AMA Journal of Ethics®
August 2017, Volume 19, Number 8: 825-833

MEDICINE AND SOCIETY

Are Physicians Blameworthy for Iatrogenic Harm Resulting from Unnecessary Genital Surgeries?

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Abstract
We argue that physicians should, in certain cases, be held accountable by patients and their families for harm caused by "successful" genital surgeries performed for social and aesthetic reasons. We explore the question of physicians' blameworthiness for three types of genital surgeries common in the United States. First, we consider surgeries performed on newborns and toddlers with atypical sex development, or intersex. Second, we discuss routine neonatal male circumcision. Finally, we consider cosmetic vaginal surgery. It is important for physicians not just to know when and why to perform genital surgery, but also to understand how their patients might react to wrongful performance of these procedures. Equally, physicians should know how to respond to their own blameworthiness in socially productive and morally restorative ways.

Introduction

In this essay, we discuss three types of genital surgeries commonly performed for sociocultural or aesthetic reasons in the United States and consider physicians' roles in both causing and preventing harm associated with these genital surgeries. First, we consider surgeries performed on newborns and toddlers with atypical sex development, or intersex. Second, we discuss secular, nontherapeutic, neonatal male circumcision. Finally, we consider cosmetic vaginal surgery.

Because sex and gender are so closely tied to our social identities and self-conceptions, patients and parents might feel an especially acute need to discuss and hold physicians accountable for harms and to rebuild trust, even when physicians consider the surgeries "successful." Thus it is important for physicians not just to know when—and when not—to perform genital surgery, but also to understand how their patients, when they are older, could reasonably react to wrongful performance of these procedures. Equally, physicians should know how to respond to their own culpability and complicity in ways that are socially productive and morally restorative.

Before proceeding, we should clarify what we mean by "blame" and "blameworthiness." We are interested in the justified expression of what philosophers sometimes refer to as "negative reactive attitudes" [1]. Susan Wolf describes the attitudes we have in mind as:

> A range that includes resentment, indignation, guilt, and righteous anger—they are emotional attitudes that involve negative feelings toward a person, arising from the belief or impression that the person has behaved badly toward oneself or to a member (or members) of a community about which one cares and which tend to give rise to or perhaps even include a desire to scold or punish the person for his bad behavior [2].

We consider whether genital surgical patients' feeling and expression of these attitudes is justified in response to surgeries recommended or performed for social or aesthetic reasons. Specifically, we are concerned with the physical and emotional iatrogenic harms patients suffer when such unnecessary (not clinically indicated) genital surgeries are "successful," and the nature and scope of physicians' blameworthiness for these harms. Ultimately, we argue that when physicians encourage parents to authorize and then perform "normalizing" surgeries for nonmedical reasons, patients' blame is a fitting response to the physical and emotional harms they suffer as a result and that it is, therefore, reasonable to view physicians as blameworthy (in the sense that they are rightful targets of such negative reactive attitudes). We argue that pediatricians should promote body positivity—acceptance of all types of bodies—to their young patients, their adolescent patients, and their parents, rather than encouraging so-called normalizing surgery.

Intersex Surgery

Surgeons have been performing surgeries in response to children's atypical genitals since the mid-nineteenth century, although it was not until the 1950s that such surgical "repair" became standard protocol [3].The surgeries have been largely cosmetic and social in nature rather than medically indicated [3]. In fact, throughout American history, fears of homosexuality often motivated intersex surgeries, as some physicians wanted to make sure that patients knew for sure which sex they were so that they wouldn't be attracted to the "wrong" sex [3]. Many parents might consent to surgeries recommended by physicians, hoping that their children's genitals would look more typical, but these surgeries can have iatrogenic consequences, including loss of sexual sensation, incontinence, scarring, and sterility [3-6]. More than one surgery is often done; in these cases, there is substantial risk of emotional trauma and of tissue breakdown in this sensitive region [4, 5, 7]. In the late-twentieth century, attitudes toward these surgeries began to change, largely because of intersex activism that began in the 1990s [4-6]. Intersex activists do not oppose surgeries required to ensure voiding, for example, but they are against the more common surgeries that alter the appearance of the genitals so that they conform more closely to typical genitals, such as removing or

minimizing a girl's enlarged clitoris or creating a vagina so that heterosexual penetration can be more easily accommodated [8]. In fact, the American Medical Association is currently considering a resolution that supports autonomy for patients born with differences in sex development, including atypical genitals [9].

If, as a society, we felt more comfortable with difference, we might not be so eager to surgically repair bodies that didn't actually need fixing, particularly when the alleged fix caused iatrogenic harm. It is possible for physicians and parents to choose a gender for a child born with genital difference based on a medical assessment of chromosomes, anatomy, and hormone levels and still decline surgical intervention. The urge to perform these unnecessary surgeries has not been based on empirical evidence, and in fact many intersex people have expressed anger at what happened to their bodies when they were too young to do anything about it [10].

We argue that physicians who recommend or perform genital surgeries that are not clinically indicated can be rightly blamed for, and are complicit in, both pathologizing natural variations in bodies and causing unnecessary iatrogenic harm. We will assume that surgeons, in performing these surgeries, do not express any malice or ill will: they might think, perhaps wrongly, that they are acting in the patient's best interest [4, 5]. Although good intentions should affect the way parents and patients express blame and hold physicians accountable for the negative consequences of intersex surgeries that are not clinically indicated, they are not fully exculpating. Physicians who, despite acting in good faith, are swayed by social pressure to attempt normalizing surgery have a moral and professional duty to inform themselves of the potential iatrogenic consequences of permanent sex assignments and other genital alterations that are not medically necessary and performed without the consent of the patient, of which there are numerous testimonials [10]. Accordingly, they should explain to parents that children born with ambiguous genitals are usually healthy and at no clinical risk and should have the right to decide whether to undergo normalizing procedures when they are old enough to make those decisions [8]. We maintain that the choice to undergo irreversible surgery for social or aesthetic reasons should be left up to autonomous and well-informed patients.

Equally important, physicians have duties to interrogate their motives for recommending or performing unnecessary procedures even, and perhaps especially, if those surgeries were once thought to be essential to patients' health. (This point applies to parents as well as physicians, but we leave the question of blame for parents aside in this article.) When surgeons perform "successful" intersex surgery on a patient that results in iatrogenic harms, a patient or a family member's expression of blame can play an important role in the process of rebuilding the patient-physician-family relationship. Expressing blaming attitudes can be a way of starting a productive and honest dialogue about the damage done and possible ways to move forward [11]. Expressing anger,

though often seen as socially unproductive, can be a means of prompting a blameworthy agent to reconsider her actions and to offer a humbling, restorative, apology, which in turn can be crucial to mending a relationship [12]. Blaming can also be a way of fostering self-respect [13]: in expressing blame, patients who were wronged as children and their parents can affirm their moral status and their moral equality with their physicians.

It is important to note here that blameworthiness does not mean that one is a bad person; unlike shame, blame primarily involves an indictment of one's action rather than one's character [14]. Thus, when confronted with the iatrogenic physical and psychological harms that result from genital surgeries that are not clinically indicated, physicians may properly feel a sense of guilt about endorsing and executing them. But they need not feel ashamed. We maintain that physicians who have performed or continue to perform clinically unnecessary genital surgeries should respond to their blameworthiness by offering an apology and rethinking their recommendation of, and participation in, so-called normalizing procedures; if possible, they should understand a patient's expression of blaming attitudes as an invitation to repair the damage that iatrogenic consequences can do to the patient-physician relationship.

Neonatal Male Circumcision

The principle that irreversible surgery performed for social or aesthetic reasons should be up to an informed and autonomous patient applies to male circumcision as well. In some religious and cultural communities, nonmedical reasons motivate decisions to circumcise newborn infant boys. Such cases fall outside the scope of the secular focus of this paper, as pediatricians' opinions are not usually sought in these instances. Most American parents, however, do not have religious concerns about circumcision; they simply ask—or are told by—their pediatricians what to do [15].

So many men in this country have been circumcised as infants—estimates range from 42-80 percent among various subpopulations [16]—that the surgery can strike us as normal. Indeed, the surgery is popularly perceived as a mere "snip" of skin [17]. But pediatricians should at least question the necessity and wisdom of recommending the procedure, given its risks [16], iatrogenic consequences—including its possible effect on sexual sensitivity or satisfaction [18]—its permanence, and the fact that its recipient might have chosen otherwise.

Secular parents may choose to circumcise their sons because they believe that it is a medically sound decision. Some studies conclude that removing the foreskin protects boys from urinary tract infections as children and then later from penile cancer or even HIV as adults [19]. The American Academy of Pediatricians (AAP) has vacillated in its support of circumcision over the years. In 2012, it released a report asserting that the potential health benefits of infant male circumcision outweigh the risks [16]. This pronouncement overturned the Academy's earlier policy statement, from 1999, which

asserted unequivocally that the potential health benefits of the procedure are insufficient to recommend that it be done routinely [20]. The 1999 statement in turn reversed a previous one made in 1989, which claimed that there were good medical reasons for infant male circumcision [21]. Yet a few years earlier, in 1971, the Academy had officially concluded that there was no definite medical indication for the procedure [22]. Clearly, circumcision is one of those surgeries about which opinion shifts back and forth [23].

In 2012, the AAP agreed that parents should be presented with honest and straightforward information about the care of the penis and the benefits and risks of circumcision [16]. Physicians might also discuss the following with parents: What is the foreskin for? What is being cut away? How is it done? How long does it take to heal? What do circumcised and uncircumcised penises look like at infancy and in adulthood? Many new parents do not know even these fundamental facts and so their decisions about their infants' bodies are based on myths, preferences, and often inaccurate information [18].

A physician's potential blameworthiness for performing infant male circumcision will rest in large part on her motives and her commitment to staying informed. Nevertheless, we endorse the general principle that pediatricians should not recommend irreversible surgery, such as the permanent removal of foreskin, on nonmedical grounds. When pediatricians perform circumcision out of deference to parents' unquestioned custom, they may be rightful targets of blaming attitudes, even anger, expressed by parents and by patients once they have grown up. However, if a physician fully in command of the current medical literature informs parents of the iatrogenic risks of the procedure, and then recommends circumcision because she views it as a medical necessity—for example, to correct phimosis, a condition where the foreskin does not retract—the physician would be blameless even if medical consensus changed after the surgery was performed.

Cosmetic Vaginal Surgery

Pediatricians have great influence over the ways in which parents, children, and teens learn and communicate about what constitutes a "good," healthy body. We see the increasing popularity of labiaplasty [24], described by the International Society of Aesthetic Plastic Surgery (ISAPS) as a "remodeling of the enlarged inner lips of the vulva" [25], as a sign that something has gone awry in the way our culture imagines what constitutes genital normality. Who decides when labia are "too large?" Why should anyone need "remodeling"?

Cosmetic vaginal surgery is being promoted by aesthetic plastic surgeons [26] and has found a ready audience of women who are dissatisfied with the normal appearance of their genitals. The ISAPS reported that 13,390 labiaplasty and vaginal rejuvenation

procedures were performed in the US in 2015 [27]. And in 2015, labiaplasty alone (excluding vaginal rejuvenation, a procedure that tightens vaginal muscle tone) increased 16.1 percent over the previous year [24]. Yet in 2007, the American College of Obstetricians and Gynecologists had asserted that "Absence of data supporting the safety and efficacy of these procedures makes their recommendation untenable" [28].

Physicians have debated whether vulvar plastic surgery is ever warranted [29]. Pediatricians, in keeping with their obligations to promote the physical and psychological health of their patients, should do more to disrupt the discontent of teenage girls and their constant scrutiny of their bodies. We believe that when children visit their pediatricians, they should see pictures of a wide variety of children, so that a range of bodies come to seem normal and healthy. For teen patients, accurate pictures would be welcome, so that teenagers can see that human bodies differ considerably and that there is no one perfect way of looking, even in the genital region. The enormous silence that obscures genital and reproductive variation can be broken by physicians willing to adorn their office walls with "The Great Wall of Vaginas," for example, a sculpture made of plaster casts of four hundred women's vulvas, or other such feminist art that celebrates difference and contributes to "changing female body image through art" [30]. Similar body positive art could serve as a teaching tool for boys and even gender-nonconforming children who may be considering delaying puberty and ultimately transitioning.

It would be odd for an adult to blame her physician for her own decision to undergo voluntary cosmetic surgery, but insofar as some physicians promote a narrow vision of what a healthy body looks like that can propagate damaging self-perceptions among patients, they might be reasonably resented by patients struggling with body image issues. For pediatricians who have endorsed surgical normalization, their reasonable feelings of guilt and remorse may lead to a laudable desire to play a larger role in promoting body positivity and acceptance and to actively disseminate the apt intersex rights slogan: No Body is Shameful® [31].

Conclusion

We have argued that physicians should not modify children's genitals for nontherapeutic reasons. In addition, we believe that they should play a bigger role in educating their young patients about genital and body variability and consider their motivations when advocating surgical normalization. When physicians do perform genital surgeries for nonmedical reasons, a wronged patient's feeling and expression of blaming attitudes can be both fitting and justified. In fact, the expression of anger can be part of a productive social interaction that can, under certain circumstances, prompt apology and facilitate psychological healing.

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ISSN 2376-6980