Introduction

Reframing the Surgical

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This special issue of *TSQ: Transgender Studies Quarterly* explores the vital and contested place of surgical intervention in the making of trans bodies, theories, and practices. It investigates surgery as an institutionally, culturally, politically, and personally situated practice.

Surgery is hard to talk about. This has been the case in transgender studies since the emergence of the field, often dated to the publication of Sandy Stone's essay "The *Empire* Strikes Back" in 1991 (2006). Perhaps the most influential of Stone's arguments was the call then for transsexual people—and, later, for scholars of transgender studies—to decenter, refract, complicate, or refuse the medical discourses that had for decades defined transsexuals as a group constituted by the desire for sex-altering surgical intervention. Even the handful of extant transsexual autobiographies circulating at the time, Stone argued, placed a too large and often magical focus on the kind of total transformation that surgery could have, and were, as a result, complicit with the dominant medico-surgical narrative of transsexualism as an identity and as a project that exchanged one binarily construed body for another. Stone's essay marked the beginning of thinking trans otherwise. With so many things to say and think about and with trans folks, medical discourses that focused on the fulcrum of surgery simply weren't sufficient. Instead, Stone argued, posttranssexuality could make room for new stories told by trans folks in embodied and kaleidoscopic ways. But in this multiplicity, the status of the surgical is left unsettled. Work in transgender studies has more often ignored or deflected the surgical question than engaged with it.

Stone's decentering of medico-surgical discourse has done a great deal to direct the kinds of work that have been recognized under the rubric of transgender studies, and the themes of her manifesto have animated the prevailing trends in trans politics of the last twenty-five years. Surgery, too often fetishized in

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popular discourse as the act that makes the trans person real—in that surgical desire makes them *really* trans and surgical intervention materializes their *real* identity—is now most often treated in trans studies as a subject of admonition. Discussions of surgery appear in much the same way that Michel Foucault describes discussions of the masturbating child in *History of Sexuality* (1978): it is talked about mostly to remind people not to talk about it so much. But as Foucault's arguments against the "repressive hypothesis" show, we talk about what we are not supposed to talk about all the time. Policy debates about trans health care, to pick one important example, nearly always center on the contested practice (and price) of complex reconstructive surgery. The current controversy over trans people in the US military revolves around who should foot the bill for surgical operations and who will fight on the frontlines if legions of trans soldiers are languishing in postoperative recovery rooms. The considerable body of literature critiquing gatekeeping protocols for diagnosis and treatment often takes aim at processes that restrict access to surgeries.

The downplaying and decentering of surgical discourse is often intended to push thinking and conversation about trans people away from lurid and voyeuristic concerns with dissected body parts, and into deeper consideration of trans identities and lives. This can be done to lay claim to a definition of trans lives and bodies outside and in defiant rejection of medical models overdetermined by normative genders and sexualities, and to assert extraclinical and never-clinical trans ways of being. It can be a political gesture to enable coalition with other marginalized communities. But for all the good reasons to turn attention away from surgery as fascination and as fetish, refusals to talk about surgery have had unintended effects.

The practice of surgical intervention in the name of transforming sexed and gendered bodies has been happening in many parts of the world for centuries. The earliest documented case of patient and surgeon sharing a common goal of surgically reconstructing genitals to change the patient's sexed body from "male" to "female," and thus her social status from "man" to "woman," happened in Germany nearly one hundred years ago.[1] Over time, new centers of practice around the world have surged and waned in popularity as techniques are developed and practitioners' reputations grow—for good or ill. While surgeons are busy at their craft, trans social networks crackle and expand, moving information and strategic resources about how to access services, and about which procedures, doctors, and hospitals are desirable, and which should be avoided. Demand for trans-specific surgical procedures has not subsided in the thirty years since surgical discourse has been decentered in trans theory and politics; rather, it has grown.

Among the benefits of engaging surgery in this forum is that we can both collectively acknowledge the ways that past and contemporary fixations on

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surgery have been problematic, reductive, exclusionary, and violent, and also open urgently needed discussions about the ways that ongoing surgical practices shape the lives, bodies, and futures of many trans folks and the policies that enable and constrain them. The desire to undergo a surgical operation is often a major organizing force in the lives of prospective surgical patients, influencing decisions about where to live, what work to pursue, what school to attend, and how to manage travel, insurance, investments, savings, personal safety, and intimate relationships. Surgical outcomes profoundly change trans peoples' bodies—sometimes resulting in self-actualizing triumph and other times in crushing disappointment and lifelong chronic health problems.

We think it is important to pay attention to the practices of trans surgery, the contexts and conditions in which it happens, the professional and institutional networks in which it is carried out, the techniques employed in its name, and the understandings of sex, gender, and indeed trans itself that its practices enact. We study trans surgical practice—historically, conceptually, materially, ethnographically—not because surgery defines us as trans people, but because it is so very important to so many of our lives. We engage with surgical discourse because of the many ways that it has metonymically grounded attacks against trans people's rights to legal recognition, medical care, and even life itself. Working to break this metonymic link by merely disavowing the centrality of surgical discourse to many trans lives—even for trans-identified people who do not seek surgery—does not allow a needed engagement with these discourses, their histories, or effects.

Patient-Doctor Relations

Surgery is a physical meeting between patient and doctor and, for each, the vertex of a complex array of intentions, potentials, limitations, and concerns. The patient's outcome cannot be dislodged from social positions and interdependencies, resources and abilities, and the surgeon's skill does not exist independently of medical, ethical, legal, or economic frameworks. As a group, these essays avoid generalizations and reifications of trans people and health-care professionals and attend to a variety of individual circumstances and particulars.

Transgender medicine presents a wide spectrum of patient-doctor relations, as even a brief historical survey in the United States shows. At one end of the spectrum, patients have expressed idealizing appreciation for those who endorsed and facilitated their physical transformations (see Plemons 2017: 77–83). Christine Jorgensen chose her name in honor of her doctor, Christian Hamburg (Jorgensen 1967: 120). After becoming a patient of Dr. Harry Benjamin in 1963, Reed Erickson founded the Erickson Educational Foundation (EEF), which provided Benjamin

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with three annual grants to research transsexualism, drawing on his patient files and working with colleagues (Devor and Matte 2007: 60). More than simply his own clinical observations, Benjamin's files contained information and thinking provided to him by his trans patients who, like Erickson, wanted to help others like themselves.

The Erickson Educational Foundation also provided substantial funding for the Johns Hopkins Clinic, the first university-based gender identity clinic in the United States to offer sex-reassignment surgery, which opened in 1966 (60). In his many extraordinary efforts to foster the development of services for and understanding of transsexuals, Erickson considered the needs of trans people and medical professionals to be complementary (54). From 1969 through 1973, the EEF funded the first three international symposia on gender identity; they led in 1979 to the formation of the Harry Benjamin International Gender Dysphoria Association (HBIGDA) (62–63), which in 2007 became the World Professional Association for Transgender Health (WPATH). In contrast to EEF's original vision of "shared social goals between trans people and the professionals who worked with them" (54), some trans folks and their advocates have critiqued WPATH and other regulating bodies for the ways that facilitating some forms of medico-surgical intervention in the name of trans medicine has also meant restricting others. Much of this tension has centered on dynamics between (prospective) patients and the mental health-care providers whom the *Standards of Care* advise to access eligibility and prepare and refer for particular bodily alterations.

If one end of the spectrum of patient-doctor relations is collaboration, the other is conflict. The dominant tendency on the part of health-care providers, particularly psychiatrists, to pathologize the expression of trans feelings led to adversarial relationships between many doctors and patients. Agnes, a patient of Dr. Robert Stoller at the University of California, Los Angeles, Gender Identity Clinic in the late 1960s, obtained approval for sex-reassignment surgery by asserting her intersex physicality while withholding information about use of her mother's birth control pills for self-medication. Notwithstanding Agnes's competence, the eventual revelation of her dishonesty (Garfinkel [1967] 2006), alongside reports of patients' postsurgery regret from Drs. John Money and George Wolff of Johns Hopkins Clinic, reinforced an already paternalistic attitude toward trans people's subjectivities. According to the EEF newsletter, Drs. Wolff and Money concurred that a "two-year preoperative probationary period in the complete female role should take place to prevent uncertain diagnosis or inability to adjust" (EEF 1970: 2; EEF 1971: 2). Hence just as patient dispositions toward doctors have ranged from approval to antagonism so too have doctors' attitudes toward patients.

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The Broader Context

Although the abbreviated history above is specific to the United States, the aspirations and conundrums it documents are not. Throughout the twentieth and early twenty-first centuries, people in many countries have sought medico-surgical interventions to alter sex and gender signifying bodily characteristics. How desires for these kinds of interventions are perceived and categorized, and how responses to them are organized, vary around the world for a number of interconnected reasons. These include locally specific conceptualizations of sex and gender and how variations from norms are understood as objects (or not) of intervention (Jarrín 2016; Winter 2009); differing political economies of health and health care; divergent philosophies of medicine; arrays of spiritual and theological traditions and their varied integration into health care and healing practices (Najmabadi 2013); technical limitations of capacity reflecting uneven distributions of material and knowledge resources; and the frictive travel of categories such as "transsexual" and "transgender" and the protocols of diagnoses and treatment through which they move (Aizura 2009), including powerful transnational documents like the *DSM* and ICD (Drescher, Cohen-Kettenis, and Winter 2012), and through nongovernmental organizations invested in "transgender" as a particular kind of figure that must be counted and protected (Dutta and Roy 2014; Thomann and Corey-Boulet 2015).

The history of trans patient-doctor relations in Argentina, for example, where surgical sex reassignment for trans folks was outlawed from 1967 until 2005 (Cabral and Viturro 2006), is different than in the Netherlands, a country whose national health service has provided trans-specific medical and surgical care for decades and has been a global hub of research on trans mental and physical health. While specific national histories vary, however, the need or desire for individuals seeking medico-surgical intervention to partner with medical professionals is common. Increasingly, though not unproblematically, trans health is becoming a transnational issue, and there is a world of alternative narratives of adversity and support, collaboration and contention.[2]

Though the texts included in this issue are wide ranging in their critiques and styles, we want to acknowledge their limited geographic and historical scope. With the exception of Joshua Franklin's ethnography of trans women confronting and making use of publicly funded surgical procedures in contemporary Brazil, all the pieces in this issue are situated in anglophone countries with a shared British colonial history: the United States, Canada, and Australia. These pieces, therefore, represent a narrow window into the practices and discourses of a mode of bodily intervention that happens in many forms throughout the world. We are unreservedly pleased, however, with the high quality of scholarship and variety of insights collected here, while nonetheless aware of the considerable breadth of perspectives, histories, subjectivities, practices, and dynamics that remain

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unrepresented. Our hope in this issue is to invigorate a scholarly discussion of surgical practice, while acknowledging that any such discussion will be incomplete until it is enriched and challenged by those whose voices are too often left unheard.

Thematic Concerns

What are we talking about when we designate some surgeries as "trans"? Is it a certain set of procedures that we reference? Or a particular subjective end toward which those procedures are aimed? Is it a question of legal or institutional legibility? The articles in this issue, taken together, show "trans surgery" to be a category straining against the profusion of possibilities generated by the conjunction of its constituent terms: *trans* and *surgery*. It is not surprising that it is hard to pin down just what "trans surgery" is or what might be counted as an instance of it, nor is it surprising that the stakes for doing so would be so high. What any person or institution means when they invoke *trans* as an identity, category of person, mode of politics, body project, subject of intervention, or means of thinking is constantly in flux (even orthographically, as is demonstrated by the variable use of *trans*, *trans-*, *trans**, and *transgender*). And though we can simply define *surgery* as the manual craft of altering bodies to relieve afflictions (see Cressida J. Heyes and J. R. Latham in this issue for a complication of this framing), defining its relationship to *trans* is not so simple. The diagnostic entity *transsexualism* emerged as one constituted by surgical desire (Benjamin 1954). But while clinical discourses held a monopoly over both the definition and treatment of transsexuals for decades, inscribing and reinscribing desperate surgical demand as its defining characteristic, clinicians' voices are no longer the only ones heard on the matter. If surgery is used to treat, ameliorate, or cure, what kinds of treatment is it enacting, and for what kinds of affliction? Is surgery a strategy for accessing resources such as legal standing or sex-determined labor or kinship practices, or a means through which to make a claim to them? As the articles published in this issue demonstrate, there are many ways of answering these questions, and the answers are both conditioned by and help to produce a range of ethical, institutional, and deeply personal realities.

In This Issue

In "When Building a Better Vulva, Timing Is Everything: A Personal Experience with the Evolution of MTF Genital Surgery," Sandra Mesics recalls a surgical team's "cold and dismissive" response to her pursuit in the mid-1970s for post-vaginoplasty orgasmic function. In "Busting Out: Happenstance Surgery, Clinic Effects, and the Poetics of Genderqueer Subjectivity," J. Horncastle puts forward a poetics of selfhood to counter the difficulty of asserting desire for a non-gender-normative body within clinical contexts that compromise agency. In "Surgical

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Subjects and the Right to Transgender Health in Brazil," Joshua Franklin deems Brazil's legal guarantee of genital surgery to trans people to be insufficient for satisfactory life outcomes because it elides crucial social and economic dimensions of stigmatization and discrimination. In "Medical Transition without Social Transition: Expanding Options for Privately Gendered Bodies," Katherine Rachlin insists that a "real-life experience" is not only detrimental but also irrelevant to those patients who seek to alter their bodies but not change their social or legal gender. In "Trans Surgeries and Cosmetic Surgeries: The Politics of Analogy," Cressida J. Heyes and J. R. Latham oppose the tendency to cast trans people as sufferers to support an argument for psychiatric medical necessity to obtain gender surgery. Although they allow for the benefit of some gatekeeping process, they insist it should not exceptionalize trans people's relation to suffering and gender and norms or their access to surgery. How health-care professionals understand and negotiate clinical encounters, including approval for surgery, is the central matter of Riki Lane's article, "'We Are Here to Help': Who Opens the Gate for Surgeries?"

All the articles share the perspective that trans and gender-diverse patients seek access to treatment free from pathologizing scrutiny, while acknowledging that treatment providers need to assure themselves that they are not enacting harm and that they can protect themselves against charges of malpractice for competently performed surgeries in the event of patient regret. Beyond that, each article pursues a methodologically and topically distinctive focus.

Within her personal testimony, Mesics points to a grassroots network of gathering and sharing medical information in the 1970s. This was important in her situation because many surgeons still considered a transsexual woman's sexual pleasure secondary to the goal of visible morphology or, worse, clinically irrelevant. The active peer network that informed Mesics surgical encounters was also important because proactive tracking of surgical developments and studious involvement in the production and circulation of medical knowledge prefigured today's community health care.

Interviewing a variety of clinicians at the Monash Health Gender Clinic, Lane examines how clinical protocols and attitudes have changed eight years after the clinic was briefly closed, owing to two postoperative regret–related lawsuits. Lane finds that many doctors have reduced their reliance on mental health workers' diagnoses of gender dysphoria for protection against lawsuits, and they resist being characterized as gatekeepers. Indeed, some openly expressed what could be called "doctor's regret" at having denied surgery to certain patients under past guidelines. Without ignoring the experiences of trans and gender-diverse people, Lane inquires into the experience and thinking of health-care professionals, facilitating what Havi Carel and Jane Macnaughton (2012) term

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"second-person perspective." They remind us that an examining doctor oscillates between positions of objective observer and experiencing subject, just as patients do in their own way. Emphasizing this subjective component may make doctors more approachable to patients. Lane's article encourages doctors and patients to "coproduce" clinical encounters in ways that can rebalance the power dynamics and improve the experience for all concerned.

In a different way, Horncastle confronts questions of categories, aims, and techniques when undergoing mastectomy as part of cancer treatment. Horncastle relates their experience of a "happenstance" clinical trajectory that "devoured rather than understood" their thinking about gender and health care. Although critiquing medical care practices, they do not advocate resistance here. Rather, they ask, "Where else can the nonnormative subject turn for succor?" Their answer is poetics. Horncastle turns to poetics as a means of claiming back a body whose legibility was made precarious through attenuated and unstable relations to protocols and permissions, and the struggle to make themselves understood to clinicians caring for a cancer-stricken and genderqueer body. From a personal and medical experience not coincident but rather peripheral with trans, they redeploy theorization for restoration, to create a "landscape that in turn provides succor."

Rachlin encounters the tensions and inadequacies of guidelines tuned to an understanding of "trans surgery" as the physical component to a simultaneously social transition, and contends with what that narrow framing means for clinical relationships, patient experiences, and collective politics. Rachlin sidesteps politics in her advocacy for trans diverse subjects not often included in the "umbrella" of trans identity politics (Davidson 2007). Those who seek gender-affirming surgery but decline trans visibility as such can be both inadvertently and deliberately excluded from scholarship on trans medical care. However, their case foregrounds an important but underemphasized role that psychologists fill in the surgical process. For decades, trans-friendly psychologists, social workers, and other mental health professionals have not just assessed patient suitability for surgery but also effectively facilitated access to surgery for their patients (van Eijk 2017).

For the trans women interviewed by Franklin, whose needs and goals relevant to postoperative employment and social proficiency are not attended to by Brazil's regimented national health care, it is the mandate rather than the availability of counseling that is punitively disrespectful. Franklin describes interviewee Laura, who felt her two years of group therapy had been important, but whose steadfast optimism frustrated the clinical team. Franklin asks, "What does it mean to desire *too much*, and what does it mean when clinicians point this out?"

Heyes and Latham argue not only against a disciplinary psychiatric diagnosis but also against a political use of psychology that situates a problem within

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trans individuals instead of problematic systems. They parse the rhetorical strategies by which "cosmetic" and "trans" surgeries are made to be analogous or disanalogous, showing how the relationships between these modes of surgical intervention implicate historical, economic, therapeutic, and moral framings of each, and how their valence relies on the precarious figure of "suffering." In their sophisticated analysis of trans ressentiment, they caution that an investment of suffering into trans subjectivity misses the wider range of trans experiences as well as many reasons and paths toward surgery.

The essays in this issue offer more information and critical deliberation than we can summarize here. Our hope is that this special issue supports and incites further research and writing on trans and gender-nonconforming surgery and helps us to see new ways to think of it and to ask after it—whatever *it* is. We thank our contributing authors for their intellectual work. We also thank *TSQ* general editors Susan Stryker and Paisley Currah, editorial assistant Abraham Weil, and the many scholars who generously reviewed submissions, offering even those not published here attentive readings and productive criticism. We appreciate all these gifts to the scholarly project.

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Notes

1. The practice of transforming social status via surgical alteration of sex characteristics began long before the modern notion of "changing" sex to an opposed category. Surgeries that changed social status include circumcision; castration; penile subincision; cutting of the vulva, labia, and clitoris; vaginal obliteration; and interventions that alter internal organs' reproductive capacity. Dating the advent of surgical sex reassignment to "nearly one hundred years ago" names the first known instance of a procedure performed in which both patient and surgeon shared a common aim that the performed procedure would alter the sexed body parts—and so sex status of the requesting individual—from one binarily conceived sex category to another (Abraham 1931).
2. For a review of international research by topic, including a discussion of the challenges of "global" research on a group whose definition is not globally shared, see Reisner et al. 2016.

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