secondly, because there was so much dense information that I had to wrap my head around, writing notes and reflecting was a helpful way to think through these interviews.

It is common knowledge that within medicine, plastic surgeons are not held in particularly high esteem. Although initially seeming to be trivial, this sentiment is also reflected in historical accounts of the development of early aesthetic medicine. Aesthetic or cosmetic surgery started to emerge periodically over the course of the nineteenth century and was characterised as an alternative form of therapy to its first label of reconstruction. After the treatment of the physical trauma of soldiers after the First World War, there was a push for plastic surgery to expand its reach and use its techniques of reconstruction for the purposes of aesthetics (Gilman, 1999). Although with good intentions, what soon became known as beauty surgery, developing into the twentieth century, had a tainted reputation, and the real Harold Gillies commented that 'beauty' surgeons were frequently criticised as 'quacks' by the medical profession (Gilman, 1999, pp. 13,14). Edmonds (2007) and Gilman (1998, 1999) demonstrate that there is a bigger picture here. It was this underappreciated value that motivated plastic surgery to establish itself as something legitimate, worth recognition, a field of medicine worthy of belonging. What did medicine do? Medicine cured illness. Therefore, plastic surgery needed to find a disease that it could cure and cure well. The illness was found perhaps in the most unlikely of places: the illness was of the psyche.

Aesthetics, health and symmetry

I was curious to know how many labiaplasty surgeries Dr Gillies had performed. He did not directly answer my question, but instead answered by giving me the details of three sub-sets of patients he had encountered in his experiences:

1. *Late teens*: This subset of patients includes young girls, who have come through puberty and whose bodies have adjusted to a new form. These girls are also newly aware of their sexuality.
2. *Women post-partum/ in new relationships*: This subset of patients includes women who want to 'fix' their body after birth, even though the changes to their bodies are completely natural. These patients want to return to a pre-birth appearance.
3. *Lesbians*: The third subset was the most interesting and most surprising. Dr Gillies stated that these patients are fixated with the appearance of the female genitals and are hyper-observant of the *symmetry* of the genitals. Dr Gillies further described this sub-set of patients as visually critical and a demanding group of patients to work with. His explanations for this group of patients seeking labiaplasty include the access to free porn, and their sexual experience not involving penile penetration, but rather being more tied to the genitals in different ways.

According to Hammidi and Kaiser (1999), beauty is often defined in a singular narrative of heteronormativity and ideas of personal desire and agency, and a reflection of common social aesthetics are often missing. This problem is clearly revealed when considering the negotiation of lesbian women and expressions of beauty within systems of patriarchy, and socially sanctioned expressions of beauty that are currently limited to beauty as an image, beauty as a system and beauty as a narrative. Hammidi and Kaiser (1999) are concerned that current theories to understand beauty offer little insight into lesbians' ability to reclaim beauty for themselves. It is to this point that I would agree. I find it incredibly interesting that Dr Gillies describes his lesbian patients as hyper-critical of their vulva, and in particular the symmetry of their labia. However, in my search, little insight is offered in terms of aesthetic surgery and lesbian women. Terry (1995) and her discussion on Dickinson's 1941 Sex Variant study may provide some context as to why the lesbian vulva has been so stigmatised and may show some role in why lesbian labiaplasty is popular. Terry (1995) writes about how, in Dickinson's Sex Variant study, he believed that markings of sexuality variants could be found

on scrutinised areas of the body, which included the labia, vagina, clitoris, etcetera. His study sparked vigorous debate about 'lesbian anatomy', and he had established a list of characteristics of lesbian women that distinguished their anatomy from that of 'normal' women. These marked characteristics included a larger bulging vulva, long labia, a 'noticeably erectile clitoris' (Terry , 1995, p. 143), the list goes on. Basically, everything that the 'normal' appropriate heteronormative *was not*, the lesbian vulva *was*.

The vulva and sexuality of lesbian women was contrasted to that of heterosexual conservative women. Dickinson in his theory had provided 'evidence' for deviant sexualities, and dangerously perpetuated firstly that the character of a woman could be reflected by her genitals, and secondly, informed the appearance of the heteronormative and perfect vulva. At the time, lesbianism was not an accepted sexuality. In any case, surely the lesbian experience of the sexualised body must be different. And even considering the role that history and the anatomical framing of lesbianism has to play, perhaps the agency of lesbians in this instance could be an interesting challenge to feminist arguments – as in this scenario, scrutiny of the vulva is less influenced by 'the patriarchy'.

Hammidi and Kaiser (1999) offer alternative narratives of beauty, which lesbians engage in to achieve beauty. The dominant one being that of an assertion of agency and freedom as a key element of lesbian style, which allows lesbian women to reclaim beauty, after facing stereotypical associations of lesbians with bad fashion and being accused of not knowing how to engage in beauty and aesthetics. Lesbians can and do move between conceptualisations of beauty, perhaps the most extreme here being labiaplasty. However, in this case, it is difficult to make the case for beauty in any other way than symmetry. As we have learnt, what is symmetrical is beautiful. However, I never had a chance to interview how lesbian patients felt about labiaplasty, or why they pursued it; therefore, I do not want to overstate this argument.

Labuski (2013), in conducting ethnography in a clinic that specialises in vulva conditions, writes a fascinating and emotional paper about women who visit this clinic reporting with vulvar pain. More importantly, she recognises that stories she began to hear in the clinic show the 'stifled nature of vulvar discourse, which… indexes a heteronormatively contoured distaste for female external genitalia.' (Labuski, 2013, p. 252). Labuski (2013) does admit that most of the women who visit this clinic are heterosexual, but this does not mean we need not be critical of the exclusion of women who experience vulvar pain when penile penetration is

not a central aspect to sexual intercourse. Lesbians seeking labiaplasty complicates heteronormative ideas about sex, beauty and sexual sensation as the discourse shifts from sexual satisfaction and 'real sex' being concentrated on penetration to other areas of the vulva, and in this case, aesthetics may matter more.

A marriage of skill and expectation

In teasing out where female aesthetics may have come to manifest their influence, and as much as the female nude is a prominent feature of high art in the nineteenth century, little attention is paid to the details of the vulva area. So, in truth, the Western perspectives[9] are found to lack a definite visual culture on which to base female genitals (Nead, 1992). Perhaps then, the only true reference we might have for female bodies and the vulva lie in patriarchal descriptions of the vulva in early medicine based on ideas of small, pink and symmetrical. There is a lack of any other framework that depart from these narratives. When I asked Dr Gillies to expand on his feelings about this subset of patients, his answer was an emphasis on achieving symmetry through labiaplasty surgery. Berkowitz (2017) states in her work on Botox that the research is split as to how homosexual orientation and sexual identity influence women's perceptions of their female body. Some researchers report that lesbians are more satisfied with their bodies compared to heterosexual women, as they are sheltered from beauty standards communicated by heterosexual relationship norms, whereas others have found that body perceptions and insecurities are much the same along different identities of sexual orientation.

The fact that labiaplasty is an elective surgery and not regulated in any way allows for a relatively easy surgical journey. However, labiaplasty does not just happen. Dr Gillies enlightened me to the fact that there is a rigorous psychological process before cosmetic

[9] I use the word 'Western' here, and in other places of the thesis very specifically, as the visual culture about the vulva is not universal. Japan is a unique situation when it comes to sexuality and representations of the vulva. In Japan, what is known as the 'winged- butterfly' is a sexual delicacy. In this case, labia are desired to be small but pulled out to the side, like a butterfly's wings (Green, 2005) (Dobbeleir, et al., 2011). However, Japan is also described as a context where sexuality is shrouded by significant shame (Christiane Amanpour: Sex & Love Around the World: Tokyo, 2018) (McLelland, 2018). Artists such as Rokudenashiko have challenged taboos and misunderstandings of the vulva and sexual secrecy and shame in Japan through Japanese erotic art called manga (McLelland, 2018). Rokudenashiko admits that what has inspired her manko (vulva) drawings in manga comics was her personal angst that her genitals were not normal. Due to the taboos about speaking about or illustrating genitals in public in Japan, she found she had no point of reference of what normal was (McLelland, 2018). McLelland (2018) also describes how the extent of this taboo is evident by that fact that in mainstream pornography, genitals are pixilated. Rokudenashiko actually had labiaplasty before she started with art, and she documents this experience in her first published manga comic (McLelland, 2018) (Rokudenashiko, 2016).

labiaplasty. He advocated for this as a fundamental part of a wider process of patient management. Dr Gillies described how operating was the easy part, but to manage the correct surgery for the correct patient at the right time can be tricky, and when dealing with the genitals, it is even more tricky. Thus, for this reason, Gillies needed time to assess the patient's personality, which takes a few consultations before surgery to do so. Gillies expresses that:

> Some patients are very hard to please… so you have to be aware… It's all about risk management. I turn away about 30% of patients because of their psychology. Aesthetic gynaecologists and aesthetic doctors are popularising these procedures, which is dangerous, and every Tom, Dick and Harry is doing [labiaplasty] and they don't report it, or the complications. And only in plus-minus five years we will see reports of these.

And thus, as a consequence of this, Dr Gillies worried, there may have to be a revision of aesthetic surgery.

We got around to discussing what patients hope to achieve through labiaplasty, and Dr Gillies said that in most cases, it was difficult to assess – most patients just do not like the way their vulva looks. Women are teased, and it is very rare that there is actually a functional problem. He had also noticed a trend for labiaplasty among female cyclists[10] and 'horsey girls'. In terms of patient management, there was something Dr Gillies wanted me to realise; he wanted me to see what it is like from his perspective. I appreciated this break in the professional boundary he had set, almost as if he was being vulnerable and allowing me a glimpse through a crack in a wall to briefly see his world on the other side. To do this, he told me about the patient he had seen before me, who was getting breast augmentation. He brought up a picture of her breasts on his PC screen, saying 'these are perfectly good breasts' and I suppose I agreed. He then clicked his mouse and the picture changed to show me an altered version of the same picture, done by software he used to show what the post-operative results would be. The depicted breasts were only just slightly bigger, a change that was hardly noticeable. Dr Gillies admitted he would do the surgery because it was not a big change, and if it had been more of an extreme request, he would not have done it. He predicted she would have been very happy with the results. I suppose the same would go for a labiaplasty patient as well. If

[10] Famous Paralympic cyclist Hannah Dines went public about her vulva plastic and reconstructive surgery in 2019 due to the trauma cycling and bad seat design had caused to her vulva. Her surgery caused an 'outcry' and pushed Specialized – a sponsor of many female cyclists – to redesign its female cyclist seats to reduce the impact on the pubis (Dines, 2019).

the request was beyond a realistic post-operative result, Gillies would not do it either, as in terms of patient management or mitigating risk, it would not be worth it.

I was curious to know more about what symmetry meant, both in terms of beauty and in terms of plastic surgery, as I had also found out it was not just something Gillies' lesbian patients, nor Dr Joseph's patients, had requested, but was a surgical standard. In our third meeting, I tackled this with Dr Gillies. He stated that 'Symmetry is what we strive for… be it for the eyelids or the labia. Is it always perfect? No, but we get pretty close.' He explained that breast augmentation surgery demonstrates this concept best. There are extensive measurements that are taken before, during and after surgery, as there can be the most variance in this case, because breasts can have various heights and sizes. He further expressed that achieving perfect symmetry in surgery is not always possible: 'If you had to conduct a study with one hundred 18-year-old females for breast augmentation, ninety-six of those one hundred would have some form of asymmetry – nipple height, size, areola colour. But that's God's fault, and if he didn't get it right, [plastic surgeons] are not going to get it right'. However, he said that,

> 'patient expectation is perfect symmetry. Normality is important, restoring normality of the anatomy, and that's not always symmetrical'. Gillies told me about a patient of his who had a facelift done nine years ago, and stated: 'She's breaking my balls about it! She believes her earlobes are not the same, that one is definitely bigger than the other, exclaiming "everyone can see it, everyone notices". Thank God for pre-operative pictures, because before her surgery her earlobes were eight millimetres out, and after her surgery they had a difference of one millimetre'.

I began to see the importance and intense pressure of patient management that Dr Gillies faced. To the patient's eye, a small difference can be dramatically exaggerated, as Gillies explained: 'Patients want perfect symmetry. What you are dealing with is soft tissue; it's a unique canvas… So, I only deal with one part of the introitus, the labia. A patient can have a labia minora reduction, and later come back for a clitoral hood reduction, but where do we stop? It's progress, not perfection.'

To elaborate this, he examined the popular culture trend of altering pictures of celebrities whose facial features have been made perfectly symmetrical, and how in these cases perfect symmetry is not attractive, and makes the face look distorted. The goal of plastic surgery was then to make features less asymmetrical, but not perfectly symmetrical. Gillies stated that

DaVinci's golden triangle can be used as an inspiration of perhaps what beauty and symmetry represent, but 'these tenants change over time, and "rules" or theories of what makes something aesthetic change over time'. Thus, he explained as a plastic surgeon, it was beyond him to question the motives of his patients; rather, his goal was to create a marriage between patient expectations and what he can do.

To make sense of these themes of beauty, normality and symmetry, I turn again to Gilman (1999) who explains that how a society produces an understanding of the body and the psyche is essential to any history of aesthetic surgery. Health and beauty are two closely intertwined aspects in beginning to understand aesthetic surgery. In the nineteenth century, medicine had a role in not only correcting the appearance of illness, such as reconstructing faces of syphilitics, but also to treat the corresponding pathology. All through its history, plastic surgery has aimed to become part of mainstream medicine by 'promising patients uniquely effective therapies for becoming happy, healthy and whole' (Gilman, 1999, p. 294)

The development of anaesthesia and antisepsis were important milestones in the beginning of aesthetic surgery, but it was some part of the Enlightenment ideology that each individual could be an agent in their own making of the self and transform their bodies that propelled the success and culture of modern aesthetic surgery. Concurrently, ideas of the body as clean and hygienic were popular, and aesthetic characteristics (ugly versus attractive) were reflective of an inner character (healthy versus ill). In Western society, 'unhappiness' with the body became associated with mental ill health. In 1898, (the real) Dr Jacques Joseph reported before the Berlin Medical Society and defended a revolutionary 'scientific' reason for operating on a perfectly healthy individual. He is quoted saying: 'The psychological effect of the operation is of the utmost importance. The depressed attitude of the patient subsided completely... The patient no longer felt himself marked by the form of his nose' (Gilman, 1999, p. 133).

The creation or idealisation of the body beautiful in the nineteenth century to the modern day was influenced by the narrative of how society (or individuals in society) may turn to medicine to improve their looks and make themselves happy with new transformed bodies. Joseph's mission was to treat the psyche of his patients by making them invisible – a normal person not standing out in society because of an aesthetic deformity or issue of conceived 'ugliness'. At this stage in aesthetic surgery, however, scars were an inevitable and visible

marker of surgery. Joseph was concerned about this, as it diminished the authenticity of the efforts made to become invisible and normal, and marked the attempt of a patient to 'pass'. This was the standard of the treatment of the psyche through the body that was favoured by Joseph and other plastic surgeons in the nineteenth century. Interestingly, this attitude was popular during the rise of psychoanalysis at the same time. It is no wonder to Gilman (1999) then that plastic surgery and its corresponding narratives of treatment delve into the world of psychoanalysis to illustrate and describe its own treatments. Cosmetic surgery has always had a complicated relationship with psychology, especially because cosmetic procedures cannot be based on a medical need for treatment, and so must be justified in some other way (Heyes & Jones , 2009). This turns the attention to the patient, how they are feeling and their personal desires in their processes of creating the self. Even more recently though, as Edmonds (2007) fieldwork shows, questions about the validity of plastic surgery have been 'rescued partly by the discovery that [it] could perform psychological healing', especially in Brazil where plastic surgery forms part of the public health system.

The boundaries between the beautiful and the ugly, the healthy and the unhealthy, and the erotic and unerotic also reveal themselves clearly when we look at the history of plastic surgery. After the mid-nineteenth century, as plastic surgery continued to advance with minimised risk, infection and scarring, it moved towards the alteration of the invisible and sexualised body. Eroticism – rooted in the body, as well as being an essential part of the psyche – also became on important part of health and beauty. The erotic body is a healthy body (free of syphilis), and therefore, should be a beautiful body (so one can identify its health), and thus also reflecting a healthy psyche. What is important here is the idea of naturality, as we have seen how scarring reflects an attempt to become beautiful, but to make this attempt authentic, it must look natural – hence Joseph's earlier concern with scarring on his own patients.

For Gilman (1999), all of these themes come to centre around a framework that he explains through 'passing'. This transformative process allows for socially defective or stigmatised people to pass as normal and blend in with a group they desire to be part of. As we see in the literature of Brazilian women getting plastic surgery to 'pass' as 'whiter' and active capitalist consumers, in the same way, women who seek labiaplasty are perhaps trying to join a group of confident, beautiful women who have 'normal' labia – and symmetry of the labia is vital to

this transformation. According to Gilman, 'passing' is not about becoming invisible, but rather becoming 'differently visible' (Gilman, 1999, p. xxi). A person does not want to disappear, but rather wants to visibly join or be associated with another group or type. In the case of labiaplasty, women are hoping to move between categories of unnatural (long, asymmetrical labia, which are still truly natural) to a constructed aesthetic 'natural' of short, symmetrical labia. Through labiaplasty, and its hopes of improving confidence and sexual experience, there is a treatment of associated mental illnesses and insecurity.

I soon got into contact with Dr Gillies' colleague Dr Jacques Joseph. I arrived at his rooms for our appointment in November 2019, and was greeted by a friendly receptionist, Julie, who was very welcoming. His waiting rooms were significantly larger than Gillies' and were well decorated. Julie offered me something to drink, and asked if I had read Dr Joseph's recently published article about labiaplasty in the 2019 Spring edition of the *Aesthetic and Anti-Aging* magazine. I admitted to Julie that I had not come across it, so she went to the coffee table in the middle of the waiting room and I noticed the article had even been marked for me with a green sticky note. Julie motioned me to a chair and said I could take a few moments to read the article while I waited for Dr Joseph. I sat down and read the article as the couple of receptionists chatted lightly behind the counter. I was keen to read what recent publications said about labiaplasty, so I started reading. The article was fascinating:

> While there is a wide spectrum of normal appearance of female genitalia, there has been a move towards close trimmed or hairless appearance of the external genitalia in recent years. This is largely due to the internet and its access to images and content on laser hair removal… as well as its easy exposure to pornography. As a result, women tend to compare themselves to these images and create an ideal appearance of themselves. Although there is no standard ideal appearance, it is preferable that the labia minora (inner lips) are symmetrical and "tidy", the labia majora (outer lips) full without loose skin, a clitoral hood that does not project far beyond the clitoris, and a mons pubis that is full but does not show through clothing. Surgical alteration of the labia minora (minoraplasty) has become the most common surgical procedure of the female genitalia, and was first performed in the mid-1980s. The generally agreed on ideal is that the labia minora should be symmetrical, thin, light coloured and straight. The two commonly used techniques are wedge resection (cake slice), or edge resection (up-down or linear excision). The choice depends on careful examination and the position of the most redundant labia (front, middle or back), and whether there is much pigmentary contrast between the inner and outer surface of the labia minora. Wedge excision is usually advocated when there is a

> continuous pigmentary edge or when the labia is thicker. Edge excision involves excising a strip of labia minora to bring them to the level of the labia majora.
>
> The "Barbie look" has become recently popular, especially in Los Angeles. This involves complete or almost complete removal of the labia minora as an edge excision to give a child-like appearance... Labiaplasty can be carried out in the surgeon's room under local anaesthetic. Approximately one hour before surgery, numbing cream is applied to the area to minimise the discomfort of the injection of local anaesthetic. In some facilities, sedation can be provided in addition to local anaesthesia. Prior to injection of local anaesthetic, the patient is placed in a low lithotomy position and the surgical markings are drawn.
>
> The patient checks the surgeon's markings with a hand-held mirror and agrees with the proposed excision lines. After excision, the edges are closed with absorbable sutures and a light pad with antibiotic cream is applied to the area (which is held in place by the patient's underwear).
>
> Post-operative discomfort is minimal as the local anaesthetic lasts for four to six hours, while discomfort and mild pain can be managed with analgesics and rest for two to three days. At home, the area is cleaned with soap and water, with antibiotic cream being applied. Normal activity is possible after a few days, but exercise, gym and intercourse should be avoided for four to six weeks (Jospeh, 2019).

Dr Joseph was a shorter, more plump man, wearing black scrubs. He was gentle, soft-spoken and nowhere near as crass as Gillies. He was sensitive and genuine in his concern for his patients. He had previously studied to be an oncologist before coming to plastic surgery. When I asked him why he pursued plastic surgery, he replied: 'Because, you see results immediately'. At first, he seemed concerned with what I wanted from him. Dr Joseph was not as engaging or charismatic as Dr Gillies, but he had extensive experience. As I briefed him about some of the questions I had, he was very clear about an increase in labiaplasty in South Africa, but this did not seem to concern him too much. His patients were all white women, between the ages of twenty-five and fifty. Joseph attributed the popularity of labiaplasty to pornography and its easy accessibility and increased consumption.[11] He believed that other beauty trends such as laser hair removal around the genitals could also be an indirect cause

[11] According to Dr Joseph and most literature, the reason for increased demand in labiaplasty is due to increased porn consumption and exposure to media influences. I do recognise this as an important part of the narrative; however, I did not have the space to explore such issues in this dissertation. This argument implies causality, which would ignore the true complexity of interrelated issues that would require a deep history of how the body has been portrayed over time, and dips more into the faculties of visual culture.

in the popularity of labiaplasty,[12] as more of the vulva can be seen and is more prone to scrutiny and aesthetic assessment. He summarised this point by saying 'we notice things now that we have not been concerned about before'.

I mentioned to Dr Joseph that I had read his article while waiting for him, and that I was fascinated that the article mentioned symmetry. He admitted that with his patients, he finds that often women are happy with only one side of the labia and desire symmetry. He mentioned that what appears in the article is just a taste of the actual procedure. He stated to me that in his practice, his patients definitely know what they do not want, and his consultations with women seeking labiaplasty are guided by them and what they want.

Dr Joseph performs labiaplasty in the chair, and I was curious to know his patients' reactions to this. He explained to me that in general women are embarrassed to ask for labiaplasty and will keep their gaze downward, use euphemisms and only much later get to the point. However, he felt that after he had assessed and explained everything to a patient, they would feel more confident and relaxed. He also mentioned that women relax once they hear it is much cheaper this way (in the chair) because there is no need for an anaesthetist, thus women can save up to R20 000. Joseph freely shared some details of the procedure with me, saying that it is painful, and that if patients are 'on top of it' and keep up with the pain medication, they will be fine. It would be painful if the patient ignored the pain, but he explained that women who have labiaplasty done know what they are doing.[13]

Similar to in my conversations with Gillies, I was curious about the functional effects of labiaplasty on sexual experience, as Gillies was rather flippant about this issue. Dr Joseph said that sometimes, due to labiaplasty, the skin of the clitoris would hang lower and cover more of the clitoris, which could increase sensation, but the labia lips do not rub together as much. Alternatively, the pulling of the labia or them being pushed into the vagina during sex no longer happens, which can make sex more comfortable. He stated that women after

[12] Dr Joseph had stated that he started to see a significant increase and developing trend of labiaplasty in South Africa since the dawn of social media and smart phones. There has been a steady increase since 1995, but it became so much greater since the use of smart phones around 2007.

[13] Something interesting that also came up in our conversation was how well-informed his patients were by the time they came to see him at his practice. They often make use of sources such as YouTube, which have patient testimonies that are useful and valuable to these women. He explained how women turn to these resources as they feel afraid of getting scant information and found that talking to other people is difficult as they do not feel comfortable talking about these things.

labiaplasty feel more confident and relaxed because this no longer happens. Joseph described his patients' expectations for surgery as something 'realistic and reasonable'. He did notice though that there was a desire to achieve something pubescent or childlike. He said he would often do a vaginoplasty and labiaplasty at the same time – the vaginoplasty would be done to repair damages and scarring resulting from childbirth.

I tried to probe what his goals were for labiaplasty surgery and his response was simplistic. He told me that in his consultations, he examines the vulva with the patient, and she points out what she does not like. Then he makes markings with a surgical pen so that the patient can see what will happen. He explained it as a 'guided experience', and also very importantly an opportunity to dispel any misinformation she may have about her vulva or sexual health. He spoke very often about how it takes 'guts' for a woman to ask for professional advice because of a shyness or embarrassment that stems from conservative preconceived ideas. He reflected that he admired and had respect for his patients and the courage they embody, as asking for such a surgery is difficult for women because of its intimacy.

Dr Joseph did about twenty labiaplasties a year and has been practising the procedure for twenty years. He admitted that if laws were more lenient in terms of advertising, he would see more cases, because if women were more aware of the procedure, he would definitely have more patients. I asked him if he sends his patients for psychological counselling, and he mentioned that so far, he has not had any requests that were unrealistic or raised any red flags.

Ethics, regulation and Botox

In our discussions, Dr Gillies and I had reached a point of mutual frustration – which sparked his interest and concurrently validated my project for him – when I asked where I should start looking for data and statistics about labiaplasty in South Africa, and perplexed, he answered sharply: 'There is no data on this'. He suggested I take a look at the *ISAPS (International Society for Aesthetic Plastic Surgery)* data that was released every year for more information about labiaplasty, but he could definitely contend that he had personally seen an increasing trend over the past five years. To him, most shockingly, was the increase in non-invasive cosmetic genital surgeries, which he has seen (and literature shows) a 700% increase in the past few years. However, these non-invasive procedures were a contentious issue for Dr Gillies. He described them as dangerous, was strongly against them, and when speaking about it, he had

a strong, stern tone in his voice, which told me he had a strong moral and emotional issue with such procedures. He continued to describe these procedures as a money-making scheme, and gave the impression that there is no scientific evidence to prove the efficacy of these procedures. Evidence and efficacy as surgical standards were very important to Dr Gillies.

I continued to press the issue of data, as I wanted to know why he confessed there was none. His reasons were critical of medicine and his colleagues, voicing his frustration to me that doctors lie and misreport about the surgeries they have done. The best estimate he had was that one to two labiaplasties are performed per month; however, I am not sure of the details (if this was per plastic surgeon, or in general). Dr Gillies himself, had attempted as a project to track statistics and information about labiaplasty, but had no luck. In his attempts to collect data, he had spoken about how if hypothetically he asked for data from all registered plastic surgeons, he would only expect a 36% return. He admitted that there was nothing valid coming through on labiaplasty, and there was a definite lack of recorded data on the procedure in South Africa. Gillies strongly voiced his frustration about this. He was greatly concerned that genital cosmetic surgeries are not accurately recorded and communicated by plastic surgeons, and pinned it down to two things: first, that 'social norms dictate that we don't talk about it', and second, an ego game amongst doctors, whereby they are greatly over-exaggerating the numbers of surgeries they are performing simply to boast.

On the occasion he had a consultation before our meeting, I would have a little extra time to rummage through magazines. I had no luck in one pile, and as unsuspiciously as possible, moved to another chair across the room and took out the second magazine in the pile. On the content page, I noticed a picture of the lower abdomen of a white woman with green and white lace underwear on, and as luck would have it, the article was about labiaplasty written in 2009, *ten years ago*. I started reading:

> Believe it or not, the concept of the "designer vagina" is no longer unusual… quite an extensive menu of additional procedures have been available for some time… These can be seen in context of the overall pursuit of perfection, youthful appearance and rejuvenation… Mrs L…told me that she had seen movies where other women's genitals did not look like hers… The quest for perfection is not limited to voluptuous breasts and a desirable butt, yet extends to the "perfect" vagina as well… Very often an insensitive remark from an equally insensitive

> partner will precipitate the request… Another underlying trigger could be differences in cultural perceptions of beauty, this is delicate ground – as delicate as the anatomical parts under discussion here. For example: in certain societies majestically, large buttocks are highly valued, as are long stretched labia minora – whereas in other societies these features are regarded as unattractive. Although the art of labiaplasty is known for its aesthetics value, there are also instances where it's performed for practical reasons… There are certainly a number of valid reasons for the rest of us to request this procedure (Potgieter, 2009).

A rough and loud 'Hello, Hayls' from Dr Gillies standing at the consultation room door startled me and brought me back from my deep focus on this article. I got up and started walking over to the consultation room, and Gillies asked 'So Hayls, tell me…,' and as I sat down in the plush leather chair, he continued: 'What have you learnt about fannies?'. This again was an excellent point of departure, as a few weeks before, I had been to see an aesthetic gynaecologist, an emerging field which I did not know much about. Also, based on Dr Gillies' previous comments about contentious fields of medicine, I was curious to know his opinions.

According to Gillies, the field of aesthetic gynaecology was controversial, and in terms of plastic surgery as a field, it is 'not something we've fiddled with' and plastic surgeons have rather concentrated on performing 'proper procedures.' This was a very important issue to Gillies, along with the narrative of performing serious surgeries. He explained that as a plastic surgeon, it is a 'serious responsibility to know what is on your table at the time and what is happening, it's a serious skill, and as plastic surgeons we deal with more serious surgeries'. Dr Joseph also mentioned how plastic surgeons would have the skill to make the labia look unoperated. Dr Gillies and I had spoken briefly about aesthetic gynaecology, at this point, and I also asked Dr Joseph about if he had some interesting insights. He disagreed with gynaecologists doing cosmetic labiaplasty, as he stated that a gynaecologist would be too rough. Although they have extensive knowledge and experience of and with the genitals, they may not have the skills of making the labia look 'unoperated', *natural.* To substantiate, he spoke about the technique and skills of plastic surgeons: they use fine sutures, take their time and are incredibly precise. A labiaplasty takes Joseph about two to two and a half hours to complete. He argues that gynaecologists use big sutures and that their skill is very different. While speaking about the field of aesthetic gynaecology Joseph argues that gynaecology is now offering aesthetic procedures to keep male gynaecologists in business, as in his

experience, women much prefer to see female gynaecologists as they feel more comfortable with them.

Gillies' opinion of aesthetic gynaecology was rather scathing, as he explained that, 'It's a dangerous field that is riding a wave of popular medicine. Procedures like this are fraught with controversy'. Labiaplasty procedures were already a sensitive subject, without clear medical guidelines and with no proof of efficacy. Therefore, it is not unthinkable for Dr Gillies to raise concern about the legitimacy of aesthetic gynaecology. To illustrate his point, he used the example of G-spot injections (a popular procedure of aesthetic gynaecology), and he states, horrified, that 'No male has ever found the G-Spot, now we're injecting stuff into it!?'. It sounds like medicine and the *Cosmopolitan* magazine seem to have very different opinions on whether the G-spot exists. Vincenzo Puppo writes in a multitude of papers (Puppo & Puppo, 2015) (Puppo, 2013) in medical journals expressing a strong medical opinion that the G-spot definitely does not exist:

> In 1950, Gräfenberg described a distinct erotogenic zone on the anterior wall of the vagina, which was referred to as the Gräfenberg spot (G-spot) by Addiego, Whipple (a nurse) et al. in 1981. As a result, the G-spot has become a central topic of popular speculation and a basis of a huge business surrounding it. In our opinion, these sexologists have made a hotchpotch of Gräfenberg's thoughts and ideas that were set forth and expounded in his 1950 article: the intraurethral glands are not the corpus spongiosum of the female urethra, and Gräfenberg did not report an orgasm of the intraurethral glands. G-spot amplification is a cosmetic surgery procedure for temporarily increasing the size and sensitivity of the G-spot in which a dermal filler or a collagen-like material is injected into the bladder–vaginal septum. All published scientific data point to the fact that the G-spot does not exist, and the supposed G-spot should not be identified with Gräfenberg's name. Moreover, G-spot amplification is not medically indicated and is an unnecessary and inefficacious medical procedure. (Puppo & Gruenwald , 2012).

Alongside the general lack of knowledge of female genital anatomy, the debate about the G-spot could go on for decades. However, there is enough doubt cast on this issue for serious questions to be raised about aesthetic gynaecological procedures that heighten the sensitivity of the G-spot. And to this point, I agreed with Dr Gillies – it becomes dangerous to practise such procedures without the appropriate evidence. Gillies reiterated that as medical professionals, they cannot go around punting themselves as experts, and with controversial procedures, this becomes even more important.

Why he took this issue of regulation so seriously was because it hit close to home for him. Dr Gillies had been a consulting plastic surgeon for a *Carte Blanche* exposé[14] of a general practitioner in Centurion, Gauteng who was performing various procedures of plastic surgery, from breast augmentation to liposuction, which went horribly wrong (Gillies also mentions later on about having to fix botched procedures by doctors who boast about how many surgeries they have done). I asked Gillies about this piece and he insisted that any sort of plastic surgery needs to be done by professionals registered with an overseeing board such as ISAPS, and he definitely recommends not having aesthetic labiaplasty done by an aesthetic gynaecologist or a GP. I struggled to understand why anyone seeking surgery would not seek a professional. His answer to me was that it was truly about price hunting. Plastic surgeons are significantly more expensive: Dr Gillies has fourteen years of experience and has the responsibility to ensure a labiaplasty is done properly, but the cost of a labiaplasty is not gazetted. He never gave me any indication of how much he charged, which I found interesting, even though I asked. Many women desperate in their 'pursuit of perfection' want to save money, and sometimes cannot afford the price of a plastic surgeon and so will go these routes. Even though Dr Joseph performed labiaplasty in the chair and the price was slightly less, it was still expensive.

In a critical paper, Creighton (2011) highlights the ethical issues that surround FGCS in medicine and how GPs in the UK are the first to confront these issues as women with genital concerns will report to them first. Creighton highlights among other issues, that this presents professional anxieties; firstly, 'professional laissez-faire relating to audits of adverse events and clinical outcomes', and secondly, the 'absence of scientific evidence' (Ceighton , 2011, p. 7). GPs face a dilemma as they are trained to heal pain, but are also bound by an oath to make sure that they carry out and recommend treatment that is evidence-based and not harmful. In consideration of the ethical issues, Creighton comments that 'it is no wonder FGCS is likened to "the Old Wild Wild West", wide open and unregulated' (Ceighton , 2011, p. 8).

[14] The piece premiered in 2018; however, the video is no longer available for viewing for obvious legal reasons. Although, I did find a statement by the practice and the doctor in question, which went to extensively defend that the doctor had plenty of experience and had performed many successful procedures. However, there is no mention of an overseeing association that this doctor belonged to. It was also communicated to me later on by Dr Masters that a GP with a MBChB has the right to operate, but only in extremely medically necessary situations; for example, an emergency C-section. Seeing as though aesthetic procedures are not medically necessary, this is a deeply problematic issue.

Furthermore, critical voices of cosmetic surgery have stated that unclear regulations have allowed a flood of untrained doctors with no true qualification or experience in cosmetic surgery to practice and oversee cosmetic procedures (Berkowitz, 2017), as we see with the case Gillies describes about GPs doing plastic surgery.

At his suggestion from our first interview, I made an effort to research the data from ISAPS, which released statistics about various procedures performed across the world every year. Of all this data published annually from 2012 to 2018, labiaplasty appeared in increasing numbers every year from 2014 when it first featured (International Society of Aesthtic Plastic Surgery, 2018). In comparison to other surgeries such as breast augmentation and liposuction, the increase was perhaps not significant, but still noteworthy. The percentage increase from the year 2014 to 2018 was 25%, and in 2018 a total of 132 664 labiaplasties were done worldwide, which formed only 1.3% of all plastic surgeries performed worldwide that year (International Society of Aesthtic Plastic Surgery, 2018). Moreover, of all these labiaplasty procedures, only 56% were performed by a plastic surgeon. South Africa appeared in the 2015 data on labiaplasty (published in 2016) for the first and only time so far, and in this case, ISAPS documented 216 labiaplasties performed among 176 registered plastic surgeons (International Society of Aesthetic Plastic Surgery, 2016).

I raised this research with Dr Gillies in our conversation, as he had already mentioned that there was no data, and I was thus sceptical of what ISAPS had released. I asked him why he believed that doctors were lying about reports or not accurately reporting. His answer pointed towards the notion of *who* doctors are and *what* they are like – it is their professional personality and characteristics that are to blame, more than the fact that the data does not exist. Labiaplasty is happening, but it is the behaviours, attributes and personalities of doctors that are preventing data from being accurately reported or reported at all. Gillies elaborated on this by saying it was the pride and egos of the doctors practising labiaplasty who are engaging within a very closed and biased professional circle; therefore, doctors would not want to report sub-standard results or complications within these spheres. Interestingly, due to the misreporting, he had noted that the ISAPS data is not representative of the truth in

terms of the labiaplasty it reported in its global statistics of 2015/16 when South Africa appeared in the release.[15]

When I got to address the issue of data with Dr Joseph, he pointed out something interesting: that perhaps the practices of data collection should not end with recording statistics from doctors, but should include patients as well. He admitted that studying the media could be a start to document this, but to him the ideal approach would be to follow up with each patient: 'the problem with medical science research is that patients disappear, they don't want to follow up'. This point had shown me that doctors alone should not be considered in the making of medical knowledge, and to create an entire picture of a particular surgery, it was important to consider patients in data collection as well.

Dr Gillies expressed concern that labiaplasty should be reported in some way, because the patient is admitted, but in some cases, it happened under local anaesthetic in doctors' rooms or simultaneously with other surgeries as an *unspoken extra* and is not documented. He also admitted to having the experience of colleagues boasting about 'how many' labiaplasties they had done and then to having to fix the botched labiaplasties of fellow surgeons' patients. He stated how this dishonesty was extremely detrimental to the field, saying if surgeons were open and honest about these surgeries and complications, a standard of practice and ethics could be set. Moreover, the fact that labiaplasty was an elective surgery and not regulated or monitored in any way allows for this to happen.

An interesting way to make sense of the controversy around unmonitored aesthetic procedures is to consider literature on Botox. Although based on research on Botox in North America, Dana Berkowitz (2017) writes a fascinating book titled *Botox Nation: Changing the Face of America*. In her book, she emphasises the modern Western society's obsession with youthfulness as attractiveness. In providing useful insights into why women want Botox and why surgeons give Botox, she also teases out problematic grey areas that regulators of modern medicine have failed to consider or address. In 2014, the American Society for Aesthetic Plastic Surgeons estimated that there were over six million Botox procedures, and

[15] To investigate further, I reached out to ISAPS to find out more about South African Statistics. They stated that if South Africa does not feature, it is due to not submitting a big enough sample size for ISAPS to include in their report or they did not receive enough participation rate from South Africa. There is also no obligation to submit data to ISAPS. This concurs with what Dr Gillies had to say.

an estimated 750% increase in Botox procedures between the years 2000 and 2014. She attributes the rise in the use of Botox due to the fact that it is a 'cash cow' for doctors, as it is a cosmetic procedure not regulated in price by health insurers. Additionally, it is also time efficient and highly profitable. In quoting Alex Kuczunski, the rise of the 'Botox Nation' means 'that we are fast becoming a culture where we look at wrinkles as a remnant of the unhealthy, imperfect past, something to be fixed' (Berkowitz, 2017, p. 5). Berkowitz also highlights how formerly medicine only had authority over sick, diseased and injured bodies, but over time this has extended to healthy bodies as well. This extension at its extremes is a lucrative business and, in some cases, shifts the medical gaze from the health of the inner body to the aesthetic of the external body. Cosmetic surgery is a flourishing sphere of medicine and is becoming more and more a normative cultural practice. Berkowitz (2017) argues that this is because it is assumed that a status of health is inscribed or reflected by the body, and that looking old may be seen as being sick. It is therefore the aesthetic of youth that is important, rather than actually being young. Similarly, Gilman (1999) explained that for Jewish men who sought nose surgery in nineteenth- and twentieth-century Germany to cure them of their Jewishness, it was not about being German, but about 'passing' as looking German.

As her work progresses, Berkowitz (2017) discusses some startling information from a well-known distributor of Botox, admitting that the risks of Botox in doses higher than twenty units are unknown, and that there is a possibility that Botox can spread to other areas of the body 'affecting neuromuscular transmission' (Berkowitz, 2017, p. 39). As Berkowitz explained in her research, the realisation that the unknown risk of Botox injections was the tip of the iceberg in terms of ethical issues. By searching on Google, Berkowitz found Dr Kramer, a dentist who offered Botox injections as an extra service to his patients. Dr Kramer had attended a two-day course at the American Academy of Facial Esthetics on Botox, and had started to offer injections at his practice. She states:

> Consider how antithetical Dr. Kramer's account is from the dermatologists and plastic surgeons I spoke about in the previous chapter, who saw it as their job to inscribe their view of normalcy and beauty onto the bodies of their patients… Finally, note that Dr. Kramer was not comfortable enough to inject his own brow — whereas almost every plastic surgeon and dermatologist I interviewed injected himself or herself regularly— and you have a cautionary tale about Dr. Kramer's insufficient training…[I] am not saying that Dr. Kramer will not one day be a skilled injector with years of practice, experience, and further training. Rather, I draw upon our conversation to illustrate the extent to which a supplier-induced demand permeates our current era of cosmetic medicine, as growing numbers of medical,

> health, and wellness providers seduce consumers with bargains on Botox and other cosmetic procedures.

Furthermore, after making this strong point, Berkowitz mentions that often distributors of Botox and plastics surgeons warn patients about the dangers of seeking out bargain Botox deals, which is a legitimate concern. However, they do this not only out of genuine concern for patients, but also to protect their own turf: 'On one side, there are the dermatologists and plastic surgeons. On another side, are the growing numbers of other licensed physicians — for example, gynaecologists and family doctors — who are interested in a piece of the pie.' (Berkowitz, 2017, p. 72). Berkowitz explained that the plastic surgeons and dermatologists she spoke to, like Dr Gillies, were extremely worried and critical of the growing number of non-specialised doctors that were offering Botox.

Additionally, Berkowitz found the framework that Gilman provides useful to flesh out some of her findings. Like I have already mentioned with (the real) Dr Jacques Joseph's patients who needed to look natural to pass, a similar narrative applies in procedures of Botox. The Botoxed face still needs to look natural to pass, as there is a negative stigma of being overly Botoxed. Therefore, it is through this instance that the idea of the natural and unnatural is blurred, and at the same time made understandable. 'Natural' in practices of Botox no longer means a face that is untouched by bio-medical technology; rather, it now implies a body that has been 'constructed through technological interventions that could not be detected'. As Berkowitz (2017, p 158) puts it: '"Natural" no longer means not having work done. "Natural" means passing for having no work done.'

In my final meeting with Dr Gillies, I felt that the atmosphere of our meeting had changed significantly. I am not sure why – perhaps the looming devastation of the impending pandemic of Covid-19 on elective surgeries must have had something to do with it, and perhaps also the persistent prying of a master's student. Upon reflection, we had our final interview just two weeks before a severe lockdown was announced. As I sat down in the plush leather chair, Dr Gillies asked me: 'What have you been doing!? I've had no consultations for labiaplasty since we last spoke.' Then sharply, he said 'what more could I possibly give you?'. His tone throughout this interview was sharp and short, and something definitely felt off. I had also felt the prompt to wrap up fieldwork at this point, but had a few loose ends to tie up.

As I thought about it more and more, from my conversations with Dr Joseph, Dr Gillies and (as you will see in the next chapter) the aesthetic gynaecologists, ethical boundaries and medical grey areas became more and more of a troubling issue. I was worried how this conversation would go, given the unfamiliar atmosphere. I had come to learn that labiaplasty was or can be a medically necessary procedure in traditional gynaecology when hypertrophy did occur. So, I asked Dr Gillies if he thought that cosmetic labiaplasty that was once a medically indicated surgery that now, as a cosmetic surgery is being justified as a treatment for sexual and bodily insecurity by psychology and then commodified by cosmetic medicine and sold? (as literature is framing, especially in terms of the practice of Aesthetic Gynaecology and perhaps GPs). His reply caught me off guard, as it was stern and defensive: 'Ethics has nothing to do with the medical necessity, because if we had to apply the same logic to boob jobs, for example, it's a bullshit argument. Because then it looks like [plastic surgeons] are preying on people's insecurities. What's the difference? In terms of boob jobs and other plastic surgeries, if there is a functional issue it is a bonus. The ethical issue is with training!'.

I had clearly touched a sore spot, but given everything we had spoken about before, I was bound to end up here, especially as the waters were getting murkier around labiaplasty. I had in no way meant to take issue with his practice and respected him as a top surgeon in his field. I realised his tone was not because I was raising problematic ethical issues; in his mind, I was discrediting a field of medicine that for centuries had been fighting against attitudes like this for legitimacy. He told me how plastic surgery as a legitimate field of medicine has struggled through history to create its own niche. He pointed to some portraits on the wall behind the plush leather chair, and there hung three sepia toned portraits – the top one being his grandfather, and the second one his father. His family has been in plastic surgery for generations. His grandfather had been a reconstructive surgeon performing reconstructions on the faces of Hiroshima bomb victims, and his father was also a plastic surgeon. From this point of emotionality, he spoke about how plastic surgery was not new, and what they have done over time has been criticised by wider medicine. It is not lifesaving, 'but they'll send their wives', he said smirkingly.

However, more seriously he raised the issue of how other disciplines of medicine are trying to impinge, like aesthetic gynaecology as we had already discussed. They want to perform their own reconstructions or aesthetics. This is dangerous to Gillies, 'because then

associations and academies start and are set up, and who monitors this? Where is this bullshit coming from?... If you asked me why plastic surgeons would be better to perform these surgeries, I don't know. But my questions to these other fields become, 'What is your protocol?.' He insisted that emerging associations should be endorsed by ISAPS, should be recognised and should not stand alone. Then, GPs can also have some form of speciality training, because 'if there is no regulation as to who can perform these surgeries, then of course you will have cases where GPs perform this, and botched cases happen'.

Conclusion

Through my interviews with Dr Gillis and Dr Joseph, as plastic surgeons they seem to have established themselves as some the forefront authority on female genital cosmetic surgery. Dr Gillies and Dr Joseph, both respected surgeons in their field, have been practising labiaplasty for over a decade and have extensive experience within the field of plastic surgery.

From the experiences of Dr Gillies and Dr Joseph, and the historical account Gilman provides, the ties between beauty and symmetry start to present themselves. From Dr Gillies' account, this is revealed through his lesbian patients, which shows how the symmetry of the labia in not just a surgical standard, but also a patient expectation. It is also interesting that this shows that genital aesthetics goes beyond heteronormativity. It becomes clear throughout this chapter that historical informed ideas of beauty and symmetry are still prominent in modern medicine today. From historical narratives, we see that plastic surgery has had to rely on psychological treatment, or definitions of psychopathology, for some of its legitimacy, and although difficult to discuss in depth without evidence from experience, Gilman (1999) and Edmonds (2007) make sense of this narrative by discussing what Gilman calls 'passing', along with an extensive discussion on how the (ill)health of the psyche is linked to overall health and beauty. Current influences of psychology in cosmetic surgery that Dr Gillies and Dr Joseph describe show how this narrative may still have a hold today. Perhaps psychology is not used to diagnose and recommend or justify cosmetic surgery, but is still used to check the mental health of a patient for the purpose of patient management. It was in my discussions with Dr Gillies that I started to understand the intense pressure of patient management.

It is unfortunate that such serious ethical issues of regulation, training and botched procedures are also part of the narrative of labiaplasty and the pursuit of the body beautiful in South Africa. It is from Chapters 1 and 2 that a picture is starting to take shape, as is an

ideal vulva that has been constructed over time and ideas of health and beauty that have been/are being inscribed on the body, not just on the visually obvious parts, but also on the hidden parts. Thus, insecurities develop and then can be managed or treated by plastic surgery.

What is also interesting in this chapter is Dr Gillies' attempts to gather data and start building a knowledge base for labiaplasty in plastic surgery in South Africa, and his frustration when he cannot capture the data he needs. Also, Dr Gillies and Dr Joseph express narratives of knowledge and skill when distinguishing themselves from aesthetic gynaecologists, who we will see in the next chapter are also attempting to establish their own band of medical knowledge. There are also attempts by doctors to protect their knowledge, skill and tricks of the trade. As Latour (1986) describes from his fieldwork in a lab, science relies heavily on documents and published knowledge for its veracity, medicine and its attempts of knowledge production can be included in this. The possession of authoritative and traceable records is essential for medicine's scientific knowledge; however, we see that Gillies is not able to create or publish this knowledge, which can allow for challenges to the validity of the claims for labiaplasty. Also, in this narrative, Latour (1986) writes that the obsession of science to produce physical knowledge prevents it from analysing its own culture. This is where anthropology is incredibly useful, as by considering Gillies' experience anthropologically, I can see that the problems he faces in creating a knowledge base are social problems. I will return to this discussion at the end of Chapter 3 and the conclusion of this dissertation.

Chapter 3: “The long and the short of it”

This chapter will introduce the developing field of aesthetic gynaecology, a relatively new field branching out of traditional obstetrics and gynaecology, and will present a discussion on interviews conducted with two aesthetic gynaecologists: Dr Masters, based in Pretoria, and Dr Johnson, based in Johannesburg, aptly named after the famous sex research pioneer team Dr Masters and his assistant Mrs Johnson. These doctors and their respective field, instead of complementing plastic surgery, seem to have rather distanced themselves from it to create their own niche area of speciality. The aesthetic gynaecologists had also noticed increasing cases of labiaplasty, but had only been practicing for no more than two years. Even though these doctors are qualified and registered gynaecologists, the field of aesthetic gynaecology is not, at the time of writing, registered with the HPCSA.

Hazan and Hertzog (2012) describe a particularly unique aspect of anthropological fieldwork: serendipity. An anthropologist’s journey is not always straightforward; it involves changes in the field that demand adaptability, agility, and alertness. Thus, an anthropologist must always be prepared for a change in theoretical frameworks and unpredictable moments (Hazan & Hertzog, 2012). Appreciating serendipity in anthropology is exactly how I discovered, not only the two doctors included in this chapter, but also their field of gynaecology. I had not planned to include aesthetic gynaecologists in my fieldwork, because at the proposal stage and initial conception of this project, I honestly did not even know the field of aesthetic gynaecology existed. However, one night at a friend’s house over a glass of wine, I was prompted to talk about my studies (it became the novelty party trick to say I was studying vaginas), and a friend of mine disclosed that at the clinic she works at, there is a doctor who does something similar to what I was describing about labiaplasty. However, she was not sure of his name, leaving me a bit disappointed but ignited with curiosity. After a few weeks of unsuccessful Google searches, I eventually stumbled across a fascinating website: ESAG – the European Society of Aesthetic Gynaecology. Aesthetic gynaecology echoed in my head with a million question marks floating in the space around it. Eventually, after a few more Google searches, I found exactly who my friend was talking about: Dr Masters, Aesthetic Gynaecologist.

Just as Dr Gillies had described, various other fields of medicine wanted to expand into aesthetics, and it seems like gynaecology in South Africa was ahead of the pack. Aesthetic

gynaecology is not a particularly well-established field in South Africa, as it has only been around for about two years, with most doctors still practising gynaecology and obstetrics as well as aesthetics. I made an appointment with Dr Masters, his rooms located in a newly developed office complex in Pretoria. Dr Masters was the only doctor I interviewed who was not in Johannesburg. Masters was a smartly dressed man, wearing heavy gold rings on both hands. He was charismatic and often enjoyed a chuckle, laughing and making jokes during our interviews. My interviews with him were also the longest – I would easily spend an hour to an hour and half interviewing him and enjoyed the diversity of perspectives that he had to contribute. Masters spoke in detail and shared a lot with me. When I had gone to see him for the first time, he started off giving me some insight into the newly formed South African Aesthetic Gynaecology Society (SAAGS) and their first ever congress that he had just been to and spoken at. Dr Masters had presented on labia elongation and labiaplasty, and how (supported by biblical references) women were never actually under Adam's authority or forces of the patriarchy, because God created Eve after telling Adam he had dominion over all things. Therefore, her non-existence at the time that Adam was given this power exempted her from Adam's dominion. Thus, women should have the freedom to alter their genitals however they like. A theme of agency and female empowerment will be discussed in more detail throughout this chapter, as it formed an important part of the narrative of labiaplasty and aesthetic gynaecology.

Dr Masters spoke to me in detail about the development of the field of aesthetic gynaecology in South Africa. SAAGS was only launched in late 2018, and while I saw Masters (even until our last interview) the society was still in discussions with regulators and the HPCSA. He admitted that it is not a regulated speciality, stating: 'we are just gynaecologists with a special interest in aesthetics'. He explained that through SAAGS, aesthetic gynaecologists were attempting to create a body of knowledge, that new doctors who come into this practice could use as a base to work from. Thus, they are hoping to create protocols, rules and guidelines to demonstrate how things should be done. He estimated that there were less than twenty aesthetic gynaecologists in South Africa. SAAGS was envisioned four years ago by a Russian aesthetic gynaecologist who has been practising in South Africa for some years. From what I could deduce, SAAGS has some sort of affiliation with the European Society of Aesthetic Gynaecologists (ESAG), and the connection between these groups was training. Dr Masters

and Dr Johnson are both members of SAAGS and have been trained under the school of Dr William Smith[16], the president of ESAG who hosts and provides training programmes for aesthetic gynaecologists that take place in Dubai. When I asked Masters about his training, he explained to me that it was not a 'start from the bottom' training, and that labiaplasty has always been done, but it has not been done in such a way that the scar is not visible. Hence, from what Dr Masters described, it sounded more like technique training and not qualification training.

Second to Dr Masters, I consulted with Dr Johnson who has been a gynaecologist for eighteen years. Over the past few years, he explained that his patients started complaining about or requesting aesthetic gynaecological procedures, saying: 'I didn't know what to do at all, so I had to go for training… My patients seemed to know more than me about labiaplasty or vaginal tightening. So, I had to train in it… It was something I found very interesting and [am] now offering the patients.' Dr Johnson then trained in Dubai with the Medial Aesthetics Association in Istanbul with ESAG. While interviewing him, I gazed around his consultation room, which was overcome with white walls and furniture, but hanging from the walls were multiple qualifications and degrees, dozens of them. He admitted he had to go overseas and travel to up-skill himself, as there was no offering of such "training" in South Africa.

Edmonds (2009) discussed new emerging specialities of medicine under the brand of aesthetics, which does not associate itself with traditional cosmetic surgery. He describes the emergence of a band of aesthetic medicine in Brazil, and discussed how it is concerned with the reproductive, sexual and mental health of patients and draws from major specialities such as dermatology or gynaecology (Edmonds, 2009). Edmonds (2009) further comments that aesthetic medicine has a remarkable talent to produce links between medical and non-medical specialities and to bring together ideas of female health and beauty. I make this point here as we see later how aesthetic gynaecologists label practices of labiaplasty as making oneself beautiful, like someone would by putting on make-up or doing their hair. Within aesthetic medicine, meanings of health are redefined and negotiated. Thus, health, instead of being the absence of disease, becomes a condition that can constantly be worked on. Furthermore, there is an intertwining of mental and sexual health, whereby the lines between

[16] This is a pseudonym.

healing and enhancement become blurred (Edmonds , 2010). Again, it is important to review the case of Dr Kramer mentioned in Chapter 2. Scholarship on Botox is a useful lens through which to view the implications and grey areas revealed by the emergence of new aesthetic branches of mainstream medicine (Berkowitz, 2017).

"What a girl wants"

Dr Masters' reasoning for why women want labiaplasty is that they are either unhappy with what they see, or are suffering from functional issues, which affect their overall confidence. Masters brilliantly used his chubby face whenever we spoke of genital issues and parts of anatomy that he wanted to indicate: 'You see, it's just like a face. Your nose here is the clitoris', and then grabbing his cheeks with a pinch and moving them about, like one would with a baby, 'This is your labia majora and minora'. I enjoyed his illustration, and he explained it was a useful technique to help his patients situate their genital anatomy. He explained to me that a lot of the genital tissue is made up of fat; thus, as a woman gains or loses weight, those areas can become more 'juicy' or bigger and bulge or lose their volume with weight loss. In either instance, it is possible for a woman not to be happy with the changes she sees with her genitals in either case.

Dr Masters also made mention of models and the pornography industry and in pictures we see. He expressed how 'people want to see something smooth, like a Barbie, all covered, nothing sticking out'. He was aware of cases of body dysmorphia, but these patients see many things wrong with themselves. But as he rambled, he started an interesting conversation based on the evolution of women's underwear, and how when female undergarments were first conceived of and worn, they had a big thick seam down the middle which irritated the vulva. Slowly the seam moved to the edges of the underwear, and on this note, he took no hesitation to make a joke. Laughing he said, 'And now, ha! You used to have to remove the underwear to see the buttocks, now you have to remove the buttocks to see the underwear'. Although a joke, he had a point. Perhaps it is not the labia that are the problem but like with the bicycle seat design issue that cyclist Hannah Dines had[17], women may be wearing underwear that is not comfortable or flattering for the vulva. Perhaps a normalisation of the 'granny panty' that is friendliest to the vulva has not yet taken place.

[17] Refer back to footnotes about Hannah Dines in Chapter 2.

Although, I came to realise that concerns about functional issues and aesthetic issues were not mutually exclusive, perhaps not in the way that was initially obvious. Masters detailed how women first notice a functional issue, such as the labia being irritated, and when he investigates this complaint further, they will explain how they cannot wear the type of underwear they want to because 'things stick out', or they battle to wear tight jeans because of a wariness that the labia will show. In terms of functional issues, these women may suffer from irritated labia, but do so as they want to wear certain clothing to look a certain way; hence, the labia are a problem in comfortably achieving that particular appearance. It was interesting here that the first concerns about the labia were not sexually related issues. However, from what Masters described, his patients are just as concerned about appearance as they are about function, some being worried about colour changes to the labia, especially after childbirth.

It was after this conversation that the direction of where Dr Masters went took a fascinating turn and he divulged in much detail about patients he had seen who had practised labia elongation in their traditional hometowns, and when later moving to metropolitan areas, had then had labiaplasty. This experience was an incredible testimony. For many reasons, the idea of the cultural meanings of labia elongation being passed over for labia reduction was something that I found deeply interesting, but also deeply troubling. However, I do not mean to have a cultural conversation as to how society has punted the ideas of 'the perfect vulva' so strongly that it forces young women to cut their elongated labia. Instead, I intend to highlight with the work by Pérez et al.'s (2015) that there is an interesting co-occurrence of labiaplasty and labia elongation among southern (not just South) African women.

Dr Masters told me that pulling of the labia is not a taboo practice and happens often among some groups of African women. It is often something young girls at an age of puberty are encouraged to do, as in some cases, it is a practice to secure a husband. He continues to say that sometimes these young women leave the village with their family and start to attend a school in a metropolitan area, then perhaps either in a boarding school shower or changing for sports, her labia may look strange to her peers, and in a generalisation of how teenagers are, the girl may get teased. Or later, when she is getting or wants to get married, she may be interested in a man who is not from her village and who may not understand the culture and traditional practices of where she comes from. As Masters explained: 'So, you'll start

understanding the conflicts that go in her mind about that now… she has this problem [long labia], and what must she do… Then all of a sudden, we have them come and ask, "Can I have it [labia] reduced?", despite the fact that they were told that they need [long labia] for their husband'.

Perez et al. (2015) spent time studying Zambian women who live in the Western Cape and still practise labia elongation. It is incredibly interesting that in a metropolitan city such as Cape Town, there is a co-occurance of labiaplasty and labia elongation. Peraz et al. (2015) write that while Zambian women practice labia elongation, this is not a common practice in Cape Town. Labia elongation in this case is taught as part of initiation rituals, by which young women are transformed from girls to women, in the process 'becoming a Zambian complete woman' (Perez, et al., 2015, p. 5). This idea of being a woman is in agreement with the practice of labia elongation, because the practice ensures the psychological health of Zambian women and that they will be respected as 'complete' women whose lives reflect their tradition. Labia elongation among these women is incredibly important for their cultural and sexual well-being, as well as acceptance within their communities. It is from this that I can understand the weight of the cultural contention that Dr Masters' patients must face when they are teased about their elongated labia and the option to have it reduced.

The study of Zambian women in South Africa by Perez et al. (2015) formed part of a research project, and in conjunction with previous work, Perez et, al. (2015) describe Zambian women visiting health facilities in Cape Town in another paper, and how these women feel embarrassed and uncomfortable when consulting with a nurse for sexual health issues. It was reported that women could meet with doctors who could reshape their elongated labia. Pérez et al. (2015) also mentioned a case where a Zambian woman was giving birth, and after the baby was delivered, the doctor took scissors to cut her labia. The nurse noticed and stopped him, alerting him that he should not as it is part of Zambian culture. In this story, the presence of both labiaplasty and labia elongation in South Africa is interesting; however, this rather explicit example reveals, the attitude of some medical practicioners towards longer labia.

Dr Masters linked these statements to his earlier presentation at the SAAGS congress to say that labia elongation is not female genital mutilation (FGM), but rather what has become known as female genital modification (FGMo). This distinction, to him, is important because young girls are not forced to elongate their labia or to harm themselves, but may be expected

by their own culture to do so. Agency (or lack thereof) is a central distinguishing factor in most debates about FGM or FGCS practices (Hellsten, 2004). Masters admitted that these cases make up the bulk of his patients. He was troubled about the conflict these women face, and so would refer his patients to a psychologist first, as he emphasised that these patients need to be sure that they understand what they are doing and the potential implications. It is not a mental illness, but a perpetual conflict: 'They need to be sure that they understand what they are doing… they are removing something. They are in-between cultures – the dominant culture where they are now, which is a dominant Western culture, tells them one thing and the culture at home tells them something else'. I found his experience with these patients fascinating. These women, and their predicament reminds me of the terms from Victor Turner (1969), 'Betwixt and between'. Tuner (1969) uses these words to emulate his theory and framework of 'liminality' in explaining the steps involved in rites of passage, separation, liminality, and reintegration. Liminality is just one of the steps in a rite of passage and emphasises a person's position of transition, not being what they were before, but not yet becoming what they will be after the rite of passage is completed. Hence, the words to describe this luminal phase 'ambiguous, neither here nor there, betwixt and between all fixed points of classification' (Turner, 1969, p. 232). The account of these patients complicated the narrative of simply treating an insecure psyche through labiaplasty. As seen by this example, Western explanations for the reason women seek labiaplasty are not always universally applicable and the reasons young women seek labiaplasty can be incredibly complicated.

Furthermore, Dr Masters was adamant that practices of labia elongation should never be equated with practices of female circumcision and mutilation, but my counterpoint to him was that as far as WHO classifications go, any form of genital cutting is considered mutilation. He responded, explaining that it is about who is acting on the practice, in the following words:

> Yes, because then you get to cutting that is mutilation. When they cut the clitoris or when they suture the labia of a young girl, that is a problem. But when women do it by themselves, that's modification. It's like any woman putting on make-up.

In many of our conversations, the choice of a woman to have labiaplasty for Dr Masters was an agentive and feminist issue. Downplaying the role of husbands in a woman's journey of labiaplasty, he stated, 'We do this for you, not for your husband. It must be what you want, not what your husband wants. Yes, your husband may be paying, but you must want it'. He

continued, again invoking ideas about beauty, and said, chuckling, 'Your husband pays for your nails, he pays for your hairdresser, but he doesn't tell you how to do your hair'.

I was incredibly curious about this situation and how he dealt with these patients. Thus, I asked him, when considering labia elongation and labiaplasty, how long is enough? Batting his eyelids flatteringly, he said 'How long do you want your eyelashes to be?'. He laughed at himself: 'How long do you want your nose to be, how sharp do you want your nose to be? How white do you want your teeth to be? It's all what women perceive. I can't be the judge of what is too long or too short. Let me show you something'. Masters got up from his chair and disappeared into his examination room, returning with a white box in his hands. While fiddling with the box, he continued to say: 'So I had a patient who said she thinks her vagina is too big. I said well, okay if it's too big, tell me what size you want.' He fumbled with the box a bit more, and from the box took out a range of vaginal dilators. Holding up the smallest one and twisting it around: 'Do you want it this size?'. Then, grabbing the largest dilator, 'Or do you want it that size?'. He pointed to the medium-sized dilator, 'I showed her that this is the size of a penis, and told her, okay, I'm going to take this one, and put it inside, and measure how many centimetres your vagina is loose around it. And needless to say, I lubricated it, I put it in… and it was tight fitting. I asked if she can cough it out, and she couldn't… So, a loose vagina was just her perception… I had to demonstrate that no [it wasn't].'

Even though it is a relatively new field, I was curious to know how popular aesthetic gynaecology was becoming. Dr Johnson commented that its popularity is slowly picking up, and it has become an important field of specialisation in South Africa, stating 'the whole body is now becoming aesthetically improved, and the gynae was being left behind… everything was covered and then women started to shave, and when you shave, you expose more things. So, we've always been following the trend of aesthetics, but we've always been behind the breast augmentations and the liposuctions, but now we are catching up.'

What was incredibly interesting to me was that both of the aesthetic gynaecologists I spoke to described labiaplasty in terms of other beauty trends**.** Dr Masters spoke of it as like doing your hair or painting your nails. Dr Johnson described it in the following way: 'every woman wants to look good. You put make-up on, you put lipstick on… you do your nails… you look good. So, why should everything else look good but you leave that area not looking good? So, it only makes sense that women want to look appropriate from head to toe.' What is

concerning here is the perpetuation that the vulva is not pretty, needing to be 'made up' and that it does not match the rest of the body in terms of attraction and appeal. The fact that this idea in this case is not just coming from popular culture but from medicine too is touchy ground. Perhaps labiaplasty is actually not that far from other aesthetic beauty trends such as Botox?

In this same breath, both doctors spoke of women who come for labiaplasty as 'empowered', and beauty techniques and practices make them feel empowered. Like lesbian women expressing agency by making a claim on beauty. I asked Dr Johnson why women seek labiaplasty, and his answer still resonated with the idea of beauty: 'women want to look better, that's the only reason. They are not happy because they are not happy with the shape.' I was curious as to what the idea of shape meant to his patients, so I mentioned that:

> I've heard that something that is very important in terms of shape is symmetry?

Johnson replied:

> There must be symmetry. With anything on your body, its symmetrical. If anything is symmetrical, it looks better. It must be symmetrical, and it must be smooth. But anything in life, if it's not symmetrical, it's not good. If its asymmetrical, then it's not good.

Perplexed at the clear correlation he mentions of symmetry and being good, it does not seem too farfetched that like earlier narratives, good could mean beautiful, and beautiful could mean symmetrical and healthy. I do not mean to incriminate Dr Johnson by his words, but I do want to highlight the philosophy that aesthetic gynaecology is communicating in this instance.

I asked him:

> So, how subjective is the world of aesthetic surgery? [Does] any sort of influence of how a patient should look come from the field? Or is it more patient informed?

Johnson replied by saying:

> It comes from the field, and we have to because we are trying to help the patient look the way that they want. So, we have to listen to the patient and what do they expect, then we can then learn to do what they expect… so I'm looking at what the patient wants, symmetry is one of them, uniformity, smooth texture. So, then you get to that point of how do you make things symmetrical, or a similar colour? So, it comes from the patient who tells us what to do.

It was in my discussions with Dr Masters that I learned, before even touching the subject with Dr Gillies, that symmetry was the basic standard of any plastic surgery. Masters emphasised that 'you have to get the symmetry right', which in terms of labiaplasty was interesting, as naturally the labia are not known for being symmetrical (Crouch, et al., 2011). Masters explained that the labia are no longer symmetrical by the time he sees them, as throughout life, the labia have gone through a whole lot of things, even though they are symmetrical at birth. Perhaps if the labia are symmetrical at birth, this instance may explain the goal to return the vulva to a prepubescent or child-like look, as described in the Feminist Primer literature (Heyes & Jones , 2009). He assured me that vulva trauma is very real, and often horse riders and gymnasts can have significant damage to the vulva, which may cause significant asymmetry of the labia – stating 'if the hymen is damaged and it's that deep, imagine what happens to the labia'.

As part of this developing field of aesthetic gynaecology, I wondered how popular labiaplasty alone was becoming in these circles. In the two years Dr Johnson had been working on labiaplasty, he had seen an increase in popularity, but the issue that may be holding back more cases is affordability. He said, 'when we go to theatre it becomes expensive… but most women are used to how they've looked for the past twenty to thirty years anyway, so they may say "Okay, I'm used to it, no one sees this", so they keep hiding it'. At his estimate, a labiaplasty by an aesthetic gynaecologist will cost about R40 000 all things considered. This price is also not for hospital admission, but for a procedure done in a day clinic. He agreed with Dr Gillies that saving money is the reason why women end up with doctors that are not qualified, and they take the risk.

I asked Dr Johnson, 'What are the functional outcomes of labiaplasty?'. He replied: 'At the end of the day, once it's done, there should be no nerve damage, but you are cutting a piece of tissue and in that tissue, there are blood vessels and that is now being removed, so as long as the [blood] supply keeps going, it's fine.' To this point, he added that that is why training is so important – how a surgeon cuts and his technique may be the deciding factor as to whether the function of the labia is still the same post-surgery. Johnson had also stated how he had done many labiaplasties in conjunction with other procedures, especially O-shots and G-

shots.[18] Not only do women want a better-looking vulva, but they want better sex too; however, it may be naive to separate hope of the ideal of better sex and labiaplasty.

In terms of demographics, Dr Johnson mentioned that his patients were women aged thirty to sixty-five who had well-paying jobs, and he emphasised that he did not have many young girls who came for the procedure because they could not afford it. Johnson's patients discover his practice via social media on platforms such as Instagram and Facebook; he was also aware of the regulations that limited his reach. I had searched for his Facebook page, and while it was informative of how to contact Dr Johnson and his specialisation as an OB/GYN, being an aesthetic gynaecologist was not officially listed.

I wanted to cross-check if psychology of the patient was important even in aesthetic gynaecology. He agreed it was mandatory and admitted that sometimes he does it himself as a standard practice of patient management. If he notices a red flag, he would refer the patient to a psychologist or clinical sexologist.

The good, the bad and the ugly

In one part of our conversation on the development of aesthetic gynaecology, Dr Masters mentioned the turf wars between fields of medicine and acknowledged that not all gynaecologists are trained as plastic surgeons, but similarly not all plastic surgeons are trained gynaecologists. Dr Masters shared with me how as an aesthetic gynaecologist he may still need the services of a plastic surgeon. If he was to augment a patient's labia majora and needed to inject fat, he would need a plastic surgeon to drain the fat, do a liposuction, clean the fat and then inject it. I could sense his frustration for space, and perhaps this is why aesthetic gynaecology was fighting hard for permissibility or a claim on aesthetics, and to remove the complication of having to involve other surgeons to make one surgeon capable of a 'one-stop shop' for aesthetic procedures. This crossover of different specialities beyond the scope of gynaecology and plastic surgery is common, and I was never able to truly find out why Dr Masters wanted this idea removed; but ironically, he advocated for specialisations to 'stay in their lane'. He respected plastic surgeons who are trained in the 'art of

[18] An O-shot is a shortened term for Orgasm Shot in which Platelet Rich Plasma (PRP) taken form one's own blood is injected into the vulva area surrounding the clitoris and so-called G-Spot within the vagina. The G-Shot is the injection of a filler or Botox into the G-Spot. Both these procedures claim to enhance the achievement of orgasm in women (American Society of Plastic Surgeons , n.d.).

reconstruction', and explained that as aesthetic gynaecologists, they had to train in this too, because general gynaecology does not require such training. Berkowitz (2017) theorises that it is in when emerging fields of medicine enter the scene with new technologies and techniques that territorial clashes reveal themselves, and this is most obvious in fields of cosmetic medicine. She mentions how one should not be surprised that cosmetic medicine is vulnerable to infringement by other fields of medicine. The fight for cosmetic territory in modern-day medicine may actually be aggravated as the industry grows rapidly 'with nebulous boundaries' (Berkowitz, 2017, p. 82).

In 2014, the American Journal of Obstetrics and Gynaecology, placed two gynaecologists in debate with one another (Pauls & Rogers, 2014). On the one hand was the view that gynaecologists are the correct doctors to perform labiaplasty, while on the other hand was an argument that gynaecologists should not be operating on normal anatomy, and should therefore not perform labiaplasty. The one side argues that symmetrical vulva structures are accepted as normal by the majority of American women (Pauls & Rogers, 2014) thus, because gynaecologists are the pelvic experts, they are the appropriate doctor to perform, but not promote, labiaplasty. Furthermore, they contend that even though they may not be plastic surgeons, requests for labiaplasty are not based on concerns of appearance alone. Experiences of low self-esteem and body-image confidence may have a heavy impact on quality of life and psychological well-being and could also affect sexual function. They also note incredibly high percentages of patient satisfaction. In contrast, the other side argues that the increased demand for labiaplasty is due to a belief that the vulva has an abnormal appearance, despite the fact that labial symmetry does not occur often. They critique the argument that the procedure improves sexual function and body image, stating that it is selective and that there is limited data to accurately confirm these claims. Additionally, they also take into consideration the World Health Organisation's (WHO) definitions of female genital mutilation, which classifies any form of genital cutting and removal of female genitals for non-medical reasons as mutilation. Furthermore, this side questions if labiaplasty is taking advantage of women's social vulnerability, concluding with the view that 'succumbing to a "boutique" mentality of practicing medicine does not become us' (Pauls & Rogers, 2014, p. 220). Thus, it seems that even big American boards of medicine cannot make up their minds about frameworks and regulations to monitor labiaplasty surgeries.

Another issue that came up in our conversations was the turf wars between doctors and specialities in medicine, as I briefly discussed earlier in Chapter 2, which revealed themselves in themes of labiaplasty as a functional treatment versus an aesthetic issue, and this started to become clearer in our discussions. Dr Masters described how a patient will go to a plastic surgeon and while pushing his nose side to side, the patient would say 'My nose looks like this, I want it to look like that'. Chuckling away, Masters said, 'They are telling him', implying that plastic surgeons have demanding patients, whereas with gynaecology, he went on, 'It is more about functional issues; for example, "I'm not getting orgasms".' It seems like, to aesthetic gynaecologists and plastic surgeons, there is an accurate division between the disciplines, with no work towards complementing each other or having aesthetic gynaecology as an extension of plastic surgery. I was fortunate that Masters spoke so openly about his experiences and his patients. He spoke about how his patients are more worried about function than appearance, stating that 'they worry about sensation'.

In our later meetings, I wanted to confront the controversy about both labiaplasty and aesthetic gynaecology. Unlike the tension I sensed with Dr Gillies, I knew Dr Masters would appreciate the critical engagement. 'Look, anything that is new in medicine comes with controversy…' he explained, and in defence of the developing field he was part of, he continued, '… the only way we can generate new knowledge is to continually question and challenge what was done before'. He had mentioned that a nearby Mediclinic could not provide him with the facilities he needed, and now he operates at a day clinic in an eastern suburb in Pretoria, saying his patients have the procedure and can leave six hours later. The innovative techniques and simplicity of the surgery allowed for such an occurrence. He admitted to doing it at this hospital as it gave patients a better rate because labiaplasty is not covered by medical aids.[19] I asked Masters why it was important to him to perform labiaplasty, and it was his answer to this question that led to a point that was troublesome, and resonated with the ethical concerns Dr Gillies had also raised. Masters explained that the importance in performing labiaplasty for him was to restore women's confidence. He explained that his patients are looking for reassurance, and looking for self-confidence in their sexuality, and for him doing labiaplasty was worthwhile if this was the patient's feelings: 'If

[19] In rare cases, such as cancer of the labia, labiaplasty will be covered by medical aid as then the labia are considered part of the medical condition to be treated.

she believes that her sexuality is determined by how her labia looks and how she wants them… then there is no harm in doing it, then I will do it… it's not harmful to her health… that's why I'm a gynaecologist doing this… I have serious challenges when GPs do it, I have serious challenges. Because there are certain things that I learn when I specialise that GPs don't learn.'

I was surprised here again, and shocked to hear that GPs doing plastic surgeries was happening. I expressed my concern to Dr Masters, and also told him about the Carte Blanche piece I had watched. His response provides a long but vital perspective:

> Yeah, so look, its nothing against, well I mean there are a lot of GPs who stay in their lane. And staying in their lane being, look, let me ask a gynaecologist first, because I'm not sure if I do this, what impact it will have then. So that's why the HPCSA in this country will only recognise someone as someone they have registered as a specialist in the field. So, at the moment aesthetic treatments done by GPs, the HPCSA doesn't recognise it. So, I as a gynaecologist, because I specialised in gynaecology, I can go and modify how a labiaplasty is done as compared to how it was done when we were trained. I have not changed anything, I follow the same principle, so I've not gone and changed it and started doing it from back to front. A GP has never been trained to do that when they trained as GP. And then if they had special training, that training has not been recognised by the regulator. And that's why, a lot of the women who end up like this, find it difficult to win a case like this in court, and they just end up going to the HPCSA. Yes, because you cannot then prove criminality when you went and took yourself to a person that you didn't know is just a GP. And if that GP can prove that he actually referred you to a specialist and you said no, then it's a problem. So, then my view is that there is nothing wrong with GP doing things, as long as they stay in their lane.

It was in these discussions that these issues came to bear. I found on multiple occasions that regulations were often skirted. It seemed as if it was also in higher places that regulators themselves had no clear guidelines to direct the practices of doctors registered with them. Thus, it became clear to me that botched labiaplasties happen, and they happen due to a problematic lack of regulation from the very bottom to the very top of medical institutions. My concern was heightened as Dr Masters had already admitted to me that aesthetic gynaecology was not a registered or recognised field with the HPCSA, and I asked if there had been any progress with the field's discussions with regulators:

> Well, look, those things take a long time, but for us because we are gynaecologists and we are registered as gynaecologists, what we are doing is practising gynaecology, and vaginoplasties were done by gynaecologists, they are in gynaecology textbooks, labiaplasties in gynaecology textbooks. *It's the*

> *reasons why patients are seeking them that is now in contention.* Not the fact that [labiaplasty is] not there. So, there is no real need for recognition, if you understand what I mean. But what we want to create, just as much as you've got a fertility specialist, we want to create a speciality – a sub-speciality of aesthetic gynaecology – and for us to do that we must have this knowledge that has been built. We must have protocols and all that and go to the HPCSA and say right, we want to now train people to become specialists in this, these are the protocols, this is what we want to train them on, can you certify them, and create that. So, we take it to the HPCSA and what we call the college of medicine, or an academic institution, so we not seeking recognition as a gynaecologist who does labiaplasty. The name labiaplasty would not exist if it was not in the textbook. Right, vaginoplasty would not exist if it was not in the textbook. Yes, the issues about using laser are just an issue of saying research papers – this is what they are saying and the protocols on using the machine. So, we just creating a knowledge base…

As much as I knew Dr Masters was a qualified and competent surgeon, this discussion revealed some unsettling grey areas. As a gynaecologist, Dr Masters has the training to perform a labiaplasty, as it is a simple gynaecological procedure. However, the area of contention is the question of skill when a labiaplasty becomes an aesthetic procedure. It was here that I came to understand Dr Gillies' great frustration and deep concern for what was going on. Anyone can then work towards creating a knowledge base and perform labiaplasty, with or without recognition or regulation. As much as Dr Masters wanted me to believe that the reasons women seek labiaplasty was the area of contention, which, yes, is a fascinating research area, I see part of Latour's (1986) argument revealed here as well. Medical professionals struggle to examine and analyse their own practices that have social and complicated areas of contention. It was also in this flow of conversation that Dr Masters clarified that voluntary associations are not regulatory bodies, have no regulatory function, and they simply serve the interests of their members. I stated to him that 'there you start to pin why we are not seeing reliable statistics.' Dr Masters responded, 'Well, I suppose for you as a researcher, it's a problem. For the patients, their confidentiality is important.' He had a point, patient confidentiality is important, but more important is the wider (and concerning) issue of women's sexual health not being taken as seriously as I would have hoped.

As with Botox (Berkowitz, 2017), the responsibility to use labiaplasty properly and responsibly fell on the patient. Berkowitz explains that in modern situations of commercialised and aesthetic medicine, it is the patients who are 'expected to be informed and knowledgeable' (Berkowitz, 2017, p. 76). To Berkowitz (2017), the move of some medical products and

treatments to commercialised medical goods has allowed for treatments such as Botox to be taken out of the hands of specialists and to be used in generalised practice.[20]

I mentioned my troubles of finding concrete data, and he was not sympathetic, but rather blunt, saying I will not find it because it is not collected routinely. I continued on this line, asking if there is any obligation, moral or otherwise, to report labiaplasty, and to him there was not. In Masters' words: 'There is no law that states so'. I also mentioned the issue of misreporting that Dr Gillies had brought up, and Masters' response was: 'Well, you really not going to get that data either… People don't want to give away their business, their tricks of the trade.' There is no obligation to report labiaplasties, and no law that requires doctors to do so; not even SAAGS was keeping record or submitting data about procedures their doctors had performed. After I had looked at the ISAPS data, I spoke to Masters about what I had found. Very seriously he responded, 'I wonder where they get their information from? Because people who have aesthetic surgery pay cash, so these things don't go to medical aids, they don't get reported anywhere, so I don't know where they get their information from.'

I felt placed in an awkward position not knowing if I could trust any data I had collected and feeling frustrated by the doctors. I challenged Masters and asked, 'Is there any reason why you don't report it or do report it?' Via this question, I found that he did not report his labiaplasty procedures, but used his patients as a scapegoat:

> First of all, remember that women who do these procedures, firstly, the community still stigmatises them, so they don't want it to be known. They want confidentiality, that's why I am in an office block. So, you not going to get accurate statistics, because I'm not going to give you statistics when the patient says don't. And there is no law that says I must. There is no law that says I must, so I will not. Yes, among SAAGS we can start doing that and start calculating. SAAGS could give you [statistics] but it can only give you information from its members. There are aesthetic gynaecologists who are not members of SAAGS, so unless a condition is notifiable by law, any statistics on how much of it is being done is generally thumb-sucked.

I explained my struggle of finding reliable data and how I had considered the ISAPS data, so I questioned Dr Johnson about how one could really know if there has been an increase in

[20] Berkowitz (2017) and Thomas (2020) deal with the commercialisation of medical treatments and the spaces in which a fight to keep these treatments within medicine takes place, in modern capitalist society, and while fascinating, I do not have the space to go into detail here.

labiaplasty in South Africa if there is little evidence to suggest so. Dr Johnson's reply highlighted many issues I already had in my mind:

> Yes, it is trouble, because it's a cash thing, not a medical aid thing. Not all patients have got what we call ICD10 codes – it's the code with the procedure that gets captured by medical aids and they cover it accordingly. Let's say I have ten patients with pneumonia and eleven patients with hysterectomies, all those figures for medical aid patients will be easily recorded, the same for government hospitals. But if you are a private patient, then there is no recording of it… it will be hard to get a national figure… each doctor will have to speak for themselves and you'll never finish going through all the doctors.

I probed Dr Johnson by asking if the reason why there is no urgent concern for reporting or even monitoring labiaplasty was because it has been considered as a 'reportedly' minor procedure with few complications. His answer surprised me, and in many ways, muddied the waters around aesthetic medicine ethics: 'It's actually a major procedure. Complications are there, but maybe they are not being picked up… Any aesthetic gynaecologist will tell you it's a major procedure. It may be a small piece of tissue you are cutting off, but if you don't stitch or cut correctly that can break down.' I was curious to know more about what he had mentioned about ICD10 codes, and I asked Dr Johnson, 'if a patient is admitted do they have to have an anaesthetist and theatre nurse and all that, is there no code that is allocated for that?'. In reply, Dr Johnson continued:

> The codes are there, but they don't get to the medical aid. These are the ones who collect the codes. They tell the government or internal health these are the codes for this year: twenty patients came with TB, 100 patients for a hysterectomy, and they get given to the government who put the statistics for the whole country together, and all the medical aids put together, and then the government will plan and see how many *Inaudible* were removed. The code [for labiaplasty] is there, but the code is not sent, because nobody claims from that code.

My reply was another question, wondering, who has the codes, what happens with them, who keeps those codes? Dr Johnson explained that medical aids will allocate the code to specific procedures and will have these codes submitted when a procedure is claimed for; however, they will not have the codes for 'cash patients'.

I asked, 'So, the data does exist, it's just sitting somewhere? Dr Johnson replied:' '

> Yes, it's just sitting somewhere in doctor's hands, but I'm sure an aesthetic gynaecologist can give his figure, but a plastic surgeon who does labiaplasty… to get data from everybody would be almost impossible.

His last statement about getting data from everybody being almost impossible seemed like a challenge of 'you'll never be able to do it'. I found this perplexing: if there is a such a demand for accurate data as Dr Gillies had tried to compile, why do doctors not submit or report these surgeries? Later on, I revisited this issue with Dr Johnson and asked how one deals with this issue of labiaplasty not being reported or regulated, and that it can be practised by people who do not have the right qualifications. His answer astounded me, as at this point, the field of aesthetic medicine seemed to absolve itself of all responsibility: 'Well, as a patient you have to certify that this guy is qualified and certified to do it. You'll have to go to the aesthetic gynae website and check if he is a member or not. And if not, stay away from them. You can also check with the HPCSA.' Johnson continued:

> People can also fake things, but check on the society websites; it will tell who is a member. Let's say for me if you go to Aesthetic Gynaecology Society, it will show you "senior member". Go to the European Society of Aesthetic Gynaecology, and it will show you I'm a member. So, there are ways of verifying, this is definitely true. You can see where somebody has got their qualifications. Social media can also confirm it for you. If you don't confirm before you have a procedure, you are looking for trouble. Like when you go to Sorbet for your facial, because you know Sorbet, you know the name now. And if you go into a garage and you want to buy a drink, you'll buy a Coke because you recognise the product, because you know the brand. If there is brand that is unknown, you'll be hesitant at first. It may even be better, but you don't know. So, with anything in life, you have [to] find and verify if it will be the right brand or not.

I was curious to know how women who wanted labiaplasty would find out about an aesthetic gynaecologist who could perform such a surgery. I mentioned to Dr Masters that I had heard from Dr Gillies that advertising regulations were strict. Masters, picking up one of his pamphlets, started to say, 'If you look at this, you can read and read and read, but you'll probably not find my name on it'. I found this interesting, 'So, you are just disconnecting the association... there are loopholes?', I asked. 'Yes, you can read on there,' pointing to details on the pamphlet. 'There is my number, but I can't give my name. I can't say I am the best at this thing'. Dr Gillies and I had spoken about this; he had mentioned to me that advertising regulations were incredibly strict around plastic surgery procedures, and a surgeon could not advertise themselves as an expert. Another reason that general practitioners performing cosmetic procedures upset him so much was, as he admitted, that there was a lot of fringe work going on, as seen in the example of Dr Masters.

‘So, how many labiaplasties do you perform?’, I asked. Dr Masters had said that so far, he had only done four procedures. It was September 2019 at this stage, and he had only started doing cosmetic labiaplasties since January 2019. In a defence of his numbers, he stated, ‘And the reason is, remember, I mentioned we send them for extensive counselling first, so we don’t rush’. I was expecting higher numbers, and I wondered how many patients had come to see him seeking labiaplasty, but perhaps did not follow through with surgery. His answer was two to three times as many. For the four labiaplasty patients he had treated, eight to twelve patients had sought it out. He was not sure why some women would consult but choose to not have surgery, but he did say that the patient might ask for something else instead, like an O-shot or a G-shot. However, he did emphasise that with every patient and procedure there is a process, and he said it to me in this way ‘We are not selling tomatoes, so somebody doesn’t come to you and say “I want a tomato” and you give them a tomato – it doesn’t work like that’.

To draw my conversation with the aesthetic gynaecologists to a close, I asked Dr Johnson the following question:

> So, my last question: How do you think we should start, especially in South Africa, thinking about aesthetic surgeries when especially aesthetic gynaecology procedures are shrouded in so much controversy? There a few movements against labiaplasty – the Wall of Vaginas, the Vulva Gallery, and these movements are advocating for “natural is the best way”, and we shouldn’t be altering things in the first place. How do we come to put these things together? Can aesthetics and women’s sexual health happen in the same conversation?

Education, in his view, was the most important thing when entering these two issues into the same conversation. Women need to be well informed as to which aesthetic procedures are available to them. Labiaplasty may not improve their quality of life, but now there is a movement to be healthier, “more attractive”, and so people are looking for ways to make this possible. This reiterates the idea that ‘it’s just like makeup’ – a simple form of modifying your appearance, and why shouldn’t people modify their appearance if they are not happy with it? (It all seems so simple).

Conclusion and discussion of Chapters 2 and 3

As a developing field in South Africa, aesthetic gynaecology and its representatives are branching out from traditional practices of gynaecology and obstetrics into cosmetic

procedures. Despite the controversy and contradictory evidence for the efficacy of procedures offered by this field, its focus and the demand for its procedures is increasing in popularity. Edmonds (2009) gives attention to a critical discussion about the emergence of aesthetic medicine from his fieldwork in Brazil and describes how aesthetic medicine associates itself with reproduction and sexual and mental health, branching off from gynaecology and dermatology, but concurrently distancing itself from plastic surgery. Similar narratives emerge from my interviews with Dr Masters and Dr Johnson. Edmonds' arguments help tease out the complexity of beauty and medicine in the practice of aesthetic medicine.

The pursuit of beauty was a clear narrative behind labiaplasty for both Dr Masters and Dr Johnson, admitting that their patients want a vulva that is smooth and tucked in so that nothing sticks out. Although, sometimes their patients would present with complaints of functional problems of the labia, these issues were soon to be found within a concern of aesthetics as well. With the explanation that having labiaplasty is 'just like doing your make-up', we can see that the labia in this context is something that needs fixing up. Dr Masters fascinating testimony of his patients who have taken part in traditional practices of labia elongation, highlights some important themes about labiaplasty in South Africa. We see revealed a social and medical ideal for shorter smaller labia, but also a complex cultural conflict that complicates simple explanations for why women may seek labiaplasty.

Dr Masters and Dr Johnson described the efforts of their patients in beautifying their vulva as agentive and empowering. Masters makes it clear to his patients that whatever procedure they chose, it should be for their sexual benefit and not for their partners'. It was in this chapter that I had learned how intertwined ideas of beauty and symmetry were in aesthetic medical practice, with symmetry being associated closely with beauty and goodness. Psychological counselling was an important part of aesthetic gynaecology as it was for plastic surgery, especially for Masters' patients who had practised labia elongation – and through undergoing labiaplasty were cutting ties with previous traditional practices and long labia. Masters had a deep and genuine concern for the well-being of these patients.

It was also within aesthetic gynaecology that there was no kept record of labiaplasty surgeries in South Africa. Dr Masters and Dr Johnson were not concerned about this but our discussions on the lack of data led to interesting debates about the regulation of genital cosmetic procedures, training, knowledge production and legitimacy.

To conclude this chapter, I would like to discuss some of the greater issues and themes that have been mirrored between Chapters 2 and 3.

In Chapter 2, the idea of agency as an important theme of labiaplasty emerged from lesbian genital aesthetics, as patients assert agency by making claim to beauty for themselves after being stereotyped as unattractive (Hammidi & Kaiser, 1999). Additionally, an interesting point that comes up here is the idea of beauty and symmetry from Dr Gillies' and Dr Joseph's patients, whereby Joseph's patients are clear about what they are looking for. It became clear that symmetry is as far as possible a surgical requirement, not just a patient demand. Dr Johnson insisted that with labiaplasty, there must be symmetry, stating if something is asymmetrical, it is not good. Even if symmetry is a surgical standard or not, there is a clear belief from Johnson that symmetry is associated with beauty, health and goodness. When we consider Gilman's (1999) argument of 'passing', symmetry is not just the goal of a beautiful vulva communicated via medical discourse over time, nor a standard of plastic surgery, but is a vital tool for 'passing' as a woman with a *norma*l and *natural* vulva.

Dr Gillies, Dr Joseph and Dr Masters are strong advocates of psychological counselling before surgery, in the name of patient management, especially when it comes to genital surgery. Edmonds (2013) demonstrates that plastic surgery over time has not only had the purpose of treating or reconstructing body abnormalities, but also the corresponding pathology, as a medical justification for cosmetic surgery was tasked with repairing the ugliness in the body and healing the psyche. There is an immense responsibility of the surgeon to get it right, as delicate feelings hang in the balance. I suppose this is why the surgeons I interviewed expressed a deep concern that labiaplasty should be done by recognised professionals.

Between plastic surgery and aesthetic gynaecology, the turf wars are clear. Dr Gillies stated that aesthetic gynaecologists and aesthetic doctors are popularising aesthetic procedures that have little supporting evidence, which is risky. Moreover, such procedures go unreported, so do complications, and as a consequence, he believes there may have to be a revision of aesthetic medicine a few years down the line. Gillies admitted that he believes aesthetic gynaecology to be a dangerous field riding a wave of popular medicine. Gillies' concern was not limited to aesthetic gynaecologists, but includes GPs performing plastic surgery as well. Dr Masters was clear in claiming his right to perform cosmetic labiaplasty and also legitimising aesthetic gynaecology; however, he also expressed a deep concern about

GPs being able to perform labiaplasty. There were useful frameworks to understand why these contentions between aesthetic gynaecology and plastic surgery were important. Such a framework from Berkowitz (2017) was insightful as she theorises that fields of medicine that are fighting over similar disciplines or niches can be critical of other fields to protect their own turf. Masters readily admitted that he was aware of these turf wars, and acknowledged that not all gynaecologists are plastic surgeons, *but* not all plastic surgeons are gynaecologists. Masters communicated that plastic surgeons deal with simple aesthetics, but aesthetic gynaecologists dealt with functional issues too, bolstering their claim on legitimacy, even though in the narratives described, labiaplasty was also about achieving beauty.

I think the turf wars of plastic surgeons and aesthetic gynaecologists go beyond the medical space and legitimacy, and extend to who has the right to operate on the vulva. Berkowitz (2017) states that it is when there is a development of new fields of medicine that these territorial wars present themselves most obviously. To Gillies, his concern with other fields performing cosmetic procedures came down to training. He explained in detail that other disciplines of medicine (such as aesthetic gynaecology) that are beginning to explore cosmetic surgery can set up their own academies and associations, but there are questions as to how this is monitored or managed. Therefore, associations representing new fields of medicine need to have authoritative supervision. Thus, the setting up of SAAGS as a localising association for aesthetic gynaecologists is extremely problematic, seeing as aesthetic gynaecology is not a registered specialty with the HPCSA (as of yet). It was interesting that to both plastic surgeons and aesthetic gynaecologists, the line in the sand has been drawn when it came to GPs performing labiaplasty.

What was incredibly interesting, was Dr Gillies' attempts to produce some sort of record gathering data from his colleagues, and at the same time an aesthetic gynaecology association attempting to create its own base of knowledge, instead of them perhaps being inspired from or working with each other. The presence of physical published information is vital to the truth and premise of science and medicine (Latour, 1986). With this in mind, for Gillies to create some sort of knowledge, he needed this information, and could not get it. In contrast, aesthetic gynaecologists who are also in a process of knowledge making, establishing their niche in South Africa, found much of their field being questioned by plastic surgeons and clinical sexologists. This was because as an association, the knowledge that would perhaps

come from SAAGs came from an organisation with no overseeing authority. Through these contentions, we see a clash of the scientific and social world, where the production of scientific knowledge is impeded by 'human affairs' (Latour, 1986, p. 13) and social phenomena. Although science denies the influence of human affairs on its practice, Latour shows that the production of scientific fact cannot happen outside of social realms. In line with Latour's (1986) argument that science cannot examine its own culture (Latour, 1986), anthropology provides a useful way to identify these complexities, to show that scientific inquiry and knowledge production is not void of social influences, and the two are intimately intertwined. The written record of labiaplasty surgeries, even if they were published, would only tell part of the story of labiaplasty in South Africa. Therefore, this is why we need anthropology to shed light on complexity and show a narrative that goes beyond the obvious.

Despite there being no published data on labiaplasty in South Africa, all surgeons reported an increasing trend in labiaplasty in South Africa over the past ten years. The troubling issue of accurate reporting that came about after finding that there was little to no published data on labiaplasty in South Africa seemed to be more of a problem to Dr Gillies than to anyone else. After informing me that the ISAPS data was not accurate, Gillies expressed his frustration about doctors lying about and exaggerating numbers of performed procedures to boast or play an ego game amongst colleagues. Dr Masters' rationale for not reporting his surgeries was that he did not want to risk doctor patient confidentiality, but also as other doctors did not want to give away their skills and tricks. The lack of reporting seems to correlate with the lack of submission of ICD10 coded procedures to medical aids. As cosmetic procedures such as labiaplasty are paid for in cash, there is no legal requirement to do so. The submission of these codes is non-obligatory; however, *something* still needs to be recorded on surgical records. As Dr Johnson admitted, they are there, but they are sitting in doctors' hands, and as he subtly implies, one should not bother looking for them because it will be impossible. This issue of data collection or the lack of labiaplasty data lead to other interesting debates on regulation, and questions about who has the knowledge and right to perform labiaplasty became a debated topic. In the next chapter, I turn from a focus on documentation in these two chapters to a broader cultural context, and engage with Dr Milburn, Dr Effiong and Dr Wiley who are against the cosmetic alteration of the vulva.

Chapter 4: Why mend any umbrellas if it's not raining?

> We all have flaws, and our bodies do things we have no control over. But we can always control being truthful.
>
> – Otis Milburn, Sex Education, Season 2: Episode 1.

It just so happened that during my fieldwork, the Netflix series *Sex Education* became a massive hit (Mangan, 2019). The charming characters and their unique individual journeys of sexual learning, discovery, identity and trauma inspired the pseudonyms of the participants in this chapter. In my fieldwork, upon reflection, I now realise the desperate need for adequate sexual health education, and I think for many people around the world, this series provided a platform to normalise sexual conversation.

In this chapter, I will introduce Dr Jean Milburn, a registered nurse and clinical sexologist, Dr Maeve Wiley, a clinical sexologist, and, Dr Eric Effiong, a medical doctor with a special interest in sexual health. Amongst discussions with these three medical professionals, my fieldwork includes interviews, book launches and seminars. This group of medical professionals does not advocate for the *cosmetic* alteration of the vulva. Dr Milburn and Dr Wiley's disagreements with labiaplasty stem from a psychological perspective and the idea that the vulva is naturally diverse, and furthermore, a lack of sexual education is failing to help women appreciate the natural variance of the vulva. Moreover, the idea of altering the labia cosmetically perpetuates an idea that the ideal vulva *does* exist. Dr Effiong's stand against labiaplasty comes from a perspective of sexual health and pleasure, as she argues that labiaplasty can in no way be empowering because it may reduce sensation in the labia. During the time that I was conducting my fieldwork, she published a book about sexual health with this narrative emphasising the importance of women's sexual pleasure.

The overarching theme here is to highlight that there are sexual health professionals who state that labiaplasty does perpetuate the notion of the ideal vulva and who are concerned with the complex sexual health issues at play. If a woman is seeking labiaplasty for the sake of aesthetics, the reasons why are incredibly complex, and besides efforts of patient management, plastic surgeons and aesthetic gynaecologists do not deal with this complexity deeply, but rather send their patients to professionals such as Dr Wiley for counselling.

Through this group of doctors, I could gain insight into why psychological support before a labiaplasty surgery is so important and necessary.

This chapter is important as it provides an alternative perspective to those of plastic surgeons and aesthetic gynaecologists and provides some much-needed nuance to the experience of patients and the perpetuation of the "body beautiful". Dr Effiong, as will become apparent in this chapter, is especially vocal about and critical of the 'male and white ideal body type'. Interesting to note in this chapter is the wave of indie art culture and media that is advocating for the diversity of the vulva which these doctors support – through Instagram pages such as the *Vulva Gallery* and artworks such as the G*reat Wall of Vaginas c*ompeting with other messages that advocate for unscientifically supported instances of vaginal steaming and genital alteration. Dr Milburn and I spent a lot of time going through various Instagram accounts during our interviews and discussing what this might have to do with the popularity of labiaplasty. For this group of participants, the popularity of labiaplasty boils down to a lack of sexual education and correct communication about the natural diversity of the female body, which leaves women vulnerable to influences of the body beautiful from wherever they may come.

Although she only appears in this last chapter, Dr Effiong was actually the first person I interviewed at the beginning of my fieldwork. Her name has become a buzz word in the world of women's sexual health, and she has been climbing the sexual health advocacy ladder with great influence and speed. My supervisor suggested I get into contact with Effiong as soon as I could, as she was soon to become a very busy person. This was most certainly the case. In 2019, she published a book, became part of the gender commission and has been a prominent voice on women's sexual health issues. Upon reflection, I was very fortunate to have interviewed and spent time with influential people and experts in their respective fields for this project. In June 2019, I prepared for an interview with Dr Effiong. We had arranged to meet at Father Coffee in Braamfontein; I walked in to see her already there, sitting at the back of the coffee shop typing furiously at her laptop. 'Hayley!' she exclaimed and greeted me with a cushy hug as I walked towards her. Her smile and general aura made me like her instantly. The waiter came past, and I ordered a cappuccino and offered to order her something, but she had already had tea. Our conversation fluttered from labia elongation to female grooming

to sexual education. She spoke at a rapid pace, trying to get as much information across as she could in the short time we had.

Dr Effiong from the beginning of our conversations made her position about labiaplasty very clear. As a sexual health revolutionist, she was strongly against the cosmetic alteration of the labia. To her, sexual pleasure was a vital component of sexual health, and labiaplasty would reduce the surface area of sexually sensitive tissue and would therefore impact overall sexual sensation. Effiong went as far as to describe the cosmetic cutting of the labia as mutilation, because a surgeon is cutting off a centre of sexual pleasure, and in her narrative, sexual pleasure is linked to empowerment. According to this logic, labiaplasty is definitely not for women's empowerment. This all boiled down to a distinctive lack of sexual health education, which allowed for an array of ideas to fester – all perhaps in some way or another allowing for labiaplasty to flourish without questioning or interrogation.

One of the first ideas that we discussed was the body beautiful, and constructions of the ideal body type, where these ideas come from and why they are so ambiguous. A part of this conversation was about female genital grooming (George, 2018). According to Dr Effiong, questions around this issue start with who decides what is appropriate and what is not, and why women feel pressured to groom. She stated that, 'if you are going to cause vaginal problems by grooming or using products, it's clearly not good for you'. She extended grooming not simply just to cleanliness, but to common practices of women making their vaginas dry prior to intercourse due to male pressure (Saethre & Stadler, 2016). These issues of female grooming and using vaginal cleansing products, she explained, is detrimental to vaginal and sexual health, but due to the taboos and myths that circulate about sexual education, women do not know that these products will not help them. Thereafter, she made an interesting point as to why women may want to be clean and look a certain way.

Dr Effiong spoke about how over time, and even today, the idea that an 80-kilogram European male is still the ideal medicalised body type, and that medical issues are based on this benchmark (Macabasco, 2021) .When one considers the South African context and assesses bodies, there is a gap in understanding what is representative. This leads to body shaming: the labia are '*too* long, fat, brown, red, pink', because the point of reference is actually misrepresentative. Thus, ideas of body shaming and being ashamed have led to the rise in aesthetics, and more seriously, a commercialisation of these insecurities of women and their

bodies. Moreover, these aesthetic concerns emphasise these things for women who do not know or understand their own bodies. In her view, Effiong believed that what to modify and how to modify it is in some way scripted. At this point, I explained what anthropologists know as 'encompassed agency', and I asked her about how in the media, many women view procedures of labiaplasty and speak of their own experience as agentive. She responded saying that we need to have honest conversations about psychological body dysmorphia placing emphasis on the psychological aspect and reminding women that vulva diversity is normal, is an important part of sexual health, and should be the way forward, not surgery.

Considering the "revolutionary undertone" of Dr Effiong's philosophy, she raised very important points about body politics. In early 2019, an image of the anatomical structure of milk ducts in the female breast went viral (Filipovic , 2019). Readers were fascinated by the truly intriguing and beautiful representation this picture displayed. The picture was news and a complete surprise for many people around the world, but as Jill Filipovic (2019) at the Guardian writes, our surprise at this image was not completely because of ignorance, but also due to the fact that 'Western science' and medicine, and its education and research, departed from the assumption that the male body is the standard. Filipovic (2019) continues by explaining that by studying deep anatomy without skin and external characteristics, it may not be clear as to what sort of body one may be looking at; however, the default body is a male. The implication of this is serious, as male is established as the default, or 'normal', and female bodies are the 'abnormal other' – 'when one sex is the default, the other becomes, well, the other' (Filipovic , 2019). The way in which this view has such a deep imprint on science and medicine gives new weight to the male artists and plastic surgeons who have influenced ideas of the ideal body over time.

Another important issue that Dr Effiong introduced was that *who* is affirmed extends beyond male and female, but classism and race are serious issues that raise their heads in discussions of genital alteration. 'We need to look at language and access; who is affirmed', she explains, as in her view, when black women in Africa alter their genitals, it is viewed as mutilation, but when white women in Western countries do so, it is seen as cosmetics. Crouch et al. (2011) touch on this point by mentioning how in the United Kingdom, legislation forbids the cutting of the labia majora and minora for cultural or non-health reasons, even when an adult women has given consent and the procedure is performed by a medical doctor. However, Western

procedures of FGCS are legitimised as valid by granting them a 'theraputic' value, while concurrently positioning all other forms of genital cutting in non-Western contexts as 'cultural'.

Dina Bader (2019) writes a fascinating paper about the representation and visual framing of female circumcision versus female genital cosmetic surgery. In this paper, Bader (2019) considers pictures published from the 1980s to 2015 in Swiss magazines, which depicted pictures of female circumcisions and FGCS. According to Bader (2019), considering the visual depictions of either practice is incredibly important in order to grasp how these two practises have come to be understood and communicated. She identifies clear double standards in the representation of these practices, and she identifies three areas where this double standard is evident. In one of the themes , 'The Portrayal of the Procedure: dirt floor vs operating table' (Bader, 2019, p. 1166), Bader emphasises how more often than not female circumcision practices are represented as an image of a naked African girl on a dirt ground floor, being held down by other people, with the camera angle looking down on the subject, emphasising her distress and pain. This is in stark contrast to FGCS procedures, which in photographs include medical professionals and explicit parts of the patient having the procedure placed out of the shot, so the patient cannot be identified. In the first case, the viewer is drawn to the picture perhaps due to the shock and distress of the subject, and in the second, the viewer sees a harmless procedure done by medical professionals in a clean environment. Even through visual representations like this, Dr Effiong was right, it is sometimes clear to see *who, where and what* is affirmed.

Furthermore, this logic extends to the idea of the body beautiful; what body type and what vulva type is ideal, what type is affirmed, and how do women feel when they are not that? In Dr Effiong's opinion, insecurities of an unattractive vulva were something one could attribute to heterosexual relationships, as these relationships are the reference point of most assumed relationships and are part of a default structure. We got lost in a conversation about the rights of sexual pleasure of women. I was completely absorbed in what Effiong was saying, and so was she in her speaking to me. She mentioned very quickly that she had to move upstairs and that I could come with her for a bit. I was not sure where she needed to be, so I got up and gathered my things into my arms and followed her out of the coffee shop as she rambled off, still on the same topic. She chatted away up the stairs, through a door, up an elevator, down

a passage and through another door into what was a television studio on the thirteenth floor of the building with a magnificent view of the Johannesburg city skyline in the light of the afternoon. She stopped speaking to me for a few minutes and instead greeted crew members working in the studio. 'You can talk to me while I'm having my make-up done', she said. Her makeup artist Mpho introduced herself and Effiong explained who I was and what I was doing, and soon the tiny little make-up room was filled with eight people who had pulled up plastic white chairs, and we all started conversing about sexual health. It was during this hubbub of conversation that I froze. We had left the coffee shop so engaged in conversation that we had forgotten to pay our bill downstairs.

During this conversation, I came to learn that Dr Effiong was part of a television show about South African women and sexual health. I was incredibly grateful for her, our conversations and the unique perspective she gave me, because, as a white, middle-class, English speaking woman, I was out of touch with the sexual health experiences of Black South African women. I found myself quite revved up with empowerment after speaking with Effiong and the crew on the set, and was sad to leave once they started filming. I made my way through the passage, down the elevator and out the door, and walked past the coffee shop. They were packing up, but I was relieved to see they were still open. The waiter admitted that he had run after us, but we disappeared, and he could not find us. I apologised and settled the debt. 'Was that Dr Effiong you were with?', he asked. 'Yeah', I replied. 'That's so cool, my girlfriend loves her!'. I thought to myself, yes, so do I. I have always appreciated movers and shakers in their fields, and the world of women's health especially deserves someone like Dr Effiong to rock the boat and make important voices heard.

A few months after our first interview, her book was launched, and I attended two of her book launches, one at the Hyde Park Exclusive Books and another hosted by the Centre for Sexualities, AIDS and Gender (CSA&G) at the University of Pretoria. These book launches were fascinating fieldwork experiences where the revolutionary theme of Dr Effiong's work continued. However, for the focus of this chapter and dissertation, the data is not particularly relevant, and therefore will not be discussed in detail. From these book launches and my discussions with Dr Effiong, I learnt that there was a 'sexual pleasure revolution' (Mofokeng, 2019) (further explanation) going on among South African women, of all ages and races. Not all insecure women were having labiaplasty; some were taking their insecurity and through

influential speakers like Dr Effiong, admitting it, and then turning it into a form of empowerment. What may have become evident in the chapters preceding this one is that I started to realise that the unreliable statistics and media sensationalised wave of popularity of labiaplasty formed only a part of the narrative. It was themes that surrounded labiaplasty that presented themselves in surprising ways, like symmetry, the study of plastic surgeons, the skirting of ethics and regulation, and the modern-day creation of the body beautiful that also became important and fascinating aspects to consider anthropologically.

Soon Dr Effiong became a prominent member of the Commission for Gender Equality (CGE).[21] It was in our last interview that I saw her at the commission, at their building that was once part of the women's prison at Constitution Hill.[22].

Again, our interviews circled around the idea of bodies, but with a new seasoning of aesthetics. Dr Effiong reiterated the point that plastic surgery happens in a sterile environment of an understood world, where people do not pay attention to the politics of the space and practice, and politics of the body is not discussed in any meaningful way. Effiong knew this because alongside her MBChB, she had trained in aesthetics, and then – to put it in her words – 'all this advocacy stuff took over'. She admitted that she would like to one day go back to aesthetics, but to a very particular niche of transgender aesthetics and health, saying: 'I don't hate aesthetics, there is a place for it'. This led Effiong to open up about medical turf wars. She expressed to me that there are professional games that go on, with egos involved. She mentioned how South African gynaecological and plastic surgery associations exist, but branches of these associations are not a unifying medical body, where everyone has a chance to present on what work they are doing. Without this function, there is no single speciality who has the right to a vulva – 'now there are turf wars over vaginas, it's ridiculous'. So, without a unifying body, there can be no questioning, as Effiong expressed:

[21] The Commission of Gender Equity (CGE) was established under Section 187 of South Africa's new constitution to advocate for the respect of gender equality and the protection and fulfilment of gender equity. The commission hopes to achieve this through a combination of research, education, policy and legislation (Commission for Gender Equality , 2014).

[22] Established in 1910, this prison jailed both white and black women, but in separate quarters. Most inmates were common law criminals, and the majority of black inmates were convicted of not carrying passes, and a large number were jailed after protesting pass laws. Black inmates especially faced brutal treatment. Famous political prisoners included Barbara Hogan, Fatima Meer, Albertina Sisulu and Winnie Madikizela-Mandela. The Constitution Hill Precinct now serves as a world heritage site (Constitution Hill, Website, n.d.).

> What is the [iCD10] code? Why do we use this? How do we classify that? Because everything in medicine is graded, right, so things will just be left to each speciality to do what they want. And it's the professional arrogance which is actually the cause [that there is no unifying body]…. It's about developing an industry, and underpinning it with the politics of health, the economics of health. If you develop an industry that is still heteronormative, still exclusionary, then there is no point.[23]

Consequently, these turf wars then, in arguing about who has the right to perform FGCS surgeries, and not being proactive about monitoring, regulation and holding other professionals to account – even though perhaps just for professional competition – have a more serious undertone: the lack of consideration for women's sexual health. Thus, professionals are left in a competition over the vulva, because each field is able to develop its own industry or speciality, as Berkowitz (2017) and Creighton (2011) highlight. In this case, according to Dr Effiong, the value of medicine being about the patient is lost. Effiong further asked critical questions of these fields: 'What should we be wanting to achieve?'.

Following this topic, we revisited the idea of who matters, what body is affirmed, and in this conversation, Dr Effiong expanded on this viewpoint by saying, 'it's not only about what body is created, but about who's pleasure matters? Are we paying attention to black women?'. As the literature shows and Effiong explained, the answer is no. Hence, this is why she is so passionate about black bodies and sexual health advocacy, because bodies are born in many variations – there is not one standard look. However, throughout history, by considering what medicine as a wide discipline advocates for, and in Dr Effiong's words, 'In the procedures offered, a certain body is affirmed and there is not enough activism'. This is a problem especially, due to the fact that the 'normalising' of one type of body in medicine is still a process of othering. I mentioned here what I had discussed with Gillies about lesbian women seeking labiaplasty. Her reply was complicated and worked around quite a few issues:

> So, there are two things when we talk about politics of the body and who matters. What's important about sexuality and pleasure is that it has to be inclusive. For white lesbian women, the question of whose pleasure matters is difficult as the reference point may still be heteronormative. The advice she may be getting is from someone who assumes she is straight. She might be told: "Oh and don't have sex with your husband for however long", which is a speedhump, so prejudice still exists for this stuff.

[23] Over the past few years with more of a recognition of transsexual reassignment surgery, guidelines have been slow to developed but are gaining increasing amounts of attention;, however, the surgical construction of a vulva especially the labia and clitoris is still a hotly debated topic (Green, 2005) (Sohn, et al., 2013).

> The interesting thing to talk about here is porn… The idea of bleaching, symmetry, "natural", is perpetuating an idea that there is a perfect vagina or vulva.

After our first meeting, Dr Effiong, put me into contact with Dr Milburn, and as discussed earlier, I soon visited her sexual health clinic in Johannesburg. Dr Milburn was a clinical sexologist and a registered nurse. She had spent time studying sex workers in America. Her knowledge of sexual health issues and the porn industry was vast, and according to her, it was clear that pornography and the shifting of the look of the vulva over time was influencing practices of labiaplasty today.[24] Dr Milburn interestingly illustrated that genital procedures were a 'wealthy obsession' and that even in her clinic the strange things she sometimes sees are from women who have money, as they can afford genital surgeries or other treatments in the name of vaginal health. It was in this session that Virginia[25], a midwife at the clinic, had joined us. Virginia and Dr Milburn admitted that another very strong reason for the increase in labiaplasty was the lack of sexual education: 'Women don't know their own genitals', Milburn explained. Similar to the views of Dr Effiong, sex education and awareness was important to Dr Milburn. She expressed a deep concern about the many misunderstandings and misconceptions there were about the female body and emphasised the need to speak about the whole vulva in discussions of sex education. Although, Milburn did admit that this reality was farfetched, as teachers themselves are victims of the same problems, and may in unmonitored situations perpetuate misconceptions.

Furthermore, Dr Milburn described how medical doctors are also victims of a lack of education, and do not understand the complexities of sexual health and the vulva. For this reason, she is very against FGCS, as doctors with a facade of knowledge are making money off these procedures and women who do not understand their own bodies. This has become more evident throughout this dissertation, as there has been an admittance from the medical community of deep gaps in knowledge when it comes to female anatomy (Puppo, 2013), especially considering the lack of evidence for the G-spot, yet aesthetic doctors campaign for its existence in order to offer Botox injections without any proof to support such a practice.

[24] Dr Milburn had given me the contact details of a strip club owner to find out more information about the sex industry and labiaplasty. I had managed to contact the person and in a brief conversation I found out that none of the girls employed at the club had any sort of cosmetic vulvo-vaginal surgery.
[25] Pseudonym is used here.

Dr Milburn and I kept in close contact. She kept my project in the back of her head and often sent me articles or the names of interesting people to research. When I saw her at the clinic again, she confessed to me how emotional she was starting to become about celebrating the diversity of the vulva and how important it is to recognise this diversity. She emphasised language here, making sure that women knew, understood, and used local languages and appropriate words for their female genital organs. This was the first step in ensuring women would be empowered through sex education.

I spoke to her about the aesthetic gynaecologists I had met, and she did not let me continue talking too much about it before saying, 'Yes yes, I hear you…', she paused, closed her eyes tight and cocked her head as if she was searching for the right words: 'It's very controversial… you know, who should be doing facial surgeries? Dentists, because they study the face in so much detail and they know all the underlying things, they are the real experts. But over time, we started with the face, and then we moved downwards to the vulva, and now we have the O-shot and the G-shot! Which have no research! And are fuelled by social media.'

Shaking her head, she took out her phone, and moved closer to me and said, 'just look at this, these are the accounts I look out for on Instagram'. I watched her scroll through Instagram, and she visited some pages advertising vaginal steaming and others offering vaginal cleansing. She explained that the message these pages are sending are problematic. 'They are telling women that their vagina is dirty and ugly. Why do we have this obsession with clean? Does it look right, does it smell right?'. She was curious to see how far the aesthetic doctor fad went, so spent some time researching and found a menagerie of 'aesthetic doctors.' What this term really entails is anyone's guess, and to these search results Dr Milburn commented: 'I could still go with aesthetic gynaes, but this lot…'. While continuing to do some more searches we spoke about regulation. Milburn was curious as to how these doctors are discovered, as the HPCSA is very strict on advertising regulations, and had had recently done a lecture about this very topic. She took me to the HPCSA website and was showing me what the regulations are; however, she told me that unless someone actually complains, the HPCSA will not do anything about these 'aesthetic doctors'. As a passing comment, she said, 'and if you take a look at the HPCSA and who they last sued, it was probably a plastic surgeon'.

Dr Milburn raised an important issue in these conversations about what has become a wave of popular medicine called 'wellness'. It was here where the lack of regulation and monitoring

of non-medical treatments come home to roost. Fads such as vaginal steaming, which are incredibly dangerous and have no benefit for vaginal health, are being promoted under the umbrella of aesthetic medicine, and often by celebrities with no science to support these fads' efficacy. A narrative explanation of this idea can be found in the ever-popular Gwyneth Paltrow's Goop Lab, where beauty, health and youthfulness are central to achieving wellness (Palmer , 2020). In an opinion piece for the Washington Post, Stamp (2020) writes about the controversy of Goop Lab and the wellness industry it promotes. As much as doctors find the wellness industry incredibly problematic, Stamp (2020) argues that:

> For virtually the whole of its existence, medicine has disenfranchised women and, to varying degrees, continues to do so. Even as medicine has modernized with an emphasis on autonomy and resolving bias, it remains, at times, paternalistic and patriarchal. It comes as no surprise then that women are overrepresented in the wellness industry, both as consumers and providers.

Thus, loose regulations and a silence about what is medically necessary, at their most extreme, allow an industry like this to flourish. Dr Millburn suggested that I get into contact with a well-known clinical sexologist Dr Eve[26]. I had tried but did not manage to get hold of her; however, I made a habit of listening to her discussions about sex on Radio 702 on Friday mornings. It just so happened that one day the topic was labiaplasty. Dr Eve's perspective was the most scathing I had heard so far; the title of the talk was *Designer Vaginas: How Junk Science and patriarchy have occupied your vagina*. According to Dr Eve, procedures such as labiaplasty were all about money, and she was deeply concerned that the 'underlying fear and insecurity of women' is being commercialised. Dr Eve was against these procedures as there is no science to support the claims being made by wellness and aesthetic vaginal health, labelling it as 'Junk Science'. Dr Eve was also incredibly critical of the fact that women's vulnerability and emotionality are being exploited, and she expressed concerns at the growing popularity of these procedures.

Additionally, Dr Milburn had put me into contact with another of her close colleagues, clinical sexologist Dr Maeve Wiley. Dr Wiley was a gentle, sympathetic woman with an incredible passion for women's sexual health. She spoke to me in detail about the pathology of how women see labiaplasty and how she goes about treating women who may feel shame about their genitals and sexual experience. We started off talking about aesthetic medicine and

[26] Dr Eve is a nickname for the popular clinical sexologist Dr Marlene Wasserman.

aesthetic gynaecology. Wiley admitted that she works with a few aesthetic gynaecologists whom she may refer patients to in extreme cases; for example, the treatment of vaginismus[27] with Botox. However, generally, she is cautious of the field, as procedures like cosmetic labiaplasty are not medically necessary, unless there is a severe functional problem during sexual intercourse. Furthermore, Dr Wiley expressed that she fears that fields like aesthetic gynaecology promote the idea of what the labia should look like and should be, but there is no perfect vulva.

When offering her take on cosmetic labiaplasty, Dr Wiley described how women do not like their labia or vulva areas, and this is because of a detachment in a part of their sexual pathology. She explained that this can be seen most clearly in diagnoses of vaginismus, where women describe their vulva and vagina as disgusting, gross or hostile. When we consider these troubling attitudes that women have towards their vulva, cosmetic labiaplasty promotes the idea that the vulva could be better, thus it is not actually solving the problem. According to Wiley, this detachment is sometimes due to the way children are spoken to about sex and their genitals while growing up. They grow up believing that their genitals are dangerous, and they struggle to find spaces to ask questions. She also mentioned how research has shown that children who are raised using anatomical names for their genitals grow up to have a more positive development and outlook of their sexuality. Wiley explained to me that she is proactive in showing her patients artwork such as the *Great Wall of Vaginas* and books such as The Vagina Monologues to demonstrate the natural shape and variation of the vulva. She does this as she feels medicine is still letting people down: 'medical pictures show an ideal vulva, not a diverse realistic set'.

In terms of ethics, Dr Wiley admitted that labiaplasty is a difficult issue, because if it was something that affected the mental health of a woman in such a significant way, surgery may be an appropriate treatment, but she then asks where do we draw the line? More importantly, how do we draw the line? To this, Wiley expressed the urgent need for medical frameworks that can monitor procedures of FGCS.

[27] Vaginismus is a painful condition involving the involuntary contraction or spasm of the pelvic floor muscles. Sexual intercourse, the insertion of a tampon or gynaecological instruments can be incredibly painful. Vaginismus is treated with dilators and in extreme cases Botox (Basson, n.d.).

Psychologist Virginia Braun (2010) has produced significant scholarship on the topic of FGCS and writes a critical paper about what knowledge has been produced about labiaplasty and what debates have surfaced. Braun (2010) starts off by recognising that FGCS procedures have gained immense popularity over the past few years, despite reliable evidence. FGCS has received incredibly positive reports in popular media, along with contradictory views that pose FGCS as the latest instalment of surgical victimisation of women's genitals and express that at last, women's genitals and associated sexual issues are getting the recognition they deserve. Braun (2010) reports on issues of accurate data, showing how statistics worldwide are not representative of reality, as issues with doctors reporting accurately and an exclusion of the private sector are common. In dealing with the medical necessity of labiaplasty, Braun (2010) considers issues of autonomy and how labiaplasty has come to be framed as something 'medicalised'. She highlights that autonomous decisions to have labiaplasty are not made in isolation, but are influenced by a web of complex social forces. Psychology becomes the first viable justification for FGCS, which renders it acceptable. Thus, the justification of labiaplasty on functional terms becomes a problem for the public health sector. In her debate with current knowledge, Braun concludes that many controversial and ethical issues need to be urgently addressed in the developing scholarship on FGCS procedures.

As Chapters 2 and 3 demonstrate, the logic may be misguided, but many women seek labiaplasty not simply for aesthetic reasons, but also for better sexual pleasure. The idea that smaller labia will enhance sensation and confidence, and therefore sexual pleasure, is a common narrative of labiaplasty conceptions (Cartwright & Cardozo, 2008). This is problematic, because women seeking labiaplasty may believe that their sexual sensation will be enhanced, and that the vulva needs to be 'fixed' to feel sexually confident. For Dr Milburn, Dr Effiong and Dr Wiley, it is comprehensive sexual health education that would be able to build confidence in women and increase their potential for sexual pleasure, without surgery. This issue is also explored by Braun, who, explains that a focus on sexual pleasure when looking at FGCS procedures does a lot to legitimise and promote these procedures, while concurrently implying that there is a normative heterosexuality and a universal body.

Additionally, Braun (2005) writes about how the possibility of labiaplasty and other FGCS procedures are sanctioned in certain contexts of genital insecurity that establish FGCS as a solution. As we saw in Chapter 2, with mental health being an important part of overall health,

Braun (2005) points out that sex and sexual pleasure have also become signs of happiness and health. To this point, Braun argues that testimonies about a patient's journey of labiaplasty and the path to sexual transformation are often spoken about in a similar narrative. Before surgery, women are painted out to be miserable and their sex life affected in a negative way. Included in these negative effects are not just physical functional issues such as pain during intercourse, but also emotional issues such as embarrassment, low confidence, and feelings of shame (Braun, 2005). The connections between these psychological concepts and genital anxiety also promote negative feelings of the appearance of the vulva, and women tend to embody and live in these narratives (Braun, 2005, Braun & Wilkinson, 2001, Braun & Wilkinson, 2003). Furthermore, Braun expresses a deep concern that psychology here provides an approval for FGCS to ease this distress.

Dr Milburn spoke a bit more about why women seek labiaplasty, and in a very reflective manner, she spoke of how much shame women feel about their genitals. In the majority of her consultations, she admits that women will apologise for their genitals before a physical exam. She said that she often has patients confess: '"I'm sorry my labia are stretched, I think it's because I masturbated as a child, so now I'm punished" and I'm thinking, oh darling, your labia weren't even near this, and just anatomically some women have long labia and others don't, and it's just like your other anatomy, some women have long necks and others don't'. Milburn expressed profound concern for women who feel this way, and continued to say that the most common question she gets asked is 'Am I normal?'.

Conclusion

In this chapter, the perspectives of medical and psychological professionals, namely Dr Effiong, Dr Wiley and Dr Milburn, show that labiaplasty perpetuates the notion that an ideal vulva exists – something that is communicated in popular culture causing anxiety amongst some women about their genital appearance, affecting their overall sexual confidence. Thus, labiaplasty should not be an answer to sexual health treatment, as the reasons leading up to these concerns are incredibly complex and should not be taken for granted with a quick fix. Effiong, Wiley and Milburn believe that sexual health education and communication of a natural and diverse vulva appearance may help women with feelings of dissatisfaction with their appearance and their sexual confidence. Furthermore, this may help women stay away from wellness industry practices and surgical procedures that are not based on sufficient

evidence. A critical gaze on popular procedures, and on who or what is affirmed though these procedures, was an important discussion within this chapter. Again, the complexities at play between psychology, health and beauty were vital arguments to consider, especially in developing fields of medicine where concrete evidence for efficacy and the justification for such procedures are unclear.

Conclusion

As I reach the end of this dissertaion, upon reflection, I have come to see the body as a canvas for social, cultural, and medical inscriptions. I also quickly realised how little space a master's dissertation would allow me to explore the complicated narratives that came up. This dissertation is condensed, and I have had to exclude a lot of valuable and insightful literature, wider debates and potentional ethnography, in order to present, what in these previous chapters only scratches the surface of labiaplasty and the medical professionals who are involved in its narratives and practice. I hope that through this dissertation I have been able to provide a glimpse of what some parts of female genital cosmetic surgery and aesthetic medicine, their corresponding discussions, and critics thereof, look like in metropolitan cities of South Africa. I must confess that I had many initial anxieties, even just saying the word vagina with confidence and meeting with highly qualified specialists. Over the past two years, I have learnt an incredible amount and have gained the confidence to strongly confront debates on sexual and vaginal health head on. To consider the themes raised, these chapters have not been written, nor should they be read, in isolation or as separate from each other, as themes have been drawn out over these four chapters with mirroring frameworks, overlapping ideas, and complicating perspectives.

The brief history at the beginning of this dissertation, situates the following chapters by showing how the construction of the ideal vulva perhaps came to be. In the renaissance period we see how the vulva was thought of and how it later became a marker of difference between African and European races and deviant or conformist feminine sexuality. The vulva through ideas of races and appropriate female sexuality, was constructed as something that should be clean, tidy, neat, and white. Classical art also had a role to play in the perpetuation of these ideas as influences of classical art posed the body beautiful as something that was symmetrical, healthy, and good. Surgeons part of the evolution of early plastic surgery, based their interpretations of what the body should be like on these narratives. Medicine is still today somewhat influenced by these ideas, especially symmetry, despite a push for representative education about the diversity of the female genitals. However, plastic surgeons and gynaecologists cannot seem to escape a flood of genital aesthetic complaints from patients. From a multitude of disciplines, we see revealed the complex connection between mental health and beauty. Work from Gilman (1999) and Edmonds (2007, 2008,

2009, 2010) provided useful frameworks to explain the choice of cosmetic surgery though a theory of passing and by this shows health and beauty are deeply connected. This chapter shows how the vulva has been shaped over time by social and cultural influences and not by accurate medical representations, as medicine as a science is influenced by the same cultural and social influences.

The deep concern about aesthetic vulva appearance and its remedies have been a hot topic since the early 2000s and have attracted much academic attention. Experts attribute the major factors perpetuating this to an increase in FGCS procedures such as labiaplasty to mainstream pornography and images of slim sleek vulvas seen in global media. This project has shown how complex discussions about aesthetic vulva appearance have become and though images have a role to play, a historical context that comes to frame these images in both popular culture and medicine are highly influential.

It is in Chapter 2 that it can be seen how medicine is still influenced by historically informed ideas of the body beautiful, as through discussions with Dr Gillies and Dr Joseph and the expectations their patients have surgical standards to achieve symmetry and a belief and expectations of patients that the vulva should be symmetrical mirror historical and classical art ideals that beauty is reflected by symmetry and beauty is healthy, symmetrical labia are beautiful (and healthy) labia. It was incredibly fascinating that this thread was discovered by a discussion of Dr Gillies lesbian patients. My discussions with Gillies encouraged my curiosity about how popular labiaplasty was in South Africa, and from what the surgeons had described it had been for some time, but this popularity was rapidly increasing. However, reliable data to track and measure the popularity of labiaplasty in South Africa was not available. By asking questions about data from Dr Gilles, I had discovered a web of incredibly fascinating insights into the contentious space of private practice plastic surgery and the surgeons who make up this field. There was no reliable documented record of labiaplasty, and no law required private surgeons to report or document labiaplasty but also because surgeons were lying about the number of labiaplasty procedures they had done. They were doing this to boast amongst colleagues and to protect their skillset and reputation for labiaplasty. This was a problem for Gillies, as he could not create a base of knowledge for labiaplasty surgery in South Africa without reliable knowledge.

During fieldwork, my stumbling across Dr Masters and Johnson and their field of aesthetic gynaecology, continued to add an interesting perspective to labiaplasty in South Africa. I was also curious to figure out why women sought out labiaplasty. From their narrative, the reason for women wanting labiaplasty firstly presented itself as a functional issue but soon to actually be revealed as an aesthetic concern. It was interesting that Dr Masters and Dr Johnson framed labiaplasty through beauty and feminist narratives, stripping labiaplasty of all its complexities and saying, 'it is just like getting your nails done'. However, for some of Dr Masters patients, labiaplasty was not a simple beatifying surgery, it was an intense cultural conflict enveloped with tensions of traditional versus modern and long versus short. I questioned Dr Johnson about how we can measure how popular labiaplasty is, and again data was not being collected with the justification that doctors wanted to protect their turf and not reveal their specific skill set, also, data was not recorded in the name of patient confidentiality. This was an interesting finding, as aesthetic gynaecology distanced itself from plastic surgery and was attempting to create its own knowledge base under a newly formed association. However, as Latour (1979) shows, it is difficult to create a field of knowledge with no traceable record of such knowledge. Aesthetic gynaecology and its legitimacy on performing labiaplasty is questioned by plastic surgery with concerns over regulation and skill. Another field that questions labiaplasty is clinical sexology.

Dr Milburn, Wiley and Effiong as a band of doctors in support of women's sexual health questioned why cosmetic labiaplasty need to happen in the first place. They expressed that they did not only have an issue with the practice of plastic surgeons or the controversy surrounding aesthetic gynaecology but challenged the establishment of cosmetic surgery and medicine to raise critical questions about how historically informed ideas of constructed normal and racial bodies comes to be affirmed or not in the practices of medicine, and how and why did an idea of the perfect vulva come to be. For this group of doctors, sexual education should be at the forefront of dealing with these issues that women face. The conversations with Dr Milburn, Dr Effiong and Dr Wiley highlights that labiaplasty and the way it has been framed by medicine and popular culture show that the construction of an ideal vulva does exist and there are deeply complex social issues at play. The reasons why women seek labiaplasty for aesthetics, are truly intricate, in a way which plastic and aesthetic surgeons do not deal with deeply. A lack of sexual education and proper understandings of

the vulva are extremely detrimental to vaginal health. In addition, the desire to look clean and groomed, which has been shaped by body politics over time, and what is affirmed in popular and biomedicine, can lead to desperate attempts to achieve these standards, such as wellness practices like vaginal steaming or labiaplasty that seem to be attractive ways to heal the mental anxiety brought on by insecurities and lack of anatomical knowledge. The links made between pathology and psychology, health, and beauty over time and by aesthetic medicine that allow for labiaplasty to be seen an appropriate treatment for vulval aesthetic concerns could perhaps explain an increase in the incidence of labiaplasty. The way Edmonds (2010) writes about cosmetic surgery in Brazil, shows this narrative. I noticed often that especially by Dr Masters, Dr Johnson and Dr Joseph the words 'natural' or restoring the vulva to something natural, were used quite often in their discussions on labiaplasty. If I apply their experiences with Gilman (1999) and Edmonds (2008, 2010) explanations of passing, patients of the surgeons I interviewed may be hoping to move between categories of *unnatural* (due to the construction of the ideal vulva) long, asymmetrical labia, which are truly natural – to a constructed aesthetic of natural, shorter, symmetrical labia. Thus, surgery seems to provide a means of treating the associated anxiety by improving confidence and sexual experience. These claims as we see from Dr Milburn, Dr Effiong and Dr Wiley should be questioned, as there is no evidence to prove efficacy. A dark side reveals itself through the playing out of this narrative in South Africa. With no obligation to produce or publish reliable data and no strict regulation on labiaplasty procedures, Gillies warns that this allows doctors trained in aesthetics to able to perform labiaplasty, without an overseeing authority monitoring. Therefore, botched surgeries can happen. Similar discrepancies in the legitimacy of Botox can also be found (Berkowitz, 2017).

In reflection, looking back on my fieldwork and in consideration of these chapters, these are some of my concluding thoughts. Although, these are not always exclusively my own thoughts. These thoughts come from conversations and critical engagement with supervisors, friends and colleagues that happened as this project went on, to whom and for which I am incredibly grateful. A period of Anthropocene can be more appropriately described by the German word Zeitgeist, a term from German philosophy meaning 'the Spirit of the age' and can be used as a metaphor to capture pulses or is indicative of a period of time. I feel that this dissertation and research on labiaplasty has revealed an interesting aspect of Zeitgeist.

Through the interviews with the plastic surgeons, aesthetic gynaecologists and clinical sexologists we see a complex web of issues surrounding what it means to have a vulva, and what this vulva should or can be like.

The idea of having a Barbie Vagina is an interesting analogy, as a Barbie does not have vulva or vagina. A Barbie has a rounded smooth piece of plastic that has been interpreted to have some sort of meaning which had been brought into the modern world, as a smooth, sleek, and tucked vulva. This ideal has become one of the many standards of feminine beauty, and labiaplasty is a surgery that can make this desired look a possibility. By interviewing some of the surgeons who perform labiaplasty, I was able to reach into the world of biomedicine and see how labiaplasty came to be framed form this perspective. In this space I found some fascinating accounts. However, there was a veil, that started to frustrate me. Plastic surgeons and aesthetic gynaecologists had a constructed a stand of legitimacy that was heavily guarded. Dr Masters admits he knows that other surgeons do not want their tricks and skill to be shared. My conversations with these surgeons about their lack of reported data and a lack of concern thereof, along with an attempt to create a standardised knowledge base for labiaplasty between disciplines has shown me that they did not care too much about women's sexual health but rather about protecting their own knowledge and legitimacy. Were they afraid of their knowledge or superiority being questioned if it were to be published and accessible?

As you have seen in the preceding chapters the institutional veil that kept certain aspects of knowledge from me angered and frustrated me, and my constant pursuit and the challenge of biomedical practice at some stages upset my informants, especially Dr Gillies. However, these uncomfortable discissions and critiques from Dr Wiley, Dr Milburn and Dr Effiong show how medical turf wars and a fight for legitimacy are incredibly important to consider, especially anthropologically, when we think about genital cosmetic surgery. As it is from this fieldwork, we have come to see how complicated labiaplasty in South Africa is. We know now that some biomedical knowledge held by the plastic surgeons and aesthetic gynaecologists is heavily guarded, and not easily accessible – but how does the veil obscure the access to knowledge? Are there somethings I could start to say about legitimacy and access to knowledge? The two fields of aesthetic gynaecology and plastic surgery in their attempt to create knowledge are not working with each other, communicating with one another, in order

for a standardised procedure and protocol for labiaplasty or other genital aesthetic procedures to be established in South Africa. In their arguing over who has the skill, knowledge, and legitimacy, they are not able to recognise the perpetuation of historical ideas of the body beautiful their field reflects, or to see the damage they are incurring to female sexual health. We see how even between Dr Gillies and Dr Joseph there are discrepancies of how labiaplasty is performed. In contrast Dr Effiong has made her knowledge of female sexual health and beauty publicly accessible. It is not guarded by white walls, or plush leather chairs, but is shared in public spaces among women on national television or radio, perhaps explaining why her advocacy has become so popular. The wide span of perspectives that the doctors in this dissertation speak about show me how chaotic the field of private practice biomedicine is in South Africa.

There is a vast amount of legitimacy and authority given to science and medicine for its research, knowledge, and emphasis on the scientific method in the process of knowledge production. However, in this dissertation we see no evidence of a scientific method in the process of knowledge making. Contradicting evidence of the efficacy of labiaplasty and a desperate state of insufficient evidence and literature allow for questioning of the legitimacy and corresponding dissuasion of such procedures from clinical sexologists. There is clearly very little understanding, even from the experts, about cosmetic labiaplasty and its incredible complexity in South Africa. However, this complexity should not be an overwhelmingly surprising element of this study, as Anthropologists throughout the history of discipline have shown how cultural and social experiences in life are not linear but are complicated, because humans are complicated. Social and human affairs will always have a place in, and therefore complicate, the spaces of science and medicine (Latour, 1986). Anthropology is an important part of this conversation, as an anthropologist needs to be pulled from the 'back of the room' (Saethre & Stadler, 2016) to the podium to remind everyone that humans are complicated and social forces have a role to play in the practice of biomedicine.

Just as Bagnol (2015), Edmonds (2008) and Thomas (2008) make the plea, I have tried to ensure that the variation of genital alteration practices in South Africa have been understood in this dissertation as practices that have roots in a web of social forces. Moreover, I have aimed to demonstrate that context is incredibly important when looking at these practices, as viewing them as strange practices of genital alteration or beautification, or when this

context is ignored, the deeper meanings and logic motivating these practices can easily be misunderstood or taken for granted. This dissertation, I hope can contribute to the wider theory of the medical humanities and medical anthropology in South Africa.

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