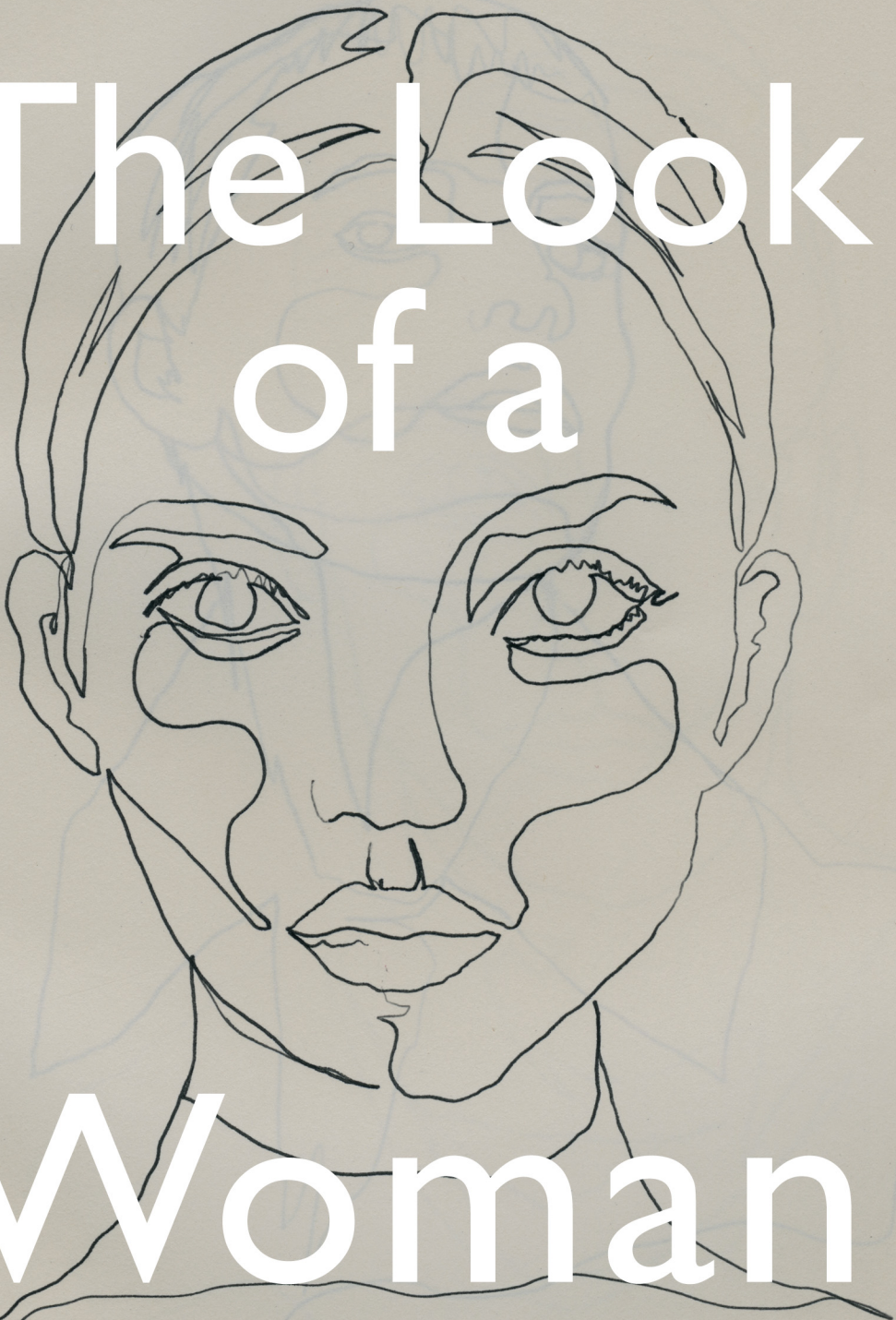
The Look of a Woman



Facial Feminization Surgery and the Aims of Trans- Medicine

ERIC PLEMONS

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For Anne

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INTRODUCTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

While drowsily recovering from the long hours of anesthetization, Krista

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

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

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

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

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

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

ENACTING TRANS- THERAPEUTICS

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

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

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

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

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

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

ACCOUNTING FOR SHIFTS IN CONCEPTUALIZATIONS OF SEX AND GENDER

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