Requests for cosmetic genitoplasty: how should healthcare providers respond?

Demand for cosmetic genitoplasty is increasing. **Lih Mei Liao and Sarah M Creighton** argue that surgery carries risks and that alternative solutions to women's concerns about the appearance of their genitals should be developed

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Women's concerns about their appearance, fuelled by commercial pressure for surgical fixes, now include the genitalia. A share of this consumer demand is being absorbed by National Health Service specialists. This article was prompted by the increased numbers of women asking for labial reduction and the concerns of clinicians about the rising number of referrals for cosmetic genital surgery.

A new complaint

More and more women are said to be troubled by the shape, size, or proportions of their vulvas, so that elective genitoplasty is apparently a "booming business."[1] Advertisements for cosmetic genitoplasty are common, often including before and after images and life changing narratives.[2] Google produced around 490 000 results when we entered "labial reduction". Forty seven of the first 50 results were advertisements from clinics in the United Kingdom and United States offering cosmetic genital surgery. Television programmes and articles in women's magazines on "designer vaginas" may also fuel desire for surgery, especially with the rising popularity of cosmetic surgery in general. The latest survey by the British Association of Aesthetic Plastic Surgeons reported a staggering 31% increase in uptake of cosmetic surgery in the UK[3]; women accounted for 92% of this uptake.

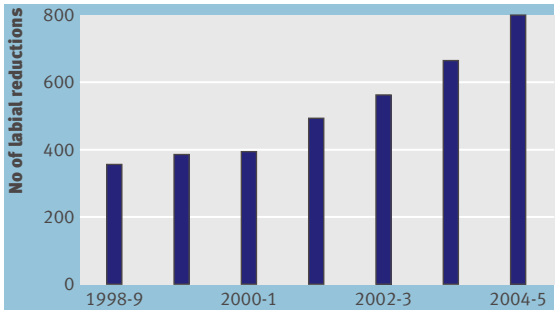
Decisions about surgically altering the genitalia may be based on misguided assumptions about normal dimensions. Recently, we reported dimensions of female genitals based on 50 premenopausal women.[4] Labial and clitoral size and shape, vaginal length, urethral position, colour, rugosity, and symmetry varied greatly. These findings bring into question assumptions about "normal" genital appearances.

NHS stakeholders are unlikely to encourage demand for cosmetic genitoplasty, but availability in the private sector could put pressure on services and distort the allocation of resources. The doubling of the number of labial reductions in the past five years (figure) in the NHS suggests that this may already be happening.[5]

A non-evidence based practice

Most reports look only at technical aspects of surgery,[6-8] and outcome data are sparse. Women are unlikely to admit to having had genital surgery, so that problems may go unreported. Psychological effects should also be thoroughly investigated because, even if an "abnormality" is clearly identified, the decision to have surgery always has a strong psychological basis. But few psychometrically robust measures exist to evaluate the long term impact of plastic surgery in general,[9] let alone genital surgery. The few reports that exist on patients' satisfaction with labial reductions are generally positive, but assessments are short term and lack methodological rigour.[10 11]

In the absence of reliable evidence, guidelines have been produced for plastic surgery in the NHS.[12]



Number of labial reductions in the NHS

The Department of Health publication *Plastic Surgery: Information for Patients* offers specific guidance on surgery for labial reduction.[13] However, there is no indication that practitioners adhere to guidelines.[14] The apparent lack of interest in developing guidelines and collecting evidence about cosmetic genitoplasty has led some doctors to align the practice with "female genital mutilation."[15] The sentiment is not without justification when girls in their preteens are being operated on.[10 11] Cosmetic genitoplasty is certainly challenging to arguments against medicalising even mild symbolic forms of female circumcision as a harm reduction strategy in some African countries.[16] The lack of nuanced understanding of help seeking processes in our society precludes meaningful discussion about the benefits and harms of surgical solutions. It also hinders development of a wider range of solutions.

Most requests are for labial reduction, carried out by gynaecological or plastic surgeons in the NHS and private sector. Surgical incision to the labia carries risks. The labia minora contain many nerve fibres that are highly sensitive; during sexual arousal, they become engorged and everted and contribute to erotic sensation and pleasure.[17] Some women request reduction of the clitoral prepuce or corpus. Research involving women with atypical genitalia (for whom genital surgery is common) has shown that clitoral surgery is associated with inability to reach orgasm.[18] Furthermore, impaired sensitivity is specific to the site of surgery.[19] Recent research has emphasised the role of the vulvar epithelium in sensuality and arousability.[20] In other words, incision to any part of the genitalia could compromise sensitivity—an important aspect of sexual experience. So what makes women take such risks when their genital characteristics fall within typical ranges?

The current medical literature provides little help—reports focus mostly on anatomical outcomes of labial reduction using various surgical techniques. We therefore interviewed healthy adults who had undergone surgical reduction of normal labia, so that they could talk about their experience without undue concern about access to treatment. Our aim is to develop an informed research protocol with robust evaluation tools that can be used for women seeking cosmetic genital surgery in the NHS and the private sector. We were struck by our interviewees' ambivalence and struggle for clarity about their decision (see box).

A gendered desire

As in previous reports,[2 10 11] our patients sometimes cited restrictions on lifestyle as reasons for their decision. These restrictions included inability to wear tight clothing, go to the beach, take communal showers, or ride a bicycle comfortably, or avoidance of some sexual practices. Men, however, do not usually want the size of their genitals reduced for such reasons. Furthermore, they find alternative solutions for any discomfort arising from rubbing or chaffing of the genitals.

Our patients uniformly wanted their vulvas to be flat with no protrusion beyond the labia majora, similar to the prepubescent aesthetic featured in advertisements.[2] Not unlike presenting for a haircut at a salon, women often brought along images to illustrate the desired appearance. The illustrations, usually from advertisements or pornography, are always selective and possibly digitally altered.

There is nothing unusual about protrusion of the labia minora or clitoris beyond the labia majora. It is the negative meaning that makes it into a problem—meanings that can give rise to physical, emotional, and behavioural reactions, such as discomfort, self disgust, perhaps avoidance of some activities, and a desire for a surgical fix.

A vicious cycle

The increased demand for cosmetic genitoplasty may reflect a narrow social definition of normal, or a confusion of what is normal and what is idealised. The provision of genitoplasty could narrow acceptable ranges further and increase the demand for surgery even more. More research is needed to learn about the social and psychological processes that have enabled many women to develop their own solutions to similarly negative preoccupations.

Resource issues aside, availability of surgical interventions could undermine the development of other ways to help women and girls to deal with concerns about their appearance in general. Surgery does not connect women with their ability to solve problems, with the result that some women just become preoccupied with the next "defect" to be fixed.

A questions for the NHS

Interventions that produce enduring psychological and functional benefits should not be dismissed. However, surgery is an extreme and unproved intervention in this instance, and it may not obviate the need for more specialist interventions. In the absence of local or national guidelines for surgeons, practice is likely to remain idiosyncratic.

Alleviation of suffering is fundamental to all healthcare professions, so who should tackle this emerging problem? When we reviewed general practitioners' letters of referral, we observed that they might have been unsure how to respond to their patients' intimate concerns without trivialising them. Some referrals may have been made in the hope that experts would persuade the woman that she was normal and deter her

SUMMARY POINTS

Demand for cosmetic genitoplasty is increasing

Surgery carries risk and has not been shown to lead to enduring psychological or functional benefits

There should be increased awareness that the appearance of female genitals varies greatly

Solutions other than surgery are needed in response to girls' and women's concerns about their appearance, including that of their genitals

from surgery. But the lack of immediate reassurance and referral to a specialist might be interpreted as proof of the need for surgery. An increased desire for the longed for fix could subsequently compromise the patient's capacity to process information on risks and limitations about their desired intervention. Even with psychological expertise, the surgical context is unlikely to encourage women and girls to acknowledge and explore their struggles to develop a range of solutions.

Transcript extracts: a real dilemma

The decision about whether to undergo cosmetic surgery is said to be a dilemma for women as it is "problem and solution, oppression and liberation, all in one."[21] And so, despite their satisfaction with the treatment, most of our interviewees were hesitant about recommending it to other women. For example,

"There's a there's a there's a balance [ ] I would be interested actually to know how many women *truly* do need the operation out of all of us [research participants], because it would be interesting."

". . . if it's, purely [:] for cosmetic reasons and to me it looked, fine, I will have my doubts [:] I think it just varies, it's just, opinion."

The need for the complaint to be real was thought to be an important basis for surgery, and what made it real was, firstly, the consistency with which it had troubled them and, secondly, by that trouble having been physical,

"So I think you know sometimes you just have to be very careful. [:] You know when it's how someone sees themselves, or how they think, because then, you know that that can change with the wind, but if it's how they *feel*, based on a you know a physical feeling . . ."

or psychological,

"There need to be strong reasons, like in my case, when my partner comes near me, I want to avoid it [partner looking at her genitals] . . ."

In the absence of either physical or psychological unease, however, it was the psychologically arduous process—the "work" involved—in seeking help from "proper" NHS doctors that authenticated the preoperative complaint,

". . . I thought, I've had to think about this, you know and I've had to [ ] [:] it's not, so it can just be oh I'm going I'm . . . Every other woman can say well I might as well have that done, I've had this done I've had that done I might as well have that done you know . . . it's the available thing isn't it . . . but once you've had to *work* to get it . . . You know to me, psychologically if you, if you go through the right channels [general practitioner and specialist] . . . rather than feeling that you can just, get it done just like that [:]. There's no understanding behind that is there?"

"True" needs and "untrue" needs cannot easily be separated in this context. The hesitancy of these otherwise articulate women may mirror that of surgeons who operate on women yet cannot reconcile their practice in principle or to recommend it as policy.

These transcripts also suggest that genital surgery may be just one of a series of cosmetic operations in a woman's lifetime. One of the women had had breast augmentation to relieve her from "self consciousness." Another one was saving for a "face lift." One young woman had had her labia reduced at the age of 17 to stop her feeling anxious. However, she was still sexually anxious and avoided sex, so she was now seeking excision of her remaining labia. Like women born with atypical genitals, the surgical fix is so compelling that it can be difficult to explore the psychological basis for surgery beforehand, or even afterwards.[22]

Key to transcript notation: [ ]=noticeable pause; . . .=text omitted; [text]=text inserted by authors for clarification; *text*=said with emphasis; [:]=interviewer's minimal encouragers

It should be thought of as the last resort, not the first port of call.

Multiagency initiatives involving health agencies, educational bodies, the voluntary sector, and the media are needed to help girls and women deal with feelings of insecurity about their genitals and about their bodies in general. We also need more commitment and investment in research as well as innovative interventions in the community to help women and girls to approach concerns about their appearance skilfully and imaginatively.

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Primary care research networks in the United Kingdom

Frank Sullivan and **colleagues** describe the new bodies emerging to coordinate and boost primary care research in the four UK countries

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In British primary care, where 80% of National Health Service consultations take place, policy decisions often depend more on optimistic theory than on evidence.[1] Conducting research has generally been a low priority for primary care clinicians in the United Kingdom. The ethos of independent small business in general practice tends more towards innovation than research, and scarce academic training opportunities are associated with a culture where research is not much expected, valued, or rewarded.[2] Yet with leadership, resource, and good relationships between researchers and service providers, primary care research can underpin effective and efficient practice in ways that specialist perspectives alone cannot.[3-5]

Moreover, the UK has developed primary care research infrastructures that have been enabling and influential internationally.[6-8] Most recently, the new national health research strategy aims to "re-engineer the environment in which clinical research is conducted" through the UK Clinical Research Network (UKCRN), which involves primary care centrally (figure).[9] This network is intended to offer a managed approach to hosting high quality research in the health service and to assuring recruitment and retention of study participants. In primary care this contrasts with the previously established diverse, capacity building, practitioner centred networks.[10] The four countries of the UK are using different approaches in primary care to realise this new network. We describe them briefly here, to demonstrate the direction and scale of the changes.

England

In England (population >50 million) one primary care research network has been established across the whole country. This is part of a wider initiative, which will include six topic specific networks and a comprehensive clinical research infrastructure through which service support, research governance, and academic staff will also be funded.[11] The England wide primary care research network comprises central coordination of eight distinct local networks. These networks link interested practice teams and local academic units of general practice to participate in a wide range of national projects led from the service, universities, and industry. The leadership is currently negotiating a sometimes painful transition away from prioritising capacity building for research at the local level and towards national priorities.[11]

A National School for Primary Care Research was established in 2006.[12] Focused initially on the five English academic departments of general practice and primary care scoring 5 or 5* in the last research assessment exercise, it has two aims. These are to improve primary care through evidence from research at each stage along the patient pathway (from prevention to management of long term conditions) and to work with UKCRN and other interested organisations to develop a world class UK primary care research portfolio.

Scotland

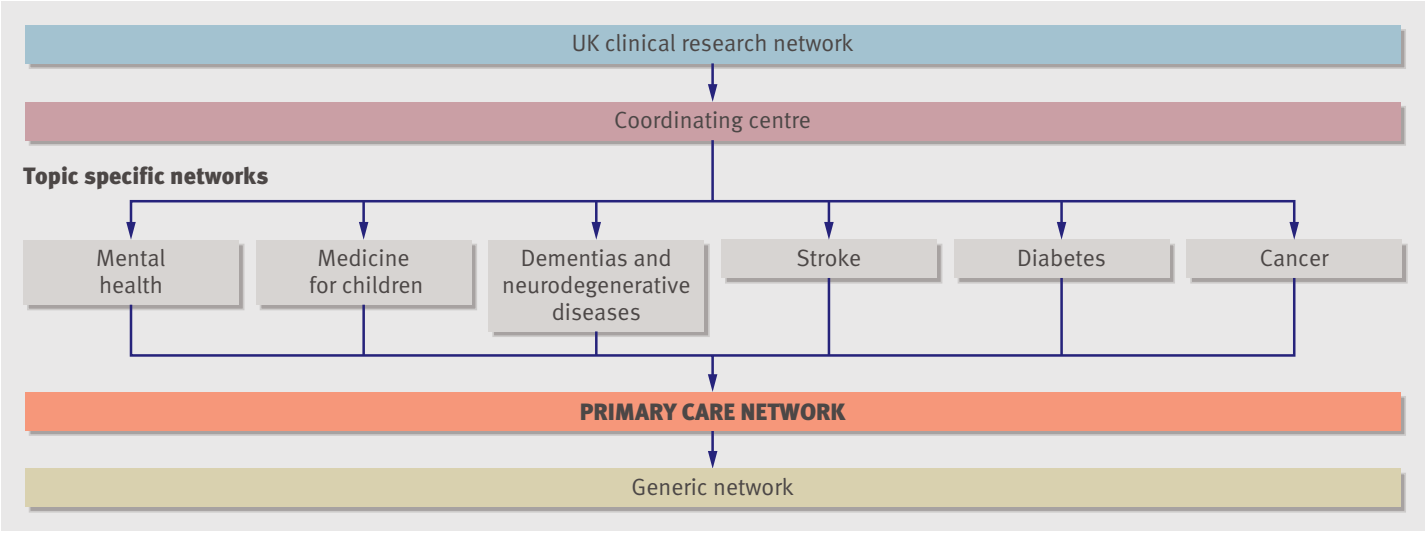
Scotland (population 5 million) was the first part of the UK to establish, in 1999, a school of primary care. The Scottish Executive and NHS Education Scotland fund the Scottish School of Primary Care to build research capacity and capability through a network called Scottish Practices and Professionals Involved in Research. The Scottish Funding Council has also recently provided extra funds to a consortium of all Scottish higher education institutions engaged in primary care research.[13] This virtual organisation includes all Scottish academics with an interest in primary care research and the many clinicians who undertake, participate in, and facilitate research while carrying out their normal clinical work (currently 1700 people).

Wales

Wales (population 3 million) will have a single unified research infrastructure—Clinical Research Collaboration Cymru—covering primary, secondary, and tertiary health care and social care. The Welsh Assembly has commissioned a research professionals' network to support research and recruit patients into high quality, peer reviewed studies. The network will eventually include up to 22 accredited "nodal" research general practices, each with a half time research nurse or equivalent resource. These practices will recruit patients into studies, develop research in neighbouring general practices and other primary health and social care facilities, and link with research professionals in hospital settings. Plans for a Welsh School of Primary Care Research are being developed.

Northern Ireland

Northern Ireland (population 1.7 million) has no ring fenced investment for research in primary care. The Northern Ireland Research and Development Office supports several "recognised research groups" which focus on specialised areas of care and are encouraged to include primary care in their work.[14] A Northern



Infrastructure of UK Clinical Research Network

Ireland Clinical Research Network is developing currently, with planned provision of a comprehensive infrastructure and central administrative resource for research in primary, secondary, tertiary, and social care. This network will collaborate with UKCRN to avoid duplication of policy and procedure development and to achieve mutual benefit in enhancing local capacity for high quality research projects. Whether a specific network similar to that for primary care in England will be established remains undecided; the progress of networks in other areas of the UK will undoubtedly inform this decision.

These models reflect a range of cultures and priorities in both the service and research arms of the health services serving the four nations. The vision of effective UK wide networking in research is not yet, however, reflected by current realities. The challenges and transaction costs of collaborations between local organisations, let alone between nations, are high. Setting of timescales and management of human and other resources will have to be realistic if the best that is promised is not to become the enemy of the evolving good.

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The surgeon stands accused

After my father had undergone emergency surgery for small bowel obstruction, I visited him in a local hospital. He was pleased with the quality of care he had received but had some reservations about the consultant surgeon who had operated on him late the previous night. He recalled the consultant smelling strongly of alcohol, and my father felt that he had been drinking before attending the hospital to carry out the emergency surgery.

This concerned me greatly until I, too, was accused of smelling of alcohol. An impromptu clinical trial of using the hand sanitiser at the foot of the bed confirmed my hypothesis. The alcohol based hand rub was the guilty party and not the consultant surgeon.

Nowadays, hand washing is a cornerstone of hospital good practice. The National Patient Safety Agency's *Clean Your Hands* campaign was deemed a success partially because of its initiative to provide hand sanitiser on each patient's bed. Perhaps the next step in the campaign should be to find a product with a more satisfactory odour.

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