"You know a girl when you see one": experiences of surgeons who perform gender/affirmation/reassignment surgery

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“YOU KNOW A GIRL WHEN YOU SEE ONE”: EXPERIENCES OF SURGEONS WHO PERFORM GENDER AFFIRMATION/REASSIGNMENT SURGERY

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DEDICATION

I would like to dedicate this work to Diane. I am so happy to have known you the short time I did. We all miss you.
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First and foremost, I would like to acknowledge my participants. Without them taking the time out of their busy lives to talk with me, this work would have not been accomplished, and I thank them for that. I would also like to thank my advisors and readers, Linda, Lance, Bayla, Diane, and Ruben. They have all given me insight and pushed me to do work I never thought I was capable of. Last, but certainly not least, I would like to thank my classmates, Eva, Heather, Kellan, Rebecca, and Tong. I am glad we had the opportunity to experience this together, and were all there for each other during the difficult times, and could share the joyous times.
“YOU KNOW A GIRL WHEN YOU SEE ONE”: EXPERIENCES OF SURGEONS WHO PERFORM GENDER AFFIRMATION/REASSIGNMENT SURGERY

ROBERT JOSEPH CHRISTIAN

ABSTRACT

Most recent research on gender affirmation/reassignment surgery focuses on discrimination and health disparities faced by the transgender community, and on perspectives and identity constructions of patients transitioning from one gender presentation to another. However, few studies address perspectives and experiences of the surgeons performing these operations. This exploratory study examines narratives of some of these surgeons in order to understand how they entered this particular practice, and how they perceive and classify these procedures. This study also aims to show the affect these procedures have on these surgeons and their discipline, and how these surgeons navigate the complex relationships between patients, healthcare providers, and surgeons, in the context of social values and popular media perspectives in the United States.
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DSM........................................... Diagnostic and Statistical Manual of Mental Disorders
FFS.......................................................... Facial Feminization Surgery
GAS............................................................. Gender Affirmation Surgery
IPA ........................................................... Interpretative Phenomenological Analysis
IRB ............................................................. Institutional Review Board
LGBT ......................................................... Lesbian, Gay, Bisexual, and Transgender
SOC .......................................................... Standards of Care, Version 7
WPATH ............................................... World Professional Association for Transgender Health
CHAPTER 1: INTRODUCTION

“Back when I was a little girl...”
— Dad

Some might say that this thesis began when I was a child. When I was growing up, my father would begin every one of his childhood stories with “When I was a little girl.” This, of course, was very confusing for me. Even at such a young age, I knew that my father was a man. But still, did he used to be a girl? Did I used to be a girl? Or was I destined to one day turn from a boy into a girl?

As I grew up, these questions received their answers when I realized how sarcastic my father truly is. Interestingly enough, when I told him what my research was on, he told me a fascinating story. He was old enough to remember when Christine Jorgensen was in the news for being the first widely publicized post-operative transgender woman (Merryfeather 2011). At my father’s school, all the girls would make the joke of starting a story off with, “Back when I was a little boy.”

When I heard this from my father, I could not believe how big an impact this idea of transgenderism had on me, invading even my earliest childhood memories, and the pervasiveness of the public perception of Christine’s surgery. In this way, I guess this thesis really was in the making since I was a child. But before this realization came to pass, something else turned my attention towards this topic.

I took a class entitled “Cultural Formation of the Clinician,” in which we reflected on the values and culture we bring into clinical encounters. One of the topics covered was
transgender identity. After doing the various readings and watching the related media, I found myself drawn to this particular community and the challenges they faced.

Those who identify as transgender, especially those who are brave enough to come out to the world and live as the gender they identify with, face huge amounts of discrimination. This discrimination comes from various sources, such as schools, employment, housing, and health care (Grant et al. 2011).

Of course, one of the issues that this population faces is access to specialty surgical care, specifically Gender Affirmation Surgery (GAS) (also known as Sex Reassignment Surgery, Gender Reassignment Surgery, or Genital Reconstruction Surgery). There are several procedures that may fall under the heading of GAS, but for the purposes of this thesis, when I say GAS surgeons, I refer to the surgeons who perform genital reconstruction surgery, chest reconstruction surgery, and Facial Feminization Surgery (FFS), known colloquially as “bottom surgery,” “top surgery,” and FFS, respectively. I personally have an interest in surgery, which is perhaps what drew my attention towards these procedures specifically. I came to the realization that GAS falls within the realm of medical anthropology, and was inspired to change the focus of my research. After discussing the topic with one of my advisors, I narrowed the focus of my study towards a gap in the anthropological literature.

To date, most research dealing with surgeons touches on surgical experience in general. This mainly deals with the enculturation process surgeons go through and the types of broad surgical identity (Katz 1999; Prentice 2012; Cassell 1996). Research in regards to GAS specifically is mostly from the perspective of the patient; there is
relatively little research when it comes to the surgeons who perform these operations. However, Eric Plemons (Michigan Society of Fellows 2013; Plemons 2013a; Plemons 2013b) has recently begun to explore the experiences of the surgeons performing aspects of GAS. His work mainly deals with the techniques and practices of GAS in regards to theories of sexed bodies, and the meanings behind what these surgeons are creating.

My research and its findings have been both fun and exciting for me. It has pushed me out of my comfort zone many times, taking me to places I never thought I would explore. It also allowed me to perceive situations in ways I had never done before. For example, I have been to numerous doctors’ offices, but had never before observed them. Here is an excerpt from my fieldnotes, describing such an instance, from when I visited a surgeon in his office:

_It was a hot summer day, with the temperatures in the nineties. I had been spending the summer in shorts and T-shirts, so I knew putting on a long-sleeved collared shirt and slacks was going to be a little uncomfortable, but it seemed like appropriate attire for meeting with the surgeon. I left quickly and made my way to the train station. Just as I was approaching, I saw the train leaving. I was already cutting it close in terms of our four o’clock meeting time, as it was already three fifty. I nervously waited for the next train, all the while cursing both myself for not leaving earlier, and whoever was in charge of the public transportation for not realizing that some people cannot wait ten minutes for the next train._

_Luckily another train came in just a few minutes. The train was air conditioned, which I was thankful for, as I was sweating from my quick walk to the station. I dreaded_
how I would look when I got to the doctor’s office. It was only a five or ten minute walk from the station to his office, but since I was late, I knew I would have to all but run to get there on time.

When the train arrived at the next stop, I quickly got off, briskly walked up the steps to the street, and made my way to the office. Just as I was approaching the office, I took my phone out to see what time it was. I made it just a minute after our meeting time, but paid the price of walking so quickly that I had started to sweat again. I worried that I would be a “hot mess” as I walked in the door.

The receptionist eagerly greeted me by name, assuming correctly that I was the doctor’s last appointment. She told me to go ahead and take a seat and that the doctor was just finishing up with his last patient. I should have known he would be the stereotypical doctor, running late. Luckily, this gave me time to cool off in the air conditioned office and take in my surroundings.

The lobby was rectangular and smaller than what I have come to expect of most waiting areas. The room was about twelve feet long and six feet wide. The entrance was in the corner, part of the floor to ceiling windows that made up the front wall. Against the glass were two couches, which were reminiscent of day beds; distressed silver-painted wood made up the arms and back, with throw pillows to lean on. There was a modern feel to the office with its couches and seamless, dark hardwood floors. The receptionist’s desk, more something you would find in a home office than a doctor’s office, was situated opposite the entrance. On the shorter wall off the entrance hung a television, cycling through the various procedures the surgeon performed, showing before and after pictures.
of patients. Opposite the windows and to one side, a glass display case built into the wall was lit up, showcasing the newest products in skin care and age-defying creams. In between the display case and the receptionist was the beginning of a hallway, making a “T” with front lobby. The hallway made its way to the back of the building, with two patient rooms along the way, culminating in the doctor’s private office.

I waited patiently for what seemed like ten minutes, listening to the soft rock music playing through hidden speakers in the ceiling, breathing in the faint smell of what I assumed was fresh paint, and watching the endless cycles of what my face could look like if I decided I found something wrong with it. Finally, the doctor emerged from the closest patient room, still wearing blue examination gloves. Within his blue grasp was an unknown object, something I can only assume was recently inside of or attached to his patient. I watched him and another man make their way to the back office, as the patient walked past me and out the front entrance, stopping briefly to talk with the receptionist. I was told by the receptionist that the doctor would see me now.

More than simply allowing me to become a better observer, this research has also been challenging. I have had to walk through the proverbial minefield of terminology and pronouns, trying not to offend anyone, including my participants. Try as I might, I did not make it through without any errors or lapse in judgment. I know I have stepped on the toes of a few people, and will inevitably continue to do so, though it is not my intention. Nor is it the intention of this research to offend anyone. Rather, it is meant to serve as a means of support for the transgender community and their allies. I hope to present my participants in the best light possible, while striving to create room for change in society.
With this in mind, the aim of this thesis is to explore the experiences of the surgeons who perform the various GAS procedures. This question of experience takes two forms in my research. First, I wish to discover how these surgeons make sense of and classify these procedures within the context of contemporary American society. The second purpose is to clarify the ways these surgeons developed and continue to navigate their identities within this context. To accomplish this, I used a phenomenological theoretical lens. Phenomenology, simply put, is the study of how individuals experience the world around them (Desjarlais and Throop 2011). This will serve to introduce a relatively under researched topic and to enhance the literature on surgical culture in general and GAS specifically. In addition, I will add new insights to the theoretical concept of local moral worlds, as well as the theory of medicalization.

The second chapter of this thesis provides background to the subject of transgenderism as it relates to contemporary American society. This entails various definitions of what transgenderism is and how it is defined in the medical context. The chapter will also discuss gender and sex as cultural constructs, and how current definitions have come to be, within a medical anthropological framework. A brief history of GAS in the United States will follow, including some of the current medical anthropology literature on the subject. Lastly, there will be a brief introduction to the history of surgery in general, and plastic surgery specifically, as it relates to this study.

Next, my third chapter discusses the methods of my study, including the original design as submitted to the Boston University School of Medicine Institutional Review Board (IRB), as well as the amendments made to the initial design as per the IRB.
Following this, I give detail as to the recruitment and interview methods used, as well as the methods used for data analysis. The results of this study will also be discussed, such as the number of participants recruited and other pertinent demographic information.

The first analytical chapter comes as Chapter Four. I discuss how these surgeons frame the concept of GAS within a reconstructive surgery framework. To do so, I use Bourdieu’s concept of habitus in the context of plastic surgery specifically, and surgery in general. How these surgeons learn this plastic surgery habitus is discussed, as well as an example of how knowledge is integrated into it.

The fifth chapter introduces the idea of “normal,” and how these surgeons use this concept in order to make sense of the GAS procedures they do. They must fit the operations into the context of a normal surgical procedure with normal outcomes and end goals, both for the surgeon and for the patient. These ideas of normal must align with the broader medical and social ideas of what is considered to be normal. This notion is explained using the theoretical concept of clinical, medical, and social gazes.

A local moral world is the topic of the last analytical chapter, Chapter Six. I define this concept in the context of the boundaries created by medical and social ideas of normality. I provide examples of how these surgeons act out their daily lives within the boundaries of this local moral world in order to maintain what is at stake for them.

Finally, Chapter Seven concludes this study with a discussion of ways in which these surgeons conceptualize the procedures – how they act them out within the boundaries of what is considered normal, serving to perpetuate existing ideas of sex, gender, and normal bodies. I also discuss how these findings contribute to the current
theoretical topic of medicalization, and how there is room for change within society by using insights gained from the perspectives of these surgeons.
CHAPTER 2: BACKGROUND

“Here I have been taking skulls apart and putting them back together for years, and I’ve never once thought about the difference between a male and female skull... Even the monkeys ... the chimpanzees, they were always noticing the difference between male and female skulls.” – Dr. D

**Gender (noun):**
1. The state of being male or female.
2. Sex (Medical Dictionary).
3. The behavioral, cultural, or psychological traits typically associated with one sex (Medical Dictionary).

**Sex (noun):**
1. Either of the two major forms of individuals that occur in many species and that are distinguished respectively as male or female.¹

One of the ways in which gender is culturally constructed in the United States is through medical and healthcare systems. When a child is born, it is up to the doctors to record the baby’s sex as either male or female; one or the other; the gender binary. However, doctors alone are not the sole source of this gender binary. Although surgeons are the main focus of this study, they do not act in isolation of culturally constructed ideas and values. In this respect, it is important to see where in the present cultural construction of gender these surgeons fit. In order to paint the proverbial landscape, I will discuss various terms, definitions, and ideas of transgenderism; gender and sex as cultural constructs, including the U.S. view of transgenderism; an introduction and history to

GAS in the U.S.; cultural politics surrounding GAS outside the United States; and a brief introduction to the history and current context of plastic surgery.

**Transgenderism**

What is transgenderism? Well, in a word, it’s complicated. According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) 5, “people whose gender at birth is contrary to the one they identify with will be diagnosed with gender dysphoria” (American Psychiatric Association 2013a:1).

For a person to be diagnosed with gender dysphoria, there must be a marked difference between the individual’s expressed/experienced gender and the gender others would assign him or her, and it must continue for at least six months. In children, the desire to be of the other gender must be present and verbalized. This condition causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. Gender dysphoria is manifested in a variety of ways, including strong desires to be treated as the other gender or to be rid of one’s sex characteristics, or a strong conviction that one has feelings and reactions typical of the other gender. [American Psychiatric Association 2013:1]

As shown through this diagnosis, gender dysphoria occurs at a variety of ages and can manifest in a variety of ways.

However, rarely outside the medical community, or even outside of the psychiatric community, is one labeled as being gender dysphoric; the popular term is transgender. However, this term has its own limitations as well. Similar to the DSM-5 definition, the term transgender is considered an umbrella term, “incorporating a complex array of people whose sense of their own gender does not conform to social expectations” (Doan n.d.). For instance, there are differences between Male-to-Female, Female-to-Male, transsexual, transvestite, two-spirit, gender queer, gender non-conforming, gender neutral, intersex, bi-gendered, and gender-bender, just to name a few. All of these
examples could refer to a person who identifies as “transgender.” It does not merely mean someone who was born a male and identifies as a female, or vice versa. Rather, the term encompasses a variety of sex, gender identities, gender expressions, and sexual orientations.

One way in which transgenderism is thought of is through the use of an individual’s unique combination of their four components of sexual identity (Bockting and Cesaretti 2001). The first is sex assigned at birth, usually male or female, or sometimes intersex. The second is gender identity – how an individual personally identifies, which may be male, female, both, or neither. Gender expression, which is how an individual expresses their gender, is the third component, and can be masculine, feminine, androgynous, or a blend of these. This may not always reflect their gender identity, but this is what is seen by society. The last component is sexual orientation, or to whom the individual is attracted.²

There are various ways of viewing these four components, but they are usually seen as a continuum, with male/masculine on one end, and female/feminine on the other. One common way of visualizing this is through the “Genderbread Person” (Figure 1³). As shown, there are infinite possible plot and label combinations for the four components. Not only that, but the plot points are not necessarily fixed. Considering the fluidity of this

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² Sexual orientation and sexual identity are distinct from transgender identity. It is most common to define one’s sexual orientation based upon the sex of the people in a relationship, which is subject to change. One may change their sexual orientation as their physical sex is changed (e.g. through surgery), but the transgender identity remains. This is one way in which the transgender community differs from the Lesbian, Gay, and Bisexual community.

³ Recently, it has been found that the creator of this particular version of the “genderbread person” plagiarized the work of others (for more information, see http://storify.com/cisnormativity/the-genderbread-plagiarist). Despite this, I have chosen to use this version because it is the clearest example.
continuum and the number of possibilities in which individuals may identify, it is no wonder that there are a multitude of terms to describe someone, as mentioned previously.

Figure 1 The Genderbread Person (From www.ItsPronouncedMetrosexual.com)

However, this idea of a continuum has its own shortcomings. One in particular is that the continuum is based on the binary of male and female. Some individuals may not consider themselves part of these two genders, and may elect for a third (or more) gender.

The term transgender arose from within the community itself, but is sometimes used in the medical profession to refer to an individual who is considered to be gender dysphoric. This is one example of how community-based terms can be so widely used that they become adopted into other groups, such as the biomedical community. The term transsexual, however, is a purely medical term. It refers to those who “pursue medical interventions such as the use of hormones of the opposite sex and/or surgeries to align
their bodies more closely with their interior sense of self” (Johnson, Mimiaga, and Bradford 2008:216). This paper is focused on surgeons, and, by inclusion, also references patients of surgeons – who by definition are seeking medical interventions. However, I will use the term transgender when discussing these individuals, as transsexual is a medical term deemed appropriate by the medical community, and is rarely used as a term of self-identity by the transgender community.

**Gender and Sex as Cultural Constructs**

Growing up, the dominant message is that sex and gender are givens, or innate. There are boys and there are girls, and you know each of them when you see one. From this perspective, the binary is so ingrained that it is hard to imagine that there are those who fall outside of those categories. However, the idea of sex and gender is not fixed; rather it changes over time and throughout cultures. The social constructivist view sees the “meaning of sex [as] historically and politically specific… It therefore has no universal or ahistorical meaning” (Grenfell 2003:68). In fact, it is only recently that distinctions between genders has arisen, where, prior to the eighteenth century, these differences were not as distinct (Dudley 2010) (I will elaborate on this idea further into this chapter). Not only is the meaning of sex and gender culturally bound, but the expressions of gender are as well. Take Figure 2 for instance.

![Figure 2 Claude Renoir at Play; Renoir's youngest son at age 4 (Pleak 2011)](image)

The picture is titled *Claude Renoir at Play*, and depicts a boy at the age of four in Paris in
1905. People are “frequently surprised that pink was the norm for boys in Europe in those times, the same for long hair with bows, and how radically this changed in the 20th century… the boy’s frilly pink dress and ribbon-bowed shoes are gender-typical for his time, but would be extremely gender-atypical now” (Plek 2011:xvi). While today there is still no complete agreement on what the true characteristics of sex and gender are, “social scientists, academics and advocates increasingly recognize and acknowledge the mutability and fluidity of sexuality and gender among groups and individuals across time and culture” (Johnson, Mimiaga, and Bradford 2008:215).

Even without a clear agreement on what makes a man a man, a woman a woman, and what constitutes the criteria for the more ambiguous versions of gender, members of a society are still able to identify themselves and the social roles they desire because of cultural influence (Lombardi 2001). As mentioned previously, the current view of sex and gender in the United States is a fairly recent phenomenon. It is both historically and politically rooted, as well as reinforced by the power of dominant structural influences. As Foucault argues, the notion of power shifted during the eighteenth and nineteenth centuries. First, it was based on sovereign power. “Power in this instance was essentially a right of seizure; of things, time, bodies, and ultimately life itself; it culminated in the privilege to seize hold of life in order to suppress it” (Foucault and Hurley 1990:136). Foucault goes on to contend that “the locus of state power… shifted from a logic of ‘sovereignty,’ which exacts obedience through bloody repression, to one of ‘biopower,’ which promotes the health and well-being of citizens” (Bourgois and Schonberg
With the development of capitalism, this biopower was essential not only in the control of bodies, but the production of bodies as well (Foucault and Hurley 1990).

It was also during this time that classificatory thought reemerged with a focus on anatomy of the body (Foucault 1973). Thomas Laqueur claimed that during this time “anatomical differences between men and women were suddenly given fresh political significance,” that before this shift women’s anatomy was not seen as different, but inferior to men. These “fresh” revelations of anatomical discovery led to the new theory of women being “opposite and complementarily different” to men, underscoring the social ideals of women being lower on the proverbial totem pole than men while simultaneously switching the focus to reproduction (Grenfell 2003:69; Meyerowitz 2002). Thus a more explicitly differentiated gender binary had begun.

The introduction of biopower, the necessity of bodies for capitalism and production, and the emergence of anatomy and its taxonomical classifications, paved the way for the invention of sex and sexuality. Foucault goes on to say that the deployment of sexuality in the nineteenth century would be one of the great technologies of power, and one of the most important (Foucault and Hurley 1990). Indeed, the ability to procreate became one of the first determinants of what defined sex. The anatomical “facts” found in the eighteenth and nineteenth centuries opened the door to biological determinism; that is, biology determined one’s destiny – in this case, being male or female. In this way, the relationship between biology and sex became the natural and the only way in which sex could be constructed (Grenfell 2003); biological existence was reflected in political existence (Foucault and Hurley 1990).
With the emergence of biopower, biological determinism, and sex as a target of power, new formulations of sexual deviancy also took root during the late nineteenth century (Bourgois and Schonberg 2009). As Foucault might argue, if one did not fit into the gender binary of male and female, or were using their sexuality in ways other than to procreate, one was considered deviant in society. This included the subjectivity surrounding homosexuality as a sexual orientation; but any person of unorthodox gender, including those identifying as transgender, could be grouped within this category (Merryfeather 2011).

However, in the early twentieth century, with the increasing visibility of the “sexual deviants” in society, as well as more and more women challenging the notions of inferiority by entering the labor force, pursuing higher education, and joining social movements throughout the nineteenth and into the twentieth century, the question of sex was called into question (Meyerowitz 2002). Again, scientists turned to the biological aspect of the human body to discover what determined a person to be a man or woman. One way they attempted to define men and women was through the morphology of the sex organs and gonads. However, these presented problems, as not all humans are completely biologically intact. For instance, there is a condition known as intersex, which includes ambiguous genitalia, in which a child’s gonads are not necessarily recognizable. There are also individuals with both gonads, or “ovotestis” which contain both types of tissue (Shrage 2012:238).

Another way that scientists looked at the different sexes was through genetics, particularly by looking at the sex chromosomes. This too has its flaws. For example,
20,000 men have two X chromosomes, instead of the “normal” XY karyotype (Green 2004). Additionally, if we rely on a person’s sex chromosomes to classify someone as male or female, it would be difficult to characterize rare karyotypes such as XO or XXY (Shrage 2012).

In the late nineteenth century, the field of endocrinology discovered sex hormones. Scientists used sex and other chromosomes to describe the initial determinants of sex – that is the initial pathway towards male or femaleness, but turned to hormones in order to describe the vast “variations and gradations” seen in sexual development and intermediate conditions (Green 2004; Meyerowitz 2002:27).

The search for a biological origin of transgenderism builds on past research dealing with maleness, femaleness, and human sex differences, and continues even today. Recent studies (Kruijver et al. 2000; Zhou et al. 1995) show that there is a difference in neuron numbers in the sexual centers of the human brain; Male-to-Female individuals share similar numbers of these neurons as biological females.

The idea of variations in biological sex gave rise to two different ideologies of sex in Europe and the United States. In Europe, these seemingly infinite variations in anatomy, chromosomes, hormones, and development resulted in a spectrum of sexes; every person exhibits both maleness and femaleness; a physical, biological bisexuality. These blurred boundaries between males and females were not as evident in the United States, which continued the male-female categories and attributed variation to “individual temperament, personality, and behavior… culture, environment, and learning… Thus in
the first half of the twentieth century, the theory of human bisexuality had less impact in the United states than it had in Europe” (Meyerowitz 2002:26–29).

As Gordon argues in her paper, appropriately titled *Tenacious Assumptions in Western Medicine*, “The biological reductionism by which modern medicine is frequently characterized is more theoretical than actual… although biomedicine both constitutes and is constituted by society, this interdependency is nevertheless denied by biomedical theory and ideology which claim neutrality and universality” (1988:19). Thus, not only is the dominant view of human sexes and sexuality rooted in biological determinism, but it also suggests that social norms should be grounded on biological facts (Grenfell 2003).

We can use Foucault’s notion of biopower, the subjugation of individuals through scientific authority and governmentality – the ways in which society uses institutions, procedures, and citizens to control bodies – to understand how this notion of male and female bodies is pervasive throughout American society. We see this through things like birth and death certificates, driver’s licenses, census data, and other forms of individual registration and documentation, where only two boxes are shown under sex. Questions have arisen as to the legitimacy of government registration of one’s sex, as these “can serve both liberatory and oppressive ends… enabling governments to locate and persecute members of stigmatized groups (Kidd and Witten 2008; Merryfeather 2011; Shrage 2012:228).

Quantifiable data collection is only one aspect of Foucault’s concept of biopower. Another is how individuals are created as subjects through the legislation and bureaucratic processes used by the state. Through the creative arrangement of power,
bodies are seen as “universal and fixed biological [entities]… Even those disciplines which would disclaim a biological basis still accept the a priori existence” of the biological body (Armstrong 1983:5). These “disciplines” include state legislations. As such, various legislations are predicated on this preexisting universality of the human body.

This can lead to pervasive discrimination on a societal level. “Historically, particularly in Western culture, people who have not conformed to their assigned gender role have been oppressed, and transgender people have been victims of societal discrimination and marginalization” (Kenagy 2005:19). In fact, the individuals of this population are likely to experience some form of discrimination or violence sometime in their lives. They face peer rejection; poorer social relationships; high rates of unemployment; employment discrimination; high rates of physical and sexual violence, abuse, and harassment; discrimination at school; harassment from police; and poor provisions of assistance or outright refusal by social services – all of which is persistent in “nearly every system and institution in the United States, both large and small, from local to national” (Herbert 2011; Gretchen P. Kenagy and Hsieh 2005; Kenagy 2005; Kidd and Witten 2008; Lombardi et al. 2002; Lombardi 2001; Stotzer 2009; Grant et al. 2011). This indirect, yet systematic exertion of violence by everyone in a given social order is known as structural violence (Farmer 2004).

As a perfect example of this idea of universal biology and structural violence, take the 1971 court case of Anon v Anon. In this case, the husband of a pre-operative Male-to-Female transgender individual “sought a declaration as to his marital status” – that is, he
was challenging the legality of the marriage. The husband discovered his wife’s biological sex and deserted her. Without any test for the determination of sex, the court found that, “as a fact,” the defendant was not a female at the time of the ceremony. The court cited a prior case that incapacity for sexual relationship is grounds for annulling a wedding, that is “of itself sufficient indication of the public policy that such relationship shall exist with the result and for the purpose of begetting offspring” (Grenfell 2003:75). This court ruling was based on the a priori existence of a biological body.

These examples show how biological determinism is present in society and can be used against transgender people, as well as others who step out of the gender binary. Although variations in behavior and identity are hallmarks of the human race, “when those variations are to a degree considered by society out of proportion to a perceived normality or to an extreme that may cause harm to the individual or society, the variation is generally regarded as objectionable, abnormal, or pathological” (Pleak 2011:xv). The legacy of dualism, both as it pertains to the male and female bodies, and the separation of the mind from the body, has made transgenderism into something that is seen as objectionable, abnormal, and pathological throughout society. So much so that this perceived deviant behavior is becoming medicalized, changing the way we describe, understand, and address it (Bockting and Cesaretti 2001). This is apparent in the classification of Gender Identity Disorder in the DSM-IV-TR, where having an atypical gender identity is seen as pathology and a mental disorder.

This socially constructed “pathology” to society, through various governmental restrictions of gender expression, creates unnecessary social burdens for those that do not
subscribe to the “normal” male-female archetype (Shrage 2012). In fact, the transgender community faces huge amounts of discrimination throughout society, on a personal, familial, and societal level.

Following the social constructivist view, individuals internalize the dominant view of society. This may lead them to adhere to societal rules and norms, even if it is detrimental to them. Pressures associated with trying to conform to social rules of gender norms leads to secrecy, shame, isolation, and the constant fear of being outed to the community (Bockting and Cesaretti 2001; Dewey 2008). The constant stigma from nonconformity to the social sex and gender norms “is a stressor with profound mental health consequences, producing inwardly directed feeling of shame and self-hatred that give rise to low self-esteem, suicidality, depression, anxiety, substance abuse, and feelings of powerlessness and despair” (Johnson, Mimiaga, and Bradford 2008). Other studies also show high rates of HIV/AIDS, suicide, depression, substance abuse, and diminished quality of life among the transgender population (G. P. Kenagy and Hsieh 2005; Kenagy 2005; Newfield et al. 2006; Rosser et al. 2007).

The social binary is also in effect at the familial level. Families of transgender children need to negotiate between the two gendered systems. At times, the family picture is more complicated, and because of community pressure or personal beliefs, parents… struggle to accept a child who does not fit within social gender norms… some react very negatively and the gender nonconformity can become a significant source of conflict between parents and a damaging source of disconnection between parent and child. [Malpas 2011:453]

Familial acceptance is an important factor, as it can have a protective effect against many threats to well-being. However, a recent report of the National Transgender
Discrimination Survey shows that more than half experienced significant family rejection (Grant et al. 2011).

This high level of structural violence and discrimination towards gender nonconforming individuals “results in an environment in which covert if not overt permission is given to society to ‘punish’ people for gender transgressions” (Lombardi et al. 2002:91). Transgender people and sexual minorities are frequently targets of hate-related violence, and few states currently identify violence related to gender expression as a hate crime (Doan n.d.; Stotzer 2009).

Unfortunately, this discrimination even penetrates the healthcare system and is present in the treatment setting (Lombardi 2001). The discrimination faced by the transgender community in this setting inhibits health-seeking behaviors, and forces the individuals to present their problems in ways that reflect how society, including doctors, view them, while simultaneously perpetuating the internalization of accepted norms and stereotypes (Dewey 2008; Johnson, Mimiaga, and Bradford 2008).

However, discrimination against gender and sexual minorities, although pervasive, is not necessarily culturally fixed. There is currently a paradigm shift operating on a sociocultural and interpersonal level (Bockting and Cesaretti 2001). Starting in the 1950’s, doctors began accepting a variation of the theory of human bisexuality in that biological sex was separated from the new-found psychological sex, which was later termed gender. The gay liberation and feminist movements continued to challenge the notion of sex from the point of view of doctors. Societal changes such as these can lead to
paradigm shifts, as evidenced by the removal of homosexuality from the DSM in 1973. (Meryerowitz 2002; Pleak 2011)

Today, these shifts continue to occur for gender and sexual minorities, including the transgender community. For example, the United States census, considered the gold standard against which all demographic data is compared (Rosser et al. 2007), has recently begun discussions to include a “transgender” option for sex. This was presented to me by Dr. Scout, Ph.D. (lecture, Boston University School of Public Health, Boston, MA, February 26, 2013). Dr. Scout went on to discuss how, although this is a step in the right direction, it still has its limitations. As mentioned earlier in the chapter, there is a huge range of self-identifications that gender nonconforming individuals use to describe themselves. Even though they may fit under the umbrella term of “Transgender,” not everyone identifies as such. These limitations are especially evident in research that only uses two gender categories, such as Male-to-Female and Female-to-Male, to explore gender differences among the transgender community (Gretchen P. Kenagy and Hsieh 2005). Lombardi says it well when she states “the differences in identities, experiences, and physical form among transgender individuals relative to non-transgender population create very different needs and strategies, and efforts must be directed toward the actual experiences of transgender people” (2001:870).

Some may see this paradigm shift as redolent of Foucault’s notion of biopower, as this new data and information about a person’s sex “is needed for carrying out scientific and medical studies that advance and protect public interests” (Shrage 2012). The depathologization of homosexuality by removing it from the DSM shows how these
bodies are no longer medically or politically classified as deviant and pathological, but are now productive and docile members of society, who still warrant surveillance. Productive is used in the Foucauldian sense of capitalist society, “centered on the body as a machine: its disciplining, the optimization of its capabilities, the extortion of its forces, the parallel increase of its usefulness and its docility, its integration into systems of efficient and economic controls” (Foucault and Hurley 1990:139). When a body is seen as “deviant,” outside of the range of cultural norms, it is not reaching its full potential. Similarly, docile bodies are ones who do not challenge or resist the structures of power and knowledge.

The transgender population, too, is shifting socially from being viewed as deviant bodies to productive and docile bodies. This is evident from the recent controversy over the renaming and placement of the DSM-IV-TR classification, part of the latest changes in the DSM-5. There, “Gender Dysphoria” has replaced “Gender Identity Disorder.” It is also no longer included with “Sexual Dysfunctions and Paraphilic Disorders,” but has its own chapter (Bower 2001; Cohen-Kettenis and Pfäfflin 2010; Malpas 2011; American Psychiatric Association 2013a).

As advocates for the transgender community continue to struggle for the common goal of acceptance of gender nonconformity, different proponents advocate for different avenues of how to get to this goal. To start, an argument can be made that gender nonconforming individuals are pressured into conforming to society’s hegemonic discourse on masculinity and femininity (Visser and Smith 2006). This can be difficult to achieve for some transgender individuals, as features of their biological sex – such as
transgender women with larger, more masculine frames – are difficult to hide, and as such the individual has difficulty “passing” in society (Doan n.d.). Certain proponents seek to abolish this binary.

A second avenue that advocates may follow is illustrated by Viviane Namaste, in her book *Sex Change, Social Change* (2005). She addresses the question about challenging the two gender dichotomous system, and attempts to undo it. “It argues that the binary sex/gender system, the exclusive division of the world into ‘men’ and ‘women,’ is oppressive. And this argument further contends that this is oppressive not only to transsexuals, but indeed to men and women who consider themselves ‘properly’ sexed and gendered” (2005:6). For this purpose, she distinguishes between “transgendered” and “transsexual” groups (2005:6). The “transgendered” position states that social change can occur through a disruption or displacement of the gender binary, similar to the nonconformity mentioned previously. The “transsexual” group, according to Namaste, describe themselves as men or women; as “properly sexed.” Namaste argues that asking about the significance of the challenge to the two-gendered dichotomous system cannot be understood, as it “forces transsexuals to speak a language that is foreign to us. And while it may have meaning and relevance for *transgendered* people, it has very little to do with the everyday lives of *transsexuals*” (2005:7, emphasis original). From Namaste’s view, the transsexual group seeks a different embodied position within the gender binary, and is not necessarily challenging it.

Thirdly, there are those that oppose Namaste’s view, as it creates another dichotomy; “a binary between ‘subversive transgender’ and ‘conservative transsexual’
identities” (Lane 2009:136). They argue the need to get past gender binaries in general, especially transgender binaries.

In the midst of these controversies and changing definitions of transgenderism and transsexualism are the surgeons whom I interviewed, discussing their work and understanding of the “normal” binary sex, and (re)constructing bodies to fit into this traditional binary system.

**History of Gender Affirmation Surgery in the United States**

In this paper, I refer to the surgical transition from one sex to another as GAS. Alternatively, these procedures are also referred to as Sexual Reassignment Surgery, Gender Reassignment Surgery⁴, and Genital Reconstruction Surgery. I do not use these last few terms, first because one is not changing the natal sex. Second, the individuals having the operations do not question their gender identity, as they know what it is. Rather, they are aligning their body to reflect their sense of gender, hence GAS. These terms, however, are used interchangeably in the literature. Throughout this paper, I will refer to these procedures as GAS. However, when quoting participants, I will use the terms which they used.

GAS is not unique in and of itself. Most of the procedures available are used in general plastic surgeries; it is only the patients and the purpose of these surgeries that qualifies it as GAS. For example, many women have mastectomies, hysterectomies, and breast implants for a variety of reasons. Similarly, men may have their testicles removed and/or testicular implants put in, and some men need phalloplasty as the result of injury

⁴ The transgender community objects to this terminology since they maintain that they are not changing their gender.
or disease. Also, both men and women have various forms of facial and bodily plastic surgery. Therefore, this type of surgery “did not take root when and where it did because of new or unusual medical technology” (Meyerowitz 2002:21).

One particular example is the intersexed condition, involving ambiguous genitalia. As discussed previously, this condition “refers to people born with physical differences that will result in their being difficult to classify as either biologically male or biologically female” (Lombardi 2001:870). Although this condition can be life threatening, many times there are just aesthetic differences. Yet, surgery has often been done so the child can be more readily identified as either male or female (Lombardi 2001). Even before GAS was considered an operation, decisions were made to declare a child male or female, after which “invasive and damaging surgery, including surgery affecting the capacity for sexual stimulation and pleasure, may take place to ensure the genitals fit with one gender or the other” (Dudley 2010:230; Merryfeather 2011). This was done because, until recently, the legal framework around the gender binary would lead to a child with ambiguous genitalia being a “non-person” (Dudley 2010:231).

GAS however, is an important aspect in the medical treatment of transgender individuals who desire it, as patients are overwhelmingly happy with their surgeries, and it greatly improves their quality of life (Newfield et al. 2006; Lawrence 2003).

In the United States, it was not until the 1930s and 1940s that transgenderism started becoming apparent in popular society. This was usually in the form of popular magazines highlighting cases of readers who had written in discussing their torn sense of identity when it came to their sex and gender (Meyerowitz 2002). However, it was not
until 1952 that transgenderism, and GAS along with it, was brought into the mainstream, national public spotlight.

Christine Jorgensen was the first American to be widely publicized for her GAS procedure. She was an ex-GI who went overseas to Europe to have her procedure done. She left presenting as a man and came back a woman. At that time, she was the most written-about person in the press (Merryfeather 2011).

In the scientific community, starting mainly in Germany, in part due to Europe’s longer and stronger study of sexuality and Germany’s “vocal campaign for sexual emancipation,” a search for answers regarding the transgender phenomenon was underway starting early in the twentieth century (Meyerowitz 2002:21). At this point, there was scientific research being done; an acceptance of the European view of GAS as a distinct form of treatment for those who identify as transgender, and not just for those with intersexed conditions; and an emergence of transgenderism in the popular press, especially with the case of Christine Jorgensen. With all this, a few doctors in the United States began to perform GAS locally and privately on non-intersexed patients, although they “were clearly exceptions to the rule,” as there was not as much acceptance in the United States as there was in Europe for these procedures (Meyerowitz 2002:48).

As one would expect with such a talked about procedure, especially in the presence of the American binary system of gender, there were those that opposed GAS, including in the medical arena. “Through the early 1960s, the doctors who advocated surgery found little support in the American medical profession” (Meyerowitz 2002:100). One main ethical question surrounding this procedure had to do with the removal of the
reproductive organs. Organ removal typically is justified as long as those organs are considered diseased (Dewey 2008). Moral oppositions as well as the fear of malpractice deterred many doctors from performing these surgeries.

By the mid-1960s, doctors who supported GAS and other treatments for transgender patients began to organize into networks, clinics, and associations. By the late-1960s, Gender Identity clinics began to open at major teaching hospitals, including the University of California, Los Angeles, Northwestern, Stanford, and Johns Hopkins. One particular proponent of the procedures was John Money, who published several articles on intersexuality, and developed a new language concerning gender, including the terms “gender role” and “gender orientation” (Meyerowitz 2002:114). Money was one of the key members in the development of the Gender Identity Clinic at Johns Hopkins. He did have his opponents though, as controversy raged over these procedures at Hopkins, both within the institution and in the media and general public (Duffy 1999). Despite this opposition, the influence of institutions such as Johns Hopkins doing these procedures gave the supporters of GAS momentum.

This momentum continued through to the 1970s and into the 1980s. This is also when the gay liberation movement and feminist movement came in. Up until this point, the definitions of sex and gender were controlled mainly by the scientific and medical communities, as part of their scientific authority. However, the gay liberation movement and feminist movement “challenged the doctors’ vision of sex, gender, and sexuality” (Meyerowitz 2002:262). Pressure like this from the general community chipped away at the momentum gained earlier. The medical community, however, seemed to take the
most away from this momentum. Jon Meyer, the director of the Gender Identity Clinic at
the time, published several articles questioning the long term effects of the procedures,
and in October 1979, announced Hopkins would no longer perform the operations
(Meyerowitz 2002; Duffy 1999). With all of this, “doctors and researchers lost their
earlier optimism… [and] could not control either the theories of sex and gender or the
practice of medicine” (Meyerowitz 2002:262).

There has been a revitalization of the transgender movement in the 1990s, which
advocated for human rights and challenged the rigid gender binary. “This movement, led
by the transgender community, has had an enormous impact in a short amount of time,
educating people about transgender identity, oppression, and discrimination” (Gretchen
P. Kenagy and Hsieh 2005:2)

**Current State of Gender Affirmation Surgery in the United States**

Despite the recent revitalization of the transgender movement, the loss of
momentum in the 1980’s and subsequent lack of research directed towards the
transgender community has led to a serious dearth of provider knowledge in the United
States. This has led to the transgender community being underserved in healthcare
settings. “American transgender people receive health care in a rather unsystematic
fashion and are fortunate to find a sensitive, non-discriminatory primary care physician
who is familiar with a transgender treatment protocol” (Newfield et al. 2006:1448). This
is unfortunate as the transgender population not only has the same basic health care needs
as members of the general population, but have their own specific needs as well, which
“should be identified and assessed within the context of transgender identity” (Johnson, Mimiaga, and Bradford 2008; G. P. Kenagy and Hsieh 2005:205).

These specific healthcare needs are not always apparent to all primary care physicians, or surgeons for that matter. When requested, these needs may seem “unconventional, strange, and sometimes harmful,” making the patients seem unconventional due to the disruption of the biological connection to the gender binary (Dewey 2008:1345). The transgender population may internalize the notion that they appear unconventional or strange, and this in turn influences their health seeking behaviors, in effect telling the physicians what they want to hear in order to access health care services. As such, the specific needs of the transgender population are not entirely known and are the subject of debate among the medical community (Dewey 2008; Johnson, Mimiaga, and Bradford 2008).

Currently in the United States, there are only about eleven surgeons\(^5\) who actively acknowledge performing GAS (Salas 2012). This is the group of people that much of the transgender population in the U.S. goes to for surgical treatment.

These surgeons, along with surgeons across Europe, North America, Australia, New Zealand, Thailand, Serbia, and increasingly other regions, require surgical candidates to conform to the World Professional Association for Transgender Health (WPATH) Standards of Care, Version 7 (SOC) (Aizura 2010; Coleman et al. 2012). The purpose of the WPATH SOC is to “promote the highest standards of health care for individuals… based on the best available science and expert professional consensus”

\(^5\) This may be a low number, as it may reflect only those surgeons who are well-known within the United States, or make the procedures a primary aspect of their practice.
(Coleman et al. 2012:166). Specifically for surgical treatments, the WPATH SOC are as follows:

While the SOC allow for an individualized approach to best meet a patient’s health care needs, a criterion for all breast/chest and genital surgeries is documentation of persistent gender dysphoria by a qualified mental health professional. For some surgeries, additional criteria include preparation and treatment consisting of feminizing/masculinizing hormone therapy and one year of continuous living in a gender role that is congruent with one’s gender identity. [Coleman et al. 2012:201]

Specifically, for breast/chest surgery, the SOC require one letter of referral from a mental health professional. In addition, they require: (1), persistent, well-documented gender dysphoria; (2), the capacity to make a fully informed decision and to consent for treatment; (3), age of majority in a given country; and (4), if significant medical or mental health concerns are present, they must be reasonably well controlled. Hormone therapy is not a required prerequisite” (Coleman et al. 2012:201).

For non-medically necessary hysterectomy, ovariectomy, and orchiectomy, the criteria are similar, but require two referrals from mental health professionals as well as twelve continuous months of hormone therapy, unless not clinically indicated for a particular individual. For metaoidioplasty or phalloplasty, and vaginoplasty, the requirements also require twelve months of “living in a gender role that is congruent with their gender identity” (Coleman et al. 2012:202).

One caveat of this however, is that the entire process can be extremely expensive. It is not unheard of for a patient to spend well into and over $100,000 in various medical costs to transition from one sex to the other. Even though GAS is “now widely accepted

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^6 No letters of referral are needed if the operations are being done for medical purposes, such as in the case of testicular or ovarian cancer.
as therapeutic” (Lawrence 2003:299), traditional health insurance plans, both public and private, do not cover transgender-related health care, especially hormonal and surgical treatment, creating barriers to access of treatment (Dewey 2008; Lombardi 2001; Newfield et al. 2006). Doctors do however attempt to help their transgender patients navigate the health care system and overcome barriers to care, such as working with their insurance plans and with billing codes to get costs of care covered. For example, in a study done by Dewey (2008), one transwoman’s doctor kept two files for her, with all transgender-related treatment going through the patient’s female name, and all male medical treatment, under the male name, sent through to the insurance. This is because some insurance companies “can refuse to cover trans- and nontrans-related medical services simply because [trans-patients] identify or have been diagnosed as having gender identity disorder” (2008:1352). Having two separate files serves to “avoid possible health insurance discrimination for both trans- and nontrans-related medical care” (2008:1352).

**Cultural Politics of (Trans) Gender Identity outside the U.S.**

One cannot think of the United States’ medical systems in terms of isolation. Rather, they are influenced by and influence the global medical system. For instance, medical tourism is an emerging commodity. It is a “combination of leisure travel and invasive biomedical procedures, in which poorer countries offer visitors from wealthier countries an appealing package of state-of-the-art clinical services… at prices 30 to 70 percent lower than those in the United States” (Ackerman 2010:404). This search for cosmetic surgery in other nations also encompasses GAS procedures.
Aizura (2010) points out that in Thailand, GAS clinics market themselves almost exclusively to non-Thai trans women. She also discusses how this came about. Prices in the United States for these procedures are high, and as such, patients look to foreign countries for cheaper alternatives. “Non-Thais began traveling to Thailand in larger numbers to seek [GAS] in the mid-1990s” (2010:429). Because of this influx, the top surgeons in Thailand raised their prices, “from US $2000 in 2001 to US $15,000 in 2006” (2010:431). Unfortunately, these prices are often too high for the local communities, who subsequently have to search for surgeons that are not as skilled at these operations.

The global character of GAS also impacts the media, and how these operations are discussed in the United States compared to other nations. For example, Bucar and Enke (2011) discuss the U.S. media portrayal of GAS in Tehran, Iran, compared to Trinidad, Colorado – both considered “unlikely sex capitols of the world” (2011:301). The small mining town of Trinidad was portrayed as signifying the “Western achievement of sex and gender freedom,” whereas the same operations performed in Tehran came “to prove that Muslim states are resolutely oppressive around sex and gender” (2011:302). The authors note how neither of these media portrayals are ever seen together, as they are built on fundamentally different assumptions and principles. Rather, they find that these portrayals carry ethnosexual judgments of these two places… In order to conceptualize the interaction of place and sexuality, we draw on transnational approaches to ethnicity, in which ethnicity is understood to be not only constituted through language, religion, and culture but also through various kinds of social and geopolitical borders and boundaries… Ethnic boundaries are also sexual boundaries. [2011:303]
Therefore, the motivations behind the GAS procedures may be seen to serve either progressive social ideals, as in the Trinidad example, or regressive ones, as in the Tehran example.

**Surgery**

An exhaustive review of the history of surgery and the accompanying surgical culture is beyond the scope of this paper. However, some historical and contemporary aspects of surgery in general and plastic surgery specifically are relevant. Appropriate aspects of surgical culture will be discussed as needed in the following chapters.

The emergence of surgery as a Western profession took place in the late eighteenth and early nineteenth centuries. Prior to this, surgeons “constituted a distinctive profession with a much lower social class than that of physicians… [and] were either called barbers or were considered to be in the same lower social class as barbers” (Katz 1999:21). In tandem with this emergence came the rediscovery of anatomy, described previously. Surgeons were able to gradually shift the view of “illness as an inaccessible, internal disorder not locatable in one part of the body,” to a view “of the body as anatomic and thus surgically manageable” (Doyle 2008:10). Disease was no longer unknowable, but locatable in specific body parts. Surgery, then, became a legitimate discipline of science. Through its promotion of a discourse of anatomy, surgery contemporaneously legitimized the subjectivity of biological bodies (Doyle 2008).

Although surgical procedures in the context of improving form and function have been present for hundreds of years, it has only been recently that plastic surgery developed. This development came in the nineteenth and twentieth centuries, when
largely deforming injuries due to war became the driving force behind plastic surgery developments, especially during World War I. “Never before had physicians been required to treat so many and such extensive facial and head injuries. Shattered jaws, blown-off noses and lips and gaping skull wounds caused by modern weapons required innovative restorative procedures” (American Society of Plastic Surgeons n.d.).

The need for restorative procedures also paved the way for the emergence of aesthetic procedures. Physicians began to realize the stigmatizing effects such disfigurements, deformities, and blemishes had on individuals (American Society of Plastic Surgeons n.d.). In this way, cosmetic and reconstructive procedures grew from the same roots. Cosmetic surgeries have thus become linked to other medical procedures, and are entangled and often overlap with reconstructive surgery (Edmonds 2013).

Today, plastic surgery deals with the repair, reconstruction, or replacement of physical defects of form or function involving skin, musculoskeletal system, cranio and maxillofacial structures, hand, extremities, breast and trunk, and external genitalia. It uses aesthetic surgical principles not only to improve undesirable qualities of normal structures but in all reconstructive procedures as well. [American College of Surgeons: Division of Education n.d.]

There are somewhere around 6,000 – 7,000 plastic surgeons in the United States (U.S. News n.d.; American Society of Plastic Surgeons n.d.). In 2012, there were 14.6 million cosmetic procedures performed in the United States, along with 5.6 million reconstructive procedures (American Society of Plastic Surgeons 2013).

Within the context of the United States, there is a broad and complex cultural view of sex, gender, and transgenderism. These cultural views have shaped the ways in
which GAS has emerged and been performed. It is with these insights that I explored the experiences of those plastic surgeons who perform the various GAS procedures.
CHAPTER 3: METHODS & RESULTS

Methods

Initial Design Submitted to IRB

This research was designed as a qualitative anthropological study, submitted as gathering interview and participatory observation data from a total of 15 to 20 participants. The participants were to consist of two groups. The first group would be surgeons who are practicing or have practiced GAS, and the second, transgender patients of an area surgeon who does one aspect of GAS. The original number of participants reflected the approximate number of gender affirmation surgeons practicing throughout the United States (Salas 2012), as well as the approximate number of patients to be seen over the summer by an area surgeon.

I proposed to use convenience sampling to recruit participants. The surgeon participants were to be recruited from one of two transgender-specific conferences. These were the First Event conference, held in Peabody, MA from January 24th through the 27th, 2013, and the Philadelphia Trans-Health Conference, held in Philadelphia, PA from June 13th through the 15th, 2013.

Recruitment for patient participants was to take place at the office of the surgeons who conducts one aspect of GAS. The IRB application went to full board review, due to a concern over patient confidentiality, especially seeing that these patients are considered a vulnerable population. Originally, I had hoped to include, as part of my participant
observation, observing the surgeon in the operating room, but omitted this option after
the meeting with the IRB.

I planned for interviews with both surgeon and patient participants to take
between 20 and 120 minutes. They would be face-to-face if possible; otherwise I would
conduct them over the phone at a time chosen by the participant.

**Results**

**Recruitment**

I had only begun preparing my IRB application at the time of the First Event
conference. For that reason, I could do no actual recruitment at the meeting. Instead, I
sent an e-mail to the offices of the ten surgeons hosting workshops during the conference.
These surgeons were listed on the First Event website with a link to the surgeons’
individual websites, which contained e-mail contact information. The e-mail I sent
explained my research project, and asked if they would be willing to meet sometime
during the conference to discuss the possibility of participating in the future. In addition, I
approached these surgeons at the conference either before or after their workshop, where
I introduced myself and my research personally. Of the nine surgeons approached, all
showed interest in the research and said they would be willing to participate in the future.

I received IRB approval June 11\textsuperscript{th}, two days prior to the Philadelphia Trans-
Health Conference. Again, I sent e-mails to the three surgeons listed on the conference
website asking if they would meet with me to discuss participating in my research. Only
one contacted me directly; I approached the other two surgeons at the conference and
asked if they would be willing to participate. In addition, a fourth surgeon, not listed on
the conference website, attended the conference. I also approached and asked this surgeon if he would be willing to participate in my research. Of these four surgeons, three had also been present at the First Event conference, two of whom I had talked with at that conference.

After this conference, I sent e-mails to the offices of the surgeons from the First Event conference, using contact information from the conference website, asking if they would participate in the study. If they did not contact me back within two weeks, I resent the original e-mail. Because the contact e-mail was for the offices of the surgeons, I was worried the e-mails were not being received, due to the presumably high volume of e-mails these surgeons receive. Due to this concern, if the surgeons did not contact me after the second e-mail, I called the phone number, listed in the contact information, for their office. I left messages with the receptionists who answered, explaining the purpose of my call and asking to have the surgeon call me back if they were interested in participating in the study.

The process of setting up interviews with the surgeons was extremely difficult. The contact information given to me by the surgeons was in the form of business cards, or was taken from conference websites. This limited my abilities to connect with them, as I had to do so through their offices, during their business hours. Of course, the surgeons were very busy during their office hours, and on several occasions I had to make appointments with their receptionist to talk with them. This was problematic for me, as I did not want to take away time that could be spent with patients. Because of this, I was very clear with the receptionists that I was a graduate student who was looking to do
research with the surgeons, and the surgeon could call me back after office hours if they desired. For some of the surgeons, they chose to be interviewed during this initial call back, and for others I needed to make an appointment to talk with them. This limited the total time I could talk with and interview these surgeons.

In addition to these scheduling difficulties, and although the IRB had approved my plan to recruit patients and to engage in participant observation at a local surgeon’s practice, a diplomacy issue arose. The surgeon in question requested I gain additional permissions from another institution he is affiliated with in order for me to observe him and his patients. This was brought to my attention towards the end of my fieldwork. The fact that the process to obtain these permissions would take several weeks and the difficulties in scheduling interviews with these surgeons, made it infeasible for me to include this aspect of the project in the time available.

**Interviews and Participants**

I obtained six total interviews, ranging from 26 minutes to one hour and 33 minutes. Five were with surgeons, two of which were face-to-face interviews. The first face-to-face interview took place at the Philadelphia Trans-Health Conference. The other took place at a separate surgeon’s clinic, during his office hours. I conducted the other three interviews over the phone.

All the surgeons interviewed were male. Two of the surgeons practice only FFS; one only “top” surgery; one “top” surgery and FFS; and one “bottom,” “top,” and FFS.⁷

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⁷ These procedures are performed in addition to their non-transgender-related practices.
Two of the surgeons practice in the Midwest, two in the Northeast, and one on the West coast.

The interviews with surgeons involved unstructured, open-ended questions on predetermined topics. These topics included (1) how they became interested in plastic surgery, (2) how they became interested in transgender-related surgery, (3) how, if at all, these patients are similar or different to their other patients, (4) their thoughts on shifting DSM criteria and diagnosis, (5) their thoughts on insurance, and (6) any stories they wanted to share about their patients.

The sixth interview was with a local informant who works for a large Lesbian, Gay, Bisexual, and Transgender (LGBT) health institution, specifically with the transgender community, and is also in contact with GAS surgeons throughout the country. I had previously met with and informally interviewed this informant at the Philadelphia Trans-Health Conference, where I introduced myself and discussed one of the workshops I had just attended. I later scheduled a formal interview with him. The interview was unstructured and open-ended, and discussed topics regarding insurance coverage for the operations and how it relates to the surgeons and the relationships between the surgeons and the transgender community.

Data Analysis

I transcribed all interview data using Express Scribe, a free transcription software, and coded using Dedoose, an online computer assisted qualitative research data analysis software. Due to the exploratory nature of my study, I used a grounded theory approach when analyzing the data. Grounded theory aims “to discover theories – causal
explanations – grounded in empirical data, about how things work.” This data comes from “in-depth interviews about people’s lived experiences and about the social processes that shape those experiences” (Bernard and Ryan 2010:267).

In addition, I approached the data using interpretative phenomenological analysis (IPA). Desjarlais and Throop describe phenomenology as “the study of phenomena as they appear to the consciousness of an individual or group of people; the study of things as they appear in our lived experiences” (2011:88). IPA, then, aims to explore, in detail, the participants’ view of the topic under investigation in order to gain an insider perspective of the phenomenon while acknowledging the researcher as the primary analytical instrument (Fade 2004; Smith, Jarman, and Osborn 1999).

First round coding consisted of my applying four different coding methods, as taken from Johnny Saldaña’s (2013) book, *The Coding Manual for Qualitative Researchers*. First, I used initial coding, which serves to break down qualitative data into discrete parts so they may be examined and compared for similarities and differences. This was followed by holistic coding, which attempts to grasp the basic themes or issues in the data by analyzing them as a whole, rather than line by line. Lastly, I used a coding method called theming the data, which requires “labeling and thus analyzing portions of data with an extended thematic statement rather than a shorter code” (2013:175).

During second round coding, I again used several types of coding methods, which often overlapped. I used pattern coding, described as explanatory or inferential codes that identify an emergent theme, pulling together material into more meaningful units of analysis. In conjunction with this, I also used a combination of focused and axial coding,
which searches for the most frequent or significant codes to develop salient categories in
the data, and reassembles data that were split or fractured during the initial coding
process to determine the most dominant codes, respectively.
CHAPTER 4: ENTERING THE FIELD

“Um, here’s what I’ll say. So there’s a lot of plastic surgeons, you know, board certified plastic surgeons in the country. And probably the majority of them do not, or would not perform, trans surgery, even though they know how. I mean, someone could be a male-to-female requesting breast augmentation, and plastic surgeons do breast augmentation all the time, there’s no reason they couldn’t do that, but the majority of them don’t do that… We are all kind of trained to do this kind of stuff, and if we had the will, probably a lot would do it. And I think there is quite a number who would do it, but I definitely know, and certainly colleagues I know in town, are like ‘No, I don’t want to get involved in that, go to [Dr. B]’. So they see patients and they send them to me, because they don’t want to get involved.” – Dr. B

The surgeons that I interviewed were all aware of the stigma that is associated with the transgender community. Some have experienced discrimination first-hand, being denied hospital privileges because of the operations that they perform. Others, like Dr. B, have colleagues that will not perform these operations on transgender individuals. However, despite societal views and the views of other medical professionals, these surgeons do in fact perform these operations. It is my intention in this chapter to show how these surgeons make sense of new procedures, including GAS, by incorporating them into an already established frame of reference, which they use to categorize these procedures.

Habitus

In order to illuminate this idea of an extant frame of reference, I turn to what Bourdieu originally called the *habitus* and the accompanying *field*. The *habitus* is “a set of generative and durable dispositions acquired through socialization. *Habitus* is also the organizing principle of action; it is a basis for regular modes of behaviour, without being

8 Pseudonyms were used for all participants and places
determining of specific practices. *Habitus* constitutes a practical logic rather than a conscious reasoning” (Samuelsen and Steffen 2004:5). Joan Cassell (1996) contributes to this definition by stating that these structuring principles and common schemes of perception and conception are embodied in repetition and enactment; that the *habitus* is “processual, based upon activity through time rather than abstract structures or ideas” (1996:43). Social practices are subconsciously acquired, and become a scheme of dispositions (Wainwright and Turner 2003).

The *field*, according to Bourdieu, designates a “specific space of social relations. Individuals and institutions, based on their *habitus*, are positioned and position themselves in a field” (Samuelsen and Steffen 2004:5). In other words, both individuals and institutions embody a certain *habitus*, a set of guiding and determining principles, and apply this in order to navigate their way through a given *field*. This navigation is seen as action without conscious thought, but is rather determined by the *habitus*, much as the impulsive moves of the tennis player is determined by embodied knowledge.

Furthermore, Bourdieu raises the notion of a collective intellectual. Lenoir describes this collective intellectual using the analogy of a sports team: “[it] resembles the sports team in terms of the spirit that drives it, the collectivist attitudes implied by its activity, and the form of apprenticeship involved – constant, intensive and regular training” (2006:26). The values of the collective ideal thus become embodied within the individual. This concept will be important in terms of the enculturation process of surgeons, discussed below.
It is with this insight that I introduce the “field” of surgery. It is within this field of surgery that individual surgeons act using their own surgical habitus. Ethnographies dealing with surgery and surgeons in general showcase the surgeon as masculine, dominant, competitive, and heroic with an active posture (Cassell 1996; Katz 1999). It is these characteristics which comprise the surgical habitus.

However, there is more to the individual habitus than just how to navigate the field of surgery; how to be masculine, dominant, competitive, and heroic. Their surgical habitus determines what is acceptable and unacceptable. The habitus encompasses and illuminates the embodied reactions towards bodies and behaviors out of place, acting in ways they should not (Cassell 1996). Individuals not only react to these circumstances, but act in and on these circumstances. Bodies, behaviors, circumstances, and actions can all be thought of in the two categories of acceptable and unacceptable. Thus, when presented with a certain operation, a surgeon determines if action is appropriate; if the operation is acceptable or unacceptable, specifically in reference to their own field of surgery.

**Embodying/Learning the Habitus**

As discussed previously, the habitus is not innate, but is rather learned and embodied through repetition and enactment. This repetition and enactment, as they relate to the field of medicine in general, and the field of surgery specifically, occur during the enculturation process early in any medical student’s career. This process of enculturation has been researched extensively. Authors have discussed how during medical school and residencies, physicians are enculturated into their medical professions (Good and Good
Medical students are taught and trained early on about the proper ways to interact with patients, the proper ways to behave emotionally with fellow physicians, and so on. During residencies and fellowships, as physicians begin to learn about the specialties they chose, behaviors are again enforced. It is during this time that these budding doctors internalize what is considered acceptable behavior and conduct, and what is considered unacceptable. These two categories of acceptable and unacceptable go on to influence and determine all actions within the field. They help to inform the doctors what proper, acceptable ways to interact with patients are, and which procedures are allowable and acceptable to perform.

This enculturation process is especially present in the field of surgery (Prentice 2012). Pearl Katz, in her book on the culture of surgeons, writes about the persistence of surgical culture through the apprenticeship system: “each generation of surgeons perpetuates that culture and passes it on by recruiting surgical residents who appear to resemble them and training these residents to emulate their thinking and behavior” (1999:ix). Katz also acknowledges other influences that play a role in the formation of the surgeon.

The most important influences, however, are the cultures of the institutions in which [the surgeon] has participated, particularly where he attended medical school, internship and residency programs, and the hospitals in which he served as a staff member. These institutions influence the image of the surgeon he aspires to become as well as the way he interprets the practice of surgery. [1999:65]

In essence, Katz is describing the learning and embodiment of the surgical habitus, and the effects this has on how individual surgeons navigate the field of surgery.
The enculturation process is also important insomuch as it instills a sense of the collective intellectual (Lenoir 2006), described above. The surgeons not only learn how to perform operations; they also embody the social practices of surgeons, and the spirit of what it means to be a surgeon. Embodied within the surgeons, the habitus manifests itself in the opinions, perspectives, and manners of being (Ricciardelli and Clow 2009) of individual surgeons, and becomes part of the predispositions they bring with them that allow them to practice in everyday life (Pope 2002).

Through the narratives provided by the surgeons I interviewed, this formation of the surgical habitus and the influence it had on their personal navigation through the field of surgery was evident. For instance, Dr. B told how he was first introduced to the concept of transgender-related surgery.

*When I was a plastic surgeon fellow at the University of Hillwood, the chairman of the department did transgender surgery. It was mostly male to female, not female to male. But when I was on service with the chairman, I helped do the surgeries. And so I met a number of transgender patients, and participated in their surgery, so I became fairly comfortable with the surgery at that time.*

Dr. B’s experience with the transgender surgery and the transgender community took place early on in his development as a surgeon. While he was a fellow, a teaching surgeon in a position of authority showed that the surgery was acceptable. Thus, through “repetition and enactment,” the surgical procedure itself, as well as all the bodies involved in the process, including transgender individuals, became an acceptable form of practice. This idea became embodied and shaped the habitus of Dr. B, which determined his actions even after his fellowship. This is exemplified in what he goes on to say.

*When I finished my fellowship and then went out on my own as a plastic surgeon, I wasn’t specifically looking to do transgender surgery. But, probably like many*
plastic surgeons, got approached by transgender patients asking would I do a breast augmentation, or would I do mastectomy, or facial feminization. And I was fine with that.

Similarly, Dr. E was enculturated early in his development as a physician. This was demonstrated in his response to whether he had received any formal training in regards to LGBT health.

Sure. Yeah, we had a semester long course on human sexuality... So it was presented to us as a spectrum of the human experience, and things you should know as a physician.

In addition, he had prior experience in dealing with and treating transgender patients.

Because trans patients will come in who had broken noses, nasal obstruction, hearing loss, scars, you know, a mole they don’t like. The same spectrum of illnesses that every other person has, or could have.

Dr. E’s early training corresponds with what Dr. B had experienced; both physicians had prior, direct personal experiences with the transgender community.

Such experiences, in effect, resulted in a habitus that categorized GAS as an acceptable form of practice. Dr. E’s comment about transgender individuals having the “same spectrum of illnesses that every other person has” reflects his understanding that issues related to GAS and the transgender community are a part of the same field of surgery as used by other patients, and are thus navigable within his habitus. In addition, this form of classification situates the transgender community he serves within the scope of “normal” – not a separate group, but just “patients.” From the beginning of the formation of these surgeons’ habitus, the authority of surgical mentors constructs operations related to transgender identity as “normal,” and therefore acceptable.
Reconstructive Habitus:

Having an enculturation process that constructs the transgender community and the various GAS procedures as acceptable provides one insight into how these surgeons made sense of these operations. However, some surgeons had no prior direct experiences with the community or the procedures. Direct experience aside, there was a range of interactions with and knowledge about the transgender community and the GAS procedures. On one end of this range, for example, is Dr. A, who has lived in the city of Bluffington for most of his life. This city has a distinct transgender presence, as the area hosts an annual transgender conference and is home to a major LGBT health center. However, as Dr. A explains, he had been unaware of the transgender presence in the community.

I had no idea of the existence of the so-called transgender community. I didn’t know there was a community... I knew very little about it, I mean I heard about Christine Jorgensen at that time years ago... But I didn’t know anything about it until eight years ago.

Two other surgeons, Dr. C and Dr. D, had known about the transgender community at large, but did not have direct experience with them. In fact, Dr. D, a facial surgeon, discussed how he was given the opportunity to work with the transgender community early in his career, but chose not to do so.

I didn’t start out with the idea of working on transgenders... When I was asked to come to Green University one day [to do plastic surgery] ... I called the chairman of the department, told him I would come. The chairman of the department was the chief of surgery, well actually he was chairman of plastic surgery... and [he] is important in one sense, because he was very much, very early involved in transgender surgery at Green University. He was doing it in the sixties. But any rate, I called [him], and I said ‘I’ll come to your program, but I don’t want anything to do with your transgender patients’ [laughs]. It was just something
that I totally wasn’t interested in. I was totally interested in reconstructive surgery.

At first, it would seem that Dr. D had what was needed for the formation of a habitus similar to those of Dr. B and Dr. E; he had a senior surgeon who showed him that transgender-related procedures were appropriate in the field of surgery. However, Dr. D states that he did not “want anything to do with your transgender patients.” Although it was not directly inquired about, it can be assumed that Dr. D did not have the necessary “repetition and enactment” with his prior mentor in order to embody the habitus of the chief of surgery at Green University. To another extent, he may have been so thoroughly “enacted” into the more dominant view of his specialization, that he was unable to put himself in a space to try on, let alone repeat and enact, the chief’s viewpoint.

This example brings forth the question of what type of habitus he and the other surgeons without direct experience did embody, that allowed for the eventual incorporation of GAS into their practice. Dr. D touches on this issue when he says that he was “totally interested in reconstructive surgery.” Indeed, the other surgeons shared this same sentiment, giving a sense of a shared “reconstructive-surgeon habitus.” Dr. A told his narrative of his reconstructive history by discussing his work in an experimental surgery lab in Sweden during the summer of his medical school training.

I went there the summer and had a great time... And when I went there, the things that he was doing, was just fascinating to me... And after that length of time, I thought... if I had the ability to do even one of those big operations that I saw him doing, all kinds of congenital anomalies, you know cleft lip and palate and big tumors and all kinds of major problems... it was all reconstructive, I thought gee, if I had the ability to do that work... I don’t think I would ever be happy as a [general practitioner], taking care of colds and giving B12 shots, when I could do something really special for people.
It was this training and enculturation into the “reconstructive field” of plastic surgery that created a habitus for framing the GAS operations as a form of “acceptable” procedures. By situating GAS within a reconstructive frame, the surgeons can now operate on bodies that need reconstruction. GAS can be seen in the same category as “congenital anomalies,” “cleft lips and palates,” and “big tumors,” making them “acceptable” operations on the broad field of surgery.

This concept is further highlighted in the ways these surgeons discuss the techniques used in the operations. As Dr. E explained,

*The key to being a good surgeon is that you don’t learn every procedure you are going to do, you learn how to operate. Just like how a carpenter doesn’t learn how to make just this table and that chair, they learn how to work with wood. A surgeon is sort of the same way. And so you know how to be safe and sound in what you are doing.*

I find this analogy fascinating, as it easily, albeit somewhat simply, explains many of the concepts discussed so far. Much as a carpenter, normally working with wood, would not work with stone, a “reconstructive” surgeon may not necessarily work with “cosmetic” procedures. However, one can imagine that if a carpenter were installing kitchen cabinets, he might work with stone to install a granite countertop. Similarly, a reconstructive surgeon may do a “cosmetic” procedure if it is done for reconstructive purposes. The actual procedure may remain the same, but its classification provisionally changes. One surgeon in particular provided a narrative that exemplifies this process.

*Changing Knowledge: The Case of Dr. D:*

Dr. D, as mentioned earlier, started off his career not wanting to work with transgender patients. Rather, he focused his attention to reconstructive aspects of plastic surgery.
surgery, including burn patients and children with congenital deformities. He goes on to explain, however, that he has become “very pro the GLBT community.” The following are from two areas of his narrative depicting his past work.

*I guess a whole bunch of things [changed]. I don’t know why I felt that way, I guess what it was that, I’m not a strict religious person, but there was a religious issue, there was a social issue. My first research in medical school was involved with burn patients, and I was very interested in reconstructive surgery, taking care of deformities, developmental or post traumatic or post disease, whatever it may be... Children are born sometimes, very rarely, with pretty unusual skull problems. Huge problems. Sometimes the eyes can be bored out to the side of the head, and lots of crazy abnormalities... They have these huge, horrible physical deformities.*

We can see in this part of his narrative his reconstructive surgeon habitus; classifying his operations in terms of fixing “deformities” and “abnormalities.” However, GAS procedures were not put into the same taxonomy as those reconstructive procedures at first. Dr. D goes on in his narrative of change to say,

*And so I wasn’t interested in doing face lifts and eye lids and other stuff. It wasn’t nearly as popular as it is now. And tomorrow I’m doing a face lift, so it has changed.*

Dr. D is discussing how his views towards his transgender patients have changed, but he is doing it in the context of his past work. In order to make sense of these procedures, he is using categories that have already been created in his past experiences. This can be interpreted as his circles of “acceptable” and “unacceptable” procedures being labeled “reconstructive” and “cosmetic,” respectively. “Face lifts” and “eye lids” were previously thought of as cosmetic categories, and not the “reconstructive” surgery that he was so interested in. Therefore, these procedures do not belong in the field of reconstructive surgery, and therefore should not be acted upon.
These categories of acceptable and unacceptable should not be thought of as static fields. Rather, they are fluid and permeable, and at times may overlap. This fluidity occurs in the form of knowledge construction. Constructivism implies that individuals construct their own knowledge, that it is not based solely on an authority, such as a book or teacher, that it is an active process (Kanselaar 2002). Rather, it “recognizes the construction of new understanding as a combination of prior learning, new information, and readiness to learn. Individuals make choices about what new ideas to accept and how to fit them into their established views of the world” (Eisenhower SCIMAST 1995:1).

This can be seen across the narratives that were given by those surgeons who did not have direct contact with the transgender community prior to their first transgender patient. Specifically, Dr. D notes his ideas of what changed.

> Maybe living here in Sun City has changed me. I’m very pro GLBT community, totally, I support them a lot. And I understand the reason. I think it’s probably more based on ignorance than anything else. I just didn’t understand these people and their issues, and how important it was to them.

In this small excerpt of Dr. D’s narrative, we can see the influence of the reconstructive surgeon habitus and the construction of new knowledge. “Face lifts” and “eye lids” were thought of in terms of cosmetic practices. However, upon receiving new information, the categories began to shift and overlap. “When presented with information… that contradicts existing ideas, [an individual] may try to accommodate both interpretations, rather than change deeply held beliefs” (Eisenhower SCIMAST 1995:2). This is precisely what Dr. D has done. Rather than changing his deeply held beliefs – his embodied reconstructive surgeon habitus – his definitions of the procedures changed. Face lifts and
other (formerly) cosmetic procedures became a part of reconstructive surgery under specific circumstances.

Though not directly stated, Dr. D is aware of this, as exemplified by the following narrative.

*But that’s what craniofacial, facial feminization, comes from. And it’s, it really came out of craniofacial surgery, taking care of these kids, because basically all the operations, other than the tracheal shave and the lip work, that I do in facial feminization, all involves taking care of kids with their craniofacial problems.*

This reflects a common narrative among all the surgeons interviewed, which was touched on previously. The surgeons discussed the techniques used to do the specific GAS procedures as being the same techniques used in their other procedures. In essence, plastic surgery in general, and reconstructive surgery specifically, provided the adequate foundation to incorporate new forms of knowledge. The underlying, embodied habitus did not change, but when confronted with new information in the form of a transgender patient, the surgeons put the new GAS procedures in the category and field of acceptable, reconstructive surgery.

I would like to come back to Dr. D’s comment of how Sun City has changed him in order to introduce Bourdieu’s notion of doxa. The doxa are “those fundamental, taken-for-granted conceptual categories that shape intellectual practices” (Swartz 1997:277). Dr. D had formed a reconstructive habitus with a certain set of classificatory categories, which influenced how he conceptualized the procedures, and in turn influenced how he practiced surgery. By stating that he did not understand the “issues” faced by the transgender community, he shows the role of patients and clinical experience in the formation of the habitus. Patients can serve to challenge these “taken-for-granted” ideas,
and can educate doctors. When the doxa is challenged, doctors must use (and possibly change) their habitus in order to navigate through this change in the field. In this way, the patients influence knowledge creation and reclassification, and act to re-educate and reform the habitus, as this is not necessarily reduced to medical school, residency, and other forms of medical knowledge.

**Larger Surgical Habitus:**

Other motivations were present for the integration of GAS into these surgeons’ practices. These motivations are not necessarily mutually exclusive from the other forms of the habitus described. They may however be considered part of the “base knowledge” that these surgeons bring with them when interpreting and categorizing new knowledge. These particular motivations are part of the larger surgical habitus.

As mentioned earlier in the chapter, surgeons are often competitive and heroic. Both of these characteristics contribute to the surgical habitus, and were apparent in the surgeons that I interviewed. In terms of competition, one surgeon in particular stands out. As part of my recruitment methods, I approached various surgeons at one of two conferences where they were in attendance. I approached one of the surgeon’s booths, which was primarily used to give information about procedures, perform consults, and schedule future appointments. The surgeon was not there, so instead I talked with one of the young women, who apparently seemed to be running things at the booth. I came to find out she was part of this surgeon’s practice. During our informal conversation, she started discussing some of the other surgeons who were at the conference. The first day of the conference, this particular surgical practice was the only one who had a booth. The
second day of the conference, two more surgeons were in attendance who had booths set up. Of course, this means that there is a degree of competition in the room. In reference to these two other surgeons, she stated “and they aren’t even board certified.”

Later, upon further investigation, I discovered that these surgeons were in fact board certified, I was just unsure as to which board had certified them. As Dr. C pointed out to me,

*It goes back to the whole issue of board certification. There’s twelve, fourteen, sixteen organizations, back in the thirties, that were recognized as basically legitimate boards... it states that they went to and trained at an institution, recognized as a legitimate institution... So the problem is that I think that most people ascribe quality with plastic surgery. But there is only one American Board of Plastic Surgery... So it can be very confusing to the lay person.*

This again ties back into the notion of field and habitus. Wacquant, while quoting Karl Marx, says,

>A field consists of a set of objective, historical relations between positions anchored in certain forms of power (or capital), while habitus consists of a set of historical relations “deposited” within individual bodies in the form of mental and corporeal schemata of perception, appreciation, and action… Each field prescribes its particular values and possesses its own regulative principles. These principals delimit a socially structured space, in which agents struggle, depending on the position they occupy in that space, either to change or to preserve its boundaries and form. [1992:16–17]

The American Board of Plastic Surgery is part of the “objective historical relation” of the field of surgery, and with it comes a form of power in the form of surgical capital. This particular surgical capital is a type of symbolic, socially salient capital, used to symbolize a surgeon’s accomplishment, and thus used to compete against other surgeons. These relations have been “deposited” in Dr. C. That is, he is aware of the surgical capital that is associated with being board certified in the field of surgery. Board certification has
structured a space in which these surgeons struggle, or compete, with one another within that space.

This sense of competition is pervasive in most all surgeons. This is due in part to the enculturation of surgical residents, who strive to get the best numbers – that is a surgeon’s prestige is based on “an experienced volume of procedures with acceptable outcomes” (Jones, McCullough, and Richman 2008:282). It can be seen in all of the surgeons’ websites, which gives their Curriculum Vitae or other lists of accomplishments, such as educations, books and other publications, lectures, and professional presentations. It was also present in the ways they talked about their histories, telling about how when they were in medical school or were residents, they studied under some of “the most famous plastic surgeons in Europe.”

As an illustration of the above, Dr. C discussed his past accomplishments while in his residency in the navy.

So during the time I spent in the navy, I learned some really advanced techniques. Basically finessed all the plastic surgery skills and training that I received at Copperfield University, one of the premier institutions of medicine in the world... So it was an opportunity to do a lot of very advanced techniques with soft tissue and bone, and when I got out into the civilian sector, it’s funny that I had all these sort of powerful tools that I wasn’t really using in the just standard, run-of-the-mill gender population.

Dr. C showcases these accomplishments as part of the larger surgical habitus, distinguishing himself from other surgeons in the same profession.

In addition, the “powerful tools” that he acquired in the navy allowed him to perform surgeries that he saw at first as “wild stuff.” By using “advanced techniques,” he again was able to highlight his individual abilities as a surgeon. In essence, the GAS
procedures provide a vehicle for surgeons to show how far they have come with some of the more difficult and advanced techniques in the field of plastic surgery.

The technical difficulties of the surgery also add to the heroic nature of the surgeries. Several of the surgeons discussed how they were “saving lives” by performing these surgeries\(^9\). Transgender patients and the needs they bring to the operating table and the operating field allow these surgeons an opportunity to excel in their field of surgery by using such advanced techniques and technologies.

These surgeons are able to classify these GAS procedures into an existing framework based off their individual (yet collective) habitus. Repetition and enactment with individuals who identify as transgender during enculturation into the surgical profession serves to develop a classification system within their doxa which labels GAS procedures as acceptable. In this way, the framework is built with this presumed classification already in it.

On the other hand, without previous experience, surgeons must find a way to make sense of these new procedures. They do so by classifying these operations as reconstructive procedures. The surgical operations are defined in these terms, and thus fit into the reconstructive habitus.

In general, these surgeons are also able to classify these procedures within the broader surgical habitus by maintaining a sense of heroism and competition. This aids in the classification process. By making sense of these procedures in a way that places them

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\(^9\) I would like to be clear that I am not arguing against the fact that these surgeons are saving lives. I very well believe that many of their patients have received an enormous increase in their quality of life in many ways. I am merely using this as an example of the motivations behind performing these surgeries.
in the broader category of acceptable surgery, the surgeons are better able to classify the operations in a reconstructive framework. Using these frames of reference, the surgeons are then able to normalize these procedures and reconstruct the patients’ bodies, which is the subject of the next chapter.
CHAPTER 5: RECONSTRUCTING NORMAL

“When you are dealing with individuals of a gender background... you’re able to get somebody to be able to fulfill their dreams, and just fade into society as a woman.”

– Dr. C

It is a given in medicine that any treatment must be in the patient’s best interest, and within a certain medical-ethical construct. In other words, the treatments must be normal. Not normal in the sense that they occur constantly and consistently in every day practice, but normal in the sense that they “make” sense. Normality in this sense has no clear definition. The abstract idea of normality becomes confusing the further one tries to define it, especially when the definition begins to rely on what is abnormal. This is a complex idea, but one that is shared and socially constructed.

In the last chapter, I discussed how these surgeons make sense of the procedures they do by categorizing them according to their plastic surgery habitus. In this manner, the procedure becomes a normal plastic surgery procedure. However, there is more to making sense of these operations than just categorization. Beyond a normal plastic surgery procedure, the surgery itself needs to be normalized, with normal end goals – that is the patients’ end goals must coincide with those of the surgeon. Each of these aspects will be discussed individually, followed by how these ideas of normality interact, and culminating with the question of who determines what normal is.

To begin, however, it is necessary to discuss and elaborate on this shared idea of normal. For this, I turn to Foucault’s concept of biopower in the form of the gaze. Foucault argued that due to reductionism in the field of medicine, bodies becoming the sum of their parts, a new way of seeing illness developed. “It is no longer a pathological
species inserting itself into the body wherever possible; it is the body itself that has become ill” (1973:136). In this way, the clinical gaze, which encompasses “all the techniques, languages, and assumptions of modern medicine, establishes by its authority and penetration” what a normal human body and mind should be, think, act, and look like (Armstrong 1983:2). The clinical gaze in the reductionary sense then serves to control bodies. It does so in the same way the panopticon controls prisoners.

This idea of the gaze is perpetuated in society, too. In essence, there is a lay perception of what men and women should look like and how they should act within society. This culminates in a societal view of what is considered normal, as society has the authority and penetrating power to establish what is normal, much as the medical community does. These values then become embodied within the members of society.

Much like the inmates of the panopticon, society serves to police themselves in a type of social governmentality, acting to control bodies. Constant reminders of the social norms, such as through popular media and art, serve to deposit these values, while social practices, such as public policies and laws, ensure that these values are carried out – a governing of bodies.

In the same way there is social governmentality through the use of the social gaze, there is a medical governmentality. Similarly to the way there is a conceptual idea of a normal body, there is a conceptual model of normal medicine. That is, the field of medicine and its members (e.g. physicians) act to police themselves, in an attempt to

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10 Foucault used the analogy of Bentham’s plans for an ideal prison: a building with individual cells in a ring, with a guard tower in the middle. The guards in the tower could see the inmates, but the inmates could not see the guards. In this way, the prisoners would eventually police themselves, acting as if the guards were watching. See Armstrong 1983.
continue to practice normal medicine. One example of how this is done is through the enculturation process. Physicians learn, through formal and informal education in medical school, residency, and clinical experience, what normal medicine is and how it should be done. Other systems are put into place to control the medical norms and the bodies that “do” medicine, such as review boards, in which doctors are held accountable for their actions, depending on whether they practiced normal medicine.

For the purposes of this and the following chapters, these three specific gazes are used: the reductionist clinical gaze, the governmental medical gaze, and the governmental social gaze (henceforth referred to as the clinical gaze, medical gaze, and social gaze, respectively). They work by creating an idea of normal; normal in the clinical and medical sense, and normal in the social sense. Goffman, in his book on stigma, explains “we lean on these anticipations that we have, [created through the medical and social gazes,] transforming them into normative expectations, into righteously presented demands” (1963:2). To not meet these demands, means to possess an attribute that makes the individual different from others, to be “of a less desirable kind – in the extreme, a person who is quite thoroughly bad, or dangerous, or weak” (1963:3). This is the motivation behind the gazes, to fit into society and embody a proper habitus – a proper disposition in and toward the world. When someone acts outside of those established anticipations, the gazes act to inform the individual they are out of place, they are abnormal.

These anticipations, these ideas of normal, work in tandem. At times they oppose each other. That is, what one gaze may view as normal, another gaze may view as
abnormal. In this sense, what is considered normal is not neat. These conceptually constructed ideas influence one another, and have boundaries that are not always clear. When these intersecting ideas oppose each other, depending on the context, a type of hierarchy of gazes is created. An individual confronted at this intersection must weigh each gaze, each idea of normal, and decide which one carries more weight. This concept is apparent throughout these surgeons’ narratives, and will be highlighted and nuanced below.

**Normal Surgery**

Surgery deals with the body. Various definitions of the word include “medical treatment in which a doctor cuts into someone’s body in order to repair or remove damaged or diseased parts,” and “a branch of medicine concerned with diseases and conditions requiring or amenable to operative or manual procedures.”¹¹ In her ethnography on surgery, Katz (1999) describes the history of surgeons as entrenched in manipulation of the body. Indeed, a normal surgery requires work upon the body.

The idea of transgenderism is complicated, as discussed in the background chapter, and it is beyond the scope of this paper to debate the origin of an individual’s transgender identity. What is central to my argument, however, is how these surgeons conceptualize this idea. Western biomedicine is rooted in the philosophy and paradigm of reductionism, which is the deconstruction of complex processes or problems into their component parts to enable better, easier comprehension (Ahn et al. 2006; Beresford 2010); the whole is the sum of its parts. One aspect of medical reductionism is the

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separation of the mind from the body. This “mind/body dualism” is built into the paradigmatic foundation of medicine. One of the basic biological assumptions “is the much-noted Cartesian dualism that separates mind from body, spirit from matter, and real (i.e., visible, palpable) from unreal” (Scheper-Hughes and Lock 1987:6). The mind is the abstract idea of the self, and the body is the physical and real, and thus able to be operated upon. In order to be considered a surgical procedure, the problem must lie within the physical body, not the abstract mind. This becomes a question of whether a transgender individual is of the right body but the wrong mind, or the right mind but the wrong body.

If the body is seen as being “wrong,” then the body may be surgically corrected to become the “right” body. In this sense, the right mind now has the right body, which as a whole becomes a normal person. This is how these surgeons see their patients. Dr. D puts it this way,

*I really do believe that transgendered people have a, well we know that they have some issues, because we know that there are differences in certain parts of the brain... And unfortunately, we don’t have a way right now to make that diagnosis, to evaluate that, but it in fact exists. Ever since I took care of the very first patient, I’ve been convinced that they are truly born in the wrong skin.*

Dr. D separates the two concepts of mind and body. During this narrative, he mentions the different structures of the brain, referencing the studies mentioned previously in the background chapter. These structures however are not part of the mind, but are strictly anatomical. Essentially, the brain is what houses the abstract consciousness of the mind. But these individual structures are reductionist aspects of the anatomical brain, and are therefore distinct from the mind. He goes right into saying that his patients are “born in
the wrong skin,” that the body does not match what the brain is – a representational hierarchy of brain structure over genital markers of gender identity. The “issues” he refers to are not issues of a wrong mind, but issues of a wrong body. An argument can be made that the brain is what “makes up” the mind, and that changing the brain will change the mind. However, Dr. D notes that there is no way to diagnose the physical brain, and the only way to reconcile the difference is to change the body.

Dr. E touches on the same idea of the mind not coinciding with the body, but extrapolates it to all of his patients.

*The goal of any good plastic surgery should be to find a balance between your sense of self and how you present. So if you are a person who feels very young and energetic, but looks like an old person and feeble, that’s disturbing to you. If you know yourself to be a healthy, vibrant person, but you look like you have… a deforming injury, that’s not yourself, when you look in the mirror you don’t see yourself, you see somebody who’s been scarred or hurt or burnt. Fixing that is very important. And if you are a woman, but you look masculine, that’s very disturbing, and so we try to fix that, too.*

Here, Dr. E continually references the “you,” the person on the inside, the mind. On the outside is the body, the thing “you” physically see when looking in the mirror. When the body is out of line with the mind, it can be “fixed.” Again, because the mind, the “sense of self,” is considered normal and the body is “deformed” and “disturbing” to the mind, the body becomes wrong, abnormal to the mind. These abnormal bodies become a problem to be solved (Manderson 2011), and can be fixed to align with the sense of self that Dr. E describes.

As mentioned, these ideas are based on the concept of medical reductionism. This scientific paradigm is not necessarily the sole frame for these physicians’ thinking. There are several other factors that act to legitimize surgery as an option for those seeking to
change and affirm their gender. One such idea that flows along the lines of the dualistic view of the mind and body comes from the DSM-5. As mentioned in the background chapter, to give a diagnosis of gender dysphoria, “there must be a marked difference between the individual’s expressed/experienced gender and the gender others would assign him or her” (American Psychiatric Association 2013a:1).

As the title DSM-5 demonstrates, gender dysphoria is considered a mental disorder. This is a bit contradictory, as “gender nonconformity is not in itself a mental disorder. The critical element of gender dysphoria is the presence of clinically significant distress associated with the condition” (American Psychiatric Association 2013a). Rather, gender dysphoria is considered “unique” as “it is a diagnosis made by mental health care providers, although a large proportion of the treatment is endocrinological and surgical” (American Psychiatric Association 2013b:14). The uniqueness of the diagnosis brings up two important concepts.

The first concept, with regards to the DSM-5, is pertinent to the notion of the gazes. The DSM-5 is part of the medical institution – it is predicated on clinical medicine and dictates how doctors should diagnose and treat certain bodies. It serves as a foundation for the diagnosis of various medical and mental conditions, based “upon manifestations, frequencies, and chronologies, concerned with linking up symptoms” (Foucault 1973:126) – the clinical gaze. The “distress” that one feels as a result of the gender dysphoria also becomes medicalized, serving as a foundation for diagnosis and subsequent treatment. Dr. B provides an example of this:

*There’s all sorts of controversies with the DSM criteria. The problem with, you know, it’s kind of like a couple decades ago when homosexuality was defined as a*
disorder, okay? And so in the 70s, people were saying ‘No, it’s not a disorder, it’s not a choice, it, this is what I was born, so stop defining this as a disease,’ right? As an abnormality. It is similar things are coming up within the transgender community, as well. The problem is, okay, you don’t operate on people who are gay. You do operate on people who are transgender. And some insurance companies are now covering this surgery, but to cover it you need to have a diagnosis. They don’t cover things that don’t have a diagnosis. Everything has a code. So it makes things more complicated. So you have to have some specific code. Transgender and gender identity disorder. Okay, well, don’t call it a disorder, call it a genetic, you know, it’s a semantical issue, it’s a coding issue, it’s an insurance coverage issue, and it makes things complicated.

We see here again the clinical gaze – the use of diagnostic criteria as a means to classify bodies and minds as either normal or abnormal. Dr. B references homosexuality and how, in the 1970s, it was taken out of the DSM because “it’s not a choice” and therefore should not be defined as a disease. The impact of this decision can be seen today in how the medical community no longer considers homosexuality a mental disorder or a disease. The clinical gaze no longer views those minds as abnormal.

Dr. B then goes on to identify one of the major controversies with the DSM criteria, namely the DSM-IV-TR diagnosis of “gender identity disorder.” He references how the transgender community resists its being called a “disorder.” In fact, the DSM-5 has resolved the issue by now classifying the phenomenon as a “dysphoria.” Gender nonconformity is no longer the issue, but rather the distress one feels with regards to the incongruence between the expressed and experienced gender and the assigned gender. In the same way the clinical gaze shifted from seeing homosexuality as a disorder, it no longer views transgenderism as a disorder of the mind. Instead, the diagnosis is used because “you do operate on people who are transgender.” In order to relieve the distress...
one feels, one must operate; but to operate, one must have a diagnosis saying the mind is right (and “rightly distressed”), but the body is wrong.

This brings the question of where this “distress” comes from. This is where the social gaze enters. The need to conform to society’s view of what a man and woman should be, and the inability to do so, such as in the case of many individuals in the transgender community, can result in this distress.

As mentioned at the beginning of the chapter, the clinical and social gazes are not independent of one another, but in fact influence each other. This of course does not mean that they always steer individuals in the same direction. For example, despite the medical community’s determination that it is not a disorder, society continues to discriminate against, and stigmatize, the homosexual community. They too may feel a resulting “distress,” but as Dr. B pointed out, “you don’t operate on people who are gay.”

We thereby see how the social gaze – causing distress among the transgender community – influences the medical gaze to provide a diagnosis that will relieve the distress, while steering individuals toward normal bodies.

One doctor provides another example of how these gazes intersect with one another but in opposing directions, this time with the medical and social gazes. I met with Dr. A at a large conference specifically for the transgender community. During one of our conversations, he talked with me about how many hospitals do not give surgeons, specifically him, operating privileges for trans-related surgeries. As an example, he discussed how a Catholic hospital in the area would not allow him to operate if he did any GAS. Dr. A tilted his head back, rolled his eyes, and shook his hands in the air as he
sarcastically stated that it would cause a scandal with the archdiocese of the area. He then talked about how he would have sued one of the hospitals in order to gain privileges there. This was obviously a passionate topic for him, as he spoke quickly and with determination, as if this had just occurred yesterday. During our interview, as he was talking about a situation that led to him looking for a new hospital to perform his GAS procedures in, he made sure to bring up the topic again.

*I mean, I would have found someone sooner or later, and if I didn’t, I would have sued a hospital to get on, because it’s really discriminatory, it’s against their own by-laws, by not letting a surgeon get in to- it’s legal surgery. There’s nothing illegal about it. There are code numbers for all the procedures that we do, a diagnostic procedure code. Diagnostic code numbers and procedure code numbers, in a major, in the medical insurance books. So, you know, it’s recommended by the AMA, it’s recommended by all the professional organizations. It’s pretty discriminatory not to do it. So, that’s what it is.*

Dr. A highlights the fact that GAS is “legal surgery.” The field of medicine, as well as society, has recognized GAS as lawful – one cannot be sued for performing these procedures. The medical gaze allows for GAS in the sense that there are diagnostic and procedural codes for gender dysphoria. It is in essence *normal* medicine. However, the social gaze continues to influence hospital politics, particularly in the form of a “moral” scandal.

A similar idea was brought up by Dr. D, during his discussion about what some of his colleagues had to say about the surgery and his transgender patients. This particular example is centered on the experiences he had in the mid-90s, when he first began to perform GAS operations:

*And when I started doing this, I think a lot of my colleagues thought that [Dr. D] probably had too much to smoke... Or he was sniffing too much of something. A lot of people were very upset about it... What was wrong with it, I don’t know.*
They had their own insecurities with transgender obviously, because otherwise they wouldn’t have thought that way.

The colleagues that Dr. D refers to have embodied the social view of transgenderism as something that is abnormal. Dr. D went on to say:

There’s no question that some of my friends, personal friends that I spend a lot of time with, are anti-, I’ve lost them. They don’t want to be associated with me anymore, it’s like I’ve got a disease on my hands, they are afraid to touch me.

Both of these examples show the effect of the social gaze. Dr. D, because he works with these patients, has a social stigma, and becomes a “tainted, discounted [person]… An individual who might have been received easily in ordinary social intercourse possesses a trait that can obtrude itself upon attention and turn those of us whom he meets away from him, breaking the claim that his other attributes have on us” (Goffman 1963:3–5).

Despite the fact that he is a surgeon, a medical doctor, a position associated with esteem, he is seen as “diseased.” Those members of both the general and medical society are policing one another, letting Dr. D know that he has stepped outside the medically and socially acceptable idea of normal.

Later in the interview, Dr. D had this to say:

The other thing was that insurance companies were starting to call some of the surgery – intensive cleft lip and palate and other craniofacial things – cosmetic surgery, and it’s not. It’s reconstructive surgery, trying to make these people look somewhat normal. This is basically cosmetic surgery – it really isn’t, it’s reconstructive surgery, but insurance companies want to call it cosmetic surgery. As such they don’t cover it.

Dr. D discusses and makes sense of his procedures in a reconstructive context, as described in the previous chapter. He does not consider the procedure to be elective or cosmetic, rather it is reconstructive, something that will return the body back to normal.
In the same way, he does not mention that the patient has a mental disorder. It is the same way he framed the concept of the surgery itself – as fixing the wrong body of someone with a right mind. It is only through framing the issue as described above that these surgeons are able to make sense of it and perform a normal surgery.

The second point I wish to make involves how the wording of the DSM-5 illuminates the separation of mental health and surgical intervention. That is, the diagnosis may be made by a mental health professional, but the treatment is surgical. This is again due to how the phenomenon of transgenderism is understood. According to the DSM-5, there is a “dysphoria” in the mind based on the conflict between how one perceives and experiences their own gender compared to how one’s gender is perceived and assigned by others. It is the mental distress that is the disorder, not the body. One way to alleviate this distress then is to surgically alter the body in order to affirm the personally perceived and experienced gender, which may in turn alleviate the dysphoria.

This separation of the mental profession from the surgical profession may explain why many of the surgeons do not consider knowledge of the DSM-5 necessary. For example, when asked about the DSM criteria and the change from the DSM-IV-TR to the DSM-5, Dr. C stated

*We basically, you know, I don’t get too caught up in all these diagnosis categories, all that kind of stuff... I think that that’s more of your psychiatric determinations and stuff like that. You know, they carry that with them throughout the process, but I personally don’t come up with diagnoses for them or anything like that.*

Similarly, when asked for his thoughts on the DSM change as far as diagnosis, Dr. E replied:
I’m not a psychiatrist, so I don’t get involved in the subtleties of alterations in the DSM.

Because these doctors are not psychiatrists or psychologists, there is no need to be well read in DSM-5 criteria. Their territory is the body, not the mind.

Despite the fact that the DSM-5 criteria do not directly affect the surgeons, they still see the need for it. Dr. B highlights both these concepts.

And some people are fairly young, and they have gone through a lot, and they have a number of issues, depression, they’ve done self-cutting, there’s a bunch of stuff going on, and I myself am not a psychotherapist, and I don’t have the ability to sort, or appropriately parse, everyone’s symptoms, and say ‘Okay, this operation is right for this person, but not right for that person.’ I just don’t have the training or the time for that. So I require people to sort of, I need help from somebody. I need a therapist to say, ‘Listen, this is not a bad idea. This person meets the criteria, and surgery is a reasonable next step.’ Especially if I have patients coming from California, or someone from England, or overseas. I haven’t met them, I won’t get a chance to meet them. And it’s very difficult, just talking on the phone with someone, to say, ‘Yep, you’re a candidate, let’s do it.’

Although he himself is not a “psychotherapist,” and therefore does not need to be extremely aware of the criteria in the DSM-5, he recognizes that it is an invaluable aspect in the diagnosis of the disorder as a first step towards surgical treatment. The treatment then does not rely specifically on the DSM-5 criteria. Rather, it is just the diagnosis that allows them to operate on the body. By separating these concepts, the idea of whether or not the patient has the right mind is no longer in question, and it is just simply the body that is out of place. Even with a mental diagnosis, in contrast to a cleft palate, for instance, or a tumor or a malfunctioning organ, the surgery is still a normal operation.
Normal End Goals – The Surgeons

The normal end goal of GAS, according to the surgeons that I spoke with, is “to be able to fulfil their dreams and just fade into society,” as stated by Dr. C. Another way of describing these goals comes from Dr. D, who says,

If you are a post-operative, if you’re lying in bed, seven o’clock on a Saturday morning, and the doorbell rings, and without doing anything to your hair or cosmetics or jewelry, you throw on a non-gender bathrobe, and you go to the front door, and the person says ‘Sorry to bother you, ma’am, but.’ I want you to be so feminine that there is no question that you’re female.

This is the absolute goal – to have a body where the distress from the individual’s gender nonconformity is alleviated; the person is put into the “right” skin, and they fit into and are recognized by society as a normal body. But how does one go about reconstructing a normal male or female body? One way the surgeons described the process is through the use of physical, biological markers.

Well, I read, I guess it was five books, on physical anthropology of the face, skull. And I was determining what was the difference between the male and female skulls, because that’s been identifiable for centuries. It’s interesting, my kids gave me a book about, oh I don’t know, two or three years ago for Christmas, and it’s all the pictures of skulls going back to, maybe, 3,000 B.C. Probably before what we would call ‘man’ really developed. And you can, even the monkeys, obviously the girls, or whatever we came from, the chimpanzees, they were always noticing the difference between male and female skulls. In other words, it was that selection of what girls like and what guys like, was already developed to some degree... I think that most people doing this surgery haven’t ever studied the skulls of living patients and dry skulls to the point that they really know measurement differences. And the other thing is contour differences, but they don’t understand the measurement differences between a normal male and a normal female.

Dr. D in this instance assumes an evolutionary standpoint when discussing the bones in the skull. Male and female skulls in humans differ from each other on a variety of levels. There are differences in the skeletal foundation, such as forehead contours, the
frontal sinus, teeth, and jaw and nose angles (Figure 3); the underlying soft tissue, such as the size of facial muscles and the depth of fatty and connective tissues; and the overlying tissue characteristics, such as skin thickness, hair lines, and the composition of the hair itself (Lee, Sakai, and Spiegel 2010; Dempf and Eckert 2010; Hage et al. 1997; Altman 2012). In addition, visible differences between male and female faces depends on more comprehensive factors, such as the frame of the face and the proportions of all the facial characteristics (Hage et al. 1997) (Figure 4). These biological markers are what Dr. D uses when reconstructing a new skull for his patients.

FFS was developed in the 1980s and 1990s, and involves procedures that are commonly offered by facial plastic surgeons, as well as some that are not as commonly used (Talley 2008; Spiegel 2008). Much of this procedure has to do with adjusting the bumps and contours of the skull, going in and shaving things down slightly. However, when doing so, the surgeon already has a normal male or female skull to work with. Even
in research centered around facial reconstruction, most methods delineating ideal forms of human faces do not consider the differences between male and female faces (Hage et al. 1997). “Achieving a beautiful result is challenging even when starting with a fairly attractive woman. When starting with a male face, the difficulty is increased immensely” (Spiegel 2008:234). The nature of the modifications change and become more extensive (Nouraei et al. 2007) when having to reconstruct a female skull from a male skull, or vice versa. To accomplish this, Dr. D consulted physical anthropological text books, which describe the various shapes and measurements of male and female skulls. He also looked at the physical anatomy of his patients’ skulls, as well as “dry skulls,” complete human skulls that have been cleaned for use in research. The use of anatomy to set the parameters of what is normal is part of the biopower used to police and control bodies, and at the same time to nurture and sustain life (Foucault 1973). Dr. D uses a clinical perspective – the clinical gaze – to create a normal skull.

Dr. B also uses biological markers, but in a different way than Dr. D.

_I’ve had patients come to me and said, ‘I just want a mastectomy and I don’t want any nipples put back on.’ And my response is, ‘Well, you know, nipples are a normal part of the human body, male or female.’ And they come back and say, ‘Well I don’t want nipples.’ And I say that I don’t think that, just because– you may classify yourself as trans, but I don’t think that’s trans. I think that’s body modification that falls outside the realm of what I would consider normal. So you can have a normal female chest that has, you can have a normal male chest, which is basically a flat chest, both of those have nipples._

As quoted earlier, Dr. B has no reservations about helping a patient who identifies as transgender change their body from one gender to the other. However, as seen here, he will only do so if the end result is a normal body. The idea of not having nipples is counterintuitive to a normal body, it “falls outside the realm” of what is (clinically and
socially) *normal*. The patient may be in the wrong skin, and the surgeons will put them in the right skin, as long as that skin represents a *normal* body.

Aesthetics

Another aspect of a *normal* outcome is to have a psychologically sound mind.

Going back to Dr. B again, he describes this as,

*The goal of the operation, other than the mechanical things of rearranging those tissue, I want the patient to psychologically feel that they have benefited from the procedure, i.e. they feel more, they identify more with the new gender, and that this was a good idea, and that they don’t regret the operation."

After all, this is a medical procedure that is used as treatment to relieve the patient’s distress. It does not end here, as almost all of the operations are irreversible. If the patient later decides that the operation was not a “good idea,” then the “distress” will not be alleviated.

If this is the case, then the patient will not become what Foucault would consider a docile member of society. The purpose of the clinical and medical gaze is to create productive and docile bodies, capable of doing work in a capitalist society, while not challenging or resisting the structures of power and knowledge (Foucault and Hurley 1990). The operation serves to put the right mind in the right body, to create a *normal* clinical body that will then become a docile member of society, who will then “just fade into society.” In order to achieve this, the end result must be a *normal* mind in the appropriate, *normal* body.

What I have described so far are all mainly aspects of the *normal* clinical body. It is the clinical gaze (sometimes intersecting with the medical and social gaze) directing
the surgeons to create normal bodies to be put into society. However, there is also a competing social aspect that the surgeons consider as well. In fact, the social gaze penetrates deep into and becomes a part of the medical and clinical encounter, becoming a part of many aspects of GAS. One example of this is aesthetics, a mix of the medical and the social. There is a tension between aesthetics (the social) and health (the clinical) in the field of medicine, and there is a blurring distinction between reconstructive and cosmetic procedures (Edmonds 2013).

Dr. B is completely aware of this.

*My goal is... to achieve the patient’s aesthetic goals... you want them to be natural looking... with good scarring that’s minimally visible... So basically, you want a good result of surgery... And you could have a good result, or a bad result, but that’s just it, you’re just trying to achieve their aesthetic goal.*

There is a clear input of societal values in the form of aesthetics for Dr. B and his patients. He wants his patients to be “natural looking” when they are done with the surgery. As discussed previously, Dr. B also recognizes the fact that there is a psychological outcome as well.

*Sometimes there’s a psychological goal... From a trans perspective, there are two things. There’s the physical outcome, and there’s also the psychological outcome. And the psychological outcome is almost more important than the physical outcome. So a female, a genetic female, with double D breast, wants to be able to go out in public with a T-shirt and not have anyone look and say, ‘Oh look, there goes a woman.’ So the psychological benefit is there, truly treated, of basically having a flat chest, is huge. Now, you may take the T-shirt off and maybe there’s scars that are visible, and it’s, maybe you go, ‘Well, it’s not a perfect result,’ you know, well, they are like, ‘I don’t care, because I’m just wearing a T-shirt, I just want to pass in public.’ So I think the psychological benefit for a trans patient can be much greater, than, for a straight cosmetic surgery patient.*

Here, the aesthetic goal is for the patient to “pass in public.” This also falls in line with what the DSM-5 considers to be the dysphoric part of the gender dysphoria. Hiding or
minimizing the scars of the patient is necessary, to hide the fact that the patient had surgery to begin with. This is part of many surgical encounters, especially in plastic surgery. Thus, being able to pass in public by becoming a normal male or female through the use of aesthetics is medically necessary in order to relieve the dysphoria.

This blurs the distinction between reconstructive and cosmetic procedures. However, in many aspects, these surgeries also carry more of a social weight. For instance, Dr. D emphasized how early hominids were able to distinguish between male and female skulls, which, from the evolutionary standpoint, selected for the defining features of the male and female skulls. But, what he is saying also reaches a social level. Popular media, among other influences, suggest to us what beauty is; that is, what an attractive person’s face looks like. The body becomes a billboard for dominant cultural meanings; the site at which these meanings about ideal beauty, circulating in popular culture, are accepted (Balsamo 1996). Continuing, Dr. D adds:

... but they don’t know the measurement differences between a normal male and a normal female. Particularly an attractive female and a normal female. Because there’s a difference. So there’s a ratio in my mind there. I’m very opinionated about this. [Emphasis added]

Dr. D shows that there is more to the practice than just simply reconstructing the skull to become more female (or male for that matter). The surgery “certainly gives [surgeons] a lot of artistic input,” as Dr. C would put it. This artistic input allows the surgeon to create not only normal bodies, but beautiful people with normal bodies. According to Dr. D, this is also what distinguishes what would be called the great surgeons from the good surgeons. In this way, it is the ability to create beauty in the American cultural sense that makes these surgeons good at what they do. It is not just simply reducing the visibility of
the scars, but making them completely invisible. The social gaze is intersecting with the clinical gaze.

Promoting beauty is a prominent feature of surgeons’ websites\textsuperscript{12}. Some websites feature pictures of beautiful women\textsuperscript{13} on the home page, although many times you cannot tell whether or not they were actually patients. Most of the websites feature “before and after” photos of patients, showcasing various procedures that can be done and the results that can be achieved. This does not stop at the internet, but is also part of surgeons’ offices as well. For example, the surgical office described in the introduction chapter had a television on a repeat cycle of these before and after images, showing the various services provided. Adjacent to the television was a glass case embedded in the wall, which displayed various beauty creams and products available for purchase. There is a certain pride in the aesthetic appeal that is obtained. One of the best examples of the power of this promotion of beauty comes from my fieldnotes taken during one of surgeon’s presentations on FFS at a conference, as described below.

\textit{The surgeon, after describing and explaining the various procedures that he does, proceeded to show examples of his work by using ‘before and after’ photos of former patients. To do this, he would show a ‘before’ picture on the PowerPoint slide, pointing out the characteristics that made the patient look masculine. This was immediately followed by the ‘after’ picture, which showed the good-looking female face that was reconstructed. This went on for a few slides, and culminated in one final example. This

\textsuperscript{12} Mainly, this comes from the surgeons who do “top” surgery as well as FFS.
\textsuperscript{13} Most of these surgeons do not work solely with patients who identify as transgender. They work with many patients seeking plastic surgery options for other reasons than changing their physical appearance to match their gender identities. As such, the pictures of women featured on the home page of many websites are not necessarily geared specifically toward those who identify as transgender.
particular patient’s ‘before’ photo had very masculine features, such as male-patterned baldness in conjunction with the type of scraggly hair one expects from older males, a prominent chin and nose, as well as a noticeable brow ridge. In my own opinion, this was an older-looking, masculine face, with wrinkles and sagging flesh. Some may even call the picture ‘unattractive’ or even ‘ugly,’ but certainly not beautiful. Then the surgeon made the reveal. The next slide showed the same person, but with a very attractive feminine face, which in my opinion looked somewhere between fifteen and twenty-five years younger than the previous picture. In a word, the person in the new picture looked beautiful. This awesome transformation was noticed by almost every person in the room, because when the ‘after’ photo came up, it was followed by gasps and ‘oh my’s’ from the audience.

We see here the blurring of the clinical aspect of the surgery, the relieving of the “distress,” with the aesthetic aspect of the surgery, the making of a beautiful person from a normal person.

**Normal End Goals – The Patients**

The patients’ end goals must also be normal; that is to say that the end goals of the patients need to match those of the surgeons. With this in mind, I turn back to, contrary to their own comments, the role of the surgeon as psychiatrist. Here there is a difference between how these surgeons talk about their role as psychiatrist, and how they actually practice this role. In this way, they can avoid involvement in what is classified as the work of psychiatrists, while also engaging in psychological work. As noted before, most of the surgeons use the DSM-5 criteria only indirectly, relying on mental health
professionals for the diagnosis of Gender Dysphoria in the form of a therapist letter, as put forth by the WPATH SOC, mentioned in the background chapter, in order to conduct the operations. This idea in itself is grounded in the medical gaze. For example, Dr. B explains

So, I think you need some kind of criteria, some kind of netting, for when you do an irreversible procedure... Basically, I do want someone else telling me that [operating on a patient] is not the wrong thing to do.

Because the procedures are irreversible the surgeons need a “kind of netting” – a safety net – in order to conduct the operation. This idea of wanting “someone else” to determine if a procedure is right or wrong is the medical gaze at work, to ensure that appropriate, ethical, and normal medical procedures are being done.

However, despite their use of mental health professionals in determining the psychological well-being and preparedness of the individual patients, the surgeons still make value judgments about their patients; they still act as a psychiatrist/psychologist, despite ostensibly rejecting the role. Dr. B, as quoted earlier, discusses how he cannot meet all of his patients before the surgery, as they come from all over the world, and he therefore relies on the DSM-5 diagnosis. Yet, once they do arrive, he talks with them and decides whether or not to proceed with the surgery, as with the patient who did not want their nipples put back on. On one hand, given the way in which these surgeons discuss the DSM-5 criteria and the mental health professionals working with their patients, a prior meeting is not necessary. Yet, these doctors still maintain their authority, as

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14 Some of the procedures, such as breast implants, are in fact irreversible, but as one physician pointed out, there will always be a degree of scarring. In this sense, some procedures are more irreversible than others. For instance, genital reconstruction is completely irreversible, while implants can be taken out, but will leave scarring and other residual damage.
surgeons, to refuse surgical treatments to the patients they believe are not adequately psychologically prepared for the surgery.\(^{15}\)

The surgeons in these cases are looking for the values that they have determined to be part of the *normal* operation. That is, they are looking for everything that has been discussed so far in this chapter. They are looking for patients who frame their needs in terms of what the doctors have considered *normal* (right mind/ wrong body), and who are searching for a *normal* outcome and body. Dr. B’s patient’s end goals were not part of the *normal* clinical body, and therefore did not have *normal* end goals. Dr. C summarizes this concept up this way,

There are – just like with any cosmetic procedure – there are some people that are quite a few standard deviations from founded in reality.

This “foundation in reality” reflects in part what the patients expect from their surgeries.

Going back to Dr. B again, he gave a hypothetical example of a “straight cosmetic” patient coming in wanting liposuction because that would turn them into a “Sports Illustrated Swimsuit model.” He goes on during that narrative to say

And then I have to tell them, ‘Listen, this is not going to make you a Sports Illustrated Swimsuit model, and I’m not going to do it if that’s your goal,’ because that’s an impossible goal to achieve. You have to be realistic.

Patients need to have possible goals to achieve; they need to have *normal* end goals.

In order to determine the patients’ end goals, the surgeons must talk with the patients, and it is through this interaction during the clinical encounter that the surgeons use their personal experiences to make these decisions.

\(^{15}\) Debating the role of the surgeon taking on some of the functions of psychiatrist/psychologist is beyond the scope of this paper. However, given what is at stake during these procedures, it may be debated that these surgeons must take on this role on behalf of the patient.
We discuss how they arrived at this situation, and everybody has been to a therapist, and they will talk about, kind of the thought process, and their transition... I’m not a psychiatrist... So, you know, I have a pretty good feel for what our patents are like, and I can kind of weed it out.

This quote from Dr. E highlights the notion that the surgeons, although not considering themselves mental health professionals, use their own clinical judgment and experience to determine if the end goals of the patients are indeed normal ones. In this way, the surgeons are in fact acting as psychiatrists/psychologists; they are determining whether or not the patients are mentally prepared, meaning normal, and ready for a normal surgery with normal outcomes.

To provide a specific, real-life example of this, I will let Dr. D tell his narrative dealing with a patient he turned away:

About 4 or 5 years ago, I had a person scheduled for facial feminization, and I'd never met [the person and their parents] ... So we are sitting there talking, all three of us, in the examination room. I met them before and just going over things, and I said – well I’m going to call this person ‘Bob,’ I don’t remember if that’s her name, and I go, ‘Bob, I’m going to ask you a couple questions, and I’m going to make some measurements on your face, then we are going to look at your X-rays.’ So I asked a couple questions and took out my measuring instrument, and he says, ‘Well, why are you doing that?’ I said, ‘Well, I need to make these measurements to guide me on what I am going to do. Some of this is Scientific, some of it artistic, but I combine both, and it’s very important that I finish the measurements, because I think that’s a very important part of getting the proper proportions.’ And he says, ‘Well, don’t you just kind of put your hands and sort of mold a piece of clay, don’t you just contour me?’ And I said, ‘What do you expect from this surgery?’ I don’t think I came up with that question. or it was something like that. He says, ‘Well, I expect to be beautiful.’ And I said, ‘What happens if you’re not beautiful?’ ‘Well, I’m not going to be at all happy.’ ‘Why is it important for you to be beautiful?’ Mother and dad are sitting behind him, so you can’t see them, and I’m sort of talking to the boy, but, I’m sort of seeing mother and daddy’s face, and think ‘Oh they’re getting sick of me alright’... ‘Why is it important to be beautiful?’ He says, ‘So I’ll have friends, I don’t have lots of friends, and I know that if I’m beautiful, I’ll have lots of friends.’ And I cancelled the surgery. I didn’t deny the surgery, I said, ‘Look, I didn’t’- and the boy, this was June, and he had graduated from high school, and in September he was
starting college, so he was obviously a smart individual. But any rate, ‘I won’t deny the surgery, but I want you to go have more experiences in life, and whenever you want you come back here, and I’ll be very happy to talk to you more, and we’ll do your surgery, it’s not an issue.’ And in my mind this person was not a transsexual at all. And whether mother and dad had never discussed this around the coffee table or the dinner table, and they were shocked. Never heard from them again, any of them. I was surprised, I thought I would get at least some kind of letter, but I never did. What happened to the person, I have no idea. I bet you he never had surgery. I hope no one ever has operated on him. Unless, in fact, he really was a transsexual and he just was immature in his thinking... But I think the diagnoses are important, that’s the key. You really want to be doing the surgery on the right people.

Dr. D does not require any form of a therapist letter before he does his operations.\textsuperscript{16}

However, he still meets with his patients beforehand, as he describes in his narrative, to conduct his own clinical assessment of his patients. Despite not being directly familiar with the DSM-5 criteria, he was able to make his own diagnosis: the person was not truly someone who identifies as “transsexual” (transgender). The argument of whether Dr. D was correct in his assessment is beyond the scope of this paper. However, an important point is that he, on his own, decided to cancel the surgery. The idea of feminizing the face (in essence looking more like a female instead of a male) in order to “have friends” is not part of the normal outcomes of this surgery. For Dr. D, the patients need to be “born in the wrong skin.” From this perspective, the patient’s goals are not normal. The patient no longer is of the right mind in the wrong body, but of the wrong mind and in essentially the right, and normal, body. Dr. D summarizes it nicely when he says that what he really wants is to operate on “the right people.”

\textsuperscript{16} The World Professional Association for Transgender Health, \textit{Standards of Care, Version 7}, does not require letters for FFS (WPATH, 2012), which is what Dr. D performs.
In order to make sense of these operations, they need to be categorized in ways that are compatible with the surgeons’ ideas of what is considered acceptable and appropriate medicine – they need to be normal procedures. In this way, the surgery itself needs to be normal. That is, they must fall within the realm of recognized, legal reconstructive surgery, and the surgeons must operate on the body, not the mind. After all, “bad, unhealthy, or morally suspect cosmetic surgery, on the contrary, would aim to change who one ‘really’ is” (Pitts-Taylor 2007:87). In addition, these surgeries must have normal end goals. That is, they must create bodies that are normal in biology, medicine, and society. Lastly, the patients must also have normal end goals. The patients must want to align with what is biologically, medically, and socially recognized as normal bodies.

All of these concepts are recognized and governed by the clinical, medical, and social gazes. They serve to steer bodies towards this larger, constructed, and abstract idea of normal. However, the concept of these gazes is just that: an abstract one. That is, there is no direct force being placed on these surgeons, which begs the question of why these surgeons act in the ways they do. This is where the next chapter leads us.
CHAPTER 6: DAILY LIVES

“None of these surgeries are surgeries that were designed expressly to treat trans people. They are all surgeries that are already being performed, have been performed for more than 80 years on non-trans people who have had disease, injury – different things that they needed these reconstructive surgeries. It’s just when you apply it to trans people that suddenly nobody’s going to do it.” – Steven

In the previous two chapters, I have illustrated the ways in which these surgeons view and classify GAS, as well as the ways in which they choose normal situations and surgeries to operate within. These ideas, concepts, and situations are maintained by the surgeons and are practiced in their daily lives, including the individual clinical encounters between the surgeons and their patients. In order to illuminate this topic further, I will use the idea of local moral worlds.

A local world refers to a somewhat circumscribed domain within which daily life takes place. This could be a social network, an ethnographer’s village, a neighborhood, a workplace setting, or an interest group. What defines all local worlds is the fact that something is at stake. Daily life matters, often deeply. People have something to gain or lose, such as status, money, life chances, health, good fortune, a job, or relationships. This feature of daily life can be regarded as the “moral mode” of experience. Moral experience refers to that register of everyday life and practical engagement that defines what matters most for ordinary men and women. [Yang et al. 2007:1528]

Here, I discuss the idea of a local moral world as it applies to the daily encounters in which these surgeons act. The surgeons must act within the boundaries of this local world according to a set of moral values in order to protect what can be lost. These values are reflected in “an intersubjective medium of microcultural and infrapolitical processes” (Kleinman and Kleinman 1991:275). The surgeons act within their local moral world, such as in the forms of patient, colleague, and institutional interactions, forming their own microculture – a culture of GAS. In the same way, this GAS microculture contains
its own political process, such as those described in the previous chapter. By acting within this local moral world, these values are made visible by their moral experience, as “morally salient explanations reflect the local moral world in which they are produced” (Hunt 1998:299). In other words, these surgeons’ narratives carry with them the values that are at risk within this local moral world. Similar shared experiences, salient within this group of surgeons, illuminates these values.

Therefore, the purpose of this chapter is to examine the boundaries of this local moral world, to inspect what is at stake for these surgeons in their daily, professional lives, and how these surgeons interact with others to create, and act within, their local moral world.

**Boundaries**

The surgeons’ local moral world is not restricted to just the clinical encounters, or even to when these surgeons specifically interact with the transgender community. In this case, it is not even a specific place where interactions occur, as the first definition above may allude to. Rather it is where any interaction occurs during these surgeons’ daily lives where they assume (or someone else recognizes) their identity as a GAS surgeon. Keeping in mind this apparent lack of definite place, when I discuss the boundaries of the local moral world I do not speak of spatial boundaries. Rather, it is the moral boundaries within which these surgeons must remain. To step and act outside of these boundaries means to put at risk “what matters most” to these surgeons.

These boundaries are created in part by the normative and normalizing clinical, medical, and social gazes, discussed in the previous chapters. The rhetoric these surgeons
have given as to how they interpret these types of surgeries, as well as the ways in which they have discussed their experiences, describe the local moral world and the boundaries that create it (Hunt 1998). By keeping within the boundaries set by the various gazes, they act to preserve what can be lost.

**What’s at stake?**

Interpreting the experiences of these surgeons in my research has given insight into some of the things that are at stake for them. These items are often not discussed directly. Rather, it is the moral experiences, in the form of their narratives, which show what is at risk of being lost. The surgeons, although having different direct experiences, share certain, salient aspects, such as the ways they categorize the surgery, and how they make sense of the procedures in normal ways. The shared topics discussed in their narratives centered on certain concepts. It was these concepts that illuminated what is in jeopardy of being lost for these surgeons. From my research, I have found that the two items that are most at stake for the surgeons are economics and their identity as physicians. Physician identity can be broken down further into their identity as a competent physician, a caring doctor, and a great surgeon.

**Economics**

One driving factor in a surgeon’s local moral world is money. Many aspects of these surgeries revolve around the economics of the procedures. For instance Steven, who is an integral member of the transgender community, is an expert on the topic of

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17 Although Steven has obtained a Ph.D., he is not referred to as “Dr. Steven” only to differentiate his Ph.D. from the surgeons’ M.D.s and D.O.s.
GAS, with years of involvement with GAS surgeons from all over the United States, discussed with me some of the costs of these procedures.

So people are having to come up, anywhere from, on the low end, two thousand dollars for like an orchiectomy [removal of the testicles], up to, you know, well over one hundred thousand.

Many of these procedures are very costly and are difficult to pay for. This, however, makes the economic aspect of the procedures an integral part of the local moral world.

Dr. D was aware of this very early on. He described to me how some of his first patients asked him to give a lecture on his procedures at a small conference, where there were “maybe ten” people in attendance,

And I presented, and as I walked out, oh, I don’t know, four, five, six people in a row came up to me and said ‘What can you do for me?’... And I went back and told Sharron, who now is my office manager, I said ‘Sharron, I think there’s a business there.’

One way in which this part of the local moral world is acted out is through insurance. Steven talked with me about how many of the surgeons are not in any insurance networks, and those who do accept insurance are mostly associated with medical schools and other large institutions, which are already used to dealing with insurance companies reliably. He explains,

Because Insurance hasn’t covered it, people for decades have been offering fee for service surgeries... They all require payment up front... you can’t get the surgery until it’s paid for 100%. And so if you are taking a group of surgeons whose business is quite lucrative and very active... and they’re getting the price that they demand with no reduction, paid in cash up front, there is no motivation for them to sign on to work with an insurance company.

One of the ways this is reflected through the surgeons is how Dr. D left the university for which he worked.
When I left the university I stopped all insurance. I don’t take any insurance at all. That was part of the problem. I wasn’t getting paid enough. So I didn’t want to be part of insurance any more.

Dr. D has been heavily influenced by the economics that can be taken away from these surgeons. His current practice has been shaped by lack of incentives given by insurance; in this case, the economic aspect of insurance (as opposed to other aspects of insurance, such as how insurance policies can determine which procedures are allowable and medically necessary).

As another example, Dr. B discussed some of the effects that insurance has on his practice.

It is just really difficult, and it’s really time consuming for my secretary... My secretary will spend an hour, two hours, really trying to deal with an insurance company trying, to get some kind of preapproval letter. And the patients say ‘The insurance company said it’s okay, so go ahead.’ And then we go ‘No, we need it in writing.’ They go ‘The insurance company won’t give me the writing, but they say it’s covered.’ And we say ‘No, we aren’t going to do it until we get it in writing.’ Because we’ve had the experience of doing the operation and the insurance company then, retrospectively, says ‘Oh no, oh no, no we don’t cover trans operations’... So we need to have it in writing that the insurance company will approve this.

In cases such as this, when insurance companies do not pay for the procedures and the patients cannot pay for the procedures (especially when considering how expensive many of them are), the surgeons have to pay the costs. Again, we see how these surgeons’ experience of insurance companies shapes the way they practice these surgeries. There is a risk of losing money during these encounters.

We can also see here how the clinical gaze is what dictates the boundaries in which these surgeons act. Insurance companies reimburse for certain procedures based on medical need. Medical need is dictated by the clinical gaze. Having a diagnosis in the
DSM has influenced the way transgenderism is defined and interpreted by the medical community, and as such has influenced the ways insurance companies view and cover these procedures. How insurance companies are changing from classifying the procedures as cosmetic to reconstructive is an example of this. We also see how the fact that just a few professionals define a medical need does not mean that the “official body” of medical regulators will do so. This ties back to Bourdieu’s concept of doxa. The taken-for-granted ideas of insurance companies do not always align with those of the medical community. Medical necessity and reimbursement are integrally related and mutually defining, and heavily influenced by one another.

*Physician Identity – Competent Physician*

In addition to the economic aspect of the local moral world, another item that must be maintained by these surgeons in their daily lives is their identities as competent physicians. On a personal level, these surgeons have legitimated the surgery in their own eyes. This was described in the fourth chapter when discussing how they framed the procedures within a reconstructive habitus, as well as in the fifth chapter when discussing how they perceive these surgeries to be *normal* surgical procedures. Therefore, their personal identity of being a competent physician is not altered.

Despite the fact that these surgeons have made sense of these operations in terms that enable them to keep their identity, they must also show other physicians, as well as institutions, that their identity as a competent physician remains intact. For this, I turn to Abbott’s (1988) *System of Professions*. Work, jurisdiction, and competition influence professions. In this light, a profession serves to do work, to address human problems,
which are “amenable to expert service” (1988:35). This service requires “expert” knowledge, and to maintain a profession, a professional group needs to control this knowledge. The profession must maintain the jurisdiction over the tasks at hand, and the knowledge required to perform those tasks. Professional power then arises from competition, due to the profession’s “ability to retain jurisdiction when system forces imply that a profession ought to have lost it” (1988:136). Language of competency serves to illustrate the way physicians challenge colleagues and forms of medical practice, while promoting new criteria of medical competence (Good 1998).

Recall how Dr. A discusses how these surgeries are “recommended by the AMA,” “recommended by all the professional organizations,” and is “legal surgery.” When the surgeons come across institutions or colleagues that question their competency as a surgeon, they need to act. Dr. A, for example, was ready to sue hospitals for operating privileges, thereby restoring his competency in a legal way. Dr. A maintains his professional jurisdiction, and thereby his competency, by using society’s recognition of his profession’s “cognitive structure through exclusive rights” (Abbott 1988:59). This again is an example of the challenging of knowledge, of the doxa, by individuals. These surgeons have created their own beliefs that do not always align with those of the larger medical community or their colleagues. Both the patient community and the surgical community influence knowledge construction.

As another example, Dr. D found himself with colleagues that questioned him, wondering if he “probably had too much to smoke” or “he was sniffing too much of something.” When asked about colleagues and others who question the legitimacy of
these procedures, the surgeons described the detractors as not being “progressive” thinkers, as being “ignorant,” or, along the same lines, as just not understanding the transgender community; they “don’t understand what gender identity disorder is.” In this manner, the questioning of these surgeons’ identities is no longer at issue; rather, the responsibility is shifted to their colleagues and the institutions, whose thinking is not yet as advanced as these surgeons. Dr. D went on to describe how

*It was really funny how the doctors really didn’t like me. It’s really changed. Now doctors all over the place are wanting to do this.*

Previously, the doctors that knew Dr. D questioned his thinking, but now the operations that Dr. D performs, as well as Dr. D’s competence, have been legitimized by time and the intellectual, moral, and professional “progress” of others.

Although their competency has been legitimated by the general acceptance of these operations by the medical community, these surgeons must continuously show and defend their personal surgical competency as well – Abbott’s (1988) competition over jurisdiction. Again, as mentioned in the previous chapter, these surgeons have described the DSM diagnosis, as well as other procedural codes, as a means to legitimize their work, and also as a “safety net” for these irreversible procedures. Dr. D, at the end of chapter five, described wanting to operate on “the right people.” The DSM, then, as well as the letters from mental health professionals, act not only as a safety net to ensure operation on the “right people,” but also as a safety net to reinforce the individual physician’s professional competency.
The idea that remaining competent is important is reflected in the various ways these physicians discuss the use of the WPATH SOC guidelines for therapist letters. Dr. B describes his use of the WPATH SOC letters as follows,

*The only thing that I require of my trans patients, that I don’t require of other population of patients, is that I need a therapist letter, stating that this is a good idea, to actually do this operation. Especially if I am doing a mastectomy on someone. I don’t want to do a mastectomy and then have the person come back and say ‘You know what, I made a mistake. I’m not trans, and how could you have done a mastectomy on me?’ So I sort of go according to the WPATH standards to get a therapist letter, basically stating that ‘I understand the irreversibility of these procedures, and I’m ready to proceed with these kinds of life changing events.’*

The reasoning behind this was described in chapter five; that is, to maintain that the patient’s end goals are *normal* and are in line with those of the surgeons. However, Dr. B goes on to say,

*I’ve had a number of patients who contacted me, and I say ‘I require a therapist letter for trans surgery.’ And they go ‘Why do I need a therapist letter? I’ve known I’ve been trans for decades, there is nothing wrong with me, I don’t need to see a therapist.’ And my response is ‘You know, if that were true of all the people who have contacted me, that would be one thing.’ But not everyone who contacts me is as certain as, say, the person who is arguing this... And I’m a little bit loose, so I don’t necessarily require patients all to be on testosterone before I operate on them, so, you know, I will, I will be somewhat flexible in my thinking.*

Here, Dr. B brings up two important concepts within the local moral world that relate to physician competency. First, he recognizes that not all of his patients are “certain” that they are trans. With this being the case, he needs a therapist letter telling him “this is a good idea,” that this is one of “the right people” to operate on. For if he were to operate on a “wrong person,” his competency would be brought into question.
Second, he notes that he is “flexible” in his thinking. He does not require all of his female-to-male patients to be on testosterone before he does the surgery. To illuminate this aspect further, I turn to my fieldnotes from a conference.

*One of the members of the audience raised his hand (of course at a conference like this one, I could only at first assume ‘he’ was a ‘he’ because of the large beard growing all around his face; however he identified himself as a male during his question) and asked if the surgeon required therapist letters. He was worried because he had only one therapist letter and argued that he was on testosterone for thirty years and has lived as a man for the same amount of time. The surgeon’s response was that he normally requires the standard two letters for genital surgery, but in cases where ‘it is obvious you are trans, you’ve lived as a man for thirty years,’ that he would accept just the one.*

In cases like this, where it is obvious that a patient identifies as transgender, there are no doubts that the patient will change his or her mind about the procedures after it has been done. Therefore, the surgeon’s competency is not in jeopardy. It is only when the patient represents the risk of not identifying truly as transgender that a surgeon’s competency can be called into question, and it is only then that the surgeon requires a therapist letter. In this manner, the surgeon playing the role of psychiatrist, as described in chapter five, is central to maintaining their identity as a competent surgeon. Those surgeons who do not require therapist letters are even more at risk, and often must “feel out” their patients, as Dr. E described, in order to be sure that “the right people” are being operated on.
Here again, the actions that are used to maintain the identity of a competent physician, such as the ways in which these surgeons choose which patients to operate on, are dictated by the various gazes. The surgeons are self-governing in the sense that they have embodied the “rules” of medicine and follow them strictly. To step outside of these rules – that is operating on the “wrong people” – means that they are stepping outside of the boundaries of what is considered “appropriate” medicine, as dictated by the professional, and state regulatory, medical gaze. These surgeons are constantly questioning the legitimacy of each individual case as it comes about. The DSM criteria and the therapist letters are then in fact a safety net, used in order to establish that it is a normal operation, therefore confirming their identity as competent surgeons in a medical-ethical framework. In addition, the DSM criteria and therapist letters can be used to address the stigma aspect of the social gaze, by providing outside approval from other medical organizations and professionals, to demonstrate competence to other institutions and colleagues. These actions are all aimed to deflect the medical and social gazes, as well as lawsuits, which then provide the surgeons with a mechanism that maintains their competency.

**Physician Identity – Caring Doctor**

Another aspect that should be part of every physician’s identity is to be a good, caring doctor; in a word, to be altruistic. This is a criterion for individuals when applying for matriculation into medical school. An article by *The Princeton Review* (n.d.) entitled “Beyond the Numbers: Making Your Medical School Application Stand Out,” lists various items that admissions committees are interested in from applicants. One of these
is altruism. “Altruism distinguishes a strong medical school applicant from a mediocre one… Many schools expect you to explain how service to others has informed your decision to become a doctor.” They suggest applicants be involved in activities that “develop their compassion and humanity.” This altruistic value is inquired about at various stages of the application process, including the medical school interview.

Seasoned surgeons are aware of this value and equate the operations that they do with altruistic actions. Several of the surgeons I interviewed highlighted this in their narratives. For example,

*Dr. E – We take it very seriously, and it’s an honor to help people in such a big thing. It’s a rare privilege to get to help people, to help people’s lives change in such a significant way.*

*Dr. A – I know I’m helping people, I know I’m saving a lot of lives, and I know I’m improving the lives of many people. So to me that’s a very rewarding thing, to be able to wake up in the morning knowing that you’re going to do something really good for somebody. So I’m happy with what I do, and I’m glad that I do that, what could be better than helping other people?*

*Dr. C – You profoundly impact these peoples’ lives… it’s an extremely gratifying thing.*

An important part of what these surgeons do is “doing something really good for somebody.” Helping their patients is seen as “a rare privilege” and is “extremely gratifying” for these doctors. It is also a key part of their identities as physicians.

The caring towards patients, however, is not only the work of the doctor, but also of their staff. While discussing his experiences with his staff, Dr. B says,

*Most of the nurses are just great, they’re fine, the anesthesiologists are fine, they treat the patients well, with respect, and they are pretty good at trying to keep the pronouns correct, and don’t seem to have much of a problem with it at all.*
The staff is part of the surgical practice, be it in a hospital or a private practice, and are a reflection of the surgeons themselves.

These qualities are important for these surgeons, as an identity as a caring doctor is important in retaining and acquiring patients. Steven provides a narrative description of how these altruistic and caring actions are perceived by patients. Here, Steven is discussing the various blogs and listserves used by the transgender community.

_They talk about what it’s like to work with the office staff. Your office staff can make or break you too. What it’s like to work with, for those who’ve had to do insurance reimbursement, how helpful or unhelpful the surgeon has been, how many revisions they’ve had to have, are they satisfied with the results, are they happy or unhappy. You know, what do they dislike, what do they like. And they really, you know, how often did the surgeon check in on them if they had problems, how available were they, did they have complications, who took care of them. And they are discussing all of this stuff._

Both the physician and the staff are part of the patient’s experience. These experiences are then presented to the rest of the community (at least those searching for these surgical procedures). It is therefore imperative for these surgeons to keep up the morally salient behavior (for all doctors) of being caring.

Dr. D describes an example of how these altruistic behaviors are part of the daily lives of these physicians, and how they are acted out.

_We had a lot of problems on the floor with nurses... [Some of the nurses] were very understanding, but there were a lot of nurses that weren’t. And we had to cut a couple of nurses away from working with my patients. I spent a lot of time talking to them about our patients, how to address them by name, you know. It’s been a big issue, a huge issue... So we have to keep working with them... It’s not easy for everybody, but we worked with it and we try to help the patients. ‘Don’t be bent out of shape because somebody calls you by your masculine name, it just happens. Don’t take it personally, because it’s not a personal thing.’ So we work at it from both sides._
During his narrative, Dr. D uses the word “we” when discussing himself and his practice. He sees everyone he works with as an extension of himself and his practice. As such, everyone should be practicing altruistic (and sensitive) behaviors when working with the patients. Dr. D realizes that this is an important aspect of his identity as a physician, as he continuously works with both his staff and his patients to develop this reputation. When his nurses were unable or unwilling to work caringly with the patients, they would be “cut,” prevented from working with his patients in order to maintain this identity.

As discussed at the beginning of this section, these altruistic values are maintained by the medical community, and are thus bounded in part by the medical gaze. That is, medical schools should only accept candidates that exhibit altruistic behavior, and this behavior should continue throughout their career in medicine. This is also maintained and bounded through the social gaze. The idea that doctors should be caring is perpetuated through various social devices, such as popular media, and is embodied in the members of the lay community, as seen in the listserves of those customers who identify as transgender. Patients therefore seek out those good and caring physicians who, and whose staff, exhibit altruistic behaviors.

**Physician Identity – Great Surgeon**

Surgeons are often seen as dominant, competitive, and heroic individuals (Katz 1999). In order to be seen as a great surgeon, one must have adequate technical abilities and decisiveness, and use craft, cunning, and technology to open and operate on bodies (Prentice 2012). Many of the surgeons with whom I talked discussed many of these traits with me.
Competition ran through many of the narratives of these surgeons. Though this is part of the larger surgical habitus, it also serves as a means to showcase their abilities as being better than those of other surgeons. One instance in which this occurred was in my interview with Dr. D.

Well, fifteen percent of my practice, maybe more, is redoing work by other people. So my issue is that most doctors, I’m going to say all doctors that I know of, none of them, none know the true differences between the male and the female skull, other than the fact that they got some bossing. They don’t know how far back to go, and two, if they wanted to go back, they don’t have the ability to get there.

Dr. D, during this narrative, shows his competitive side by highlighting his abilities, aspects that make him a great surgeon. These technical abilities and expert knowledge are what separate him from other surgeons. He is staking claim to this jurisdiction of expert knowledge and expert skill (Abbott 1988). To many of these surgeons, part of why they are such popular surgeons among the transgender community is because of their extensive technical backgrounds that allow them to operate so efficiently.

Continuing with these surgeon character traits, creativity and innovation in technology and technique, thereby helping to advance the field of medicine, is highly sought after (Katz 1999). Atul Gawande (2008), a surgeon at the Brigham and Women’s Hospital in Boston who published a book entitled Better, discusses one of the three core requirements for success in medicine: ingenuity. Ingenuity “is not a matter of superior intelligence but of character… It arises from deliberate, even obsessive, reflection on failure and a constant searching for new solutions” (2008:9). Gawande tells a story of one doctor who is extraordinary due to his “combination of focus, aggressiveness, and
inventiveness” (2008:223), that patients “deserve” doctors who “push the rest of us to innovate. There is no reason we cannot aim for everyone to do better” (2008:199).

Dr. C, another of the highly competitive surgeons, discussed with me how he was at the forefront of endoscopic technology when it was first beginning to be used in the field of surgery. He also mentioned, when discussing the current types of surgery that he does,

[These surgeries are] very, very challenging to basically be able to change the facial skeleton, aspects of it, and then sort of shrink wrap and change the soft tissue to boot. So very, very advanced type surgery... You sort of get to push the envelope a little bit.

The challenging nature of these surgeries, and the fact that they are “pushing the envelope,” make these surgeries “very advanced,” reserved for the “experts” at the forefront of the field.

Many of the aspects in this chapter highlight how these surgeons characterize this as progressive surgery. By saying that they are “open minded” and “progressive,” that is socially inclusive and liberal, in their thinking, and not “ignorant” as to the issues at hand, they reaffirm that these operations are not transgressive procedures; as something that may be morally wrong. Rather, their words make them pioneers at a new frontier, and other surgeons and the rest of the medical community will eventually follow them.

These aspects, which these surgeons use to show their identity as great surgeons in their everyday lives, are part of the enculturated values that are passed down to future surgeons during their residencies (Katz 1999; Prentice 2012). They are a part of the community of practice, the “collaborative, informal networks that support professional practitioners in their efforts to develop shared understandings and engage in work-
relevant knowledge building” (Hara 2009:3). Surgeons are, in this way, dictated and bounded by the social aspect of the medical gaze. They are maintaining the cultural identity of surgeons, and at the same time, through these communities of practice, implementing new knowledge and shaping old knowledge to suit the needs and context of their practice (Le May 2009). They are putting themselves ahead of other plastic surgeons by pursuing new and innovative procedures.

**Interactions in the Local Moral World**

Although they play a major role in the local moral world, the surgeons are not the sole actors. Rather, the patients they serve, as well as the transgender community at large, play an equally important part. The qualities of action by which surgeons maintain what can be lost also serve as a means to retain and acquire new patients. In fact, the patients are indeed looking for these qualities in the surgeons they choose. Steven points this out in one of his narratives, where he is discussing how patients pass along information within the transgender community.

*Steven: They [the surgeons] are definitely checked out by the [transgender] community, and kind of in an underground sort of way the information gets around pretty quickly. There are several listserves, trans people, there are some that are very, very specific lists about people considering or who have experienced very specific surgeries, where folks just can get engaged from anywhere in the world really, and discuss what their experiences have been like…*

*Robert: What kinds of things are they saying?*

*Steven: Some people it’s ‘the surgeon was fine but they were completely unavailable and they wouldn’t help me with any complications afterward and I had to go to somebody else.’ You know, so they’re not following up on their patient care… Some of it is cosmetic, some of it is literally care based. Some of it is you know ‘the staff were really awful to deal with and were insulting and condescending,’ or ‘wouldn’t help me’ or ‘wouldn’t see me.’… Some of it is just literally skill level, they did something they weren’t able to quite do and they*
didn’t have any back-up or anybody to help them out with it… Most of the reasons that people would shy away from folks is based on results and complications, and after care, of surgical care, and availability. And the surgeons that have the best outcomes and the best follow-up get the most people.

In this narrative, we can see that many of these aspects overlap with what is being maintained by the surgeons. The patients are looking for caring, competent, and technically able (i.e. great) surgeons.

The doctors are aware of the value that the patients put on these characteristics. For example, Dr. C, when discussing the first transgender patient he operated on, said,

This particular patient was very, very kind in that they sort of said ‘wow, you seem like a really nice doctor, you spent a lot of time with me, you go the extra mile, you’re exactly the kind of person that a lot of us are looking for.’

Dr. C recognizes the fact that these patients are looking for a surgeon who is caring, supportive, and willing to “go the extra mile” for their patients. In addition, Dr. D is aware of his patients’ needs for a competent, technically skilled surgeon. Referring back to his earlier comment about how fifteen percent of his practice is redoing work by other surgeons, he went on to say,

And that’s a real problem with the patient because they spend a lot of money doing their first surgery, they don’t look female, and now they need more surgery because it wasn’t done properly the first time.

Not only does Dr. D reference the competency aspect of the surgeon’s identity, but he also references the economic aspect of what is at stake, not just for the surgeons, but for the patients.

By being aware of which characteristics the patients value the most, the surgeons can then act accordingly within the local moral world in which they come together. These surgeons are able to market themselves to their patients, for example through the use of
their websites, photos, and conference presentations. In this way, the patients are part of
the social gaze, which acts to set the boundaries for these surgeons to act within, and
helps to shape the local moral world.

One great example of the transgender community helping to form the local moral
world comes from Drs. C and D. Dr. C discussed with me how “in a bad economy,
people open their minds.” Dr. D elaborated on this by saying,

Now doctors all over the place are wanting to do this because plastic surgery, like
everything else in the world, is slower and they don’t have as many face lifts to
do. ‘And what am I going to do? Oh wow, there’s a transsexual, I can do that.
That’s just a matter of taking off a few bumps here and there.’

These statements highlight again some of the key aspects that are significant to these
surgeons, such as economics, competency, and being a great (or even just a better)
surgeon. Even though these other surgeons may have these types of characteristics in
general, if they are not applied specifically to the transgender community and GAS
procedures, the patients influence the outcomes. As Steven discussed previously, the
transgender community circulates their experience and knowledge about these surgeons.
This community discussion directly influences the doctors.

And pretty quickly you see the field narrow down, and that’s where you see some
of the surgeons world-wide that just have a tremendous amount of people going to
them, and others that are kind of struggling to peddle themselves. And some of
it... I just don’t think that [the surgeons] are aware of what is being said about
them.

Indeed, at times the surgeons do not realize what is being said about them. Dr. A
describes his experience of the various blogs which mention him,

But most of it, a lot of it is from their own blogs, so I have nothing to do with it. I
don’t even look at them. I’ve never even looked at those blogs. I just didn’t have
time to look at it. And I hear of it secondarily, that people tell me that ‘oh
everybody writes great things about you’ and I know every once in a while someone says ‘oh you’re a butcher, you’re a terrible surgeon, you just want money, you don’t care about them,’ you know? That’s someone who’s like critical of everything in the world. Some people are just hard and think it’s their job to criticize everything, I don’t know. Because we take very good care of everyone that comes our way.

Even though Dr. A is not completely aware of what is being said about him in the various blogs, he still preserves everything that is in jeopardy for these surgeons, and applies them specifically to the transgender community. He is caring towards his patients and has the technical abilities to do these GAS procedures specifically.

When surgeons do not possess these characteristics, the transgender community spreads the information amongst themselves, and make it known which surgeons are the “right” ones to go to. So, coming back to the example given by Drs. C and D, those surgeons that do it just for the economic profit and lack the rest of the characteristics that are necessary in this local moral world, do not succeed, and, as Steven said, are “struggling to peddle themselves.” In this way, the patients act within the local moral world as well. Their individual interactions with the surgeons and collective interactions within their community directly influence and help to determine what is most important for these surgeons in their daily lives. Dr. C summarized it best when he said,

*There’s no quote ‘designation’ as a transgender surgeon, you know? That’s something that patients basically determine.*

Overall, what can be lost for these surgeons often overlap with one another. Economics is directly related to the ability to bring in new patients. To accomplish this, the surgeons rely heavily on referrals, both from other doctors and also their previous patients, as well as self-marketing through websites, photos, and presentations. In order to
maintain these referrals, the doctors must continuously act to legitimate the procedures that they do, as well as their competency in the field. In addition, to set themselves apart from other surgeons in their field, they must show that they are great surgeons and caring doctors. At the same time there is a tension between the categories created by insurance companies, the doxa of the surgical community at large, and the surgeons performing trans-related procedures. There is also a disproportionate influence of insurance classifications for those surgeons who do accept insurance compared to those who do not, creating different conflicts of habitus and doxa. The patients and the transgender community also play a major role in shifting these categories and assumptions, and in reforming knowledge within the local moral world. These aspects all interact and work together, being dictated and bounded by the clinical, medical, and social gazes. They are acted out by surgeons, colleagues, institutions, and patients, in the individual clinical encounters, and in other aspects of these surgeons’ daily lives, to create and reflect this local moral world.
CHAPTER 7: CONCLUSION – CLOSING UP

“I’m not sure that working with a transgender population is any different than working with a different population.” – Dr. E

In this thesis, I have explored some of the ways in which these surgeons make sense of these GAS procedures in the context of the everyday world they live in. These surgeons have been enculturated with what it means to be a plastic and reconstructive surgeon, as well as which categories of procedures they are able to perform. They classify GAS as a form of reconstructive surgery, which fits into their habitus as plastic and reconstructive surgeons. Other motivations, such as competition and heroism, are also incorporated into these procedures, and fit into the surgeons’ broader surgical habitus.

The surgeons also were able to fit GAS within the structure of normal surgery. These operations are conducted on normal people with sound minds, and have normal medical and social outcomes, and stay within the bound of the various medical and social gazes. I then took a step back to see how these surgeons act within these boundaries, set by the medical and social gazes. In order for the surgeons to maintain what is at risk for them, such as economics and their identities as physicians, they must literally and metaphorically operate within these boundaries.

I have used the theoretical concept of local moral worlds, and would like to add an insight: when observing a local moral world, one must keep in mind the world is shared. Any given outcome is the process of shared interactions, acting to keep what is important. But what is at stake for one group or individual may not be the same as that for another. When maintaining what is important relies on a different outcome for each
group, the result is a single outcome, with someone losing something central, and someone hanging onto something else that is essential. When the outcome is the same, for example reconstructing a *normal* body, the result is a collision of perceptions.

Dr. D gave a brief glimpse of this towards the end of our talk:

*I have a little cartoon when I give my lecture of three rabbits, it shows them looking inside their slacks, it says “Being a female,” being a transsexual, walking down the street, “is not looking in your slacks to identify what sex you are.” It always amazes me that more people have gender reassignment surgery than they do facial feminization. To me that’s totally backwards, but that’s the way it is. I never understood that. It’s at least three or four to one.*

Dr. D is maintaining his identity as a surgeon. He is a facial surgeon. He acts to create new faces for people, to reconstruct a *normal* body, so society views them as *normal*. For his patients, what is important often times is a sense of personal, embodied identity, one that may or may not be visible to society.

Lenore Manderson discusses how certain body parts, such as the breasts are “dense with social significance” (2011:190). “An understanding of a body-for-others affects images of the self. The self is produced through interactions between the lived body (the body-for-me) and the body as experienced or perceived by others, and as re-interpreted or fed back to the individual; there is a continual feedback loop” (2011:189). Even though the genitals may not be seen by society, how they would be perceived influences the perception of the self. Meaning is embodied within the genitals. What can be lost for the individual having genital surgery is not influenced by what can be directly seen by society, but by the embodied meaning of the genitals. Yet, the outcome is the same for both the surgeon and the individual: to remove and reconstruct that part of the
body. What is at stake for Dr. D leads to the same outcome, the same goal as his patients; but the understanding of these goals, and the perceptions of them, are different.

Furthermore, the process of acting within the boundaries of the local moral world, that is adhering to the clinical, medical, and social gazes and maintaining what is important, serves as a double-edged sword. These surgeons act indirectly to medicalize transgenderism. Medicalization in this sense is the expansion of medical jurisdiction to cover forms of behavior socially constructed as deviant, such as alcoholism, domestic violence, criminal behavior, learning disabilities, and gambling (Finkler 2001).

Conrad (1992) describes how medicalization occurs on at least three distinct levels. First, the conceptual level uses medical vocabulary to define the problem; second, the institutional level, in which organizations may adopt a medical approach to treat a problem; and third, the interactional level, where doctor-patient interactions gives a medical diagnosis or treats a problem with a medical form of treatment. The very process of obtaining these surgeries pertains to all three of these levels.

Individuals must first go to a mental health professional to obtain the diagnosis of Gender Dysphoria and present the diagnosis to the surgeon in order to receive treatment\(^\text{18}\). The diagnosis of Gender dysphoria is part of the institutional level; it is part of the vocabulary and defines the “disorder.” Surgical hospitals, on the organizational level, (usually) require at least one therapist letter, acknowledging the patient has this

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\(^{18}\) Many people do not actually receive the diagnosis of gender dysphoria, but rather have a referral letter from a mental health professional saying they “meet the criteria for” this diagnosis (Ruben Hopwood, personal communication, February 24, 2014).
“disorder.” These surgeons then operate on the individual, using surgical treatment, the third level, to treat the “disorder.”

This diagnosis serves multiple purposes other than as a means to obtain this surgery, such as a means to get people mental health treatment, hormonal treatment, and to win legal battles for the rights to treatment and to live in their identified gender (Ruben Hopwood, personal communication, February 24, 2014). Nonetheless, one of the primary uses of the diagnosis is to obtain surgery. Dr. D, in his discussion of operating on “the right people,” mentions,

*In that sense, I think the diagnosis, if a psychologist or psychiatrist can make the definite diagnosis, I think it would be extremely important, because I think we need those things.*

In order for these, and other, surgeons to sustain what can be lost, they “need” a diagnosis. They need to be sure that they are operating on “the right people.”

In a more strict sense of medicalization, one can argue that much of this diagnosis, and the treatment associated with it, are not entirely necessary. I do not mean to say that these surgeries should not be done, nor do I mean that these surgeons are not in fact helping these patients. What I do mean is that part of the diagnosis itself may be predicated on a social issue. As discussed in Chapter Five, the critical aspect of the diagnosis is the distress one feels due to the incongruence between one’s experienced and expressed gender identity, and one’s assigned sex (American Psychiatric Association, 2013a). As many of the surgeons discussed with me, one of the primary goals of the surgery is being able to pass in public. As such, surgical treatment acts to alleviate this distress. What is not mentioned is the social dimension that creates this distress. These
individuals who identify as transgender may carry with them a social stigma that becomes “deeply discrediting” (Goffman 1963:3), as identifying as transgender is a form of socially deviant behavior. By altering the body to fit the societal ideas of normal, this distress may become alleviated. An important note, as Ruben Hopwood points out, is that this dysphoria is not entirely predicated on the internalization of social deviancy. “There are people who experience internal dysphoria and who are not treated as deviants socially at all. Many trans people cannot tolerate the body that is not the right one” (personal communication, February 24, 2014). However, for those who have internalized this socially constructed idea of deviancy, the medical jurisdiction has taken over the task of correcting “deviant” behavior by re-creating normal bodies.

By re-conceptualizing their patients’ experiences in a reconstructive and medical context, and acting within the boundaries of the medical and social gazes (including using the DSM diagnosis), they act to re-create normal bodies. The surgeons act to take these bodies, which do not fit within the normal cultural idea of male and female, and operate on them in order to make them normal. The body has become a template for cultural inscription (Manderson 2011). These medical procedures have then indirectly become a means to control what normal bodies are, and incidentally act to perpetuate current cultural practices, including the gender binary and current definitions of sex and gender19.

This is not necessarily bad. These surgeons do in fact help their patients and affect them on a very deep level. Pitts-Taylor (2007) discusses women’s cosmetic surgery, and

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19 I must note that it is the patients who seek out these surgeons. There are many people in the transgender community who want to fit within this gender binary, and seek out these surgeons to help them more fully fit into the dominant binary culture. This is why these procedures indirectly perpetuate these current practices.
the arguments surrounding it: “By treating cosmetic surgery as an intervention in identity, it becomes easier to take women’s bodily experiences with gravity, seriousness, and empathy, and to understand how women might see surgery as the best solution under the circumstances” (p. 88). Indeed, surgery as it pertains to the transgender community may be the best solution under the circumstances. For some, it may be the only solution. The surgeons themselves also seem to be aware of the predicaments faced by the transgender community and the threat of medicalization. Dr. B, for instance, on discussing how the DSM is a needed protective measure for both him and his patients, says “that doesn’t mean that it’s a needed item as it is written now.”

With this in mind, there is room for change in this local moral world. Ideas of sex and gender, after all, are not static, but are fluid in both time and space (Johnson, Mimiaga, and Bradford 2008). This goes for both the medical and social aspects of what a man and woman should look and act like. As such, these views can alter the clinical, medical, and social gazes, and change the boundaries of these local moral worlds.

One way in which these changes can occur is through the transgender community itself. Many of the surgeons that I interviewed discussed with me how the United States is becoming more and more progressive in terms of being more accepting towards gender nonconforming individuals in general (not just the transgender community specifically). In this way, the individuals in the transgender community, as well as the community as a whole, are able to, as Dr. C put it, “quote ‘Come out of the closet.’” That is, they can be more vocal about topics such as individual rights when it comes to gender expression, as well as about educating the public. Facebook, for example, just recently added more than
fifty different gender identification options for those who identify as something other than simply “male” and “female” (Oremus 2014).

In addition, those individuals in the transgender community are able to educate physicians. For example, Dewey (2008) found that some members of the community attempt to educate their physicians, “that perhaps this education will eventually change peoples’ perception and the future quality of care for trans-individuals” (p. 1349). Even Dr. A was educated by a member of the transgender community when his resident told him how he needed to do the surgeries. In these ways, the transgender community acts to change the way the clinical, medical, and social gazes view the community, and the boundaries that they create. The gazes are then both boundary-defining, but still bounded by the individuals within the local moral world. The blurring of the edges of the boundaries can be focused and nuanced by members of the local moral world, and at times can be erased and redrawn.

Another way in which change can occur is through new research. After all, the focus and inspection of the inner anatomy of bodies drastically changed the way medicine and society view sex and gender (Grenfell 2003). In the same way, current research and practices act as a form of medical and social change.

We live in a heavily research-dominant society – a key aspect of the legitimization and normalization of surgeries and other practices is through evidence-based research. In this way, the clinical and medical gazes are heavily influenced by new and emerging evidence. This influence can leak further into the social gaze (for example, by means of popular media, such as various blogs, newspapers, and other various news
outlets that report new scientific findings). As noted above, society as a whole is becoming more accepting of the transgender community, including the field of medicine. Medicine and society influence and are influenced by each other, together focusing and redrawing the boundaries of social acceptance. As one non-surgical physician pointed out, it is no longer necessarily that physicians are biased towards patients that identify as transgender, but rather they do not necessarily know how to go about treating them for transgender-specific healthcare needs.

When asked about whether or not he has had any negative feedback in regards to the GAS aspect of his practice, Dr. E said,

*I’ve never run into that. I’ve run into exactly the opposite. I’ve presented this at national meetings and international meetings, constantly. And it’s always met with widespread interest. As far as, because people recognize the value of it and the fact that it’s helping people.*

As Dr. E says, there is “widespread interest” in his work and research with the transgender community.

As more research becomes available, it can also be used to address the relative dearth of LGBT curriculum in medical schools. In this way, research acts shift the medical gaze by helping physicians to not only accept, but more importantly to understand the issues that the transgender community faces.

Steven discusses this in one of his narratives:

*It still is just so unusual for people to relate to, is really what it comes down to. If you can find something to relate to in someone else’s experience, you can humanize them. But if their entire experience is something that you can’t imagine, can’t relate to, you have nothing of comparison in any way, they don’t ever get to become human. Because you simply can’t empathize with whatever it was that they’re, you know, they are just strange or sick, and so it really is just hard to relate to that.*
As he describes, the understanding of the transgender community is very important. Using research in the medical community, especially in medical school curriculum, will help broaden the understanding of this particular group of “distressed” people.

At the same time, however, we must also be aware of the effect this will have. Medical institutions are capable of perpetuating social stigma, especially when they are invested (e.g. through economic gain from surgical procedures) in keeping the label present (Waxler 1981). By continuing the practice of GAS without taking into account the societal influence on transgenderism, by maintaining that this is the best solution under the circumstances (Pitts-Taylor 2007), the medicalization and stigma of transgenderism are perpetuated. Only when there is true social acceptance, when transgenderism becomes a “normative expectation” (Goffman 1963:2), will it no longer be stigmatized.

This brings us to an interesting and confusing crossroads with multiple intersecting perspectives. I have shown the social constructionist perspective of how social categories constrain and create “experience.” There is also the critical standpoint, that symbolic and structural violence towards the transgender community influences individual experience and actions. In addition, there is the phenomenological and existential “raw” experience of those seeking these surgeries. Even with true social acceptance of all gender and sexual identities and expressions, there will continue to be those for whom bodies and identities do not align, and will need correction through procedures like GAS. This seemingly “simple” argument of acceptance becomes complicated as we sort out these perspectives.
Call and direction for Future Research

There are, of course, limitations to my findings. The surgeons come from very different areas across the United States, and the experiences they have depend on their individual situations. My results therefore may be generalizable to GAS surgeons in the United States, but may differ from individual surgeons’ experiences in specific contexts. In addition, I was unable to observe directly the interactions between the surgeons and their patients. These observations would no doubt have aided in the analysis of the research data, and may lead to better understanding or new insights into the experiences of these surgeons.

It is with this that I make a call for more research, not only with the transgender community specifically, but also those who work with them, those who share their local moral worlds. By researching those who are involved in the various generative and constructing processes of this local moral world, we can gain better insights and understanding into the ways medicine and society view and treat individuals. By finding the boundaries of the local moral world, we can act to shift and recreate them.

Steven, in his narrative, went on to say,

In looking at empathizing or relating to people, one of the things that I think the surgeons that work a lot with the community have been able to do is as they have physically worked with people’s bodies, talked to them, examined them, changed them, talk to them some more, as they have been through that process with them, and seen the responses and reactions, and the physical transformation, I think they are probably the closest to developing a way to comprehend or to relate to people’s experiences. I mean it’s still from the outside, but there is a bit more of an understanding because of what they are doing. Which for the folks who have the ability to really relate, they are the surgeons that I see who have so significantly shifted and who the community really attached to. Because they feel like they are understood.
These surgeons’ experiences provide insights and deeper understandings to how people and society experience bodies and genders. They do more than operate on bodies. They “transform” individuals. With more research, they may even help society to transform itself into a place without genders.
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CURRICULUM VITAE

ROBERT JOSEPH CHRISTIAN

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EDUCATION

Boston University – Boston, MA
Master of Science Candidate, Medical Anthropology, expected May 2014
Thesis – “You Know a Girl When You See One”: Experiences of Surgeons Who Perform Gender Affirmation/Reassignment Surgery

Kansas State University – Manhattan, KS
Bachelor of Science, Anthropology, Magna Cum Laude, December 2011

Kansas State University – Manhattan, KS
Bachelor of Science, Biology, Magna Cum Laude, May 2009

PRESENTATIONS

Society for Applied Anthropology Conference – Albuquerque, NM
Poster Presentation
2014
Poster title: “You Know a Girl When You See One”: Experiences of Surgeons Who Perform Gender Affirmation/Reassignment Surgery

EXPERIENCE
Boston Health Care for the Homeless Program – Boston, MA

Volunteer – Transgender Clinic
2013 – Present
• Collect and compile transgender-related healthcare information to be used in patient brochures.

Center for Environmental Management of Military Lands – Ft. Riley, KS

Seasonal Archaeology Technician, Cultural Resource Management
Summer 2011, Summer 2012
• Phase I archaeological investigation of both pre-historic and historic sites, including shovel test pit excavation, pedestrian survey, and deep (auger) testing.
• Phase II archaeological investigation of both pre-historic and historic sites, including test unit excavation, determining vertical limits of sites, evaluation of areas of moderate and high artifact density.
• Artifact curation, including cleaning and cataloging of both pre-historic and historic artifacts.

Mercy Regional Health Center – Manhattan, KS

Materials Management Technician
2006 – 2012
• Shipping, receiving, and distribution of supplies.
• Communication with all hospital staff, including physicians, nurses, and administrative personnel.
• Leader in the implementation of hospital-wide computer system change; involved in communication with department heads, managing inventories, and educating hospital personnel on new system.

Kansas State University Department of Chemistry – Manhattan, KS

Chemistry Laboratory Instructor
2009 – 2012
• Teaching of Chemistry I and Chemistry II Lab courses during various Fall and Spring semesters, with 15 – 18 students per class.
• Presentations of lab safety and lab techniques, and weekly lectures on material for that week’s module.