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Our concluding thoughts turn to the future, of course, and this is our opportunity to offer the warmest of good wishes to Deborah Kirklin, who has been a passionate advocate of the field throughout the period in question, for the continuing success of the Journal under her editorship. We appreciate enormously the generous invitation to write this 10th-anniversary editorial, and we close our remarks with the observation—as practitioners and as readers!—that the flourishing of the Journal and the flourishing of the field of medical humanities are significantly linked. Their continued and extended joint flourishing is, emphatically, our fervent wish.

Competing interests None.

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Looking at and talking about genitalia: understanding where physicians and patients get their ideas about what's normal and what isn't

Katrina Karkazis

The papers in this issue by Wall and Howath and colleagues provide a much-needed focus on the ways in which images of genitalia carry implicit messages about what is normative and thus acceptable (*see articles on pages 75 and 80*).[1 2] By construing the normal and abnormal, these authors argue, genital images shape self-perception and social attitudes about genitalia and, in so doing, the extent to which physicians and women problematise certain genitals and thus play an important role in decisions about the necessity or appropriateness of elective genital surgery.

Wall focuses her attention on the way in which medical illustrations in textbooks, atlases and patient-education materials construct what is understood as abnormal genitalia in the case of children with intersex conditions (or disorders of sex development). Conditions, she notes, "that overwhelmingly turn on *visual* manifestations of sex".[1]

Drawing a distinction between norm as average and norm as ideal, Wall argues that all too often these two norms are conflated, and the average is upheld as the ideal. This is in part a function of the nature of medical illustration itself: a generalised representation must be depicted in one or two illustrations leading illustrators to flatten the range of human variation. Although seemingly descriptive and transparent, these illustrations impart not what is, but what ought to be. Genital images are important not simply because they shape ideas, but because those ideas—in subtle and not so subtle ways—drive treatment practices. Images that we uncritically read as descriptive may very well be proscriptive. Wall reveals how illustrations take on this latter role.

Images both create and perpetuate a norm, but as Howarth *et al* note,[2] few studies have examined variation in genital morphology, which begs the question, if images are selected and illustrations are drawn so as to be representative, on what data do they draw? How or on what is this norm constructed when few real-life measurement samples are available to say what reflects the general population, especially as it pertains to female genitalia?

Howarth *et al* tackle this problem from a particular angle.[2] Their interest lies not in trying to document the range of genital variation, but rather in showing how norms (that is, ideals) may vary depending upon context. They examine three sources of imagery—anatomy texts, feminist publications and pornography—to determine if depictions of the vulva differ according to their source. They, too, find that the images reinforce an ideal, albeit a mutable ideal. They ask to what extent these images shape physicians' and women's ideas about what is normal and thus decisions about labial reduction surgery.

Not surprisingly, both papers note that genital images scarcely reflect the range of human genital variation. Indeed, since the feminist health movement in the 1970s, we have known that feminist depictions of female genitalia differ significantly from clinical depictions, acknowledging a range

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of variation in female genitalia and detailing the striking differences in anatomy and appearance among women.

Thirty years later, however, clinical sources continue to fail to represent or convey this variety. One has to look back to *Human Sex Anatomy: A Topographical Hand Atlas* by the gynaecologist Robert Dickinson[3] to see the extraordinary diversity in the appearance, shape and size of women's external genitalia represented in a medical text. Dickinson's text is striking for its largely descriptive nature: in contrast to the studies he cited, Dickinson catalogued clitoral size, for example, with no proscription as to what was normal.

In the case of intersex conditions, where the most prevalent diagnosis is characterised by atypical clitoral growth, measurements of so-called normal infant clitoral size were only available decades after the entry of clitoral reduction surgery into the standard of care. One wonders, then, if measurements were not available, on what basis did physicians understand genitals as problematic? Certainly, visual images played a role in their construction of the abnormal.

Yet even when norms are available, physicians often do not refer to them. Howarth *et al* cite a recent review article of roughly 1000 cases of labial surgery that found no preoperative comparisons with published norms. Similarly, when I asked physicians how they determine whether a clitoris is enlarged, almost all said they did not rely on measurements. As one surgeon said: "It's an impression of how it looks. If you open the diaper and see a phallic structure then, clearly, that's going to be objectionable. I don't have an actual measurement. Maybe it's my sexism or something, but I've never measured clitoral size. It's by visual. As we're doing the surgery, we'll look at it stuffed back and say, 'That looks good, or it still really looks abnormal'. It's very much a judgement thing".[4]

Rather than accept this judgement as 'factual' or immutable, Wall and Howarth *et al* ask physicians to understand and interrogate how such a judgement might be formed. They further argue physicians and surgeons have a moral duty to redefine normal and abnormal once a patient enters the room.

How might this be done? Wall outlines several ways in which images might be presented that could avoid strict dichotomisation where variation is not construed as a violation of the norm. Howarth *et al* suggest training health-care workers about the morphology and functions of genitalia, and how shapes and proportions vary. This point is well-taken: sexual health training in North American medical schools is woefully inadequate, and they cite evidence that medical students feel their training in sexual health is poor. They also suggest training physicians to communicate to patients biases in available images.

Howarth *et al* further suggest we would do well to research genital variation. I agree, but we need to be careful here. Measurement has frequently been used as a technique in resolving critical border disputes such as the boundaries between races, between the normal and the abnormal, and between male and female. Many studies have shown that more than an accurate appraisal of the actual body, ostensible attempts to quantify and typologise human bodies have been infused with cultural notions about gender and racial difference. Moreover, such standards may have the effect of pathologising the bodies of those who fall outside the norms because the average and the ideal are routinely conflated. In studying genital variation we need, then, to be careful to avoid typologising and further stigmatisation.

To their suggestions I would add a third, which is tempering patients' and surgeons' faith that surgery can achieve the 'normality' patients so desire. The surgeon Jeffrey Marsh[5] has noted that surgeons tend to say they will 'correct' a certain feature when what they should really say is that they will *partially* correct it: "It is rarely the case that the operation is so perfect that there is no residue of the original difference". Indeed, this 'conceit of cure' can make surgeons feel that medicine can provide an answer to most things, even to social problems.[6]

Most physicians see their taxonomies and images as apart from culture. Suzanne Kessler so rightly noted, however, "how hard one 'looks' at genitals and what one 'sees' is constrained not by the optic nerve but by ideology".[7] As the two papers in this issue underscore, understanding how our ideas about what is normal or isn't for genitals isn't simply an academic exercise, it is critical to good medicine.

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