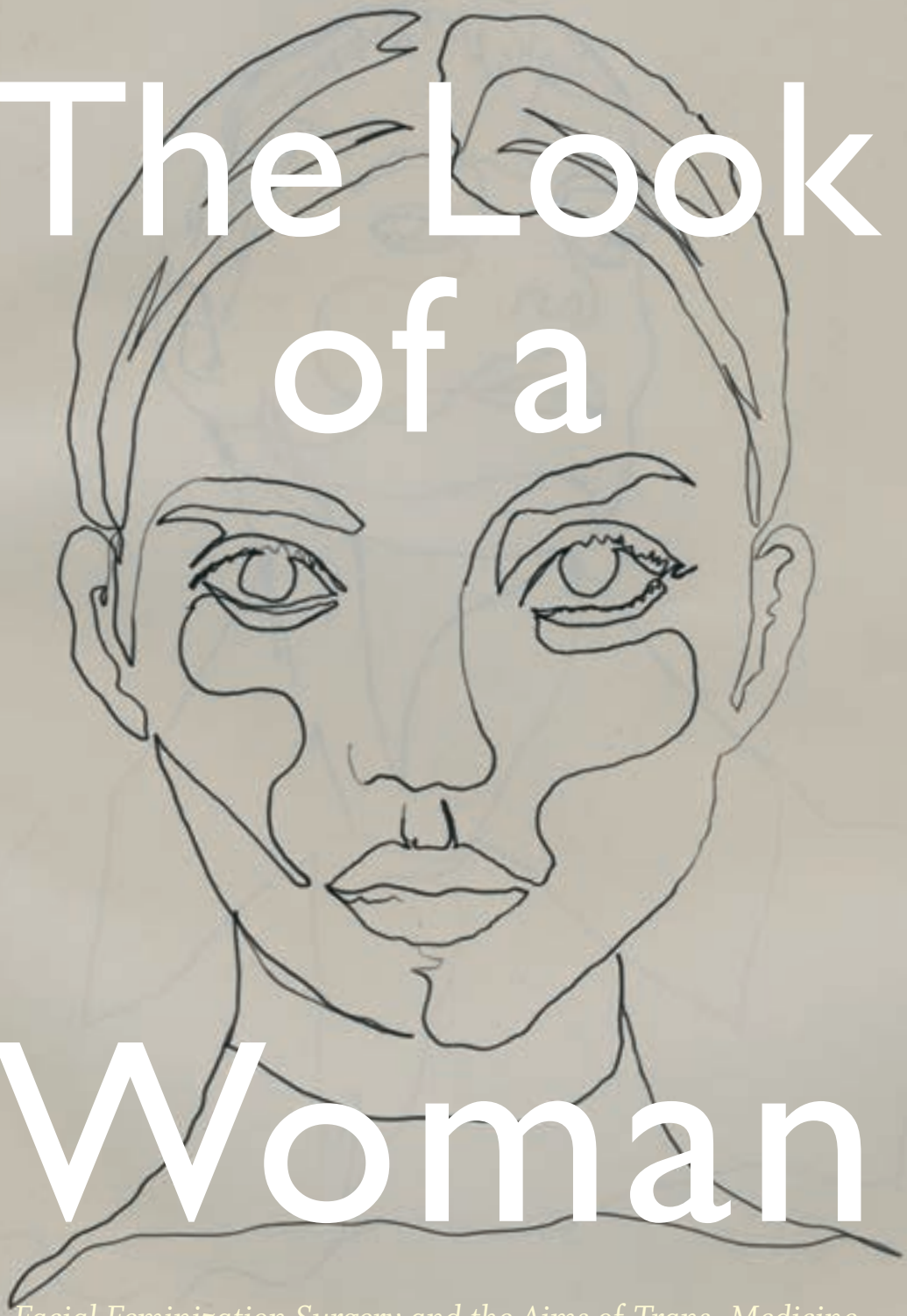
The Look of a Woman



Facial Feminization Surgery and the Aims of Trans- Medicine

ERIC PLEMONS

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For Anne

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INTRODUCTION

In weighing the indication for the [genital sex reassignment] operation, another factor should be considered, namely the physical and especially facial characteristics of the patient. A feminine habitus, as it existed for instance in Christine Jorgensen, increases the chances of a successful outcome. A masculine appearance mitigates against it. Such patient may meet with serious difficulties later on when he expects to be accepted by society as a female and lead the life of a woman. —HARRY BENJAMIN, "Transsexualism and Transvestism as Psycho-Somatic and Somato-Psychic Syndromes," 1954

The argument of this book is a simple one: as ideas shift about the kind of thing that *sex* is, so do the interventions required to change it and the logic of medical practices intended to do so.

Early surgical procedures that aimed to change a person's sex focused on the genitals as the site of a body's maleness or femaleness and took the reconstruction of those organs as the means by which "sex" could be changed, that change always from one binarily conceived sex category to the other. Prospective patients' declared need for genital reconstructive surgery and clinicians' defense of its therapeutic legitimacy anchored the 1950s formulation of *transsexualism* as a psychological condition best treated with physical interventions. While genital surgery remains important to many trans- people, over the past several decades it has been demoted from constituting "sex reassignment surgery" to but one of its possible iterations.[1] No longer exclusively defined by genital form, as treatments for transsexualism once conceived it, now sex is both spread across the entire body—with

interventions in chests and breasts, bones, hair, voice, and comportment all made available for purchase—and ever more crucially located outside of the body, in spaces of ongoing social interaction and recognition.

Developed in the mid-1980s, facial feminization surgery (FFS) is a set of bone and soft tissue reconstructive procedures intended to feminize the faces of trans- women. First considered by patients and operating surgeons as an auxiliary procedure in support of the "real" change of sex enacted by genital surgery, now patients who undergo FFS and the surgeons who perform it assert that facial feminization is not a cosmetic operation that simply improves trans- women's appearance; instead FFS itself transforms patients' bodily sex. To claim that facial reconstruction enacts a change of sex is to posit a model of sex—a conceptualization of what and how *sex* is—that departs significantly from the mid-twentieth-century model upon which the diagnosis of *transsexualism* was developed and its genital-centric surgical treatments established. Divorced from an essentialist logic that fixes the truth of sex in discrete anatomical forms, the transformative efficacy of FFS doesn't take place in the closed space of the operating room, nor is it located in the discrete and individual body of the patient herself. Instead FFS works when others recognize and respond to a postoperative patient's face as the face of a woman.

For the patients and surgeons with whom I worked during 2010–11, it was simply obvious that *woman* was not a category constituted by a particular genital anatomy. To be a woman, they asserted, was to be recognized and treated as a woman in the course of everyday life. According to the FFS patients I talked with, if the goal of trans- surgical intervention was to help them realize their identity as women, the most effective site of that intervention was not focused on the generally concealed shape of their genitals but on the visible characteristics of their face. It was *looking* trans- that got FFS patients into trouble on the street. It has been the specter of the masculine-*looking* trans- woman that has fueled proliferating "bathroom bills" across the United States in recent years. For FFS patients, facial surgery was radically transformative because it was a practical acknowledgment that sex was a fundamentally social identity. This is the common sense of FFS: if medical transition is desired to transform a social identity, it must target the social body.

Claims to the transitional efficacy of FFS have been denied and disputed by those who remain committed to a genital definition of sex and thus a genital surgery definition of sex change. Critics argue that "real" sex is genitally

defined, or even chromosomally defined, and that no surgery—certainly not facial surgery—can truly change it. Such disputes demonstrate that, in practice, the aims of trans- medicine are not clear, nor are they commonly held among the many players involved in seeking, shaping, and delivering transition-related medical care to trans- Americans. Tensions in the proliferating understandings of the aims of trans- medicine are evident in recent changes to federal, state, and private insurance coverage for "transgender health." Federal regulations passed in 2016 stated that transgender Americans could not be discriminatorily denied coverage for "gender transition services," but stopped short of defining what those services might include.[2] In the absence of an affirmative policy, some insurers understand *transition* broadly, drafting policies that include endocrine interventions, hair removal, voice surgery, chest or breast reconstruction, genital reconstruction, and facial feminization surgeries. Others remain committed to a genital-centric understanding of what transition is and how it might be surgically achieved. The patchwork of covered procedures is not only about money—though funding is always central to debates about American health care. More centrally, varied policies and coverages reflect a prismatic understanding of what it means to transition medically and, more fundamentally, how and under what therapeutic logics trans- medicine is good medicine.

The growing popularity of FFS is emblematic of a shifting landscape in American trans- medicine, one that has been steadily moving away from a narrow focus on genitalia as the site and form of bodily sex and focusing instead on practical enactments of sexual difference that only rarely rely on a congruence between social presentation and genital morphology. The common sense of FFS does not locate surgical efficacy in the atomized, individual body that underwent surgery; instead FFS is understood to work in and through the responses, attributions, and forms of recognition that that body accrues in the interactions of everyday social life. FFS changes the project of surgical sex reassignment by reconfiguring the kind of sex that surgery aims to change.

This book explores how a recognition-based model of sex and of sex change that would have been bafflingly nonsensical when American trans- medicine was institutionalized in the 1960s acquired the force of common sense forty years later. Foregrounding the narratives of patients who undergo FFS and the surgeons who perform their operations, I contend with the history and dynamic present of American trans- medicine to consider

what the persistence of some surgical practices and the emergence of others can tell us about how therapeutic logics of trans- medicine are shifting and what *sex* can and could be as a thing made changeable in the surgical clinic. Let me show you what I mean.

Krista had just completed a three-day postoperative exam in Dr. Douglas Ousterhout's office when she eased herself tenderly into a chair opposite me.[3] Fresh white gauze bandages wrapped around the crown of Krista's head, down over her cheeks, and under her chin. The short, stray ends of black sutures were visible at her nasal septum, just under her nostrils, and peeked out from under the dressing on her head in neat rows, tracing her hairline as it descended to her ears. Her eyes and eyelids were blackened and swollen, but the yellow and greenish tones of healing had already begun to appear.

Though Krista was pleased with her recovery progress, she had really hoped to avoid having this surgery. A few years earlier, after seeing Ousterhout give a presentation on "the ten traits of a male face" at a large conference for trans- people, Krista had set about systematically trying to camouflage those traits of her face without the surgery he recommended. She covered her forehead with long, straight-cut bangs. She covered her nose and brow with bulky, nonprescription eyeglasses. She experimented with makeup techniques to minimize the squareness of her jaw. Though she was somewhat satisfied by the results of her efforts, she was simply tired of all the work. "I just couldn't stand the thought of doing all of this for the next twenty years. Just to leave the house? I was thinking about it all the time. My hair had to be perfect. My glasses had to be perfect. It was too much."

Despite her best efforts to cultivate the clothing, makeup, hairstyle, and comportment of the women around whom she lived and worked, other people often saw and responded to Krista as male. But not only male. She was often seen—and treated—as a male who was trying and failing to look female. Krista was sure that her masculine face was spoiling her other efforts at femininity. She felt that she could never truly and simply be accepted as a woman so long as her face constantly threatened to undo her. In one operation lasting just under eleven hours, Ousterhout had rebuilt the bony structure of Krista's forehead, reduced the bridge and tip of her nose, advanced her scalp, reshaped her hairline, reduced the width and squareness of her jaw, shortened the height of her chin, raised her upper lip, removed her thyroid cartilage (Adam's apple), and plumped her lips.

While drowsily recovering from the long hours of anesthetization, Krista

had ignored the instruction of the hospital recovery room nurses and tried to stand and walk to the restroom on her own. She rose to her feet and lost consciousness, falling flat on her newly rebuilt face and knocking out a front tooth. Despite being at the very beginning of what would be a long recovery from radical reconstructive surgery as well as an unanticipated root canal, Krista was optimistic. "I'm still puffy," she said, "so I don't really know how I'll end up looking. But all things considered, I think it has gone really well." She had taken the city bus to her appointment that morning. "For the first time in a long time," she explained, "I didn't have to worry about having my bangs just right or wearing just the right pair of glasses. Nobody was looking at me like I was trans-. I looked around and thought, Wow, this is cool." People on that bus were undoubtedly looking at Krista's face covered in gauze bandages, protruding sutures, and colorful bruises. But she found joy in the certainty that whatever they might have seen when they looked at her, the stuff of her maleness was gone. Now she was just another woman on the way to see her plastic surgeon.

Ousterhout developed the procedures now known as facial feminization surgery in the mid-1980s. For decades afterward his name was nearly synonymous with the practice. By the time he retired in 2014, he had performed nearly 1,700 FFS operations—far and away the most of any surgeon in the world. Though he performed other cranio-maxillofacial reconstructive and cosmetic surgeries in his solo private practice, by the mid-1990s FFS patients constituted roughly 80 percent of his thriving practice. During the year I spent observing in his office I met patients who had traveled from Canada, New Zealand, England, Wales, the Netherlands, Germany, India, and Japan to see him. Rumors of his impending retirement increased his caseload as hopeful patients booked appointments just under the wire.

When I met Ousterhout for the first time, he explained FFS as a procedure whose necessity for trans- women was both commonsensical and self-evident. His explanation was delivered, in part, with the use of a *Bloom County* comic depicting three cartoon characters pulling out the waistbands of their underwear and looking down at their (cartoon) genitalia. He slid the image across his desk with a wide grin on his face. "You don't walk down the street looking in everyone's pants before you decide what sex they are. You look at their face," he explained plainly. The absurdity of the comic helped to punctuate his claim; it was so obvious that even cartoon characters knew it. If what a trans- woman ultimately wants from the medicosurgical interventions grouped under the sign of "transition" is to become

a woman, then, Ousterhout asserted with absolute certainty, the most dramatic and meaningful change she can undergo is not focused on her genitalia or other hidden parts of her body but on that part that others see the most: her face. Though he did not purport to be offering anything so grand as a *theory* of sex or gender, the ability of this story, and ultimately of FFS, to make sense as a sex-changing intervention certainly depended on one.

Ousterhout's just-so story about what and how "woman" was constituted was one that he fervently believed. So did Krista and the thousands of transwomen that Ousterhout and a handful of other American FFS surgeons had operated on over the past thirty years. Administrators of European gender clinics began incorporating FFS into their holistic health care programs for trans- women in the late 1990s, and a growing number of clinicians from around the world now name avoiding FFS as one reason to start young trans- girls on testosterone blockers before pubertal bone structure changes begin.[4] But as self-evident and commonsensical as the story of sex-as-social-recognition can seem inside the surgical clinic, it is not one that would have always made sense.

When American clinicians conceptualized the diagnosis of transsexualism in the 1950s, they operationalized the emergent distinctions between bodily sex and social gender to define the transsexual as a person who experienced a mismatch between the two. Transsexualism, wrote the pioneering physician Harry Benjamin (1954:220) in 1954, "denotes the intense and often obsessive desire to change the entire sexual status including the anatomical structure. While the male transvestite *enacts* the role of woman, the transsexualist wants to *be* one and *function* as one, wishing to assume as many of her characteristics as possible, physical, mental and sexual." According to this foundational clinical model, the primary thing that a transsexual person (at that time *transsexual* referred almost exclusively to trans- women) wanted and needed in order to be "physically, mentally, and sexually" a woman was reconstructive genital surgery. Though many transwomen continue to value and prioritize genital surgery, a lot has changed about trans- medicine since the 1950s.

ENACTING TRANS- THERAPEUTICS

I use the term *trans- therapeutics* to describe the sets of implicit assumptions and explicit claims that underwrite trans- medicine as a beneficial and therapeutic practice. Trans- therapeutics are the logical frameworks within

which various interventions come to make sense as "good trans- medicine." Like all treatment logics, trans- therapeutics link understandings of origins (What is the nature of the concern for which trans- people seek surgical interventions, or the aim toward which particular interventions are attuned?), treatment rationales (Which interventions are appropriate responses to that concern or aim?), and outcome measures (How will we know if those interventions adequately addressed that concern or met their intended aim?). These questions and their answers work together to determine the kind of thing *trans-* is as a clinical object that can organize particular clinical interventions; they shape it as a kind of body project to which particular interventions seem to naturally and rationally correspond. The assertion that facial reconstruction constitutes an enactment of surgical womanhood relies on a particular configuration of trans- therapeutics—a claim about how, why, and by what means facial surgery is good trans- medicine.

Trans- therapeutics change because ideas about sex and gender change. So do ideas about *trans-* as a term that animates medical practice. So do technical capacities and institutional wills to respond to claims for medicosurgical services in the name of trans- medicine. Changes in trans- therapeutics matter because they determine the kinds of care that trans- people can receive, how that care is organized, and thus what kinds of medically mediated bodies are possible and what kinds are not. How did the claim articulated by Krista and her surgeon that a trans- woman can change sex by surgically reconstructing her face—a claim that would have made no sense in the 1950s terms in which transsexualism was formulated—acquire a rhetoric of self-evidence in the mid-1990s? What kind of sex is this? What can the growing popularity of FFS and other nongenital interventions help us to understand about American trans- medicine and the shifting understandings of sex and gender on which it depends? One of the primary aims of this book is to attend to the conditions under which FFS has been increasingly incorporated into contemporary trans- therapeutics and what its growing popularity can tell us about how that therapeutic logic is changing.

The medical anthropologist and science studies scholar Annemarie Mol (2002:vii) has argued that rather than treating clinical diagnoses as naturally given entities to which forms of intervention respond, it is through practices of intervention that medicine "enacts the objects of its concern and treatment." The things that medical actors do with their hands and instruments, the studies they design and questions they ask, and the services that patients request bring clinical entities into being in particular ways

(Mol 2002; Mol and Berg 1994). It is through practices that contested ideas about sex, gender, and trans- bodies are materialized into action and incited into speech; they move from abstract concepts into material bodies and observable techniques. What are trans- people asking from the surgeons whose services they seek? What is the nature of the sex that FFS aims to alter? Under what model of trans- therapeutics can FFS be said to work? What work does it do?

In my focus on the productivity of patient interventions, I adopt Mol's (2002) analytic of enactment. Emerging from scholarship in science and technology studies focused on the daily practices by which experts make knowledge, a focus on enactment is committed to ethnographic specificity. It foregrounds contextualized doing—the things that are happening in examination rooms and operating rooms—to better understand the specific conditions under which claims to knowledge are produced and come to have the force of fact. Enactment insists on specific actions unfolding in time and space (Mol and Law 1994). It allows me to begin from the premise that neither woman nor femininity nor trans- medicine is a singular or stable thing for which FFS is a discrete kind of response. All of these are enacted, brought into being as things in the world through the use of particular practices employed by patients and their surgeons.

ACCOUNTING FOR SHIFTS IN CONCEPTUALIZATIONS OF SEX AND GENDER

Ideas about how and as what *sex* is defined have changed considerably since the 1950s, when American sexological and psychological researchers created clinical distinctions between physical sex and psychosocial gender. Reflecting American anxieties after World War II about the place of men and women in economic, family, and political life, their research aimed to control and treat forms of sexual and psychosexual difference by rendering that difference classifiable in a raft of new diagnoses, including transsexualism (Downing et al. 2015; Irvine 1990; Karkazis 2008; Rudacille 2005). The definition and divisions of physical sex from psychosocial gender that emerged from that clinical research did not stay confined to the clinic. The conceptual separation of sex (conceived as bodily form and matter) from gender (conceived as a set of power-laden social roles and relations largely and variously derived from the material forms of sex) became a central

premise upon which late twentieth-century feminist politics, scholarship, and activism was based.

In the 1990s, however, the philosopher Judith Butler confronted American feminism with an "imminent critique" of the terms by which feminism had been organized. In her iconic book *Gender Trouble* (1990) Butler questioned the role that heterosexuality and "natural" femininity had in constituting the identity category "woman" upon which feminist politics depended. Enmeshed in a Foucauldian concern with the regulatory power of sexuality and a psychoanalytic approach to understanding sexual difference and subject formation, Butler sought not only to denaturalize gender—this was the project of social constructionist feminism of the 1970s and 1980s—but also to denaturalize and historicize sex.

Adapting a linguistic framework developed by John Austin (1962), Butler advanced a performative theory of gender, arguing that gender (masculinity or femininity) does not flow from a naturally sexed bodily essence but is instead made to seem essential through continued acts of repetition (what Butler, after Derrida [1988], called "citation"). Thus masculinity and femininity are not inherent properties of bodies or of persons. Instead individuals become recognizable to themselves and others as instances of masculinity or femininity by doing things that are already understood in those terms, by citing gendered norms. Sex and sexual difference are, Butler argued, produced the same way. Male and female bodies come to seem opposed or mutually exclusive because of the way we talk about them, study them, place emphasis on distinctions rather than commonalities, and use metaphors that leverage existing understandings and values of masculinity and femininity to understand biological or genetic—or in the case of FFS osteological—processes.[5] As such, she argued, ideas about how sex difference is constituted are themselves among the most entrenched products of citational gender practices, making sex as unstable and contingent a category as gender. They are mutually reinforcing and co-constitutive: sex/gender.

One of the reasons Austin's framework was so generative for Butler is that, rather than engaging solely with language, Austin was concerned with communication. While language can be studied as a closed system with logics and structures unto itself, communication requires production and reception, and, crucially, it happens in a context. Central to Austin's formulation of performativity (and so key to Derrida's critique and Butler's adaptation) is a concern with the existing rules and norms of social life

that determine what can be communicated, by whom, to whom, and under what circumstances. Like communicative language, in Butler's view, sex/gender is determined in and through relations of authority; it is enabled and constrained by power. In acts of citation, reception, and recognition, forms of power are negotiated, making some claims to sexed/gendered being possible and others impossible.

In a performative model citation and reception of sex/gender norms are predicated on recognition, the act of exchange by which we come into being for ourselves and each other. Social norms and expectations determine *who* is recognizable *to whom* and *as what*. What kinds of bodies are recognizable as female bodies? What kinds as male? If we accept that sex, as Butler and others have argued, has a history, then it is clear that there is no single answer to these questions. Instead what kinds of bodies and thus what kinds of persons might be recognized as female change across time and place, in relation to who is looking and what they are looking for. The intersubjectivity of this model is crucial. If recognition is the means through which sex/gender becomes materialized and naturalized, then the conditions of recognition are the conditions of gender: I am a man when I am recognized as a man. It is precisely this kind of productive recognition that animated the practice of facial feminization surgery. Surgeons and patients were attuned to the promise that facial surgery could make transwomen recognizable to others as the women they knew themselves to be. The efficacy of FFS as a sex-changing surgery was claimed in and through acts of recognition.

I do not lay out this framework in order to stage a performative reading of FFS. Indeed, following Butler one would argue that all gendered acts—especially ones so self-consciously oriented toward the production of normative gender—are performative. To argue that FFS is among them would not provide much insight or attend to the specificity of FFS practice. Instead I read FFS as the material result of integrating a performative model of sex/gender into a plan for trans- medicine. When sex is understood as a product of recognition, then surgery explicitly aimed at altering the terms of that recognition becomes self-evidently and commonsensically a sex-changing intervention. Though surgeons and patients did not describe their shared theory of sex/gender as performative, they articulated its main claims as the common sense that underwrote the transformative power of FFS. The trans- therapeutics of FFS were performative.

Because assertions of sex-as-recognition were central to the patients and

surgeons with whom I worked and because the claim to FFS efficacy depended on them, rather than relying on an *analytics* of performativity, I treat the model itself as an ethnographic object—a move that Stefan Helmreich (2011:136) has called working "*athwart theory*: thinking of theory neither as set above the empirical nor as simply deriving from it, but as crossing the empirical transversely." For Helmreich, theory is "at once an abstraction as well as a thing in the world; theories constantly cut across and complicate our paths as we navigate forward in the 'real' world" (136). I treat the theory of performative gender—the assertion of sex-as-recognition—as a historically particular style of thought whose wide-reaching influence includes a framing and articulation of trans- therapeutics that was not possible before the 1990s.[6] It is by assigning productive power to acts of recognition and valuing the sociality of sex by emphasizing the productivity of social recognition that FFS is understood not as complementary to a trans- woman's transition but the very means by which woman comes to be. The performative intervention interrupts the distinction between "enacting the role of woman" and "being a woman" that Benjamin initially used to distinguish transvestism from transsexualism. In a performative framework sex and gender are intersubjective and irreducibly social things—a distinctly different kind of subject and different kind of sex and gender than the biologically universal, anatomical, and atomistic model of sex that first conceived the transsexual as a person whose desire to be a woman necessitated transformative genital surgery.

To be clear, I am not suggesting that the theorization of performative sex/gender was *causally* responsible for the growth of FFS and other forms of nongenital trans- body modification, nor that scores of trans- women are marching into medical offices waving *Gender Trouble* over their head or speaking of their transition in the terms of high theory. I am arguing that arriving as it did into the ripe critical space opened by social constructionism and an emerging skepticism of scientific and medical authority, the central elements of gender performativity became discursive resources by which claims to the nature of sex and gender—and thus the nature and form of trans- therapeutics—could emerge as such in the 1990s in ways that they could not and had not before.[7] Theories describe the world and also become things in the world that produce affects and effects.

The French feminist theorist Anne Emmanuelle Berger (2014:78) has argued that "gender theory is not a pure conceptual construction, that it is also a cultural artifact, and that it has to be treated as such, that we have

to raise the question of its contexts of production and reception, its modes of existence, and its rhythms of circulation" (see also Valentine 2007). I take up Berger's provocation to consider how the premises of gender performativity have shaped claims about the nature of sex and gender and the medical practices intended to intervene in them. The claim that sex is made real in and through acts of intersubjective recognition—that sex is performative—is the animating logic of FFS; it underwrites a trans- therapeutics within which FFS as a sex-changing technology acquires the force of common sense.

Of course the explanation of trans- medicine as focused on nongenital body parts and as being oriented toward a goal of recognition was not solely produced by a shift in discursive resources. Its emergence in the 1990s has a great deal to do with changes in how trans- medicine was administered and the kinds of narratives trans- people could tell about their lives that had been foreclosed in the previous decades by gatekeeping diagnostic protocols that trained a focus on genitals and genital surgery.

FROM "WRONG BODY" TO "INVISIBLE ME"

The practice of FFS begins at the first surgical consultation and ends at the last postoperative checkup. But the conditions of its possibility—the political, institutional, and conceptual histories that led to the emergence and continued popularization of FFS—stretch to the earliest moments of American trans- medicine and portend shifts to come. The historian Joanne Meyerowitz (2002) has argued that the shift of trans- medicine from university-based clinics to private practice in the late 1970s and 1980s is the event that has had the greatest impact on trans- health care in the United States. In making the move from research hospitals to private practice, trans- medicine was part of a massive wave of privatization of American medicine in the 1980s. In for-profit trans- medicine, as in other medical specialties, patients qua consumers were newly empowered—and expected—to direct their own health care decisions (Balint and Shelton 1996). While this meant a welcome break from the paternalism and restriction that had characterized university clinic programs in the 1960s and 1970s, it also introduced new problems of access. Many trans- people were unable to afford expensive specialty surgeries. Others paid a small number of surgeons who provided a much-needed service in exchange for a very handsome fee, opening questions about whether surgeons' work was driven

by a will to generously help people in need or to exploit and profit from that need (Morreim 1995).

The ethical contentiousness of care versus profit was especially debated in regard to the exponential growth of elective surgery in the 1980s and 1990s (Blum 2003, 2005; Bordo 1997; Gilman 1998; Morgan 1991).[8] A growing consumer commodity, elective surgery was marketed to achieve the American values of individual improvement, self-actualization, and self-esteem that were crucial for a strong economy and fundamental to the robust nationalism of the cold war era (Edmonds 2009; Gilman 1998; Haiken 1997; Meyerowitz 2002; Serlin 2004). Political, economic, and popular shifts toward the neoliberal values of personal responsibility and market-based solutions to social problems in the 1980s and a rapidly specializing medical profession (Starr 1982) helped to create an American health care system that celebrated individual choice and freedom (Mol 2008; Patton 2010), making each of us responsible for cultivating the self-actualization that comes from living as fully realized individuals in "healthy" bodies (Briggs and Hallin 2007; Rabinow 1996; Rose 2007).

Once the hallmark of transsexual self-narrative, "wrong body discourse"—the explanation of trans- embodiment as, for example, being a woman trapped in a man's body—was adopted by people seeking surgical self-realization of many kinds (Frangos 2006). Thin people trapped in fat bodies (Bordo 1993; Throsby 2008), attractive people trapped in ugly bodies (Davis 2003a; Huss-Ashmore 2000), and young people trapped in old bodies (Frost 2005; Holliday and Taylor 2006) turned to a market saturated by surgeons whose procedures promised to make mismatched selves and bodies into harmonious pairs (Gilman 1999; Shilling 1993). Immersed in a context of surgical self-optimization and newly empowered to direct the processes and components of their own transitions, many trans- Americans in the 1990s embraced a new narrative about what surgery was meant to do. Rather than moving them from one "wrong body" to a binarily opposed "right body," surgery could be for trans- people what it was for others: a means of individual self-actualization, a way to make an "invisible me" visible to others. Disaggregated from narratives of pathology and increasingly available in a fee-for-service, consent-based, and patient-centered treatment model, the popularization of FFS in the mid-1990s depended upon these dynamics; it was part of an American trans- medicine tuned to a newly defined outcome of self-fulfillment and personal authenticity.

Of course medically mediated self-fulfillment is not available to every-

one. Medical transition can be very expensive, and the high cost of surgical procedures puts them out of reach of many who desire them. Even more expensive than genital reconstruction, and with only very recent and exceedingly rare insurance coverage, FFS is a luxury available only to the resourced few. I take up these critiques at length in chapter 4.

FROM PASSING TO RECOGNITION

What distinguishes FFS from other trans- surgeries is the primary role it gives to the social life of the body. While an individual body undergoes surgical interventions, the change that FFS enacts takes place irreducibly between people. Perhaps nowhere is this made clearer than in the imaginary scene in which Ousterhout explains the goal of FFS: "If, on a Saturday morning, someone knocks at the door and you wake up and get out of bed with messy hair, no makeup, no jewelry, and answer the door, the first words you'll hear from the person standing there are 'Excuse me, Ma'am.'"

Other FFS surgeons I interviewed narrated similar scenes, and many patients reproduced them when describing their hopes for postsurgical life. Rachel fantasized about walking into a store and having the clerk ask, "Can I help you, Miss?" Gretchen imagined sitting on an airplane without having to endure the reproachful stares and palpable discomfort of the passenger seated next to her. Tracy hoped that she would no longer "scare small children" when she walked down the street. It was in moments at the doorstep, in the shop, on the airplane, or on the street that FFS patients would know that the procedure had worked, that it had done what they'd hoped it would. It was in the "miss," the "madam," and the not-looking-twice that their womanhood would be enacted.

Some people—including some of the FFS patients I talked with—might consider such scenes to be instances of passing. *Passing* is a term with a fraught history in U.S. racial and sexual politics (Cooley and Harrison 2012; Ginsberg 1996; Hobbs 2014; Robinson 1994). For some trans- people the term is contentious because it implies deception. Some trans- women object to the language of passing because, they argue, to say that someone passes as a woman is to affirm that woman is not a category to which she rightfully belongs. The author and activist Julia Serano (2007:176–82) has argued that passing is often used to describe the actions and efforts of a person whose body and behavior are being scrutinized, thereby obscuring the active role of those scrutinizing her. This singular focus, Serano writes,

creates a double standard in which the gender work of non-trans- people—whom she calls *cisgender* or *cissexual*—is solidified as natural and effortless while trans- people's gender is maintained as artificial and deliberate.[9]

Rather than a project of passing, FFS is more productively read as a project oriented by an aim of recognition. Though no less complicated, approaching trans- body projects, especially FFS, as aiming for recognition offers a set of analytic tools and stakes that move beyond questions of authenticity and artifice, truth and falseness, duplicity and strategy that often structure discussions of passing. Theories of recognition from Hegel to Honneth share a fundamental understanding of the individual not as a bounded and atomistic subject but as one formed in and through relations with others. They focus on the dynamic productivity of intersubjective interaction. Recognition is fundamental to a performative model of sex/gender and, as the scenes above attest, is central to the imagined and actual means through which FFS does its work.

A shift from passing to recognition allows us to attend to what happens when a trans- woman's efforts toward being recognized as a woman are refused. Refusals of her womanhood do not only negate her efforts toward desirable recognition; they also produce forms of recognition that she does not desire. In this way recognition is productive, but not always affirmative.[10] Being recognized in an unwelcome way can be destructive and dangerous (McQueen 2015). This kind of unwelcome and "undoing" recognition (Butler 2004) can happen interpersonally—when, instead of "miss," the shop owner mutters something hateful and threatening, in relation to the state when facial surgery is irrelevant to questions of legal sex, and politically when other trans- people read some kinds of recognition as liberatory and others as dangerously conciliatory. The dynamic and entangled relations of recognition allow us to see FFS as suspended in tensions with each of these in ways that "pass/not pass" does not. When FFS works (or not), it does more than change one person's face.

WRITING ME IN

It would be difficult to overestimate the role that my being a trans- man has played in this research. It has shaped how the project was conceived as well as the kinds of data I was able to collect.[11] This acknowledgment is not meant to flatten or trivialize significant differences between and among people who identify themselves as trans- (transgender, transsexual, trans*,

or any one of many shifting and proliferating terms). The patients I interviewed, talked with, and shared time with had been recognized for most of their lives as boys and men and had come to the surgical clinic looking for surgeons' help to transform their body so they could be recognized—by themselves and others—as the woman they knew themselves to be. Some identified as trans-, some as transgender, some as transsexual. Many talked about these words as relevant to their life or terms with which they related, but they did not explicitly assign them to themselves, and I did not ask them to do so.

I am in a body that has allowed me to think of gender as flexible and malleable. My transition was emotionally exhausting and often excruciating. I hope to never experience such profound self-doubt and self-scrutiny ever again. But the physical ambiguity of that period—the time when my sex could be and was read differently several times in a day or even in the course of a single interaction—was mercifully brief. With some help from twice-monthly testosterone injections, my body facilitated the shift from woman to man that I resolved to make. No surgery was required to enact this shift—though some was certainly desired and eventually undergone. I am a man in every sense of the word that matters to me. And crucially, I am not alone in my claim to manhood. My status as a man—and thus as presumptively male-bodied—is reflected back to me from all directions. Strangers and intimates recognize me as a man. So does the state; the big block *M* on my driver's license, passport, and birth certificate completes the story of my identity. The coherence of my sexed appearance and identification documents allows me to obtain legal employment, move unimpeded across national borders, and gain access to the myriad privileges of unquestioned white manhood. Considering my story in the abstract, some may contend that I am not in fact a man and that my "real" sex is safely confirmed by my XX chromosomes. Those folks and I are working with different definitions of sex, different ideas about what the word *man* denotes, and that's okay with me. Because my status as a man is recognized and consistently accepted by individuals and institutions, because it blends me in and keeps me safe, I can afford not to care about the opinions of naysayers. I shrug in the shape of that privilege. That there was a significant gap between my story of medical transition and theirs was a fact not lost on the trans- women with whom I spoke during my fieldwork.

Some bodies avail themselves of theories of gendered fluidity and flux, play and performance. Others do not. Some bodies bear signs of distinction

that are so strong and so immediately recognizable in the social milieu in which they exist that no dress, no makeup, no mannerisms, no hormones, no deeply felt personal claims can effectively resignify them. In some cases the persons who inhabit such bodies take up their outsider status proudly and to great effect. They relish being physical catalysts for social change and for upsetting a normative gender system that divides and denigrates us all. Other people do not want to be the vanguard for changing the gender system in which they live. They want, like the overwhelming majority of people, to be simply and unquestionably recognized as the man or woman they know themselves to be. But for some bodies this desire is nearly impossible to achieve. The shapes of acceptable femininity are constrained far more than those of acceptable masculinity (Serano 2007). For the transwomen I met in the course of my research, the fact of their face marked the difference between the life they had and the life they wanted.

There are many who object to the surgical impulse, arguing that an often lurid focus on surgery has, for too long, overdetermined trans- as a medical category—both for those trans- people who desire surgical transformation and for those who think and write about trans- lives. While I am sympathetic to that critique and grateful for the creative and vital scholarship that has emerged in its wake, I think it is important to remember that the practice of trans- surgery has gone on uninterrupted in the United States for over six decades. In that time there has not been a single day in which the surgeons who specialize in trans- specific procedures have not been busy at their craft, and not a day when the queue of hopeful patients has disappeared. I am an ethnographer of trans- surgical practice not because surgery defines us as trans- people but because it is so very important to so many of our lives.

Inside the clinic patients' personal stories, rationales for seeking surgery, and theories of trans- embodiment are transformed into a set of plans. Surgeons don't operate on desire or justice or fantasy or redemption or self-actualization or shame or any of the other things that surgeries might mean to trans- people. Surgeons perform procedures on body parts. Those procedures are oriented toward particular goals, nameable transformations that are planned in advance, for a particular reason, and (hopefully) evaluated for their success or failure after the fact. How patients relate to those goals, how they contribute to their formation and make sense of them afterward are intimately linked to the technical work of surgery but are not the same as that work.

Facial feminization surgery is not simply one more way to enact the end goal of woman that was first articulated in and through transsexualism and its genital surgery treatment. It is not the same project focused on a different body part. Instead FFS is animated by a different understanding of what and how sex is. It articulates an alternative therapeutic logic and, by implication, an alternative framing of what trans- medicine aims to do and how and why it aims to do it. In the FFS clinic patients and surgeons assert a trans- therapeutics centered on a body enlivened and invested with socially particular meanings. They enact a surgical logic that moves sex/gender out of individual bodies and into the social space between people, where the performative claim that sex/gender is made real through recognition can be worked into a surgical plan. This project takes the claims of FFS patients seriously—that the fulfillment of their desire for transition can be enacted through facial reconstruction—and contends with the historical, political, and ethical implications of that claim.

But one step at a time.

CHAPTER BY CHAPTER

In the first chapter I explore the origins of FFS in its historical and geographical moment: San Francisco in the early 1980s. By analyzing how Ousterhout's treatment philosophy has changed over time, I show how shifts in ideas about sex and gender and in the delivery of trans- medicine in the dynamic 1990s impacted the way he understood and performed FFS. Initially committed to the genital-centric definition of transsexualism in relation to which FFS was complementary, over time and in consultation with his patients Ousterhout come to understand FFS as itself enacting a change of sex.

In chapter 2 I examine how conflicting models of trans- therapeutics are worked out in the surgical clinic. By analyzing one initial patient consultation in Ousterhout's office and another in the office of a plastic surgeon, Joel Beck, I argue that these divergent clinical strategies are indicative not only of shifts in trans- treatment paradigms but of broader trends in the ways Americans use surgery. No longer limited by the "wrong body" model of pathology that structured trans- medicine between the 1960s and 1980s, by the first decades of the twenty-first century trans- people could join the ranks of millions of Americans who sought surgery in order to manifest their true self. This change in treatment philosophy multiplies what it means

for trans- surgical interventions to work, thereby implicating a shift in the aims and logics of trans- medicine.

In chapter 3 I look at the ethical history of American trans- medicine as a distinct "geography of care" and show how it continues to bear on the clinical present. Surgeons' efforts to frame their work with trans- patients in ethical and affective terms both respond to the fact of poor trans- health care and leverage that legacy to distinguish "good" surgeons from "bad." Described as an act of friendship, generosity, and deific repair that patients reciprocated with gratitude, loyalty, and individualized moralistic praise, facial feminization surgery was an act of restitutive intimacy whose status as such depended upon the elision of the financial transaction between doctor and patient. As surgeons claimed to care for their trans- patients for "all the right reasons," their ability to surgically enact woman depended in part on the cultivation of affect as a vital surgical technique.

In chapter 4 I move out of the surgical clinic to look at contexts of recognition in which the claims to performative womanhood that surgeons and patients name common sense are explicitly refused. Rather than an instance of passing, I suggest recognition is a more productive way to understand the aims of FFS and one that allows a consideration of the effects of FFS in scales other than face-to-face interaction. The personal recognition of belonging and authentic identity that FFS patients seek is contentious for some trans- women who claim that rather than individual recognition as normatively female, what they need is political recognition as an identity group. Advocating collective refusal of the narrow norms that constrain sex/gender subjectivity, these critics argue that FFS costs trans- women more than they should bear. The personal and face-to-face recognition that FFS patients seek is also refused by the state, whose definition of sex and surgical sex-reassignment remains centered on genital anatomy. By engaging the complexities of recognition over the dichotomy of pass/no pass, I argue that we are better able to contend with the effects of FFS beyond the individuals who undergo it.

In chapter 5 I go into the operating room to watch FFS get done. In that space I was confronted with tensions between the abstract tools I had for thinking about sex/gender embodiment and the visceral materiality of reconstructive surgery. Interspersing detailed field notes of one patient's operation within an analytic exploration of the place that trans- bodies have occupied in gender theory, I explore tensions between the body in books and the body on the table. It is ethnography that provides a meeting place

between the two, insisting that it is in the situated practices of living that bodies, like ideas, acquire potential and meet their limits. Cutting, sawing, and suturing are examples of potential and limit, both for me and for the patient whose deeply intimate transformation I witnessed.

In chapter 6 I ask what happens to patients after surgery. Exploring the narratives of three patients—one directly following surgery who is imagining its ultimate effects, one whose surgery is considered an unqualified success, and one who finds that FFS did not do for her what she hoped it would—multiplies questions of how and for whom FFS works, unsettling any simple narrative of what this surgery can do. In the end I think through some ways that a shift to intersubjective and recognition-based definitions of sex/gender are influencing medical practice and how we think of trans-therapeutics in America today.

NOTES

INTRODUCTION

1 Sex and gender identities and terminologies proliferate. In recent years the word *transgender* has become common as an umbrella term meant to encompass a wide variety of established and emerging identities. This language is constantly shifting and being inhabited differently by different people. When I write about trans- people as a larger group, I adopt the term *trans-*. Whereas Stryker et al. (2008) use the term *trans-* in order to leave open the possibility of kinds of crossing that are not limited to gender, I use the open-ended hyphen to call attention to the many possible endings of the term, all of which are important to the people who identify themselves as such.

2 U.S. Department of Health and Human Services, "Nondiscrimination in Health Programs and Activities," 81 Fed. Reg. 96 (May 18, 2016), *Federal Register: The Daily Journal of the United States*, July 2016. Online.

3 Drs. Ousterhout and Joel Beck insisted that I identify them by their real names. All other names of patients and doctors are pseudonyms, except those cited in published works.

4 For early European clinical trials on FFS, see Becking et al. 1996; Gooren and Doorn 1997; Hage et al. 1997a, 1997b. For invocations of eventual FFS as an endorsement of adolescent hormone intervention, see Cohen-Kettenis et al. 2008, 2011; Rosenthal 2014; Shumer and Spack 2013. For a critical discussion of such endorsements, see Sadjadi 2013.

5 Butler's contemporaries who were taking up the gendered histories of sciences in other terms include Jordanova 1989; Laqueur 1990; Russett 1989; Schiebinger 1989, 1993; Stepan 1986.

6 Of course credit for this shift in thinking about gender does not go to Butler alone. One could call on a long tradition of sociology, from Cooley to Goffman and later Garfinkle (1967) and Kessler and McKenna (1978), who have all studied gender as a form of socially structured doing, a deliberate action that gets its sense through recognition. Anthropological scholarship of gender has had an abiding interest in attending to specific social practices and how they trouble simple biological narratives of sex difference. These stretch back to Margaret Mead ([1935] 2001) and Ruth Benedict

(1939) and, more influential in the latter twentieth century's development of gender theory, to the pathbreaking work of Esther Newton (1972, 2000; see Rubin 2002). Butler's crucial contribution to these long and fruitful lines of scholarship was to use the critical lens of gender enactment to destabilize the givenness of sex.

7 By the end of the 1990s the theory of gender performativity had traveled far beyond the readers of Butler's abstruse text. By the time *Gender Trouble*'s tenth anniversary edition was published in 1999, claims to performative sex/gender had been explicitly invoked by activists, used by the American Psychoanalytic Association and the American Psychological Association to reassess their principles and positions on homosexuality, engaged in art exhibits at prestigious galleries, and used in jurisprudence and legal scholarship (Butler 1999:xvii). In 2001 the *International Journal of Sexuality and Gender Studies* published a double issue on Butler's impact on fields as diverse as archaeology, film, Renaissance studies, and political theory. Butler's work on sex/gender in the 1990s helped mark a fundamental shift in the way many people understand what sex and gender are, how they are done, and how they might be productively done otherwise (see Schippers 2014:1). Stripped of the intricate conceptual links in which Butler had suspended it, decontextualized from its long and rich histories in linguistic scholarship (see Bauman and Briggs 1990), *performativity* became a metonymic shorthand for a bold new response to the constraints of essentialist and biologically centered theories of sex and gender against which feminist and social constructionist thinkers had been agitating in the 1970s and 1980s. Condensing meanings beyond those Butler initially assigned it, gender performativity became a discursive resource—a distinct way of thinking and talking about subjects and bodies, knowledge and power—by which new claims to the nature of sex and gender could be made.

8 Statistics kept on the incidence of cosmetic and reconstructive surgeries show an increase in these procedures and dollars spent on them year over year since professional groups began collecting these data in the mid-1990s (ASAPS 1997; ASPS 2014).

9 Still others argue that the goal of passing can obscure and effectively foreclose the possibility of a trans- specific radical political subjectivity (Bornstein 1994; Green 1999; Stone [1991] 2006). This group does not object to passing per se; they are concerned with what strategies of erasing trans- visibility mean to a liberatory politics premised on making space for difference by rendering difference visible. For a history of the prefix *cis-* as applied to gender and sex, see Aultman 2014; Enke 2013.

10 For critiques of Taylor and Honneth on this point, see McBride 2013; McQueen 2015.

11 It's not uncommon for trans- people to experience "research fatigue" (Davidmann 2014:110), the exhaustion of being asked over and over again to contribute to research studies. I was acutely aware of this risk, especially since much of my research took place inside the especially vulnerable space of the surgeon's office. The presence of an observer inevitably impacts the clinical dynamic. I tried to minimize my impact on clinical interactions by remaining outside the patient's field of vision whenever possible, by giving patients the option to include me in some clinical interactions but exclude me from others, and by reserving questions and discussion with the surgeon not only to times away from patients, but when there

were no patients in the office. Still, there is no disappearing as the third party to a two-person exchange. Sometimes surgeons used my face as an example to describe characteristics. Sometimes patients wanted or felt compelled to talk with me in the lulled and anxious minutes waiting for the surgeon to return to the consultation room. Sometimes they asked me questions about their own consultation, knowing that I had observed several others and that I had experiences that were from the perspective of neither patient nor doctor. In these ways, I became a part of the clinical experience for patients, a resource for reflection or for information.

My one-on-one interviews with patients (I conducted twenty-eight formal interviews) frequently took place in a side office in the clinic, but sometimes patients preferred to meet elsewhere, including the hospital cafeteria or the convalescent facility, or to talk while walking in a park near the hospital. Not all those I asked to participate in this research agreed to take part. Some declined completely. A few consented to allow me to observe in the operating room once they were under anesthesia but did not want to talk with me. Out of respect for patients, adherence to research protocols, and deference to the principles of anthropological scholarship, I deferred to participants' wishes and allowed those who did want to talk with me to set the tone and length of our interaction. Some formal interviews lasted just fifteen minutes; others lasted for more than two hours.

Disclosing the fact that I am trans- was sometimes helpful in building rapport with the trans- women I talked with. In some instances it helped to produce a kind of fellow feeling and assured my interlocutors that I was not interested in pathologizing or exoticizing them, as so much research has done. Nor was I interested in turning their stories into melodramatic tales of suffering or hagiographic tales of resilience. My trans- status also became a tool for conversation. For example, a patient named Rhonda described knowing she was a woman "ever since [she] came out of her mother's womb," and then stopped and said, "Well, *you* know what I mean!" Her assumption about our common experience allowed her to share and relate to me as an insider.

That there was a significant gap between my story of medical transition and theirs was a fact not lost on the trans- women with whom I spoke during my fieldwork. Trans- women often remarked at how masculine I was. They looked me up and down and asked how long I had been on testosterone. I was once called a "lucky son of a bitch." Though I had found these kinds of comments irksome (because they made me self-conscious and were too often accompanied by what felt like condescending squeezes of my biceps), in the course of this project I have come to understand them differently.

1 · On Origins

1 For more on the founding and activities of the Erickson Educational Foundation, see Devor 2002; Devor and Matte 2004, 2007.

2 Documenting the existence and operations of these clinics is a difficult task. In addition to the officially and institutionally recognized centers counted by Restack