Prof. Dr. Mandy Mangler

Die Chef-ärztin, die Frauen eine Stimme gibt.

DLF Kultur

DAS GROSSE GYN BUCH

Selbstbewusst für den eigenen Körper entscheiden

Sex, Zyklus, Wechseljahre aus weiblicher Sicht neu verstehen

Krankheiten erkennen und therapieren

Insel

Gynaecology is still dominated by men – with direct consequences for the health and body-image of us women. That's why I have written a book that looks at all areas of gynaecology from a woman's perspective.

Prof. Dr Mandy Mangler

Photo: Benjamin Zibner & Sonja Riemann

Mandy Mangler rose to public prominence thanks to her podcast "Gyncast", through which she reaches hundreds of thousands of listeners. The goal of this project is to educate the public about the female body and all the gynaecological issues that women might be confronted with over the course of their lives. This book draws on conversations with patients and listeners as well as on her work as a doctor and researcher. It looks at how women can live a fulfilling sex life, offers a different perspective of PMS, explains when you should see a fertility specialist if you're trying to get pregnant, takes period pain seriously, offers empowering tips for dealing with vaginal infections, as well as providing a load of information on current cancer treatment options – all without ever losing sight of social aspects. The book for all women who want to know how their body works.

Prof. Dr Mandy Mangler was born in 1977 Mandy Mangler is the head physician at two Berlin clinics for gynaecology and obstetrics with a focus on operative therapies and gynaecological oncology. Since 2021, she has been teaching as a Professor of Women's Health and Obstetrics at the Protestant University of Applied Sciences Berlin. Mangler hosts "Gyncast", a monthly podcast published by the *Tagesspiegel* newspaper, is an active advocate of equality and diversity in medicine, and was the recipient of the Berlin Women's Prize in 2022. Mangler has five children and lives in Berlin with her partner.

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Prof. Dr Mandy Mangler

The Big Book of Women's Health

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Esther Kogelboom and
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Insel

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Sometimes it's tough having a female body – having a menstrual cycle, having periods and breasts. It can be a challenge to embody your sexuality from a female perspective, to get pregnant or try avoid getting pregnant, and to navigate your way through menopause. And it's certainly no picnic being sick in a female body. Because often gaining a clear picture of the female body is obscured by outdated ideals, projections, and myths – and that is especially true of the field of medicine, where the male body is still viewed as the norm. Even the way we look at our bodies in the mirror is shaped by these ideas and conceptions, meaning they exert an influence on all aspects of our lives.

Like all medical specialties, gynaecology has long been a thoroughly male-dominated are of knowledge. In the German-speaking world, it was not until the early 20th century that women gained full access to universities. And although 77 per cent of gynaecologists are female, making gynaecology the specialty with the highest proportion of women practitioners, when it comes to the positions at the top of the ladder (the heads of gynaecology departments, professors, and clinic directors), 81 to 87 per cent are held by men. And there has never been a single woman at the helm of any of the professional associations for gynaecology in the German-speaking world. Which means that even in gynaecology, for years, perhaps even decades, the training, the therapeutic guidelines, and the prevailing medical opinions in the field have all been primarily shaped by men. This has serious consequences for the way that the profession views its patients, for their health outcomes, and for their own self-image. "Nowhere in medicine is there more power over women's bodies than in gynaecology," noted the former vice chair of the German Association of Women Physicians, Prof. Gabriele Kaczmarczyk, who also worked for many years at the Charité hospital in Berlin as the equal opportunity officer.

In medicine as a whole, for a long time, there was a prevailing assumption that the differences between men's and women's bodies were so negligible, that women could be viewed scientifically as slightly smaller men.

This presumption led to the situation that up until the 1990s, most pharmaceutical studies simply excluded women as test subjects – too great was the fear that they could fall pregnant during the course of the study, with the medication posing a risk to the unborn child. Since then, things have begun to change, but we are still a long way away from reaching an accurate representation of women in this area. It takes more effort to assess the results of female subjects in these studies, because it is necessary to take into account a woman's menstrual cycle, and to differentiate between pre- and post-menopausal women, and between those using hormonal contraception and those who do not. In fact, in order to achieve reliable findings, you would actually need to include more women in such studies than men.

Women's bodies are not only anatomically different from men's bodies, they also exhibit immunological, genetic, and hormonal differences – each of which have impacts on every area of medicine. Which is why women need a branch of medicine that is tailored to them. The fact that knowledge about the differences between male and female anatomy is not consistently applied in the broader field of healthcare can be life-threatening. A classic example of this is the fact that women are more likely to die after suffering a heart attack than men because they exhibit different symptoms. And because these symptoms are less well known, the seriousness of their condition is often not recognised by emergency room staff, which means they do not receive the treatment they require with the adequate urgency.

Now you could be forgiven for thinking that this issue of transference – where forms of treatment that have been designed for men are then inadequately applied to women – is not an issue for gynaecology. After all, gynaecology has always been explicitly about the female body. But gynaecology is far from being immune to this situation. Recommended dosages for specific medications are an example of how gynaecology draws on research that was carried out on male bodies. And these guidelines fail to recognise that the medications have a different effect on women and can cause more or different side effects.

However, the source of many of the problems generated by the male-dominated nature of gynaecology can be found in the fact that a male doctor's perspective of the female body is by nature different to that of the patient herself or that of a female doctor. There are some research ques-

tions that men in decision-making positions and in research groups don't pose because they simply don't recognise their importance. They see the female body from their male perspective. It took me quite some time to understand how this mechanism works.

To offer a metaphor from the medical field: when a venous access is inserted in a patient to administer an infusion, sometimes, the person carrying out the procedure will miss the mark slightly, inserting the device a little to the side of the vein, which in German is described as "para", meaning "beside". This means that the infusion also flows beside to the vein, into the surrounding tissue, rather than into bloodstream. In my opinion, a certain portion of the institution of gynaecology is also a bit "para", just a little off the mark.

This has all kinds of consequences. It starts with the most fundamental terminology. In common parlance, we typically use the word "vagina" to refer to what is actually the "vulva". Meanwhile, in German medical terminology, the vulva and the vagina are still referred to collectively by the term Scheide (which is in turn a direct translation of the Latin root, *vāgīna*, meaning "sheath"), which is a gross simplification. People still speak of the "hymen" even though nothing of the sort exists. Contraception is a major issue that is unequally distributed between the sexes. Even in the practice of gynaecology, we still far too often equate sexuality with the penetration of the vagina. Far too often, women are not advised that it is not necessary to be admitted to hospital to undergo an abortion and that the procedure can be carried out at home by ingesting a medication. Or that a woman – even when she is giving birth in the delivery room – should always retain autonomy over her own body.

Operations such as hysterectomies are often performed without considering the fact that we still do not really understand what this procedure means for the bodily integrity of the patient, for their sexuality, and for their ability to orgasm. The research groups involved in investigating the effects of hysterectomies have largely failed to pose targeted questions about these matters. They look into the consequences for vaginal penetration, but not into the consequences for the patient's ability to orgasm. As a result, there is a distinct lack of information on this issue.

Not so long ago, I was chatting with a couple of male colleagues at a conference and inquired about the effects that a particular surgical procedure had on female sexuality. One of the gynaecologists present announ-

ced that the lubrication of the vagina is unaffected by the procedure, and thus also female sexuality. What about the clitoris, I asked him. Is the patient still able to feel arousal and pleasure after the operation? My colleague stared at me with a perplexed expression. He had not even included the clitoris and female arousal in his considerations – however, from his male perspective, he had indeed considered it important that the vagina remain capable of lubrication and thus of being penetrated. And yet, studies have shown that it is possible for the vagina to become lubricated in response to stimulus that is not perceived as arousing or pleasurable at all. The discussion ended with the flustered colleague leaving the room to regather his composure. His world view had been shaken, and he found it difficult to deal with.

Until recently, there was no pre-op patient information form being used in Germany that contained an accurate depiction of the vulva. It was missing the clitoris, our organ for pleasure and orgasm. After a good deal of persistence and in collaboration with the intelligent individuals responsible for producing the information form, I ultimately managed to get this corrected in a new version produced in 2023. The argument against correcting the depiction was that it was too complicated, that women wouldn't understand it. And that may well be true if the first time a woman ever hears that their clitoris is not just glans and a hood but also has a shaft and bulbs and extends deep inside the body (more on this in the chapter on the clitoris) is right before they're about to go in for an operation. But the same argument could be used to claim that it would have been better not to disabuse humanity of the notion that the Earth is flat.

Internalised Misogyny

For our podcast "Gyncast", I work as a doctor together with the journalists Esther Kogelboom from *Tagesspiegel* and Anna Kemper from Zeit, with Julia Prosinger having been involved in the early stages. The myths that we investigate on the show are often founded on misogynistic conceptions that all of us have internalised. A body – and this is particularly true of a female body – is never a neutral medical terrain. None of us can completely free ourselves from the stereotypical images and opinions to which the female body has forever been subjected – be it as an object of desire

or as a vessel for delivering offspring. And of course, these conceptions also have an influence on the field of medicine.

The original idea of the podcast was to produce ten episodes providing listeners with information about various areas of women's health. But with every gynaecological topic we looked at, there was just so much more to say, and in every nook and cranny we discovered so much dust that needed to be cleared out, that we are now continuing the format without a predetermined end point – which is also thanks to the amazing response we've received from our listeners. With their engagement, we were able to put together an interactive format with which we can carry out surveys and collect statistical data that is also of interest from a research perspective. One thing that became clear to us through all this is that there is a huge need for education and information, and this transcends all generations. That was also one of the motivating factors for writing this book.

In this book, I want to provide information about women's bodies and health, but also about illnesses and treatment options, and I want to do so from an explicitly and uncompromisingly women-centred perspective. Time and again I see that when it comes to many issues related to women's bodies, even highly informed patients have massive gaps in their knowledge or have absorbed inaccurate information.

In my day-to-day work as a doctor, I try to understand the people who come to see me, to acknowledge their needs and identify their illnesses, and to have a positive effect on their lives. Whether it's by treating a condition or helping them to manage things themselves or simply providing them with knowledge and information. Whether it's due to a medical condition or a pregnancy, my patients come to me in a vulnerable situation, and I see it as my job to ensure that they not only get healthier, but also feel empowered to manage their own health more effectively when they leave my consultation room.

Which is precisely where this book comes in: I want it to provide women with more knowledge about their bodies and to helps them to feel confident in being able to ask the right questions when they see their doctor, to interact with them as equals, enabling them to access the treatment that is right for them. And I hope that it sparks the odd perspective shift that has a positive effect on the life of the reader, regardless of whether that effect is big or small. And I want to help readers to feel comfort-

able in their bodies, enabling them to take good care of them and remain as healthy as possible.

A quick word on the language I use in this book. Though I typically refer to women and use female pronouns, in some instances I use more neutral terms, because I am aware that, despite the Greek root of the term gynaecology (*gynē* means "woman"), not everyone who enters our consultation rooms identifies as a woman. By using these more neutral terms, I hope that all readers feel included, regardless of their gender identity.

Perhaps you will read this book from start to finish, perhaps you'll flick ahead to chapters that are currently of particular importance to you, or to your daughters, your mother, aunts, nieces, girlfriends, or other people close to you. Whatever the case, I hope from this point forth, we can become allies, and that this book will come to stand beside you like a friend who happens to have a wealth of gynaecological knowledge.

My Path to Gynaecology

While I was studying medicine in Berlin at the turn of the millennium, for the longest time, I was unsure which specialty to choose. For years, I had next to no contact with gynaecology, in part because there is not a lot of emphasis placed on it at medical school. It is somewhat underrepresented in the curriculum, and the socio-political components are completely ignored. Looking at gynaecology from a specifically female perspective, for example in terms of female sexuality or abortions (of which some 100,000 are carried out every year in Germany) or even analysing something as mundane to us as a bra from a medical and scientific perspective – you would be hard pressed to find anything about these topics while completing a medical degree at university.

It was only towards the end of my degree that I started to think more concretely about which specialty I would choose. And then, in a sudden epiphany, it was clear to me: I'm a gynaecologist. Now, I am the head physician at two Berlin clinics, which makes me, as I mentioned earlier, part of a select group of women. In a specialty which now has a majority of women working in it and in which the patients are female, there are just three head physicians in the gynaecology departments of the German capital – out of a total of 21. Things are no better in the field of university medicine: when I was made acting head physician of gynaecology at

the Charité hospital in Berlin for a year in my mid-thirties, I was the first woman to occupy the position, and am still the only one to have ever done so.

This situation cannot be put down to a lack of qualified young women. A recent census carried out by the German Medical Association recorded 18,427 gynaecologists in Germany, of which 77 per cent are women. Across Germany, the proportion of senior physicians in gynaecology departments at university hospitals is up around the 70 per cent mark. But the appointment committees both for professorships and leadership positions are still overwhelmingly male, and there is a lack of modern accommodations offered by employers such as job sharing, which would allow for management positions to be divided between more than one physician.

This is why, in my role as clinic director I try to speak up in the public domain, and I don't shy away from making demands that some people might not agree with. I believe that my voice should be heard as a representative for so many women and families. Which is why I decided to get involved with the Association of Women Physicians in Berlin. In addition, I serve as the elected representative of Berlin's head physicians. Until recently, I was chair of the Society for Gynaecology and Obstetrics Berlin, an organisation with a long and storied tradition, and I was just the third woman to occupy this position since 1840, among some 120 men.

When I was awarded the Berlin Women's Prize in 2022, I was genuinely moved. The ceremony took place in the Rotes Rathaus, where the offices of the mayor of Berlin are located. The prize was presented by the minister for healthcare and the state secretaries of Berlin. That evening, we spoke about the structural neglect of issues of great importance for woman, including topics such as the underrepresentation of female anatomy in medical studies.

In this vein, I also make a concerted effort to try to increase the share of women invited to present at gynaecological conferences, which is typically around 21 per cent. It is not at all uncommon to see "all-male panels" at such events, where all the speakers at the lectern addressing gynaecological conditions or female sexuality are men. I often get in touch with the organisers of these conferences and ask them why there are so few women speakers and offer to assist them in recruiting women speakers. I often receive a negative response, with the organisers washing

their hands of any responsibility. The most common excuse is that "we were unable to find any qualified women". This was one of the motivations behind my decision to team up with my brilliant colleague, breast specialist Dr Marion Paul, to organise the Berlin Cancer Conference in 2021, to which we invited only women speakers. We wanted to make a point and to actively refute this argument. We could have filled a week-long programme with high-calibre women speakers; it wasn't hard to track them down at all. Some conference organisers are simply not interested in achieving parity when it comes to speaker lists. They believe that "the best candidate" should be invited to present. Which in reality just compounds and intensifies existing forms of discrimination, because first of all, women face structural obstacles to make it into leadership positions, and then, because they do not occupy these positions, they are not invited to present at conferences, which in turn would foster their careers. I am of the opinion that we should always question why women are not given a voice.

The leading medical journals realised this years ago. The international Lancet Group, which publishes 18 medical journals, released a "diversity pledge" in 2019 committing to increase the percentage and representation of women in medicine, coining the term "manel" for all-male panels. Meanwhile, the strong Berlin Medical Association made the progressive move to rename the journal *Berliner Ärtzeblatt*, containing the masculine form of the word "doctor", to the gender-neutral *Berliner Ärzt:innen*.

The majority of the senior doctors at my clinic are women, with just one man occupying this position. You might well ask me why I do not ensure that there is gender parity in these positions, and in another setting, I probably would. But I think it is important to represent the 77 per cent of women working in gynaecology. And I also want to make up for the unequal representation in other departments.

There are also studies that suggest that it does indeed make a difference if a patient is treated by a male or a female doctor. One study found that a higher proportion of patients survive the first 30 days after an operation if the operation was carried out by a woman. Readmissions are also less likely, there are fewer complications, and the average hospital stay is shorter. The authors of the study came to the conclusion that male and female surgeons practice medicine differently: "Women are more likely to follow the clinic's guidelines, employ more preventative measures, are

more patient-focused in their communication, perform standard examinations just as well or better, and offer more psychosocial counselling."

These studies also contained other hypotheses: one is that the few female surgeons who have managed to get by in this highly competitive field were just more competent, and also that women tend to have a more holistic understanding of medicine and thus incorporate more complex therapies, which result in better outcomes.

A study that looked at whether there is a difference in outcomes when both patient and surgeon have the same gender found that in particular when it came to female patients being operated on by female surgeons, there was a lower risk of complications. Certainly an interesting field of inquiry that requires further investigation.

The first woman in Germany to complete her *habilitation* (qualifying her to teach in tertiary institutions) in medicine, and indeed the first woman to achieve this qualification in any academic field, was Adele Hartmann, who received this distinction in 1919. She had to fight hard for it. Nowadays, it's difficult to find out much about her, there are just a handful of images or mentions in the written record. Meanwhile, men have perfected the art of repeating each other's names incessantly and thus inserting each other into a line of tradition. Medical devices and conditions and surgical techniques are often named after the men who invented or discovered them. People like Adele Hartmann, on the other hand, have largely been forgotten. Hartmann only very recently began to receive a minimal amount of recognition, when, for example, a street in Munich was named after her in 2002. Adele-Hartmann-Strasse is located near the LMU clinic in Grosshadern, is 70 metres long, and ends in a dead end. The programme named after her at Ludwig Maximilian University aims to promote the appointment of female professors. Which is wonderful, but it's much too little. The fact that I was able to complete my *habilitation* 94 years after Adele Hartmann is not only thanks to her, but also thanks to all the other people who worked to create the structural conditions to make it possible for women like me to reach this level.

For the sake of comparison, let's take a look at Rudolf Virchow. In his day, he was a well-known physician and politician. He began his career in 1843 as a "junior doctor" at the Charité hospital, conducted many clinical studies, animal experiments, and autopsies. Virchow also had to beat a

path for himself against the resistance of older doctors, who found him presumptuous and downplayed his achievements.

His wife, Rose Mayer, was the daughter of the well-known and influential gynaecologist Carl Wilhelm Mayer, and in proud family tradition, Rose's brothers also became doctors. Had she been born 100 years later, Rose would presumably have become a doctor too. But since she was born in 1832, she was not permitted to study. Instead, she had six children with Rudolf Virchow, who received a great deal of professional support from her father, and she organised their domestic and social life. She ensured that he was able to dedicate himself entirely to medicine and to the advancement of his career. And yet, during his lifetime, not only did Rudolf Virchow not support women, he actually actively campaigned against women being allowed to study medicine. To mark the 200th anniversary of the birth of Rudolf Virchow, I was invited to give a speech in his honour in my capacity as chair of the Berlin Society for Obstetrics and Gynaecology. As I delved deeper into his life's work, it became increasingly clear to me that he would never have achieved the things he did without his wife Rose. Which is why I ended my talk with the demand to rename the "Rudolf Virchow Clinic" at the Charité the "Rose and Rudolf Virchow Clinic".

Patriarchal Structures Disadvantage Everyone

I was recently interviewed by a journalist from my local region. The headline of his article read: "Head Physician Mandy Mangler Sees a 'Massive Problem with Men' in Gynaecology". When I read the title, I got a lump in my throat. Because of course it's not men who are the problem but patriarchal structures. These structures, which are largely dominated by men, often function to benefit them. They provide men with privileges. But they also have detrimental effects for men.

For example, when I started in my current role in 2016, my rounds as head of the clinic were set to be held once a month, from 5 to 8 pm. For me, it was difficult to integrate these rounds – which were also not particularly effective – into my daily routine. Anybody who has a life outside the hospital or who has childcare responsibilities knows how important this window is. It's the time of day where you might eat together with your family, discuss homework with your children, and plan the coming day together. So after

waiting for a while, I eventually requested that we move these meetings to another time slot. The reactions ranged from jokes at my expense and malicious remarks to outright aggression.

A self-assured woman demanding changes to the structures of an institution? That is threatening and needs to be warded off – regardless of whether what she's suggesting makes sense or not. The critics of my proposal presumably also wanted to prove that they were indispensable for their clinic well into the evening. After a number of heated debates, these consultation hours were moved to 2:30 in the afternoon. So it was worth putting up with the resentment. Not just for my own daily life, but for that of my colleagues and the people who will come after me.

When we talk about enhancing career opportunities for women, we often reach a point where we are arguing for the rights of one group over another: women against men or men against women. For me, though, the aim is more to work together to create something new and overcome patriarchal structures. So that men are also not ridiculed or held back professionally if they want to go on paternity leave. Because men also suffer when they cling to outmoded rules that put a strain on their family life and were designed for a different era. And male doctors don't like being shouted at any more than female doctors do! But they often conform to the existing structures, something I perceive as passive, obedient, even submissive. That might make them loyal to those above them in the hierarchy, but not to the practice of gynaecology. Courageous women could be their allies in shaping a more humane working environment.

And we shouldn't forget that men enjoy many privileges they are often not even aware of. They give each other promotions, they are strong networkers. The fact that individual abilities often play a subordinate role in a person's career path becomes clear when you look at the men in leadership positions who are incompetent both professionally and on an interpersonal level. When a woman with new ideas manages to break into these circles, it is perceived as disruptive.

I often ask myself in my daily life: What can I do to foster gender equality in our society? I believe our society would be more civilised and effective if leadership positions and teams were just as diverse as our society itself.

For men, our questioning of the status quo and our desire for progress is often seen as an existential threat. Clearly, though, for us women, it is exis-

tential in an even more fundamental way. Being considered in medicine and represented in research is crucial to our very survival. Over the coming chapters, I'd like to take a closer look at some of these issues

Mandy Mangler
Summer 2024

Our Bodies

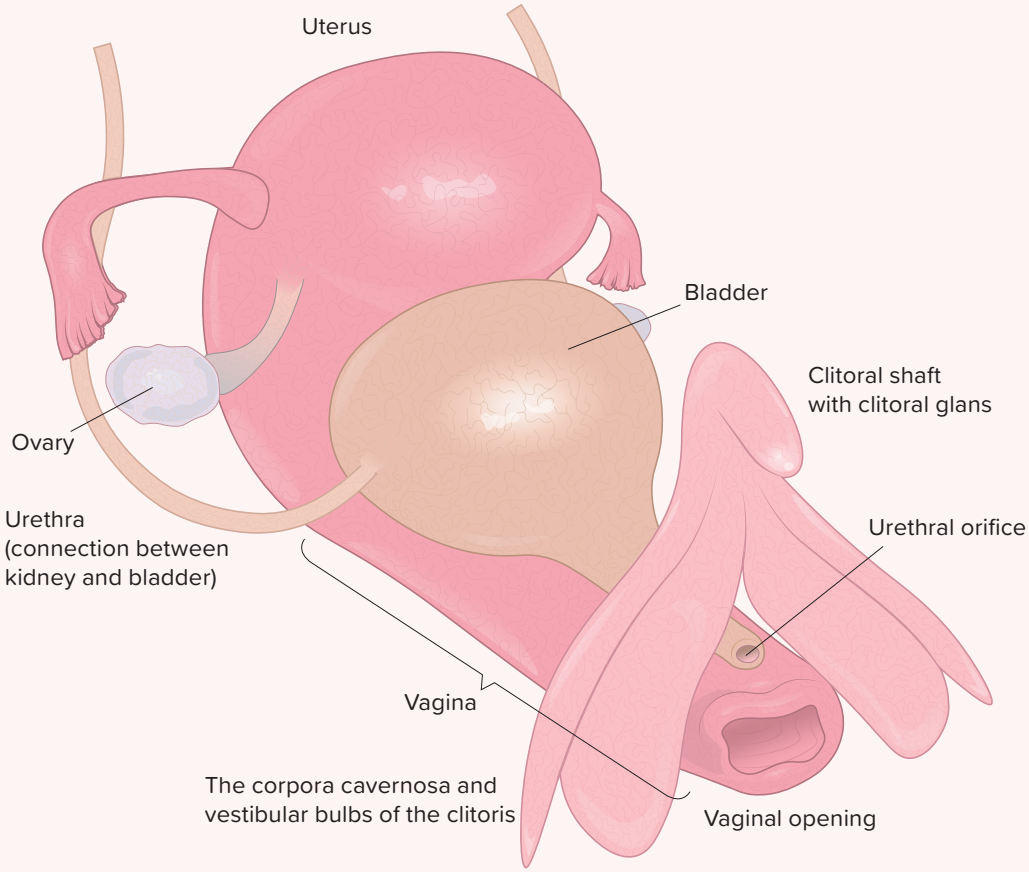
What they can do, what they need, and what gives them pleasure

The Great (!) Unknown

The Clitoris

Female anatomy in the pelvis

No other organ has been as spectacularly misinterpreted, erased, and ignored as the clitoris. This is particularly astonishing when you see how big it is – as you can in this illustration.

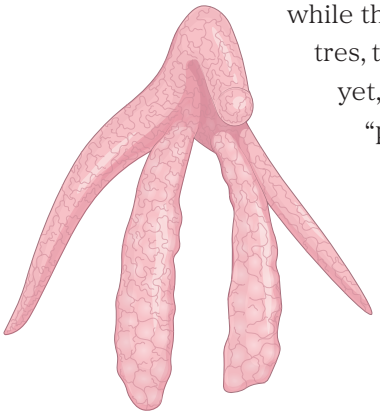


Understanding the Clitoris

If you look at your own vulva in the mirror, at the spot where the two inner labia – the labia minora – meet, you can see the shaft of the clitoris with the glans, which is encased in the clitoral hood. This skin, sometimes referred to as the clitoral foreskin, can be carefully pulled back to give a better view of the glans of the clitoris. Because the clitoris and the penis are anatomically made of the same structures, many of the same terms are used for them. They both develop from the same embryonic primordia, what is known as the genital tubercle. You can see and feel the clitoral glans and shaft in an unaroused state. You can also feel the connection between the clitoral shaft and the pubic symphysis (the bone above it). It is long and narrow and contains nerves and blood vessels. The clitoris keeps going behind the clitoral shaft, with the two corpora cavernosa and the vestibular bulbs. They extend like four limbs, two on each side, and are located behind the labia beside the urethra and vagina. You can imagine the clitoris, with its four limbs – two narrower ones at the rear and two more voluminous ones at the front – perched atop the vagina and urethra like a rider on the back of a horse. As such, the term "clitoris", derived from the Greek meaning "little hill", only refers to the external part of the organ.

It is easiest to locate the two front limbs, the vestibular bulbs, when the vulva is aroused, because then they become engorged with blood and the labia feel puffed up when you touch them. The two narrower corpora cavernosa are located parallel to the bone known as the pubic ramus. The best way to find them is to start from the pubic symphysis and to run your fingers along the edge of the bone towards the vagina. When unaroused, you can recognise them because, in contrast to fatty or connective tissue, they feel soft, slightly springy to the touch, and when aroused, they feel a little more taut.

Together with the shaft, these four limbs comprise the anatomical components of the clitoris and are all connected with each other. The clitoris consists of both cavernous and spongy tissue – another similarity between the clitoris and the penis. The glans of the clitoris, however, is home to some 8,000 highly sensitive nerve endings, while the glans of the penis has only around half that number. The clitoris exists solely for the sensation of arousal and pleasure; it has no other function. And by the way:



Non-erect clitoris

while the average length of a non-erect clitoris is 11 centimetres, the average penis measures 9 centimetres in length. And yet, generations of schoolchildren were taught about the "pea-sized tickler" (in German, the word *kitzler*, a common designation for the clitoris, translates as "tickler"), or about the little "pearl" or "button" that was at most depicted in their biology books by a dot, while on the opposite page the corpus cavernosum of the penis was presented in great detail and discussed at great length.

One of the ways in which women's arousal and pleasure have been trivialised is through the language we use for it. In German, for example, the term *kitzler*, which does indeed derive from the Old High German word for "to tickle", *kizzilōn*, refers to the attempt to induce a reflex of involuntary laughter through the gentle touching of the skin.

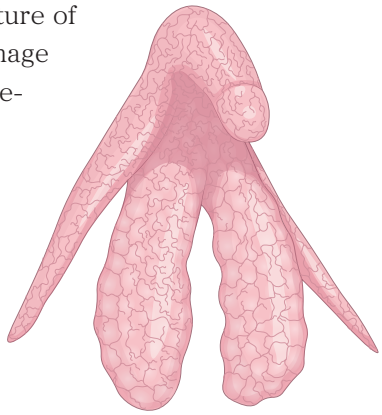
Since the information provided in university courses, textbooks, and anatomical representations continues to be inadequate, even female doctors often do not have a thorough understanding of their own anatomy. Currently, the only way for us to expand our knowledge is by independently seeking out the few publications or textbooks that include accurate representations. And these are not easy to come by. And yet, it is crucial to consider the impact of all our therapeutic practices on female sexuality. Research findings about the clitoris are fundamental for the clinical practice of gynaecology, obstetrics, urology, proctology, and other fields of medicine. It is not just in the event of surgeries on the vulva or the anterior vagina that it is crucial for both patient and doctor to know where the nerve endings, the erectile tissue, and the support apparatus of the clitoris are located. This knowledge is also of the utmost importance for obstetrics and midwifery.

The History of the Discovery of Our Pleasure Organ

Our knowledge of the existence and anatomy of the clitoris is a particularly interesting chapter in the history of medicine. Over the past 150 years in particular, the clitoris received next to no attention. One reason that is often cited for this is its lack of visibility. After all, it is only the glans, the clitoral hood, and the shaft that can be recognised from outside as part of the vulva. And yet, the thyroid is also hidden in the tissue surrounding it. It is located inside the throat, you cannot see it from outside; but there is no lack of knowledge and anatomical information about the thyroid.

The answer to the question of why anatomists have so neglected the clitoris is probably related to the fact that, since they were surrounded exclusively by men, they failed to recognise its significance – after all, *they* didn't have one. What's undeniable though is that no organ has been so spectacularly misinterpreted, ignored, and erased by medical science. Right up to the present day, the history of the discovery of the clitoris is a history of repeated astonishment. Many girls and women still do not understand their anatomy. And this has serious consequences for the way they interact with their sexuality.

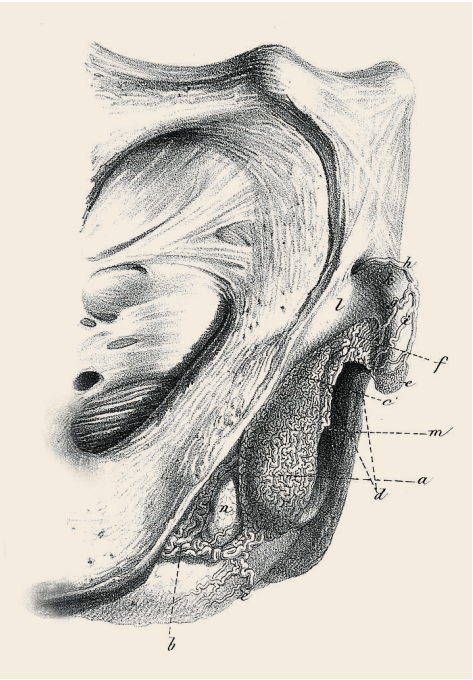
In the late 1990s, an Australian urologist, Helen O'Connell, decided to make the clitoris the focus of her research. When looking at the textbooks she used for her work, she'd been struck by the huge discrepancy between the depth of knowledge contained about the penis and the comparatively paltry information on the female organ of pleasure. So she decided to devote her efforts to the subject. In 1998, she published her research findings on the ramified, deep-rooted structure of the clitoris. In 2010, she also managed to create a 3D image of a stimulated or erect clitoris, leading people to celebrate her as the discoverer of the clitoris. In actual fact, though, Helen O'Connell is the rediscoverer of the clitoris. This designation should in no way be seen as diminishing her achievement. O'Connell was the first person to doggedly insist on creating an accurate representation of this organ and used technology such as magnetic resonance imaging (MRI) to achieve this. She has scientifically documented how



Erect clitoris

the clitoris is stimulated and becomes erect and has underscored the significance of this for us women.

But in whose footsteps was Helen O'Connell's following? In the year of his death, Realdo Colombo (1516–1559), an Italian anatomist, became the first person to mention the clitoris as a sexual organ. Colombo collaborated in part with Michelangelo – and imagine how spectacular it would have been if the most important artist of the High Renaissance had sculpted this organ in marble! Unfortunately, Colombo did not create any drawings of the clitoris, leaving only written descriptions. In 1672, the Dutch physician and one of the founders of experimental physiology, Reinier de Graaf (1641–1673), created the first known drawing of the clitoris, and quite a decent one at that. The depiction is held in the collection of the Rijksmuseum in Amsterdam in the form of a copperplate engraving by Hendrik Bary (1632–1707), but it is only occasionally shown in the context of special exhibitions. In 1836, the French physiologist Marie-Jean-Pierre Flourens (1794–1867) produced an accurate, detailed drawing of the organ. In 1844, Georg Ludwig Kobelt (1804–1857) published a text entitled *The Male and Female Organs of Sexual Arousal in Man and some other Mammals in an Anatomical-Physiological Relationship.* Thanks to the anatomist Kobelt, we have further detailed illustrations from this era. He injected certain chemicals into the minute blood vessels of the clitoris of a corpse, enabling him to create a three-dimensional representation of them. This would have been roughly comparable to the exhibitions of bodies preserved using the plastination technique by German anatomist Gunther von Hagens.



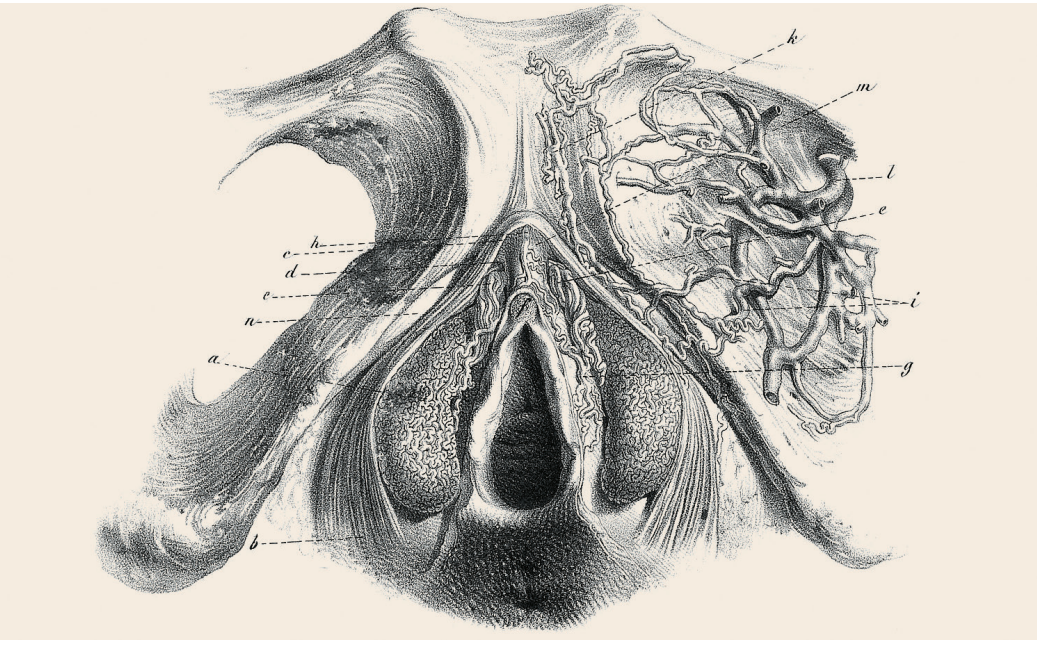
Lateral cross-section of the clitoris, drawn by G. L. Kobelt 1844

In his book, Kobelt hints at the explosive potential of his investigations, and his drawings are truly beautiful. All those years ago, he sensed that an understanding of the power of the clitoris would spark controversy. He begins his chapter on the female "organs of sexual arousal" with the following words: "Perhaps, in my explorations of the

male organs of sexual arousal, I have been successful in at least partially earning the agreement of my readers. In the present section, in which I have set myself the task of demonstrating that the woman is also in possession of an apparatus which in its composite parts is thoroughly analogous to the male organ of sexual arousal, I should scarcely expect a similar level of success, for all such attempts pertaining to our hitherto incomplete knowledge of this element of the female body have fallen upon deaf ears."

Kobelt attempts to give an account of the clitoris and its significance, but he is only partially successful. He recognises that it serves a function in the process of sexual arousal, but that this can result in a female organism is something he fails to mention.

After Kobelt, the true size and significance of the clitoris gradually faded into oblivion. And this was no accident. In the late 19th century, women began to gain more social power, which made the notion of an equally strong female sexuality all the more threatening. This was compounded by the prevailing prudery and the lack of understanding of the connection not only between the clitoris and the female orgasm, but also of its relationship with reproduction. All of this led to the circumstance that for a long time, the clitoris was viewed as insignificant and undesirable, meaning that visual depictions ceased to be made.



Kobelt's anatomical frontal drawing of the vaginal opening and the clitoris