

Making the Gendered Face:
The Art and Science of Facial Feminization Surgery

By

Eric Douglas Plemons

A dissertation completed in partial satisfaction of the
requirements for the degree of

Doctor of Philosophy

in

Anthropology

in the

Graduate Division

of the

University of California, Berkeley

Committee in Charge

Professor Cori Hayden, Chair

Professor Lawrence Cohen

Professor Charis Thompson

Spring 2012

Abstract

Making the Gendered Face: The Art and Science of Facial Feminization Surgery

By

Eric Douglas Plemons

Doctor of Philosophy in Anthropology

University of California, Berkeley

Professor Cori Hayden, Chair

Early surgical procedures intended 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 these organs as the means by which "sex" could be changed. However, in the mid-1980s a novel set of techniques was developed in order to change a part of the body that proponents claim plays a more central role in the assessment and attribution of sex in everyday life: the face. Facial Feminization Surgery (FFS)—a set of bone and soft tissue surgical procedures intended to feminize the faces of male-to-female transsexuals—is predicated upon the notion that femininity is a measurable quality that can be both reliably assessed and surgically reproduced. Such an assertion begs the questions: What does a woman look like? What forms of knowledge are used to support a claim to know?

This project examines these questions through ethnographic research situated in the offices and operating rooms of prominent American surgeons who perform FFS. I explore the tensions between two different forms of knowledge that surgeons rely on and appeal to in the identification and surgical reproduction of femininity: scientific and aesthetic. The status of "the feminine" at work in Facial Feminization is one that sometimes finds its sense through a link to the biological category of "the female" and other times describes the aesthetic category of "the beautiful." Though the tension between the female and the beautiful is one that is well worn, it is complicated here by the long-contested ethical and medical status of the transsexual body as a site of sex changing interventions. FFS unfolds at the edge of an ongoing history that draws the contested medical and ethical treatment of trans- bodies into the rapidly changing field of contemporary trans- medicine in the United States. My analysis of FFS, engages with this history and to show how its invocation and articulation in the present gives shape to the ethical and practical dynamics at work in the clinic.

From examinations to final sutures, I show how the distinct histories and epistemologies involved in FFS create new forms of knowledge about the feminine body and, in the process, new ways of conceiving of and living in the transsexual body.

Table of Contents

Acknowledgements	ii
Introduction	iii
Chapter 1 Making the Gendered Face	1
<i>The Procedures</i>	32
Chapter 2 “Facial Feminization Surgery Is Different”	36
Chapter 3 The Market in Beneficence	62
<i>Celebrate!</i>	97
Chapter 4 The Clinical Examination	100
Chapter 5 On Race and Resemblance	125
<i>My Adam’s Apple</i>	146
Chapter 6 The Operating Room	149
Chapter 7 And After	167
Bibliography	183

Acknowledgements

Above all, my sincerest thanks go to the patients and surgeons with whom I worked on this project. Their honesty and generosity consistently reached far beyond my expectations. The graciousness with which they shared their spaces and their stories was invaluable to me both as a scholar and as a human being. The things I learned through the research and writing of this project surprised me often, and there is far more than can fit into the document that follows. My hope is that I have done a measure of justice to the complexity and richness of the people and things that I witnessed during my research. My apologies, in advance, for where I have fallen short of this goal.

I have been fortunate in this project and throughout my graduate career to have the mentorship and advice of some truly outstanding members of the faculty at Berkeley and beyond. My thanks go to Juana Maria Rodriguez, Sharon Kaufmann, Sabrina Agarwal, Cathy Gere and Rachel Prentice for their interest and assistance in thinking through parts of this project. A special note of thanks goes to the members of my dissertation committee—Charis Thompson, Lawrence Cohen and Cori Hayden—each of whose comments and conversations made me think harder and so made this product better.

This project has also benefited from many hours of thoughtful reading and discussion with my graduate student colleagues. Thanks to Theresa MacPhail, Antony Stavrianakis, Emily Chua, Nick Bartlett, Xochitl Marsilli Vargas, Liz Kelley, Martine Lappé, Allison Tillack, Mara Green, Chris Roebuck and Katie Hendy.

Finally, a special word of thanks to my family for their unwavering and long-suffering support of my academic and personal efforts. None of this would have been possible without the loving support and encouragement (in all its forms) of my wife, Anne. I am told that dissertations are not typically dedicated. But whether or not it is officially so, this one is dedicated to you. We did it, Annie!

Funding for this project was provided in part by a Wenner-Gren Dissertation Research Grant and a Dissertation Year Fellowship from the Berkeley Center for the Study of Sexual Cultures.

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.

—Dr. Harry Benjamin¹

Krista had just completed a five-day post-operative exam when she agreed to sit down to talk with me. She moved slowly down the short hallway of Dr. Howard's office, her tall, thin frame balanced on the shoulder of her friend, Mark. He had driven her to the appointment, leafed through magazines while Howard examined the progress of her healing, and now guided her tenderly into a chair opposite me. Fresh white gauze bandages wrapped around the crown of Krista's head, down over her cheeks and under her chin. The short, strayed 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 the progress of her recovery, she had not wanted to be in this situation. In fact, she had actively tried to avoid it. A few years prior, while attending a large conference for trans- people, she had seen Dr. Howard give a presentation on "the ten traits of a male face." Newly aware of these characteristics, she set about systematically trying to camouflage each of these aspects of her own face without the surgery he recommended. She covered her forehead with long, straight-cut bangs. She covered her nose and brow with bulky eyeglasses. She experimented with make-up to accentuate some features while minimizing others. 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 20 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."

Long before arriving in the surgeon's office Krista had spent a great deal of time and effort working to cultivate a gendered body and aesthetic that were recognizable to those around her. Like most Americans today, she had made a lifetime of choices about hairstyles and clothing, diet and exercise, comportment and behavior that were structured, in large measure, to convey to others a sense of how she felt about herself. As a transsexual woman—who was born male and later sought the help of physicians and surgeons in order to make physically manifest her sense of herself as a woman—getting

¹ Benjamin 1954:228.

others to recognize her as the woman she knew herself to be was not easy. Despite adopting the behaviors and aesthetics that many other women use to signify themselves as such—long hair, curvy jeans, fashion jewelry and shoes that looked better than they felt—Krista was often recognized by others to be male. But not only male. She was visible as a male *trying to look female*. In other words, she was visible as a trans- woman.

Being recognized as trans- was, in and of itself, not a problem for Krista. She had come to terms with this aspect of herself and had chosen to be open about her identity with many people in her life. Whereas some trans- people prefer to keep their former identities private, Krista intended to be out as a transwoman. But she wanted to be out on her terms, to be in control of this information about herself. And, in her opinion, her masculine face was spoiling the possibility of realizing this desire. No matter how much and in how many ways she presented herself as a woman, when people saw her, they saw a man. So long as this was the case, she felt that she could never truly be what she ardently wanted to be: a woman in the world. This desire had led her to Dr. Howard.

Dr. James Howard² developed the procedures now known as Facial Feminization Surgery (FFS) in the mid-1980s in response to a patient request (this story is told in Chapter One). Since that time Howard has become synonymous with the practice, having, at the time of this writing, performed nearly 1,600 FFS operations—far and away the most of any surgeon in the world. Though he continues to perform other cranio-maxillofacial reconstructive and elective surgeries in his solo private practice, FFS patients constitute roughly 80% of his clientele. And demand is steady.

When I met Howard for the first time, he explained FFS as a procedure whose necessity is both commonsensical and self-evident. This explanation was delivered, in part, through the use of a Bloom County comic depicting three cartoon characters pulling out the waistband 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 gender they are. You look at their faces,” he explained quite plainly. Indeed the absurdity of the comic helps to punctuate this truism, and to make it clear that any other model of the formulation of social sex is, itself, comic.

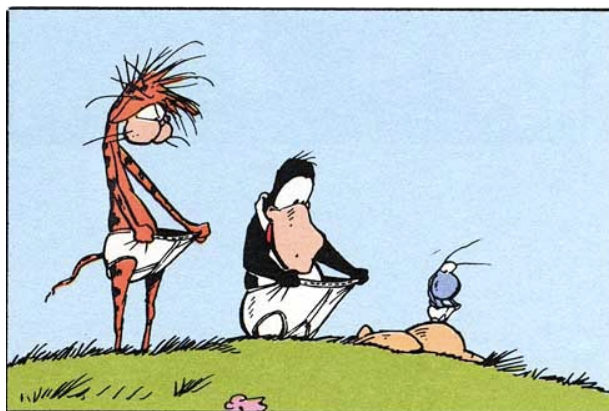


Fig 0.1. Bloom County comic that Howard uses to demonstrate his assertion that, “You don’t walk down the street looking in everyone’s pants before you decide what gender they are. You look at their faces.”

² All names of patients and doctors are pseudonyms, except those cited in published works.

Genital sex reassignment surgery (GSRS),³ the operation most commonly associated with transsexual transition and the one that is typically taken to constitute a “change of sex,” is a significant undertaking that unquestionably enacts a meaningful change in the body. But in terms of changing how others recognize and respond to a person’s embodied gender in everyday social life, the impact of GSRS is exactly nil. The genitals remain hidden in the vast majority of social interactions. If what a transwoman ultimately wants from the medico-surgical interventions grouped under the sign of “transition,” is to be recognized by others as a woman then, Howard asserts with absolute certainty, the most dramatic and meaningful change that she can undergo is not focused on this hidden part of her body, but on that part that others see the most: her face.

What sets FFS apart from other, more commonly performed surgeries intended to feminize the face—such as facelift and blepharoplasty (eyelid surgery)—is its focus on the modification and reconstruction of facial bones as well as soft tissues. Bones provide the underlying structure to the face and, in FFS discourse, are the site in which essential claims to femaleness reside. While soft tissue changes are an essential part of FFS, the desired effect of “feminization” is generally considered to be impossible to achieve through soft tissue procedures alone. Surgical discourse makes it clear that skulls are not neutral structures upon which sexually differentiated soft tissues are draped (cf. Schiebinger 1987). Instead, it is the skull itself that provides the architecture of facial sex difference. Altering the soft tissues without changing the male characteristics beneath them would leave a patient looking “like a man with a facelift,” one patient told me emphatically. Krista’s face, now bolstered by wraps, sutures, casts and drains, had undergone much more than a nip and tuck.

What patients wanted—what they saved for, sacrificed for, and sometimes traveled thousands of miles for—was to look like women. I met Rosa directly following her initial consultation (which was also her pre-operative appointment; her surgery was scheduled to take place the following morning). When I asked her why she had chosen to travel all the way from Italy to have surgery with Howard as opposed to undergoing surgery with any number of accomplished surgeons in Europe, she answered succinctly.

Other doctors just do plastic surgery. They’ll give you Botox in your forehead or change your nose, but no one does the real work that we need except Dr. Howard. I came here because he is a pioneer and he is the best in the world. I don’t want to look like a transsexual. I want to look like a woman.

Rosa’s sentiments reflected the goals of nearly every patient I met while conducting a year of ethnographic fieldwork in Dr. Howard’s office. While their motivating desire could be simply stated—“I want to look like a woman”—accomplishing that end is quite

³ This surgery is referred to by many different names, each of which carries distinct political stakes. Other than SRS, the most common terms used are Gender Reassignment Surgery (GRS), Gender Confirmation Surgery (GCS) and Gender Affirmation Surgery (GAS). Etner, et al., differentiate SRS from GRS (and by extension GCS and GAS) by explaining that SRS typically deals with the genitals while there are many other surgical interventions—such as the creation or removal of breasts, or the restructuring of the face—that have a greater impact in patients’ gender attribution than do the genitals (2007: 90). Though I think the implied substantive distinction between sex and gender in this formulation could use some productive troubling, I am adopting their line here. Because my discussion of these surgeries focuses exclusively on the genitals, I use the term GSRS.

a complex endeavor. Its complexity comes not only from the technical surgical work itself, but from the fundamental problem of its formulation: how to turn a social category, “woman,” into a technical possibility such that it can both be recognized and surgically reproduced. What, in short, does a woman look like? What kinds of knowledge are used to support a surgeon’s claim to know?

This dissertation offers a response to these questions that moves far beyond an examination of the procedures themselves. FFS relies upon and helps to produce multiple forms of knowledge—surgical, scientific, anthropological, and aesthetic primary among them. Through fieldwork in the offices of two surgeons—Dr. James Howard and Dr. Mitchell Page, a plastic surgeon who has recently begun to perform FFS—I examine how discourses of “science” and “aesthetics” differentially structure surgeons’ claims to both recognize and reconstruct “the feminine” in this growing contemporary practice. Indeed a tension that runs throughout my analysis of FFS both as a concept and as a practice, is the conflicting definition of “feminization” itself. Sometimes a biological category and sometimes an aesthetic one, appeals to the evidence and epistemologies of each of these discourses are strategically deployed by doctors and patients as they work to communicate their goals, experiences and expectations of what these surgeries can and will do. I will demonstrate that these different epistemological frameworks yield not only different claims to what a woman looks like, but also distinct understandings of the project of transsexual transition itself.

The story of FFS unfolds, in large part, through its relations with multiple contested histories, including those of physical anthropology, gender and race science and, most particularly, that of trans-specific medicine in the United States. I will show how the invocation of this history and its articulation in the present help to shape the ethical and practical dynamics at work in the surgical clinic. My hope here is to both draw meaningful attention to the complex interconnections of the forms of knowledge, ethical commitments and personal experiences that come together in the practice of FFS, and to consider how attention to these manifold dynamics can help to reframe extant discourse on the materiality of the trans body.

The materiality of the trans- body has been a persistent problem in feminist and queer theorizations of gender over the past several decades. At issue has been a struggle to define what a “woman” is in relation to the physical characteristics of a female body.⁴ The contested status of “woman” as an embodied reality, a felt sense of oneself, the product of socialization, or some other kind of essential property has cast a doubt on whether someone born male can ever really “change sex.” I suggest a reframing of the stakes of the “problem of the trans body” anchored by the assertion that FFS is not ancillary to genital sex reassignment surgery, but is itself an enactment of sex change—albeit a different kind of sex. In this analysis I aim to work through theories of the discursive production of sex and gender that have dominated gender theory in recent decades, to suggest a reading of the materiality of the trans body that is empirical but not essentialist. This is a distinctly anthropological engagement with the subject that is rooted in my fieldwork with surgeons and extensive interviews with transwomen undergoing facial surgery. From examinations to final sutures I show how the distinct histories and

⁴ While these concerns apply to “men” and male bodies as well, the focus of feminist writers on the constitution of the category “woman” has dominated much of this literature.

epistemologies involved in FFS create new forms of knowledge about the feminine body and, in the process, new ways of conceiving of and living in the transsexual body.

Doing Gender in the Clinic

The clinical interaction is a kind of distillation of the knowledge about and experience of gender as a property of the body. Here, patients' experiences of "being read" as male are externalized from the realm of the subjective and individual experience of gendered embodiment into the ostensibly objective medicine and science of human difference. To be sure, the modes and objects of clinical knowledge cannot and do not represent all—or even most—ways of knowing the body as a social object. They do, however, exert an extraordinary influence on the ways in which bodies are understood and acted upon in the contemporary moment. This is all the more the case in relation to the project of medically mediated transsexual transition. Medical and surgical interventions intended to enact a physical change of sex—whether that be located in the chemistry of the sex hormones, the patterns of body hair, the thicknesses and vibrations of the vocal chords, or the external morphology of the genitals, chest or face—are premised upon the notion that indicators of bodily sex are stable, identifiable and essentially dimorphic. These specific surgical interventions itemize and control gender, making it into a (matching) set of corporal properties. Operationalizing these fundamental assumptions, the processes of medico-surgical transition work to change "one" sex into "the other." This goal reflects both the express desires of the patients who undergo these various procedures, as well as the broader "incurable proposition" (Garfinkle 1967; Kessler & McKenna 1978) that human beings come in two discretely defined sexes: male and female. The neat totality of these oppositional sex categories masks a considerable inter- as well as intra-category variation in all of the ostensibly "sex specific" categories above as well as countless others. When it comes to sex, differences are more important than commonalities (Epstein 2007; Fausto-Sterling 2000; Lorber 1994). This is certainly the case in the project of medico-surgical transsexing.

While the clinical encounter does offer a necessarily limited and particular point of view on FFS, I would argue that it is, at the same time, a privileged one. It is to the surgeon that these patients turn when all of their other, often extensive, efforts to be recognized as women have fallen short. It is here that the ineffability of "femininity" is translated and rendered communicable through images and numbers. Here that the elusive attribution of "woman" becomes a thing to be transacted, a set of techniques to be performed. In the clinical encounter, surgeons come to stand for—through their claims to (differently) represent—what everyone else will see in the post-operative face. Sometimes these claims take specific form ("the delivery man will call you ma'am") and other times they take general form ("you'll be able to pass as a woman whenever you choose to"). In both cases, surgeons promise that a future form of the face will affect a new social reality. Through the weight and lexicon of medical expertise, surgeons transform patients' faces into quantifiable, communicable measurements of sex, and then return them to the ratification of experience. In the clinic, the surgeon *sees* what must be done in order that once the patient leaves the clinic everyone else *will see* a woman.

In this story, the body is a practical impediment. In the clinic, FFS is not about how the patient experiences her gender or her body; *it is about her knowledge of how*

others experience it. This knowledge of others' perceptions is often gained the hard way: through enduring stares, shrill insults, social isolation and physical violence. It is what she comes to know about her body through the responses of others that brings the patient into the surgeon's office.

What Patients Want

Just as Krista described her need to change her face in order “just to leave the house,” most of the 28 patients with whom I conducted interviews and observations, and the many others with whom I shared casual conversations, explained their desire for facial transformation in order to carry out everyday activities. As much as patients might want to be beautiful women after surgery, their primary desire was to walk through the world being recognized as women—which, in a sense, meant not being recognized at all. But just as physician discourse often conflated or collapsed the biological category of the female with the aesthetic category of the beautiful when describing the aims of feminization, so too did patients draw on both of these notions when communicating what their goal of being a woman actually *means*. *Woman* is difficult to define as a surgical category precisely because it is difficult to define as a social one. Not surprisingly, patients had different ideas (and ideals) in mind when they imagined the kinds of transformations that would allow them to be the kind of women they wanted to be.

When I asked Rosa if she had a particular idea of what she hoped to look like after surgery, she immediately said, “Yes,” and reached into her bag. She pulled out a stack of papers wrapped in plastic sleeves and held together by a binder ring. She shuffled through the stack, unfastened the ring, and put a page on the desk in front of me. There were three photographs that had been clipped from magazines and pasted to a sheet of white paper. As she began to talk I was not sure which one I was supposed to be looking at. “I want to look like a woman,” she began.

I want a face that a man falls in love with. Like an angel. Innocent. You are a man. You understand. Look at her [pointing to an image on the page.] What do you feel? Body is nice, but look at her face. In that picture you can't see her breasts, but you can see her face. *She's beautiful*. You feel inside something like love. I want a face that a man sees and it makes him turn red.

Rosa was not sure what her particular features would be when all was said and done. She did not expect Howard to replicate the model's face onto hers. She did, however, expect that her face would be one that would do something for others and, in turn, do something for her. Rosa described the changes she was after in terms of how particular aspects of her face evoked gendered attributes. When our conversation turned from the effect she desired to the precise means of achieving that effect, she gave an inventory of her face and the multiple ways that it works against her.

The bone above my eyes gives me an aggressive look. I have dark, shadowed eyes. If you see that actress Hillary Swank, she has this. Something doesn't match on her face. Nose, obviously. My nose is male. Upper lip. I can't wear red

lipstick. If I wear red lipstick it makes me look like a man in a dress. When I watch videos of myself, my expressions never look happy. I look angry.

Rosa was confident that following surgery she would “feel more sure of [her]self.” It was this confidence that made women beautiful. Just something about them that had such power and sex appeal. Women, in her telling, were not aggressive or angry; their faces are built to be adorned. Though she knew that Howard could not necessarily make her beautiful,⁵ she was confident that he could make her a woman. For her, that was enough.

Gretchen had much more modest desires. Her hopes for surgery were less about eliciting a particular response, than avoiding a reaction altogether.

Just... I hope that I won't have this kind of jerk that was sitting just to my left on the plane this morning who was seemingly horrified by seeing this [gestures to her face and body]. He was probably having the idea that I was fantasizing about him or something. I just hope that next time, he won't think about it twice. 'Yes, I'm sitting beside a girl. So what and that's all.' End of story.

Pamela expressed her desires this way:

I'm doing it [having FFS] so I will feel that I "pass" [making air quotes]. Whatever that is. And of course the operative word there is “feel.” I'm tired of thinking, is that person reading me? No? Well how 'bout that person? I want to think about something else as I walk down the sidewalk.... Like, say, what a nice dress in the window. Maybe that's it.

Going unnoticed is a thing that most people take for granted. Erving Goffman (1963) called those who do not draw unwelcome attention from their bodily appearance “normals.” Normals, Goffman argues, simply cannot understand how it feels to be the object of derisive looks and hostile attention from complete strangers. To be a member of a stigmatized group is to be the object of disdain. When some aspect of your physical body is the source of that stigma, there are, according to Goffman, two possible responses. You can come to terms with the fact of your stigma and attempt to “normificate” it by acting normal, as though the stigma did not exist. Or, you can normalize it by making a conscious effort to correct it. Though “norming” surgeries are sometimes the objects of ethical debate,⁶ the validity of the desired outcome is hard to dispute. In an article entitled, “Self-Help for the Facially Disfigured,” Elisabeth Bednar put the matter simply.

Whether we are shopping, riding the subway, or eating in a restaurant, all of which are casual day-to-day social encounters, there is the initial stare, then the look away, before a second, furtive glance inevitably puts the beheld immediately in a separate class. For those who experience this discrimination, the question of the moral justification of surgery to increase societal acceptance is

⁵ She pointed out photographs in Howard's book in which surgery did not necessarily improve a patient's attractiveness, but it did change her sex. When referring to before and after photographs she said, “See this is an ugly boy and this is an ugly girl, but it is a girl. Other doctors can't do this.”

⁶ I take up a discussion of this in Chapter Two.

merely rhetorical. There can be no greater wish than to melt into the crowd or to walk into a room unnoticed (Bednar 1996:53).

The patients and surgeons with whom I worked, referred to the fact (or fantasy) of going unnoticed as “passing.”

The language of passing is contentious for some transpeople because it can be read as implying a sort of deception; being taken as a member of a group to which one does not *really* (where *really* refers both to an ontological truth and to the rightful membership based on it) belong. This deception is also often marked by a supposed opportunism; passing is really only considered as such when a person passes from an undesirable group and into a desired one (Gilman 1999). It therefore frequently carries a connotation of a strategy to access particular forms of privilege. Many transpeople object to the language of “passing” because, they argue, to say that one “passes” as a woman is to acknowledge that “woman” is not a category to which she rightfully belongs. As Julia Serano insists, “I don’t pass as a woman. *I am a woman*. I pass as a cis-gendered woman” (by which she means a woman who has never changed her gender).⁷

These sorts of concerns about what it means both politically and ontologically to pass, were only voiced by two of the patients with whom I spoke. Despite their reservations, they, like all other patients I met, held the desire to pass as an incredibly important and explicitly stated aim. As historian of medicine Sander Gilman explains, “The happiness of the patient is the fantasy of a world and a life in the patient’s control rather than in the control of the observer on the street. And that is not wrong. This promise of autonomy, of being able to make choices and act upon them, does provide the ability to control the world. It can (and does) make people happy” (1999:331-2). Like language, social roles do not exist in isolation (Wittgenstein 1953:§243); they are by definition shared properties conveyed between people in given social group. A person’s individual conviction that she is a woman is not enough to make her a woman in any social sense. To be a woman requires not simply the conviction that one is a woman, but the recognition of that status by others. FFS is a surgical recognition that how one feels about and lives their sexed and gendered embodiment is not a private, psychic reality, but is the product of social life, of living with others. Passing is not a subjective act; it is a social one.

Nearly all clinical literature as well as most popular literature on transsexualism suggests that transsexualism is a property (and problem) of an atomized and bounded individual. This focus on the individual and psychic nature of the bodily dissatisfaction that characterizes transsexualism is named explicitly as well as through the invocation of metaphors of isolation, internality and invisibility. While an individual body may be the site of the material intervention, the change enacted in FFS takes place irreducibly between persons. The efficacy of FFS is located not in the material result of surgery itself, but in the effect that the surgical result will produce in the perceptions of imagined

⁷ Other writers argue that the goal of “passing” not only obscures but effectively forecloses any possibility of a trans-specific radical political subjectivity (Bornstein 1994, Green 1999, Stone 1991). These writers insist that living as out trans-people is the only way to call attention to the oppressive gender system that devalues and delegitimizes trans-lives and bodies, among others. This kind of visibility can come at the great cost of personal and emotional safety, leading to a conflicting desire to be a part of the solution while maintaining ones safety and sanity (Green 1999).

others. Perhaps nowhere is this made clearer than in the imaginary scene through which Howard explains the goal of his surgical work:

If, on a Saturday morning, someone knocks at the door and you wake up and get out of bed with messy hair, no makeup, no jewelry, and answer the door, the first words you'll hear from the person standing there are, "Excuse me, ma'am...."

This incredibly powerful scene was a staple of Howard's conference presentations, and was repeated in slightly altered and personalized forms by many of the patients who had selected Howard as their surgeon. Through this turning outward—and the making of femaleness at the site of the exchange with a stranger—FFS reconfigures the project of surgical sex reassignment from one rooted in the private subjectivity of the genitals, to one located in the public sociality of the face.

Time after time, patients told me that their primary desire was to go through their daily lives and be left alone, without thinking about what others may see when they look at them. Krista rode the city bus on the day before our interview. On that day, for the first time in recent memory, she did not prepare extensively before leaving the house. "I didn't have to worry about having my bangs just right, or having just the right pair of glasses on. I just got on the bus and thought, 'Wow, this is cool.'" Although her face was covered in bandages, sutures, and bruises, and people on that bus were undoubtedly looking at her, Krista found joy in the certainty that whatever they might have seen when they looked at her, they did not see a transwoman. The stuff of her maleness was gone. It was a novel—but so, so welcome—experience.

It is important to remember that the stakes for passing are often quite high, often quite serious. The desire to pass does not only exist for the gratification of personal goals, but also achieves a mode of physical and emotional safety. It is crucial to remember that trans- people are disproportionately incarcerated, unemployed, and lost to suicide and other violence. I make this point not to hold counter discourses hostage to its message—as in an accusatory stance from which any divergence is a de facto support of transphobia or worse—but to tell the complete story of the context in which these procedures become objects of desire, and accomplish practical goals sometimes on the measure of life and death.

The Materiality of the Body in Gender Theory

The materiality of the trans- body has been a consistent problem in queer and gender theory, a body of literature that has, for the last thirty years at least, found its grounding in the abstractions of literary and linguistic theories. If we read the radical uncertainty and total constructionist understandings of sex and gender represented in this literature as a poststructural response to the certainty of modernist and foundationalist claims to knowledge, then it should not be surprising that these interventions also need some tempering. As Andrew Sayer has noted, "If the only choice is between either regarding objects as having essences fixed for all time or conceptualising [sic] them as merely transient or even ephemeral... then most social phenomena, which lie in between these extremes, will be occluded" (as quoted in Hull 2006:3). My aim here is not to argue against the theories of discursive and performative gendering, but to take seriously the problem of the material body—for the surgical body is stubbornly material.

Judith Butler's (1990) formulation of performative gendering fundamentally changed the field of gender theory. While the Austinian performative speech act on which her theory was largely based was demonstrated through examples of institutional forms of authority (employment, state contracts, ceremonial naming, etc), Butler's performative occurs within a Foucaultian analytic of power as diffuse and capillary. In Butler's work, the naming and enacting power of the performative utterance shifted from the concrete institution—the state, the employer—to the abstract but totalizing heteronormative matrix. Rather than administrative and top-down, here power is fundamentally a thing that circulates and works horizontally at least as well as vertically. What the analogy of linguistic performativity facilitates in relation to theorizing gender is an acknowledgement that gender only happens—or, in other words, manness and womanness is only conferred or made recognizable—in relation to other existing modes of knowledge and authority. Established means of recognizing gender exist before each of us becomes an instance of one gender or another; these are the means by which we become recognizable as a gendered at all. In this framework, Butler can argue that gender is, essentially, what we say it is. It is not given by nature, nor does it emanate from the body directly as an essential or pre-determined property. For her it is crucial to see that there is no *there* there; no real origin—neither physical nor psychical—from which interpretations necessarily flow.

This turn has been read as both a positive and a negative one for trans- folks. Positing the body as an effect of discourse denies its status as prior to social and subjective knowledge. So, too, does the derivative reading of Butler's intervention: conflating linguistic performativity with theatrical performance. Though Butler herself has argued that the interpretation of her argument as one advocating a theatrical performance is a misreading, this kind of theorization gained a great deal of traction in the years immediately following the publication of *Gender Trouble*, drawing, in the early 1990s, a focus on the body's surfaces. Theorized as performance, gender was a volitional project, something that a willful subject could actively choose to do and undo. Like fashion, gender was play; it could be put on and taken off, artfully constructed by a willing (and well ornamented) subject (Bornstein 1992; Garber 1991). In this frame, transsexualism was a self-fashioning project in which the *self* in question was literalized to the body. Through the election and acquisition of hormonal and surgical interventions, the body itself could be redesigned and rewritten, shed and changed (cf. Bornstein 1992).⁸

Many transsexual writers have found fault with both the gender-as-performative and gender-as-performance positions, largely on the grounds that they inadequately theorize the specificity of the material body.⁹ These critics claim that reading the body either as radically contingent (as in theories of performativity) or as a neutral object whose gender can be willfully donned and discarded (as in theories of performance) elides the specificity of the transsexual experience. Several trans- writers sought to

⁸ See Halberstam (1994) on the dangers of portraying transsexualism as costuming.

⁹ Criticisms against the evacuation of the body were not only leveled by trans- people, of course. Indeed the claim that Butler's theory ignores the material is the one that is most frequently levied against it. Feminist scholar Vicky Kirby describes this position succinctly. "Critics of postmodernism warn against the effects of presuming to dissolve matter in an acid bath of rhetoric, for even if the mediated or constructed nature of reality is granted, the pressing facts of bodily existence still endure. The fear is that if the stuff of matter is problematized, or perhaps even lost, then the anchor of political contestation is also cast adrift" (1997:102).

reassert the primacy of the body on these grounds and argue that trans subjectivity could not be understood without it (Califia 1997, Cameron 1996, Cromwell 1999, Green 2001, Kotula 2002, Rubin 2003). In various ways, these authors expressed frustration with what they saw as the obfuscating abstractions of the very gender theories that were celebrating gender transgression.

The richest of these responses is Jay Prosser's *Second Skins* (1998). Prosser examines transsexual autobiographies with the explicit aim of reconstituting the "material figure of transition" and naming the substance of the transgender image as "unequivocally material" (6). His opening chapter, "Judith Butler: Queer Feminism, Transgender, and the Transubstantiation of Sex," stages the text explicitly in contrast to what he reads as Butler's unmooring of the body through the assertion of the radical constructedness of sex. Prosser formulates a trans- subjectivity that is centrally configured around the contested relationship to its material, corporeal condition. His analysis acknowledges the historical origins of the classic "trapped in the wrong body" narrative, but also asks that we take it seriously. "The image of wrong embodiment describes most effectively the experience of pre-transition (dis)embodiment: the feeling of a sexed body dysphoria profoundly and subjectively experienced" (69). Through the analysis of trans- autobiographies, Prosser argues that being a trans- person *is* a feeling of profound alienation or dissociation.¹⁰ Since it is a problem of the body, it can only be abated through an intervention in the body.¹¹ And that body is one that matters.

Notwithstanding criticisms that Prosser's and others' responses constitute a misreading of Butler's project (Butler 2003, Salamon 2010), the desire to recuperate a distinctly trans- body is one that I think should be taken seriously. If it is indeed the case that there is something irreducibly material to the ontology of transsexualism and/or transgenderism, how can we talk about it? How might we reassert the body without bringing with it the authoritative claims to some kind of pre-discursive naturalness and ultimate "truth" that the turn to discourse was meant to unseat? Gayle Salamon (2010) has argued that the first step toward this goal is to interrogate what we *mean* when we talk about "the body." She turns to psychoanalytic and phenomenological theories to consider how these models offer a way to conceive of transgender body and subject formation that is not based in their status as pathologies or as exceptions meant to prove other, ostensibly more important rules (e.g., Kessler & McKenna 1978). Salamon provides a generative and thoughtful re-reading of these archives, but remains concerned with figuring the body through subjecthood. In other words, for her, the body is always a secondary effect—or symptom—of more fundamental psychical and epistemological realities.

Salamon acknowledges the (above cited) trans- authors' frustration with theoretical abstractions and their call for a treatment of the body as "real" but, in the end, refuses it nonetheless. "It could be protested," she writes, "that we have responded to that call by offering only more linguistic abstraction and speculation, and this objection might not be altogether without merit" (92). Indeed while noting that her turn to Husserl and

¹⁰ In Prosser's formulation this is akin to what Oliver Sacks (1990) has called "bodily agnosia."

¹¹ Pamela, a transwoman with whom I shared many wonderful hours of conversation over a weekend-long conference, was very interested in biological and physiological theories about the origins of transsexualism, "Because it *feels* physiological," she explained.

Merleau-Ponty may be “precisely the dismissal of the real world against which critics of theoretical and philosophical approaches to gender warn us,” she argues that such a view, “misses the purpose toward which such speculative endeavors aim” (91-92). “The phenomenological project is not an attempt to do away with the real world,” she goes on, “but rather to question our suppositions about that world so that we might see it more clearly and utterly” (92). I will note first that Salamon is quite right on this final point. Still, it does not seem to me that she answers the question of trans- materiality that she set out for herself. I would argue that rarely can the world—or a body—be seen more clearly and utterly than when that body is hit by a bottle thrown from a passing car. It is not that thinking through the material conditions of embodiment is somehow *better* than thinking through the philosophical frameworks of its possibility. Rather, beginning from the lived material body as one that is essentially *social* and thinking through the implications of its social life is precisely the call to re-center the trans- body that transpeople themselves have been making. The body in FFS is, if not exclusively material, certainly irreducibly material. It is the body that invites attacks—subtle and overt—from total strangers that patients came to the surgeon’s office to change. They were not there to think gender. They were there to become women, accepting the conditions of possibility that such an act entailed.

I move through these prevailing theories of (trans)gendered embodiment to set the stage of an ongoing conflict. The spaces made for trans- bodies in gender and queer theory after *Gender Trouble* have not always been easy for trans- people to occupy. Models of performativity and performance have each enabled conceptual, political and practical room for trans- folks that earlier reactionary regimes foreclosed¹² but nonetheless, an anxiety about abstraction in the face of the very physical project of transition remains. Mine is not an effort to discipline these theories, but to breathe life into them. It is their perceived lifeless abstracting (and abstraction) of lived bodies that has made them the object of much critique from writers in the last decades, trans- and non-trans alike. I do not aim to refuse or refute theories of performative gendering—for I find these theories not only compelling in themselves, but complementary to the prevailing wisdom of anthropologies of gender at least since Margaret Mead (1935). Instead, I want to work within this theoretical landscape to populate its figures and concepts with people and things.

If it is the case that the body marks a material limit to the discursive production of sex and gender, then identifying the constitution of that limit is a distinctly anthropological problem. By this I mean that how the body is conceived, and in what ways and situations it limits and enables particular sex/gender attributions and assignments is a question that cannot be addressed by general or abstract theorizations of gender. Instead, it is a particular problem of lived practice. Looking at the specificities of FFS—one very public form of material practice meant to literally turn males into females—can help to elucidate just what kind of limit the face is imagined to be, at the site of its articulation and proposed rectification: in the surgeon’s office. My aim in this dissertation is to think through the constellation of authorities that give meaningful shape to the practice of Facial Feminization Surgery. This constellation will, by its very nature, be partial. Sex and gender are never accomplished properties of bodies or selves, but are

¹² Cf. Daly 1978, Raymond 1978 and for an excellent contemporary review of similar sentiments, Heyes 2007:139n9.

always unfolding in relation to myriad complexities of social and biographical forces. The particular ethical and medical history of trans- healthcare bears on its present, giving shape to patients' choices, desires, and expectations just as it shapes surgeons' understanding of the project in which they are key players.

This is a story about how materialities materialize, how knowledge of the body is produced, on the one hand, within matrices of gender, race, and the history of a very controversial diagnosis and, on the other hand, through the material practice of its surgical treatment. Just as Leo Bersani and Samuel Delany use graphic depictions of sexual acts to counter the over-abstraction of the queer, so I want to bring the question of embodiment to the material structures of the body itself. I turn my attention to transsexual body modification not as an exception meant to prove a general rule, but as site within which the unspoken and taken-for-granted truths of the raced and gendered body are made explicit. This is a fundamental project of anthropology. The project of medico-surgical sex reassignment—of any part of the body—requires the identification of how “normal” bodies are sexed. As this index grows, the list of interventions intended to achieve that “normal” body grows as well.

The Surgeons

The two surgeons in whose offices I conducted field research are different from each other in many significant ways. So much so, in fact, that throughout this writing I have struggled to keep comparisons of their practice and of their approaches to FFS from seeming a caricature. To the extent that the mode of anthropological knowledge production is one of comparison, placing these surgeons' philosophies and practices in relation to each other is a critical means by which the particularities of each is made discernible (cf. Strathern 2005). I spent several months working in Dr. James Howard's office before I met and began working with Dr. Mitchell Page. Although I had learned a great deal about Howard, about his work, his patients and his personal commitments during the early part of my time in his office, it was not until I experienced the contrast of Page's work that I understood how truly distinct each of these doctors practices are from the other. This productive contrast—and occasionally equally engaging points of convergence—helped to give shape to my understandings of the philosophical, practical and emotional stakes of FFS as a surgical and life-changing enterprise.

Insofar as these two surgeons are the focus of this dissertation, it will be clear that the bulk of the focus is on Howard's work and practice. He is my main character, if you will. This focus both reflects his dominant role in the history and contemporary practice of FFS, and mirrors the structure of my fieldwork itself; I spent most of my time in his office. Most of my interviews were conducted with his patients, a reflection of the practical reality of the field rather than a concerted methodological decision on my part. He saw FFS patients nearly every week—sometimes several in a week—whereas Page's FFS patients were fewer and farther between. In addition, because Howard has performed so many more FFS operations over his long career, I met several of his former patients while attending conferences and in other social situations. By contrast, I never ran into one of Page's former patients outside his clinical offices.

Dr. Howard was a craniomaxillofacial surgeon who had run a long-time private practice. He was a friendly and outgoing man who spoke rapidly and was always ready

with a joke. Although he was in his early seventies during the period of my fieldwork, you'd never guess this based on his alacrity and ever-present readiness and desire to be engaged—in work, in conversation, in something. The unexpected inactivity of a missed or late appointment would irritate him as he sat, toes tapping under his desk, flipping through the latest surgical journal to arrive in the mail, waiting for the next patient to see or thing to do. He had a very matter-of-fact approach to the work he did, whether it was with FFS patients or the other patients for whom he did reconstructive and aesthetic surgeries: he explained the problem that needed correction, assessed his ability to meet the patient's expectation and that was that. Howard was certainly aware that very complex emotional and personal transformations often found their materialization in his office. He acknowledged that it takes a tremendous amount of trust for a person to allow a surgeon to do to their faces what he does, and he admitted that he would not let anyone make such radical changes to his own face. But he knew that there was something more to the project of FFS than simply looking different. He made an effort to understand the commitments of his transwomen patients—a shelf in his office bookcase was devoted to a small collection of books on trans- people—though he certainly had his faults where this was concerned. In the course of his everyday work, Howard did not dwell on the enormity of the personal project that FFS often represented to his patients. He did not treat them with kid gloves, or ask anything about their transitions that was not medical in nature. When a patient arrived for a consultation about FFS, he assumed that he knew why she was there, and he took on what he understood his role to be: as her surgeon.

Dr. Mitchell Page was the junior but managing partner of a small private plastic surgery practice. As an aesthetic and cosmetic¹³ plastic surgeon his practice specialized in surgical and skincare treatments that aimed to help patients “enhance their natural beauty.” From liposuction and tummy tucks (offered in combination in the “Mommy Makeover”) to rhinoplasty and facelift, the practice was dedicated to rejuvenation and beautification. In his late 40s and graying at the temples, Page's mild, soft-spoken manner helped to diffuse the effect of his sheer physical size. His broad shouldered and tall frame (admittedly, I am on the short end of 5'7”) was made all the more prominent when draped in a white coat, crossing the width of his office waiting room in just long two strides.

In 2005, Page's senior partner suggested that he look into Facial Feminization Surgery. Having completed a fellowship in craniofacial surgery, Page had some experience with the bone work that differentiates FFS from other surgeries of the face. Though he considered himself technically capable of performing these procedures, Page was reluctant at first. At the time he did not know anything about transpeople and was worried that the stigma attached to them would attach to him by association.¹⁴ Several years later, however, he was grateful that he followed his senior partner's advice. At the time of this writing, FFS constituted 30% of his practice, as measured by income earned rather than number of patients. “Thank god,” he said, “because there are a million plastic surgeons now, or people who want to be plastic surgeons.” In addition to the personal reward he felt from the gratitude of his patients, FFS gave him a market advantage in a

¹³ For a discussion of this terminology, see Chapter Three.

¹⁴ “In general, the tendency for a stigma to spread from the stigmatized individual to his close connections provides a reason why such relations tend either to be avoided or to be terminated, where existing” (Goffman 1963:30).

saturated pool of plastic surgeons. He had recently welcomed an endocrinologist and prominent American genital sex reassignment surgeon to his practice in an effort to develop what he hoped would become “a hub of transgender medicine.”

As surgeons performing FFS in the contemporary moment, Howard and Page are heirs to (and participants in) a common history of trans- medicine in the United States. Their individual relationships to that history and how they engage the treatment logic of genital sex reassignment surgery (GSR) and, by extension, FFS are markedly distinct, however. As will be clear throughout this dissertation, in spite of the similarities between these doctors’ understandings of their roles as surgeons who care for trans- folks, there are also important differences in their approaches to what being this kind of doctor means in practice.

The Patients

The patients that I met during my fieldwork were almost invariably generous with their time and their stories, especially considering that we often met in the surgeon’s office—an undoubtedly stressful and anxious time. They talked with me sometimes for a few minutes and sometimes for a few hours telling me about their lives and about their decisions to undergo Facial Feminization Surgery. I conducted formal interviews with 28 patients, and 19 agreed to fill out a short survey about how they had learned about and ultimately selected the surgeon in whose offices I met them. The survey also asked them to report on the medical interventions they had already undergone or planned to undergo for the express purpose of transforming the gendered characteristics of their bodies (see Table 0.1).

Demographically speaking, patients were overwhelmingly white. The two exceptions were one Filipina and one Indian patient. Though most patients were living in the United States, I also met patients who had traveled to the US for their FFS consultation from Canada, Italy, Denmark, India, Wales, Germany, New Zealand and Japan (this patient was a French national living in Japan). Though many patients arrived to consultations and to the hospital alone on the morning of their procedures, others brought partners or friends. These people offered moral support and sometimes served as sounding boards as patients considered the surgeons’ assessments. About a quarter of the patients who I met (either in interviews or in consultation appointments) were in these offices on fact-finding missions. They were either there to learn what surgery could do and what it would cost, or as part of a larger effort to determine which of the few FFS surgeons they would opt to use. In other words, not every patient who arrived for a consultation ultimately decided to undergo surgery, but most did. A few patients had had consultations with both Page and Howard and were able to speak to their experiences of the differences between their approaches and those of still other surgeons who they had met.

Those patients who agreed to be surveyed ranged in age from 23-60 years old, though most were in their 40’s ($n=4$) and 50’s ($n=8$). In general, the fact that these patients were older gave them greater access to the considerable financial resources needed to pay for these surgeries (more about this in Chapter Three). It also made their face particularly gendered objects. Not only had these patients’ faces undergone the

Results of Informant Survey: Schedule of Gender-Related Medical Interventions

#	Age	Race ¹	Gender ¹	GSRs ²	Hair Removal ³	Collagen ³	Hormones ³	Breast Aug ²	Thyroid Cart ²	Other Facial	Other
2	60	Anglo	Female	Not yet	2 yrs	2 yrs	1 yr	Not yet	Yes (2009)	Face/neck/lids	
3	47	BLANK	Female	Not yet	1 yr	No	1 yr	Not yet	Not yet	No	
4		Asian	BLANK	Yes (1990)	No	No	25 yrs	Yes	No	No	
5	39	White	Female	Not yet	6 yrs	No	11 yrs	Not yet	Yes (2001)	Nose (2003)	
9	31	South Asian	Female	Not yet	6 yrs	No	4 yrs	Not yet	Not yet	No	bilateral orchiectomy (2006)
10	45	Caucasian	Female	Yes (2009)	4 yrs	No	3 yrs	Yes (3 months)	w/FFS	No	
11	52	White	Female	Not yet	1 yr	No	1 yr	No	Not yet	No	
12	54	White	Male body (bigender)	Not yet	Not yet	Not yet	Not yet	Not yet	Not yet	No	
14	32	Caucasian	Female	Not yet	1 yr	No	2 yrs	No not sure	w/FFS	No	
15	57	White French/	Female	Not yet	Not yet	No	Few months	No not sure	Not yet	No	
16	23	Irish	Female	No not sure	Few months	No	Few months	No not sure	w/FFS	No	
17	51	Ukrainian	Female	Yes (1985)	No	No	34 yrs	Yes (1987)	No	Nose/chin	
18	41	Mixed Caucasian	Female with some physical issues	Not yet	1 yr	No	2 yrs	No not sure	Yes (2009)	No	
19	53	Caucasian	Female	Not yet	2 yrs	No	2 yrs	Not yet	No not sure	No	hair transfer to cover scalp incision scar
21	51	Caucasian	Female	Yes (2000)	11yrs	No	12 yrs	Yes (1999)	w/FFS	No	
22	58	White Irish/	Trans-female	No will not	4 yrs	No	No not sure	No not sure	Yes. Only procedure desired.	No not sure	
24	54	Polish	Transgender	Not yet	1 yr	No not sure	Yes (2008)	No not sure	w/FFS	No not sure	
25	48	Caucasian	Female (genetically male)	Not yet	2 yrs	No	Yes (2006)	No not sure	w/FFS		
29	48	White	Female	Not yet	3 yrs	No not sure	BLANK	No not sure	No not sure	Will have face lift	Planned: tummy tuck, butt tuck, dermabrasion, ear pinning, voice surgery

¹ Self identified.

² If patients had this surgery, their date of the procedure is given. "Not yet" indicates that they plan to have this procedure in the future. "Not sure" indicates that they have not yet decided whether they'll have this procedure.

³ Time given indicates amount of time prior to interview that patients had been undergoing this treatment. "Not yet" indicates their desire to do so in the future. "No not sure" indicates that the patient has not yet decided to undergo this treatment. "No" indicates that this patient does not currently nor does she plan to undergo this treatment.

masculinizing effects of testosterone during puberty,¹⁵ but they also had what surgeons describe as “aging faces.” Each of these components had an impact on the face that patients wanted to change, as well as the ideal of femininity—both female and beautiful (a category liked to the ideals of youth, especially in the United States)—that they hoped their new faces would embody.

Many expressed a long-standing and sometimes life-long desire to change their bodies, but the role of facial surgery in this overall desire for bodily feminization varied considerably. For example, Rosa, who had traveled from Italy to have surgery with Dr. Howard, first learned that Facial Feminization Surgery was possible in 2001, and immediately set it as her goal. At that time she had been working a modest paying customer service job and decided that she would need to change her line of work in order to save money for the surgery. She also wanted to establish a career that did not involve interacting with the public so that the healing process and change in identity that would follow FFS would go as smoothly as possible. Rosa quit her job and went back to school to become a handwriting analyst for her country’s national court system. After several years in that position she had saved enough money to travel to the United States to meet Dr. Howard for the first time. For Rosa, the journey to the operating room had taken ten years. Her job changes, educational investments, and savings plans had been organized around the goal of a more feminine face that she felt would change her life in ways that nothing else could. When we spoke on the day before her operation, she was confident that the life changes and sacrifices had all been worth what Dr. Howard would do for her the next morning.

Rosa’s story is just one example of the extraordinary impact that the desire for this surgery had had on the lives of the women who sought it. One way to understand this desire is as “desperation.” Indeed that framing of the desire for the bodily intervention that is understood to constitute transsexualism as such is a pervasive and powerful one. It both marks the desire for intervention as urgent and comes to be a characteristic—perhaps the most defining characteristic—of the people who have this desire (this topic will be taken up at length in Chapter Four). It is true that some of the people who I met while they were surgical patients (or potential surgical patients) could be described as “desperate.” For example, Zoe acknowledged that she had considered suicide until she was able to procure her facial surgery. The cost of her FFS led her to bankruptcy. Rhonda wept softly throughout our interview. She had been on hormone therapy for 34 years, had undergone surgical reconstruction of her genitals, breasts, and now face. “I just needed it to be softened out, just to get through life,” she told me of her FFS. “After life, I want to be set free out of this shell. I wouldn’t wish my worst enemy to go through transgenderism.... I’m glad life don’t go forever.”

These stories are undoubtedly heart rending. And they do help us understand both the value and the limits of bodily transformation. Not every person who I met shared her

¹⁵ The structural distinctions between male and female faces emerges during puberty (see extended discussion of this in Chapter One). Proponents of using hormone blockers to delay puberty in trans- youth frequently argue that to do so spares the young transwoman the effects of bodily masculinization, including masculinization of the face. This framing of the effects of testosterone help to support the narrative that female bodies are fundamental structures upon which maleness is later added through the addition of bone and soft tissues.

story in this same way, however. Others spoke instead about FFS—and transition more generally—as an act of liberation, self-realization, or as simply a difficult but necessary mode of self-care or self-defense. By the time Rachel came to terms with her trans-identity in her early 50’s, she felt that transitioning was her only real option.

How many times have people told me in the last year how brave I am? And I appreciate it that they say it, but I really don’t look at it that way. It’s only brave because people make it so hard. You know, if somebody sets your house on fire, is it brave to run out of it? That’s how I see it. I’m running out of a burning house at this point. I guess I could have just sat there and died. I do want to give myself *some* credit. For me, the most important thing I could do was change my face.

Though we could certainly read Zoe, Rhonda and Rachel’s stories as instances of “desperation,” I do not think they are best understood this way. Instead, I want to think of FFS as an object of desire and of longing, but not as a diagnostic of the desperate. While the interventions involved in transsexual transition may be specific to a particular personal project, the notion of longing for a body that is a more true reflection of how one knows oneself is not. What happens if FFS—and other trans- surgeries—are framed as longed for and desired without being desperately needed? What happens if trans- people, then, can long for and be desirous of a body, without being desperate *people*? It is through these perspectives that I listened to and now write about the experiences and expectations of the transwomen I met in the field.

Methods and Personal Stakes

It would be difficult to overestimate the role that my being a transman has played in this research. It has shaped how the project was conceived, as well as the kinds of data I was able to collect. At the outset, my conception of the project was significantly informed by my own experiences of coming to terms with my trans identity and of taking practical steps to transition from female to male. This research leaves aside questions of identity and motivation and instead examines the structures, practices and problems that mediate between the individual who desires a gender-specific physical change (whatever it is), and its practical accomplishment. My desire to focus on surgeons and their work comes, in significant part, from my status as a member of the “marginalized” group of trans- people. In this story, the surgeons are my Other.

By acknowledging myself as a member of this group, I do not mean to flatten or trivialize significant differences between and among people who identify themselves as trans- (transgender, transsexual, or any one of many shifting and proliferating terms). In fact, I often bristle at terms like “trans community” and other such phrases that presuppose and thereby establish some idea of networked connection out of a single common characteristic. Though trans- people often do share an identification with a common set of terms meant to denote an experience of gendered otherness, what we mean by those terms and how we experience the particular sort of gendered otherness unique to each of us is, well, unique. I don’t mean this as a kind of ultimate disintegration into the particularities of identity politics. I simply mean to call attention to the fact that—contrary to a considerable body of writing on trans- people—we are a very heterogeneous group.

One major axis of this difference is between transwomen (or those who identify as transfeminine) and transmen (or those who identify as transmasculine). Indeed I am frequently prompted to agitate against the erasure of this difference, especially in response to research that claims to be about “trans people” but is in practice exclusively about transwomen or transmen. While I understand the political efficacy enabled by focusing on the commonalities shared between marginalized groups and recognize that standing together is often not only an appropriate but also a good political move, the erasure of the differences between transwomen and transmen in theorizing about gender—or the empirical research that often informs theorizing about gender—is a significant problem. Such an erasure flattens the project of transition (variously construed) as one that is fundamentally about the movement away from one gendered (and sometimes embodied) identity and toward another. A focus on movement ignores the particularities of what one is moving away from and what one is moving toward (or to, depending upon the project) (Prosser 1999, Salamon 2010). These are not inconsequential details.

If, for example, the project in question is transsexual transition from female to male or male to female, one has to acknowledge the different stakes of this movement. Put quite simply, male and female are not equal opposites. This foundational premise forms the central analysis in most all research on gender, but it somehow recedes into the background in trans- research that focuses instead on the putatively value neutral movement that constitutes the name of ‘trans’ as such (cf. Prosser 1999, Salamon 2010). People who engage in transition begin from different places and arrive at different places in terms of politics, power, and economics. Their “movements” from one body to another are enabled by medical technologies that potentially require the expenditure of radically different amounts of money, and yield very different results. In short, differences between MTF and FTM transitions—and the identities that structure them—are differences that matter.

It is for this reason that I want to be very clear about who I am writing about here. The patients that I interviewed, talked with and shared time with were transwomen. Some of them self-identified as transgender, some as transsexual. Many talked about transgenderism or transsexualism as concepts that were relevant to their lives or terms that they related to, but they did not explicitly assign one of these to themselves. In the course of our interviews, I never explicitly asked patients to self identify in these terms. In this writing, I adopt the term *transsexual* to describe the surgeries under investigation here, because the claims that anchor them are ones based on the body’s sex-specific, physical characteristics. In recent years, the word *transgender* has become commonly used as an “umbrella term” meant to encompass a wide variety of established and emerging identities, often including *transsexual*. What makes *transsexual* distinct within this larger set of terms and identities is that it denotes the actualization of, or desire for, interventions in the sex-specific characteristics of the physical body. This is an imperfect and contested definition, to be sure. This language is constantly shifting and being inhabited differently by different people. When I write about transpeople as a larger group, I adopt the term *trans-*. The open-ended hyphen is meant to call attention to the many possible endings of the term, all of which are important to the people who identify

themselves as such.¹⁶ It matters to me, as a transman and as an individual committed to thinking through and being with transfolks as they (we) make our lives.

I am in a body that allows me to think of gender as flexible and malleable. My transition was emotionally exhausting and often excruciating. To be sure, I do not wish to experience such profound self-doubt and self-scrutiny ever again in my life. But the physical ambiguity of that period—the time when I could be and was read differently several times in a day or even in the course of a single interaction—was mercifully short. My body facilitated the shift that I had resolved to make. No surgery was required to enact this shift—though some was certainly desired, and eventually bought and paid for. The fact is, I pass. Everyday. No questions. Ever. This fact was never lost to the transwomen I spoke with during my fieldwork. Both during interviews (when I chose to out myself) and during casual conversations at conferences, transwomen often remarked at how well I pass. They asked me how long I had been on testosterone. I was once called a “lucky son of a bitch.” Though I typically find these kinds of comments irksome (because they tend to elevate passing above all other kinds of privilege), in the course of this project, I have come to understand them differently.

As I observed clinical appointments and surgeries in the operating room, as I spent time with surgeons killing time in their offices and traveling to present their work at conferences, as I interviewed patients before and following their procedures, and as I read and read and read, I felt for and with every person I encountered in my fieldwork. This includes the patients and their hopeful friends that often accompanied them to the office and OR, and it includes the surgeons and their ever-present assistants who recognized that they were, in fact, doing life-changing work. None of this is simple. Not emotionally, epistemologically, professionally or politically. But it was a place and time in which all of these things underwent significant change and renegotiation, at the line between desire and its making.

¹⁶ Where as Stryker, Currah and Moore (2008) use the term *trans-* in order to leave open the possibility of kinds of crossing that are not limited to gender, here I use it in order to draw attention to the multiple gendered endings to the word trans that have come to hold important personal and political stakes for those who use this word to identify themselves.

Chapter One

Making the Gendered Face

The classification of individuals into dichotomous sex categories inevitably involves cultural work made possible by a history of definitional acts.

—*Steven Epstein*¹

Origin Story

In 1982 Dr. Darrell Pratt² approached Dr. James Howard as a colleague asking for a favor. Pratt was a plastic surgeon who, among other things, worked with patients in the Gender Clinic associated with a major West Coast research university. Candice, a male-to-female transsexual patient on whom Pratt had successfully performed genital sex reassignment surgery (GSR), had returned to the clinic some months later with a new surgical request. Though GSR had changed her sex both genitally and in profoundly personal ways, it had made exactly no impact on how others perceived her sex in everyday social life. Candice had done as much as she could to change the gender markers of her body and comportment: she was on estrogen therapy, she had grown her hair, she made strategic choices in clothing and make-up, she had undergone electrolysis and retrained her voice. Despite her best efforts, she was still being read as a male, as someone pretending to be female and not pulling it off. The fact of her new female genitalia—the bodily metonym of sex difference whose transformation is often considered to instantiate if not to define “sex change”—was secreted away behind the bounds of propriety in social life: no one knew it was there. But they did see her face. It was clear to Candice that her face was the problem. She had a man’s face. No amount of make-up or decoration could hide it. She wondered if anything could be done.

Dr. James Howard was a cranio-maxillofacial surgeon³ who had built a distinguished career reconstructing the faces and skulls of children and adults with severe injuries and congenital deformities. This was the first time Howard had encountered such a request, and he was not sure whether he could accomplish the effect that Candice desired. Prior to this request, “masculine” and “feminine” were not terms that he had

¹ Epstein 2007:254.

² Pseudonym.

³ This designation indicates a combined speciality. A maxillofacial surgeon works on the entire skull and face, including the upper and lower jaws. Craniofacial surgery is a subspeciality of maxillofacial surgery that typically addresses congenital deformities of the skull, face and jaw.

considered in relation to his years of work in craniofacial reconstructive surgery. “Here I had been doing surgery at [a major research hospital] for several years,” Howard explained, “and I had never thought about the differences between a boy and girl’s skull.” As a cranio-maxillofacial surgeon, Howard’s work had, up to this point, been organized by the directive to make pathologically abnormal skulls and faces into “normal” ones. And, up to this point, “normal” had not been a sexed or gendered category.

Rather than refusing the request of Dr. Pratt and his patient on account of this uncertainty, Howard set about trying to determine what constituted “masculine” and “feminine” as craniofacial categories, and whether the differences between them were ones that surgical reconstruction could safely ameliorate. His work was animated by an understanding of this proposed intervention as working within the logic of the larger transsexual surgical project, namely that transsexual surgical interventions are intended to enact a change of sex. And he took this project quite seriously. To him, the patient’s desired characteristic of *feminine* was (and is) an adjective describing the sex category *female*. As such, his research about craniofacial sex difference was not open or general; it was guided by a pragmatic telos: identify male and female structures of the face in order to turn the former into the latter.

The typical tools available to the reconstructive surgeon were inadequate to the task of identifying distinctly sexed craniofacial structures because these differences are not ones that matter in anatomical or physiological terms. In other words, the wide array of craniofacial forms that are recognized as “normal” are attributable to many kinds of variation—sexual among them. If males and females have different craniofacial complexes (let us leave this an open question for now) that difference is not medically noteworthy. He therefore made recourse to another science for which the problem of skeletal sex distinction has been a longstanding concern: physical anthropology. From these resources Howard learned the morphological characteristics of the skull that anthropological practitioners (archaeologists, osteologists, physical and forensic anthropologists) use to assign sex to human skeletons. It was from these sources that the notion of a distinctively female facial structure first became, for him, a scientific fact.

With this new knowledge to hand about the specific sites in the facial skeleton where sex was manifest, Howard next needed to quantify this difference. In order to develop a surgical plan, it is not enough to know that the chin of a male is longer than that of a female, for example; one must know *how much* longer it is. To answer this question Howard turned to a set of craniofacial growth standards that were produced by a nearly 50-year study conducted at the University of Michigan. The atlas that resulted from this study provided the measurements—means and standard deviations—by which anthropologists’ general locations of sex distinction could be rendered into a precise strategy for intervention.

Finally with the knowledge of both the sites of sex difference and the quantification of that difference in terms of millimeters and angles, Howard needed to consider what the limitations of surgical practice and human facial structure would allow him to do. With the ends of “female” firmly established, he had to evaluate and settle on the means that would make achieving that end possible. It wasn’t that he needed to learn a new set of practical skills; Howard was, by all measures, an accomplished and esteemed surgeon who had helped to develop many extremely complex and radical craniofacial reconstructive surgeries. The challenge was that he had to learn to *see* the skull in a new

way. Characteristics that he would now say mark distinctions between male and female had, until then, been unremarkable—and indeed unnoticed—variations within a guiding frame of “normal.” In order to cultivate the practice of seeing differently, and reflect on possible surgical techniques, he visited a large collection of dry skulls housed at the dental school at the University of the Pacific in San Francisco, California. This collection provided material examples of skulls—all presumably sexed in one way or another—upon which Howard’s calculations could be practically assessed.

It is from this three-part research endeavor that James Howard developed the bone and soft tissue reconstructive techniques that are now referred to as Facial Feminization Surgery (FFS).⁴ In this chapter I flesh out the origin story above through an examination of the sources upon which Facial Feminization Surgery was originally established. In this genealogy I show how gendered ideals of the “feminine” skull taken from physical anthropology, a series of dental cephalograms of elementary and high school students in the Upper Midwest, and the private skull collection of an early 20th century orthodontist were brought together to produce the female face at the heart of the FFS project. FFS is an unlikely heir to each of these forms of knowledge, all of which were produced under particular circumstances with the intention of being put to much different ends than this. Distinct forms of argument and proof from each source contributed to the fundamental claim that dichotomous sex difference is a *natural* characteristic of the skull that (1) is universally manifest in particular morphological sites; (2) can be expressed in statistical norms; and (3) is nonetheless in the eye of the beholder.

The medical and scientific forms of knowledge at work in FFS (and in all forms of somatic sex change) assume male and female to be two natural and stable groups characterized by distinct physical characteristics. Like all claims that purport to name a distinction between two groups of people—and in the process help to constitute these groups as distinct—the truth of this assertion is much more conditional and contingent than its simplicity suggests. Nevertheless, the demands of categorization compel those interested in the production of duality (either expressly so, or through the good faith assumption that sexual duality exists and therefore data demonstrating its existence is a reflection of the world rather than the making of that world) to create two groups—male and female—out of a wide variety of normal human craniofacial variety. An ideological commitment to craniofacial sexual dimorphism common to all of these sources made it possible for Howard’s search for a female form to yield a definitive result. Steven Epstein’s (2007) work on how modalities of social and biological difference are engaged in medical research is instructive here. He writes, “Sex categories do have an obvious biological grounding in the body. But the precise ways in which sexed bodies correspond to our social categories—or fail to do so—are obscured by an overwhelmingly strong ideology of sexual dimorphism: the belief that males and females are utterly distinct, if not opposite, and that no middle ground exists” (253). While this characterization is generally accepted in reference to genital morphology—the bodily site most frequently associated with sex reassignment surgery—its extension to the morphology of the face is complicated by a variety of factors including but not limited to an individual’s age and racial and ethnic background.

⁴ Of most relevance to Pratt’s patient, Howard developed a series of forehead procedures (typologized I-IV) that are essentially four different ways to arrive at the same “feminine” forehead result depending upon the anatomy of the patient.

In developing FFS, Howard was not a sloppy or naïve practitioner who willfully ignored or somehow misunderstood that any line drawn between male and female craniofacial complexes is an uncertain and unstable one. No one knows better than a surgeon that individual anatomies differ, sometimes quite substantially. In point of fact, the heterogeneity of anatomical forms was somewhat beside the point in this case. I suggest two reasons for this. The first is pragmatic. Accounting for the infinite variation of craniofacial structures in people recognizable as females—for it is recognizability rather than facticity that animates FFS—would bring the project to a grinding halt. A will to intervene demands action that must, of necessity, be directed by a particular path out of the seemingly innumerable possible ones. This is the case in FFS just as in any surgical procedure that aims to produce a “normal” or “typical” form. The second reason that variation was not important in Howard’s research was determined by the goal of the project itself. His task was to produce a markedly feminine face, and this is *by definition* a form at one extreme of a sex-based anatomical distribution. Considered in this way “feminine” emerges not as an adjective describing all things female, but as a subset within that broader category. So Howard’s goal of producing a female form was actually much more narrow than his use of the binary sex category marker of “female” would suggest.

Indeed it will be clear throughout this chapter that the meaning of *female* expands and contracts both within and between the forms of knowledge used to produce the female face of FFS. Sometimes referring to a sex category representing approximately half of the human population, sometimes referring to a desirable “feminine” aesthetic (a quality that is differentially linked to the sex category of female but is not reducible to it), sometimes defined by the absence of particular materials and other times by their presence, the shifting definition of the word (and category) *female* is both enabled—and obscured—by an ideological commitment to sexual dimorphism in all of these sources. In other words, the existence of definitive male and female forms is never in question; it is only their definition that must be ascertained. This is the case whether the proof of sexual dimorphism is the aim of the research or merely an assumption used to create it. In spite of this constant work of definition, it is the supposed naturalness and constancy of *female* as a category that allows it to travel across contexts as though it were an inert body, a true thing about which other things might be said. As such, the “female” skull identified by anthropologists, the “female” patients whose faces were measured by orthodontic researchers, and the “female” structures observed in a dry skull collection all seem to refer to the same kind of human body. But making these different forms of knowledge work together to tell a single truth requires a lot of work. This chapter is a story of that work.

Anthropology and the Making of Two Faces: Male and Female

Prior to the development of FFS, sex differences of the skull did not exist, surgically speaking. Dr. Howard was the first surgeon to describe the sex differences of the skull for the purpose of explaining how the particularly sexed characteristics could be changed. His 1987 article in *Plastic and Reconstructive Surgery* reported his early work in feminizing craniofacial surgery. Although his innovations in this field were prompted by requests from transwomen, and transwomen have been the overwhelming majority of

patients seeking feminizing procedures, this initial article discusses the feminization of females with “masculine” features. In this instance, “feminization” is a process that aims to produce a particularly pleasing aesthetic—as measured by the patient’s post-operative attractiveness—as opposed to the transforming perceptions of the patient’s sex, *per se*. The article begins with a justification of the interventions themselves; it opens this way:

Identification of an individual as male or female generally takes only a fraction of a second. Within a group of females we are also rather quick to determine which we consider to be beautiful, attractive, plain, unattractive, and perhaps even ugly. However, when asked to explain why an individual woman was delegated to one of these classes we are left to try to explain this on the basis of various contours, angles, plains and textures. No attempt will be made in this paper to try to determine what those characteristics are. It is a contention, however, that some of the characteristics that we commonly see in the female face as being less than ideally attractive are features of a masculine nature.

There are several points to make about this opening paragraph. First, and most importantly, the subject of this article is the general observer—universalized by the pronoun “we”—who stands in assessment first of another (read: every other) individual’s sex, and then of that individual’s attractiveness. The object at issue here is the female body, one that is classifiable from “beautiful” to “ugly,” though what constitutes those categories is hard to say. Assessment of sex and desirability is, therefore, always about *perception*; the focus is on the response that the face provokes, rather than the face itself. “Some of the characteristics that we commonly see in the female face as being less than ideally attractive,” he writes, “are features of a masculine nature.” Here, the category of *female* is one that both includes all members of the female sex (whose self-evidence as such is assumed), but it is also hemmed in by the unwanted intrusion of “masculine” features. Females are not only and always feminine; the presence of the “masculine” renders them “less than ideally attractive.” Howard’s acknowledgement that “female” and “feminine” are not reducible to each other is one whose clarity is sometimes foregrounded and sometimes recedes in the discourse of FFS. Let us turn now to the claims that underwrite surgical practice.

In this article, Howard based his claims to the differences between male and female skulls not on the work of physicians or anatomists—for whom such distinctions are largely inconsequential—but rather on that of “physical anthropologists” and “forensic pathologists” who “are concerned with the identification and separation of skulls by sex.” This statement established “anthropological differences” as the source of truth claims about the sexed face and skull and brought the authority of anthropology to bear on the question of surgically conceived somatic sex and, by extension, sex change.

The small number of professional surgical articles on FFS that followed Howard’s initial publication also cite anthropological evidence as the basis for claims to a distinct sexual dimorphism in human skulls. In one case, authors of a study on forehead contouring and rhinoplasty in FFS deferred completely to Howard’s expertise. They used the text from his opening passage verbatim, even going so far as to include the exact citations that Howard used to support his claim (Dempf, et. al., 2009:1). As the pioneer in FFS, Howard’s representation of sex difference is taken as an established fact, a given. Other authors refer to anthropological differences between male and female craniofacial complexes as the basis for their work in feminization, as well. For example, Habal, et. al.,

write that “The surgical contouring procedures used [in FFS] are based on the evaluation of the anthropological differences between the male and the female skeleton” (1990: 146), though they do not offer the sources for this claim.⁵

Though the sources of anthropological authority in sex assignment appear fuzzy in these surgical accounts, its history with the practice is a long one. Physical anthropology grew out of the naturalist movement in eighteenth century Europe. From these very early days, the skull occupied a central place in anthropological research. Convinced that it was the faculty of reason that exalted humans above animals, that reasoning was a capacity enabled by the brain, and that brain size indicated one’s capacity for intelligence, scholars set out to measure brains in order to rank the intelligence of human groups. Historian Londa Schiebinger has stated that, “Skull shape and size became by the late eighteenth century the measure *sine qua non* of intelligence” (1993:135). While brains were hard to come by and even harder to preserve, the lasting cranium proved a ready study object.

At its essence, early physical anthropology was a contrastive enterprise, creating distinct groups of people from the larger human race.⁶ The study of human skulls was an essential aspect of this project. Research agendas were structured around desires to understand human origins, especially in relation to what Johann Blumenbach (1752-1840)—often called the father of physical anthropology—considered the five “principle varieties” of humans. Now recognized as racial typologies, Blumenbach’s Caucasian, Mongolian, Ethiopian, American and Malay groups were classified according to their physical characteristics and associated geographic origins. To this end Blumenbach became an early collector of human crania, the study of which earned him notoriety as the developer of craniometry as well as comparative anatomy (Spencer 1997). Like his contemporaries, Blumenbach’s interest in understanding the variation that existed between groups of human beings settled in the physical body.

Skull collecting in the name of scientific research began in earnest at the turn of the nineteenth century and remained a significant undertaking for naturalists and practitioners of the then emergent discipline of anthropology until the early decades of the twentieth century. In the United States the popularity and promise of phrenology⁷

⁵ One study cites research carried out by noted contemporary anthropometrist Leslie G. Farkas when asserting that “facial dimensions and proportions” are “notably different between men and women” (Nouraei, et. al., 2007:318). Another uses Farkas in maintaining that “the differences between [male and female] faces are on average small” (van de Ven 2008: 293). Though the surgeons who authored these articles (and others, including Shams, et. al., 2009:9) cite Farkas when asserting physical differences between male and female facial structures, it is not clear whether they use his figures in planning surgical procedures.

⁶ This work of contrast and division of races continued until after the Second World War when, under the leadership of Harold Washburn, the “new physical anthropology” abandoned its focus on racial difference and began to study processes of microevolution (Haraway 1989).

⁷ Though it is now dismissed as a “pseudo-science” and often lampooned as the exemplar of an “old” idea that has since been replaced by “good science,” phrenology piqued the interest of many influential scholars. Historian of science Lucille Hoyme noted that, “In reconstructing the family tree of their science, physical anthropologists are likely to pass over phrenology quickly and put most emphasis on more sober sciences such as anatomy. Yet phrenology is as truly an ancestor of physical anthropology as astrology is of astronomy, or alchemy of chemistry” (1953:412). Indeed the founder of American physical anthropology, Ales Hrdlička notes that “In the [eighteen]thirties, collection and study of human skulls received great impetus in this country through the establishment at Boston and Washington of phrenological societies, in

contributed to eugenicist and other human origins research in the creation of enormous public and private skull collections (Blakey 1987; Fabian 2010; Gould 1981; Van Wyhe 2004). It was a central belief in the illuminating power of craniometrics—or the measurement of skulls—that animated research during this time, rather than a theory that guided the execution of any measurement in particular. Historian of medicine Elizabeth Fee recounts the optimism and disarray that accompanied the burgeoning belief that numbers held the key to understanding all manner of human difference.

Craniology more accurately was a collection of techniques for measuring all possible angles and dimensions of the skull than a science with an articulated theory. It was assumed that important insights would eventually emerge from the tables and charts, angles and ratios compiled in a Baconian orgy of quantification. Measurement was glorified as the essential basis of science; both anatomists and psychologists wanted above everything else to be ‘scientific’. If there was more to craniology than measurement for its own sake, it came from the impulse to create a differential psychology (Fee 1979:419).

For these naturalists and anthropologists transfixed by measurement, the skull not only held truths about racial difference, but also promised to reveal the essential differences between men and women. “If social inequalities were to be justified within the framework of liberal thought, scientific evidence would have to show that human nature is not uniform but differs according to age, race, and sex” (Schiebinger 1987:43). It was the notion of hierarchy among racial groups that provided a framework for analyzing the essential differences between the sexes. Existing notions of racial difference provided ready analogies along the great chain of being, with apes at the bottom and white men on top. Though studies of the origins of racial and sexual difference were ostensibly investigating two different kinds of difference, these categories always informed each other.

By the middle of the 19th century, existing theories about essential differences between men and women were called into action by growing political movements for women’s rights, particularly in Western Europe. The threat of the potential shift in power that the movement represented prompted members of the London Anthropological Society (LAS)—an all male group at the time—to begin investigations into the natural differences between men and women. Luke Owen Pike, a member of the LAS stated his research aim plainly: “If there be any truth in science, the intellect of woman not only has but must have, a certain relation to her structure; and if it could be shown that there exists no difference between the male and female minds, there would be an end of Anthropology” (as quoted in Fee 1979:418).

Women’s heads were diagnosed as being inferior to men’s, largely based on the claim that their overall smaller size indicated a close relation to the underdevelopment characteristic of children. In addition to the immaturity indicated by their child-like

which became interested at that time many physicians and other men of science” (1919:31). Hrdlička acknowledges the work done by these societies as the “preparatory period of physical anthropology in this country” (ibid).

structure,⁸ women's inferiority worked through analogy to the already accepted inferiority of the non-white races. In 1863, during his term as President of the LAS, James Hunt published a paper entitled, "On the Negro's Place in Nature," in which he argued that "there is no doubt that the Negro's brain bears a great resemblance to a European female or child's brain and thus approaches the ape far more than the European, while the Negress approaches the ape still nearer" (as quoted in Fee 1979:421). Here, ideas about both racial and sexual inferiority helped to populate the middle rungs of a sexed and raced hierarchy. Hunt's formulation of this hierarchy—one that is representative of many schools of thought at this time—equated "the Negro" *male* brain with that of the European female or child, but marked the "the Negress" as below each of these in its similarities to the apes. The black woman, doubly marked by her status as both female and black, is degraded to the status of the near-animal and is assumed to possess the same limitations in intelligence as the apes. Schiebinger has argued that, "The depiction of a smaller female skull was used to prove that women's intellectual capabilities were inferior to men's. This scientific measure of women's lesser 'natural reason' was used to buttress arguments against women's participation in the public spheres of government and commerce, science and scholarship" (Schiebinger 1987:43). Researchers argued that women, like people of the "lower races" were like children and thus unfit for intellectual pursuits.

While the skull was initially an object of interest in the question of sex difference because of the focus on the cranium, efforts to identify what Pike called "structural" differences between men and women also turned to the bones of the face. Skull collectors often attributed gender characteristics to the specimen in their collection. German anthropologist and Honorary Member of the London Anthropological Society Johann Alexander Ecker created a craniological profile⁹ of males and females that conceived of females as anatomical (and political) intermediaries between children and males.¹⁰ Ecker acknowledged that his "characteristic cranial profile" did not apply to all females, but could most easily be found in "handsome women." And taken even further, he went on to extol the virtues of this ideal and "handsome" profile as constituting the very definition of the female.

We need not be surprised that we do not find this female type equally pronounced in every head, just as little as we find in every male figure the

⁸ The language of physical anthropology continues to link females and children together under the category of the underdeveloped (or "pedomorphs"), leaving mature males as the exemplar of the developed and mature human ("gerontomorphs") (see, for example, McCown 1982).

⁹ Ecker identified the characteristic particularities of the female face as the following: (1) The facial parts are small in comparison to the cranium. "The facial oval thereby appears shorter, rounder, and more child-like" (352). (2) Like the infant skull, the cranial roof [bones of the top of the head] predominates over the cranial basis [essentially, the direct distance between the ears (tragus)]. (3) Lesser height of the cranium. (4) Greater flatness of the roof of the head, especially toward the back of the head (parietal bone). (5) A perpendicular position of the forehead. "This straight frontal line imparts something noble to the female head" (353). (6) The transition from forehead to vertex [the place at which the four major bones of the cranium come together on the top of the head] is more of an angle than an arch.

¹⁰ "It is undeniable," he writes, "that the female skull in its proportions stands intermediate between the male and the infantile skull" (1868:355). Within a long history of using craniofacial differences to place human groups in hierarchal relation to one another, identifying females as intermediary figures "between" males and children is tantamount to locating them *above* children but *below* males.

masculine habitus. But that this form occurs so well pronounced in heads which we designate beautiful and womanly, proves that this form is typical for the female sex (Ecker 1868:355).

In Ecker's estimation, it is clear that those heads "which we designate beautiful and womanly" are, by definition, those that typify the female sex. As a *type*, then, the female is characterized—and thus the category itself is constituted—by its recognition as "beautiful." It is through its inherent ability to appeal to and please the viewer's sense of beauty that a skull becomes an instance of femaleness. Fee recognizes the powerful shift enabled by this move: desirable gender becomes recognizable *as the form* of craniofacial sex.

Ugly women, intellectual women, women with large brains or large facial bones were exceptions, but all could be disregarded as they were not true representatives of the sex. Ecker had succeeded in translating the female stereotype—woman as beautiful child—into a craniological profile. Whenever skulls could be found approximating this type, they could now be identified as female (Fee 1979: 424).

The collapse of the categories of the *feminine*—as recognized by the desired characteristics of "handsomeness," "beauty," and "womanliness"—and the *female*—as an anatomical category—is a crucial one. Once it has been established that the best way to discern physical sex is through the evaluation of desirable gender, then the project of sex assignment becomes an essentially social one. This is as clear an example of performative sexing as any I have seen (Butler 1990, 1993). A skull is female when it can be recognized as desirably beautiful. When it is not desirably beautiful it classified as either male, or unfortunately exceptional. It is clear that raced and gendered ideals have always informed studies of the skull.

There is no doubt that contemporary physical anthropologists regard these overtly racist and sexist research agendas as troubling and unfortunate periods in the history of the discipline. While the political and ideological commitments that shaped this research have been renounced, much of the knowledge produced about human bodies during these early years—and certainly the materials upon which that knowledge was based—have remained. I turn now to an examination of how archaeologists and physical anthropologists have assigned sex using the craniofacial skeleton in the 20th century. I pay special attention to the first half of the 20th century because it is the ideas of this period that Howard explicitly cited as the source of his understanding of anthropological processes of sex differentiation. He writes,

Prior to the computer and discriminant function analysis,^[11] these scientists [physical anthropologists] primarily utilized three skeletal characteristics to separate the male from the female skull: the chin, the nose, and the forehead.

¹¹ Discriminant functions are statistical operations used to determine which values in a set of measurements can most reliably be used to classify given objects into a limited number of groups. In other words, discriminant functions do not identify groups, they identify criterion by which a given object can be included in groups already established by the researcher. These came into widespread use in sex determination—indeed that is what they are almost exclusively used to do since sex is considered a variable with only two possible values: male or female (Howells 1995:2)—when computers that could run these operations became widely available (Mays 1998:88). For an early explanation (and optimistic framing) of the utility of discriminant function analysis in archaeology, see Giles and Elliot 1963.

Identification: Sexing the Skull in Physical Anthropology

Anthropologists have long been involved in assigning sex to human remains. There are two primary reasons for the centrality of this practice in physical anthropological and archaeological research. First, when investigators assign a sex (male/female) to a set of remains, this sex status is a key factor used to ground investigations of health, demographics and gender systems in past societies. As human skeletal biologist Simon Mays explained succinctly in his text *The Archaeology of Human Bones*, age and sex “form the background against which other bone data can be interpreted” (1998: 66). Once remains are sexed, information based on that understood sex is used to develop theories of gendered difference in things like work, ceremonial practice and kinship structures. Secondly, knowledge about the sex of skeletal remains is essential for ascertaining information about the “population” from which a particular individual came.¹² Likewise, population group is required in order to determine sex. This is the case because the relative size of skeletal features is essential in assigning them to both a sex and a population group. For this reason, the assignment of sex has never been separate from the determination of the racial/population group from which it comes (Gere 1999). This tangled and shared history is an important part of the story of Facial Feminization Surgery and the claims to essential difference that animate it. As was made clear in the brief history of skull collection above, gender/sex distinction is shot through with the political and ideological practice of racial differentiation. Indeed it was the project of designating racial groups (and hierarchies) that produced the skull collections upon which many measurements of sex distinction were eventually made.

As opposed to other bones whose differences are more difficult to detect through observation alone, skulls are considered valuable in sex assignment because the sex differences they exhibit are discernible to the naked—and well-trained—eye.¹³ Prior to the development of complex statistical analyses that became popular methods for assigning sex in the 1960s and ‘70s (Mays 1998), the sex assignment of human remains was an exclusively embodied skill attributed to the experience and aptitude of individual practitioners.¹⁴ It is these pre-statistical, pre-computational methods that Howard explicitly identified as the source of his “anthropological” assessment of the female skull, for it was indeed the visual assessment of sex that most informed his project. The sites and forms that Howard ultimately designated as problematically “masculine” come directly from this research. In what follows, I provide an explanation of how practitioners of physical anthropology assigned sex prior to 1960, with special attention to how these methods manage uncertainty.

¹² On the formulation of the concept of “population,” see Haraway 1997:248-9.

¹³ Many bones have been studied for their utility in assigning sex. These include the clavicle, sternum, scapula, humerus, sacrum, teeth, tarsal bones, several aspects of the pelvis (ventral arc, inferior pubic curvature, iliac articular surface, sacroiliac osteophytosis), and the femur, among others (Stewart 1979: 93-126).

¹⁴ Developers of statistical models used to determine sex and population group continue to work on systems that they hope will move their practice away from the skills of individual researchers and toward the objectivity of pure numbers. As the preeminent physical anthropologist W.W. Howells explains succinctly, “Your eye, checking with memory, weights certain visible characters as determining kinship, whereas measurements weight themselves objectively” (1995:1).

To the extent that human skeletons can be characterized as sexually dimorphic, that dimorphism is radically conditioned by significant differences in skeletal sizes and shapes across human groups. While it may be taken as a general rule that males are larger and more robust (note the gendered language here) than females, the value of this kind of comparison is only valid *within* a particular group (Howells 1995). So one can say that Northern European males are larger and more robust than Northern European females, but that same female specimen takes on much different meaning in relation to a population that, as a whole, is on the smaller and more gracile (again, note the gendered language) end of the spectrum. Without knowing the sex of a body, it might, for example, be possible to mistake a Northern European female for a South Asian male, and vice versa.¹⁵ Because forms and degrees of sexual dimorphism differ between population groups, general statements about the skeletal differences between males and females are *true* only in limited sites of comparison. “Cranial sexual dimorphism,” write Komar and Buikstra, varies by population and is not as accurate in sex diagnosis as estimates based on the pelvic bones.... Correct classifications for the skull typically range between 80 and 90% *when the unknown is known to be morphologically similar to the reference sample*” (2008: 135, emphasis mine).¹⁶

Sex assignment is also limited by the developmental age of the body in question. It is notoriously difficult to assign sex to pre-pubescent skeletons as the sexually specific changes caused by the sex hormones during puberty have not yet occurred.¹⁷ Similarly, it can be difficult to assign sex in old age. As a result of the drop in estrogen and concomitant relative increase in the influence of testosterone, post-menopausal females often take on some of the skeletal characteristics of males (Meindl, et. al. 1985). The story of skeletal sex differentiation thus features testosterone as its only active agent (cf. Martin 1991). Prior to puberty, all skeletons look alike and can be (sometimes mistakenly) assessed as female. After menopause, the increased power of testosterone begins to “masculinize” bony structures. Femininity, in this scheme, is truly both childlike and time bound. Claims to the distinctiveness of female facial structures are imbricated not only with race but also with age. In short, in-group comparison marks the limit of sex assignment. General rules may guide assessment of sex in cases when population is unknown, but accuracy—and, therefore, utility—is significantly reduced.

Let us proceed, however, on good faith that the identification of sex-specific morphologies that follow are made about skulls of a known population, between the ages of 15 and 45 years old. Our good faith leads us to assume this, as does the fact that while the dependence of race and age on the sexing of skulls is widely acknowledged, they are

¹⁵ I thank Professor Sabrina Agarwal for this illustrative example.

¹⁶ “Cranial sexual dimorphism varies by population and is not as accurate in sex diagnosis as estimates based on the pelvic bones.... Correct classifications for the skull typically range between 80 and 90% *when the unknown is known to be morphologically similar to the reference sample*” (Komar & Buikstra 2008: 135, emphasis mine).

¹⁷ Note the markedly gendered language through which T.D. Stewart explains the skeletal changes that occur during puberty. “As the female moves from puberty into adulthood her skull retains much of the *gracility* and *smoothness characteristic of the prepubertal period*, whereas the male’s skull during this time becomes *less gracile*, relatively larger, and *much rougher* in the areas of muscle insertions. The resulting differences are most noticeable in the orbital borders, supraorbital ridges, mastoid processes, occipital crest (especially its medial protuberance), malar bones, and chin” (1979:88, emphasis mine).

never held as limiting conditions through which we must read generalizations about craniofacial sex difference. By this I mean that although scholars acknowledge the very limited conditions in which the general characteristics they identify can be used to accurately assign sex to specific bodies—and every body is a specific body—, and although they note that there is considerable sex overlap in virtually all structures of the human body, they nonetheless list craniofacial differences in the forms of polar opposition. There are simply two choices: male and female.

For an exemplary index of craniofacial sex differences as understood by physical anthropologists in the first half of the 20th century, I offer a text from Alěš Hrdlička, widely acknowledged as the founding figure of American physical anthropology. He founded the *American Journal of Physical Anthropology* in 1918, and served a forty-year tenure as the curator of the Division of Physical Anthropology at the American Museum of Natural History (which would later become the Smithsonian Institute) beginning in 1903. During this time Hrdlička amassed what was the largest collection of human osteological material in the world (Montagu 1944). Although like his contemporaries, Hrdlička’s collection was primarily undertaken as part of a project that aimed to determine the origins and nature of racial difference (Blakey 1987; Hrdlička 1919), understandings of sexual difference were an essential corollary of this research.

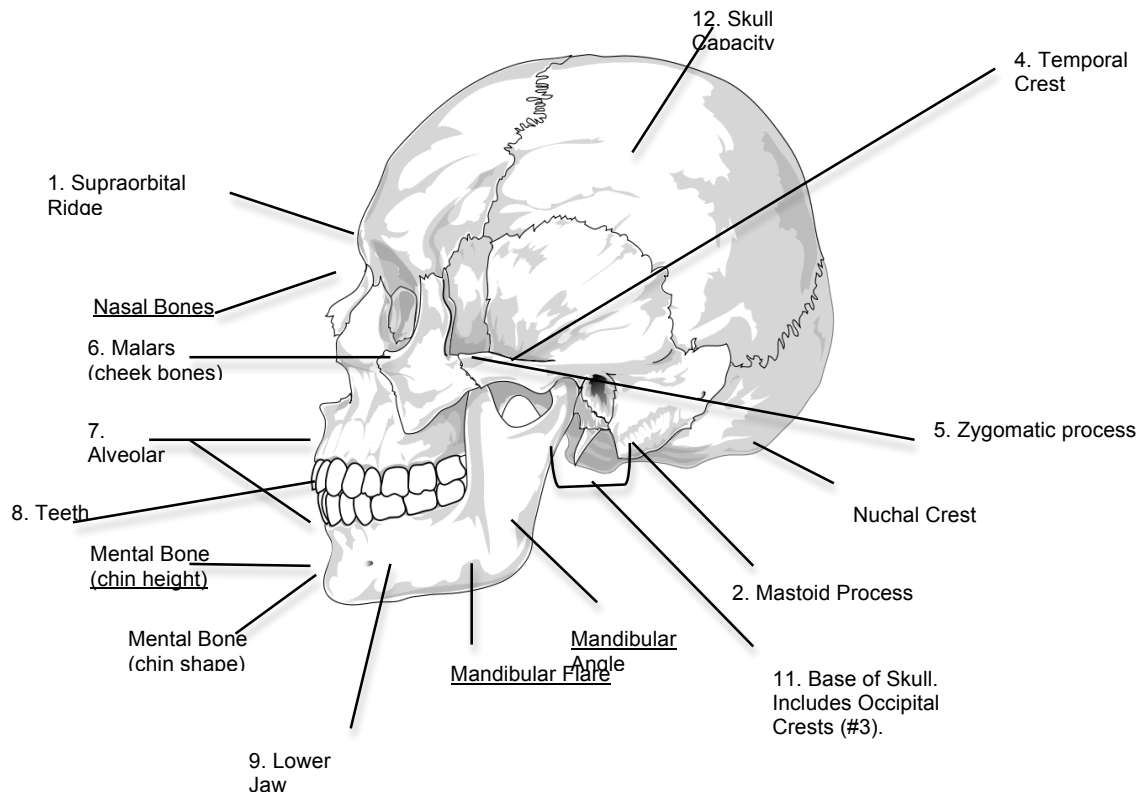


Fig 1.1 Aspects of the human skull thought to display sexed characteristics. Numbered items correspond to Hrdlička’s descriptions in *Practical Anthropometry*. Underlined items are sites of surgical intervention in FFS. Note that the nasal bones, though not included among anthropologists’ indices of sex difference, are a site of surgical feminization. Note also that the multiple sites of sex difference in the cranium are not objects of surgical intervention. The nuchal crest, while not specifically included in Hrdlička’s index, does appear in Simon Mays’ list of the “Specific aspects of the cranium useful for sex determination” by anthropologists (Mays 1998:36). For a description, see Table 1.1.

Table 1.1

1. **Supraorbital ridges** (ridges above the eyes; also called *bossing*): “If we should characterize them, as we do in practice, by the term ‘traces,’ ‘slight,’ ‘moderate,’ ‘medium,’ ‘pronounced,’ and ‘excessive,’ the male skulls will show ridges from moderate to excessive, while the female skulls will be restricted to those of from traces to moderate” (113).
2. **Mastoids** (prominence from the underside of the mastoid portion of the temporal bone): “Mastoids may be ‘small,’ ‘moderate,’ ‘medium,’ ‘large,’ or ‘excessive.’ Male mastoids generally range from medium to large, female mastoids from small to medium.... In individual females of especially strong muscular development the mastoid processes may reach a size corresponding to the ‘moderate,’ or near medium, male” (113).
3. **Occipital crests** (prominence at the posterior, inferior part of the occipital bone): “When well or markedly developed as a rule [these] indicate a male. In general, it may be said that the more marked the muscular ridges and depressions on the occiput and the rest of the vault of the skull, the more likely it is that of a male; and vice versa” (113).
4. **Supramastoid and temporal crests**: These crests and their “roughnesses, when markedly developed, [are] as a rule male, smoothness of the parieties and the rest of the vault speak for female” (114).
5. **Zygomae**: They “may be ‘slender,’ ‘moderate,’ ‘medium,’ ‘strong,’ or ‘heavy.’ They range in males from medium to heavy, in females from slender to near medium. They are generally also broader in the males” (114).
6. **Malars**: “On the whole, in the male they are high and stouter, in the female low and more delicate. In both sexes, of course, there are some intermediary conditions” (114).
7. **Alveolar arches** (the part of the upper or lower jawbones where the teeth are set): These arches “tend in the male to be very appreciably higher, in the female to be lower than the general average.... The arches may also differ more or less in the two sexes in strength, being weaker in the female” (114).
8. **Teeth**: “Teeth are not very good criteria for sex differentiation. On the whole the female teeth tend to be slightly to moderately smaller on all dimensions.”
9. **Lower Jaw**: “The lower jaw in the male shows on the average greater size, thickness, and weight as a whole, a higher body throughout, a higher symphysis [sic] especially, a broader ascending branch, an angle less obtuse than in the female, stouter and rougher gonion regions, and strong condyles. A lower jaw of moderate size and strength, with a low symphysis and body, a rounded or pointed and smooth chin, only moderately broad ascending ramus, delicate or but moderately strong condyles, smooth gonion regions, and an angle of more than 125°, may safely be diagnosed as feminine.... A square chin points strongly to male sex, but is not wholly unknown in the females. Markedly everted angles are as rule masculine” (114).
10. **Palate**: The palate “in the male skull is usually larger, broader, and normally relatively less high than in the female” (114).
11. **Base of the skull**: “The base of the skull in a well-developed male is stronger and more sculptured or rough, in the female it tends to be flatter and somewhat more delicate. It is justified to speak of a ‘male base’ and a ‘female base.’ In all of these features there is some interdigitation between the two sexes” (114).
12. **Skull capacity**: “Skull capacity is a highly useful item in the sexing of skulls.... In general a capacity of above 1450cc. suggests a male, capacity of 1300 cc. or less suggests a female. There are exceptions, but they rapidly grow rarer as one proceeds either above or below these figures” (114).

In his 1939 text, *Practical Anthropometry*, Hrdlička identified twelve distinct sites of sexual differentiation in the human face and cranium (see Figure 1.1 and Table 1.1). Hrdlička summed up these points with an indicator he called the “physiognomy of the face,” “or the total impression that the face, especially with the lower jaw in position, makes upon the experienced observer” (115). In describing this general impression he notes that, “The average male skull presents a decidedly more masculine physiognomy than does the average female cranium” (ibid). The combination of many distinct features “gives the face a certain expression which is of great help in identifying the sex of the skull” (ibid). Put simply, the gendered expectations of the researcher as to what characteristics constitute masculine and feminine appearances become tools for assigning sex. Skulls that, to the researcher, look masculine are thereby assigned male sex, and skulls that look feminine are female.

Sex differences in the human skull (and other bones) are relative, not absolute. The assignment of sex and the creation of a scale that puts males on one end and females on the other is predicated upon and reifies the idea that male and female are mutually exclusive categories. The processes of sex assignment, then, are intended to find the most reliable sites and kinds of difference that allow the placement of a particular human skull into one of those two categories.

While all of these characteristics are listed as components in the process of sex assignment, investigators—both contemporary and past—acknowledge that the determinative power of any and all of these are limited. In other words, while particular bony characteristics frequently indicate either male or female sex, they do not always do so. Hrdlička acknowledged that, “Aside of the sexual organs proper, the characteristics of the two sexes, whether in soft parts or the skeleton, are not completely distinct, but overlap or interdigitate under even the most normal conditions” (111). The normal variation in human forms makes it impossible to locate and characterize unequivocal and absolute site of bodily sex difference.

Nevertheless, Hrdlička claimed in 1939 that the “experienced and careful observer”¹⁸ could “correctly” identify sex in 80 per cent of cases in which an adult cranium was the only object available for analysis. That number increased to 90 per cent when the lower jaw was intact, and rose to 96-98 per cent when the entire skeleton could be examined. In 2008, Komar and Buikstra cited an 80-90 per cent success rate in sexing the skull (2008: 135). “But,” Hrdlička acknowledged, “out of each hundred there will still remain two to four skeletons which, even though complete, show such indefinite sexual characteristics that it will be impossible to identify them by any expert, as either male or female, with certainty” (113).

Even in cases when a complete skeleton is available for analysis, the assignment of sex is not always possible. In 1979, T. Dale Stewart created a five-unit scale that investigators could use to indicate their certainty as to the sex of a given specimen. Stewart’s scale was based on the maximum diameter in the femur and humerus—which, he argued, are among the most dimorphic of skeletal characteristics—but it has since

¹⁸ Hrdlička was quite specific as to the kind and amount of training that an anthropological anthropometrist should undergo. “The worker must have good eyes both as to vision and color. He should be free from halitosis and other unpleasant odors. He must be, if he is to meet with success, sympathetic, persevering, orderly, thoroughly honest and careful. Careful of the sensibilities of his subject; careful in technique, careful in reading the scale of his instruments, careful in recording” (1939:14).

become widely used as a scale to indicate researchers' certainty about sex, more generally. When plotting the values that he hoped could be used to establish a line separating (two and only two) sex groups, Stewart acknowledged that, "An overlap in the distributions for the two sexes is always present, so *only the extremes of shape are reliable indicators of sex*" (86, emphasis mine). Stewart's five-point scale of (un)certainty can be represented graphically as follows.

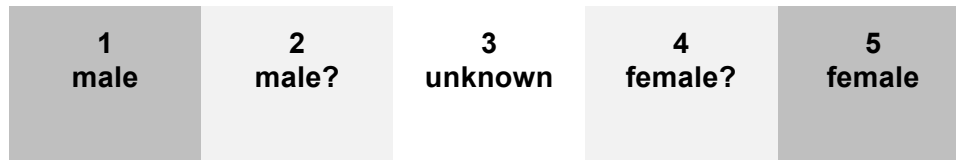


Fig 1.2. Scale of researcher certainty in sex assignment (Stewart 1979).

Three out of five points on Stewart's scale are characterized by uncertainty. Categories 2, 3 and 4 indicate situations in which sex is hard to discern because a given skeleton (or part of a skeleton) exhibits characteristics that are not distinctively male or female. This may be the case because some indicators on a single skeleton fall within "female" ranges and other indicators fall within "male" ranges. For example, one skull may exhibit a "female" brow but have a "male" chin. Investigators may be uncertain about assigning sex to a skull that is internally contradictory or one that does not clearly exhibit sex characteristics in any of its aspects. Certainty is achieved at the opposite ends of the scale; the closer one moves to the center, the less certain one becomes. Thus, some skulls can be said to not have a sex at all.

Like these anthropologists whose methods for assigning sex¹⁹ worked toward the production of certainty, Howard was interested in the extreme end of the scale where the female form was certain. It was this form—the undoubtedly female rather than the probably female or the most likely female—that Dr. Pratt's patient wanted. Therefore, it was that form that mattered. The specificity of this desire is not so concerning to me as the fact that its status as the extreme end of a range of possible forms is wholly absent from the discourse of "natural" and sexually dimorphic craniofacial difference that underwrites FFS. The certainty born of extreme opposition obscures the fact that the neat and mutually exclusive categories of male and female—0 and 1—are artifacts of distinct moments when through methodological and ideological interventions, the variety of human forms gives way to the supposed dichotomy of sexual difference. Claims to

¹⁹ The process of examining the human skull (or any part of the skeleton) in order to categorize its sex is typically referred to as *sex determination*. The language of *determination* puts the epistemological burden on the object itself; the skull holds a truth about sex that the researcher must learn to see. Such a framing naturalizes craniofacial sex difference and effectively masks the multiple interventions undertaken in its production. It is for this reason that I have been describing this process as *sex assignment*. My hope is that this choice of language has helped to shift the epistemological burden onto the investigators, making it clear that it takes work to turn a variety of overlapping and contradictory forms into two neatly oppositional categories. The need for a scale of researcher certainty makes plain that it is the researcher who is creating "facts"—and perhaps later the stories that flow from them—rather than simply reporting a "fact" that the skeleton manifests.

fundamental, oppositional difference are powerful. Especially when they give material form to the desire to alter one sexed body in order to produce *the* other.

As I noted above in my discussion of 19th century anthropological methods for assigning craniofacial sex, these practices are some of the clearest and seemingly most straight-forward examples of performative sex production that I have seen. I am certainly not the first person to see this connection. Feminist archaeologists have critiqued the way that their discipline has relied on contemporary notions of gender to help create knowledge about the past. Among these critiques are critical readings of the methodologies I have been describing. Historian of science Cathy Gere (1999) has argued that the practices involved in assigning sex (or “sexing”) human skeletal material are deeply enmeshed in culturally specific ways of understanding the body. Gere applies Butler’s (1993) critique of the social production of bodies to a sample of texts that address the sexing of human skeletons in archaeology in the mid 20th century. She argues, as I have here, that the very kinds of performative mattering that Butler describes are made visible in the methods that archaeologists use to sex human remains. Social assumptions about sex and race color the ways in which skeletons are placed in these categories, thus quite literally determining how bodies matter.

This is a critique that is shared by some feminist anthropologists. Pamela Geller wages a pointed critique against what she sees as the reluctance of archaeologists to adequately respond to the significant body of gender theory developed over the last forty years.

It is troubling that physical anthropology has not engaged with feminist perspectives beyond early second-wave discussions, as these have been roundly critiqued and problematized. Specifically, third-wave feminist and queer theories destabilize the categories of sex and gender, characterizing them as changing and changeable (Geller 2005:599).

Geller’s criticism focuses on the dependence of bioarchaeology on the universalizing narratives of biomedicine. These, she argues, “distort the past and ultimately reify the modern sex/gender system” (2008:115). The assertion of universal and timeless sexual dimorphism is not the only one at issue for Geller; she is concerned with how assumptions of naturalness undergird processes of classification all the way down. Though she is critical of ceding too much power to “Western understandings and the supposedly ‘objective’ methods of the natural sciences” (2005:599), Gellar also holds a place for the value of biologically based assessments and draws our attention to the uses of those assessments. “Comparing bodies does allow for identification and assessment of biological differences. However, the process of categorization and attachment of specific (and narrow) meanings pertaining to ‘normal’ masculinity and femininity requires reflection...” (Geller 2008:119).

This final statement reveals a persistent tension within archaeological scholarship about how and when to use biologically based evidence about sex and gender, and how and when to critique it as contributing to a narrow ideological regime. Many such critiques take up Butler as a tool for rethinking assumptions that link bodies to the gendered behaviors that archaeologists are often keenly interested in investigating (cf. Perry & Joyce 2001). Thus they seek to decouple the physical from the social, calling attention to the ways in which unstable links between these aspects of human life in the

present suggest the possibility of similar kinds of incongruities in peoples of the past. These interventions do much to destabilize gender, but are still divided as to the status of the human body (and, in particular, the human skeleton) in such a frame. Archaeologist Joanna Sofaer responds to critiques such as those levied by Gere and Geller in asserting that,

Sex has a material reality. It is not simply a representation. It therefore seems difficult to do without osteological notions of biological sex. While an osteological approach may be culturally constructed, it has a clear contribution to make as an effective way of dealing with differences between bodies by providing categories that can be investigated in terms of the social relevance in the past (2006: 96-7).

Sofaer acknowledges the extraordinary and lasting influence of the Butlerian destabilization of the sex/gender binary. For her, this move collapsed the distinction between the biological and the cultural that effectively defined the disciplinary boundaries between material culture schools of archaeology and osteoarchaeology, moving all consideration of the body into the realm of “culture.” The danger in such a move, Sofaer argues, is that it becomes difficult to account for the materiality of the body, especially “morphological differences between the sexes in the skeleton that are effectively out of the deliberate control or manipulation of people” (99). In order to avoid this, she suggests that we reconsider the utility of the biological/social distinction that Butler’s work challenged. “The utility of gender as a concept is therefore as it was originally conceived: it provides an explicit distinction between the biological and the cultural” (Sofaer 2006: 99).

In some respects, this is a tempting framing of the problem. It addresses the shortcomings of a totalizing constructionist paradigm—or what Julia Serano has recently dubbed “gender artifactualism”²⁰—and recognizes the stubborn materiality of the body. However, Sofaer suggests that we address the problem of materiality by simply reinstating the old division between the biological and the social. This solution doesn’t offer a vision that incorporates Butler’s criticism; it self-consciously ignores it. In my reading it does so by simplifying Butler’s argument about how the line between biology and society is constituted, but it also makes recourse to bones—not bodies, but *bones*—as pre-social by definition. This framing keeps the body’s surfaces (skin, hair, dress, compartment) as sites for cultural elaboration, but brackets off the bones as more essential and therefore inaccessible as objects of cultural “control or manipulation.”

Sofaer suggests that the way to get out of the osteoarchaeology=science=sex / interpretive archaeology=culture=gender formulation is to think of the physical body (and in this case the skeleton) as material culture. She shows that the skeleton is shaped by gender-specific practices, making it a gendered as well as a sexed object. The introduction of the body as an object of material culture expands what kinds of claims the body can ground (now cultural as well as natural) but it does not unseat the limiting dichotomy. By this I mean that in this formulation the physical body is knowable

²⁰ I heard this term for the first time in a keynote address that Serano gave at the Lewis & Clark College Gender Symposium, March 10, 2011. By using this term, Serano intended to mark the way in which some constructionist framings of gender conceptualize gender as having nothing whatsoever to do with the biological; gender is simply an artifact of a particular time and place.

differently by both science (biology) and interpretation (culture), but the privileging of scientific determination of sex as the grounding for gender claims still remains. One must know that a skeleton is female to then interpret certain bone formations as the result of a gendered form of work, for example. Framing the body as material culture still posits a fundamental distinction based on skeletal structure that can then be altered through time. It introduces the social to the skeletal, but still privileges the biological.

This debate is illuminating in relation to FFS. There *is* something stubborn about bones. Of the various medical and surgical interventions undertaken to enact a change of sex—endocrinology, urology, gynecology, plastic surgery, hair transplant, hair removal, voice modification surgery and craniofacial surgery—craniofacial surgery is unique in that it is the only mode of intervention that directly alters a patient’s bony structure. The materiality of bones—as opposed to the ephemeral and life-dependent quality of skin and soft tissue, organs, hormones and voices—both engages and enables distinct kinds of knowledge in relation to the sexed and gendered body. As a bone-altering procedure, FFS relies upon and helps to reproduce a narrative of the human skull as an essential—and crucially, therefore, *pre-social*—site of sexual difference. FFS changes the stakes of archaeologists’ debate about bodily materiality when their methods for assigning sex shift from being *descriptions* of sexed bodies of the past, to *prescriptions* of how to make sexed bodies in the contemporary.

The multiple epistemological and methodological uncertainties in physical anthropological sex determination are elided in the process of bringing the “fact” of sexually dimorphic skulls into the surgical realm. Howard undertook research with the aim of determining the differences between male and female faces, and he found it. The general category of “the female skull”—unmoored from its contextual and conditional relationships with race, ethnicity, age and nutrition in anthropology—was a category that could travel.

The bone interventions that emerged from this research in physical anthropology include: brow reduction, rhinoplasty, reduction of mandibular flaring and squareness, reduction of the height of the chin, and contouring the mental bone (chin) to achieve a pointed shape.

Quantification: The Michigan Series

When craniofacial sex entered the surgical realm, it did so not as a conceptual category, but as a pragmatic one. Surgery is interventive medicine. It is action oriented. Because the goal of Facial Feminization Surgery was to produce in a skeletally male patient the structures of a female, Howard understood—and continues to understand—his task as one with delineated and particular parameters. Equipped with the specific sites in the craniofacial skeleton where sex differences are manifest, Howard next needed to quantify those differences in order to produce them surgically. If the supraorbital bossing and frontal sinus are smaller in females, *how much smaller are they?* If the chin height (from the tops of the bottom teeth to the inferior point of the chin) is smaller in a female, *how much smaller is it?* Howard’s personal experience led him to a source that could answer those questions.

Prior to entering medical school, Howard had earned a dental degree from the University of Michigan. During his tenure as a dental student, he worked as a research

assistant on a long-term project designed to measure craniofacial growth. The University of Michigan Growth Study (UMGS) began around 1930 as a longitudinal study of children enrolled as students at the University School. Dean Willard Olson and Professor Byron Hughes designed the study that began collecting data on students who entered the school as first graders and followed them until they finished twelfth grade. In the early years of the study, graduate students overseen by the Orthodontic Department were responsible for collecting maxillary and mandibular dental casts, lateral jaw radiographs and occlusal plane (the plane passing through the biting surfaces of the teeth) radiographs from each child. In 1953, lateral and occlusal plane radiographs were replaced by the collection of lateral and posterior cephalograms (x-rays of the skull).

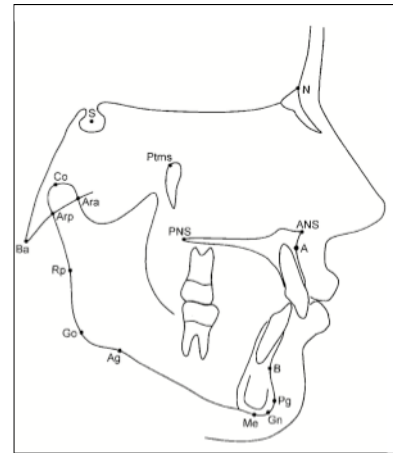


Fig 1.3. An example of a cephalogram tracing that includes several major landmarks.

In the 1950s and 1960s the UMGS was funded in large part by a research grant and a large program project grant from the National Institutes of Health.²¹ Much of the large project grant was devoted to developing methods of computerizing and storing the data produced in the study in a form that would make it accessible to other researchers. Through the language of statistics, this information was made to travel to “those persons in laboratories who do not have access to such data” (1974:2). The NIH renewed the program project grant in 1971, and it was still active when in 1974 the University of Michigan Center for Human Growth and Development published *An Atlas of Craniofacial Growth: Cephalometric Standards from the University School Growth Study* (Riolo, et al., 1974). The data in this volume form the basis for Howard’s measurement of “normal” male and female ranges of craniofacial structures. A copy of this book was sitting on or near his desk during every day of my fieldwork in his office. Pink post-it notes had marked particular pages of the text for so long that their crumpled and exposed edges had faded to white, even in the muted sunlight that filtered in through his office window.

The *Atlas* contains only “descriptive statistical information” as opposed to interpretive analyses of the statistical findings; the authors note that these would be better suited to exploration in future journal articles. The descriptive statistics in the book represent a series of measurements taken on 83 individuals (47 males and 36 females) who attended the University School without interruption from the ages of six to sixteen.

²¹ The UMGS has been collected along with ten of the eleven known collections of longitudinal growth materials in the United States and Canada to create the American Association of Orthodontists Foundation Craniofacial Growth Legacy Collection. “Available documentation of the growth process includes skull x-ray images of various sorts, hand-wrist films, dental radiographs, facial photographs, and physical measurements for children of varied ethnicities, growth patterns and untreated dental malocclusions” (http://www.cril.org/aaof/aaof_home.asp (accessed 5/5/10)). Though I have found no direct evidence to support this conjecture, I suspect that the interest in hand-wrist film is in relation to *The Atlas of Skeletal Maturation* published by T. Wingate Todd in 1937. Todd’s study sought to develop a method to assess the health of children through examining the bones of their hands using longitudinal radiograph series (<http://www.cwru.edu/artsci/dittrick/museum/artifacts1/headspanner.html>).

The collection consists of 3,266 observations in total. Data represented in the *Atlas*, however, are exclusively those from lateral cephalograms (profile view). Researchers also included subjects' height and weight, though no explanation for this is provided. According to the Study's curator, though no data on racial or ethnic origins was recorded, the research subjects were Midwesterners, "primarily of Northern European descent." This subject population of 83 Northern European teenagers determined the kinds of findings that were ultimately produced by this study.

In order to be useful as series data, individual cephalogram images must be rendered into a common form.²² This process involves tracing images from x-ray film onto paper. Each of the cephalograms used in the study were traced²³ four times and submitted to a series of inter-researcher checks for accuracy.²⁴ Next, landmarks were placed on the tracings to establish common points of reference (see Figure 1.3). The number of landmarks given in any cephalometric study varies considerably depending on the objectives of the research. In the case of the UMGS, 57 points of reference were used. But, as has always been the case in the measurement of the skull, the identification and placement of those landmarks is a difficult task. According to the methods section of the *Atlas*, "The first three sets of tracings were rejected because of quality variations revealed by serial evaluation of inconsistencies in tracing routine and in landmark placement" (4). In the rejected sets of tracings, the landmarks were designated by one researcher, and the tracings were completed by another. This problem was corrected in the fourth and final set of tracings by having a single researcher carry out both tasks. A second researcher reviewed this final set of tracings and then sent them to be digitized and stored on magnetic tape.

The process of digitization involved scanning the tracings using an "automatic computer-controlled line follower" (5) that produced a series of x and y coordinates for lines, landmarks, and other features of the tracings that were not included the study but that researchers acknowledged might prove useful in further research. Geometric operations were calculated using selected landmarks.²⁵ Each page of the atlas

²² Cephalograms themselves are the result of many processes of standardization. The orientation of the skull in the image is called the "Frankfurt Plane." The Frankfort Agreement, first drafted in 1883 by German researchers, "consists of the definition of the Frankfort horizontal as a means of standardizing the orientation of the skull for the purposes of comparison and illustration, as well as a set of definitions of measurements, volumes, angles and indices employed in craniometry" (Spencer 1997:404). The film is taken at a standard distance from the midline of the patient's head, and is enlarged at 12.47 per cent, Howard informed me. This standardization is especially helpful in Howard's practice, since patients visit him from all over the world and can arrive with the proper films in hand, no matter where they've been produced.

²³ Tracing is done on a 0.003-in acetate paper with a 0.05-mm lead pencil. The side [of the head] closest to the film is traced. In tracing the mandibular structures, the superior part of the body and distal part of the ramus should be traced (the side [of the body] closest to the film). Whenever there is a double image, the contours of the image can be traced by bisecting the two images (Weinzweig 1999:82-3).

²⁴ "If the data of a subject met all of the error checking specifications, these new subject ages were added to a fast retrieval data bank" (7).

²⁵ Such measurements included distances, angles, perpendicular distances, differences, sums and multiplications and additions of variables. The Michigan Interactive Data Analysis System (MIDAS) was used to perform the statistical functions on the measurements. The mean, standard deviation, and sample count values calculated by MIDAS were used as input to programs which produced the CalComp plots and printed tables which are included in [the] atlas (Riolo et al., 1974:8).

demonstrates the results of one set of measured variables (see Figure 1.4). For example, one page may show the distance between two points, and another the angle measuring the relation between two points. In the center of the page tabulated data is given for male and female subjects, listed by years of age from 6-16. Each row includes the sample size reported, the estimated mean value at each age, and the estimated standard deviation from the measured variable. "If one assumes that the data are normally distributed, one would expect 95% of data values to be within two standard deviations of the mean" (1974:10). The authors indicate that "[statistically] significant sexual dimorphism" can be found in some variables at some ages, but that "Some measurements show no sexual dimorphism" (11). At the bottom of the page a graph shows the male and female means values plotted against age. These graphs provide a visible rendering of the changes in skull shape and size during puberty. The sexually indistinguishable skulls of pre-adolescence can thus be seen to quite literally take shape across the plots of these individual graphs.

Though not identified as such by the authors of the study, it is clear from these reported data that the determination of sex difference in craniofacial growth was a primary aim of the research. Male and female categories organized the presentation of the research findings, and were the values rendered visible through charts on each page. This study is structured by the assumption that male and female are relevant comparison

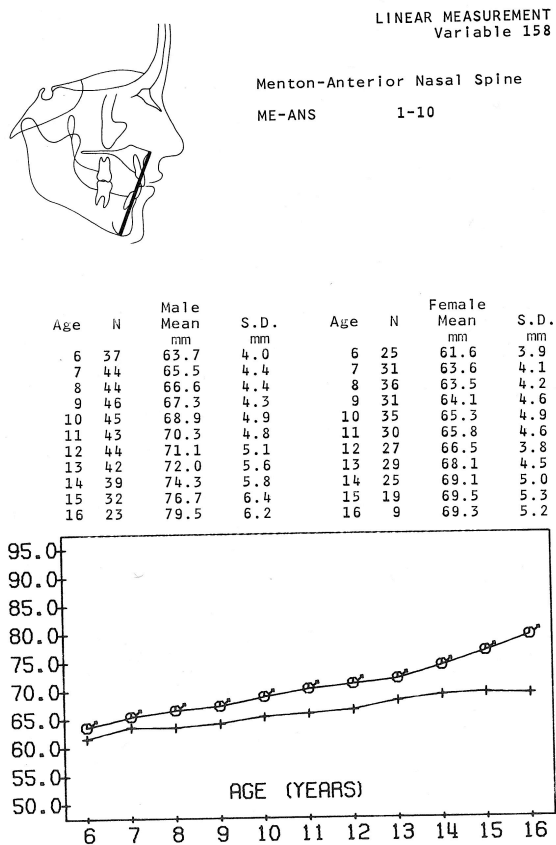


Fig 1.4. A sample page from the UMGS.

groups. Judith Lorber has observed that study designs such as these, “Rarely question the categorization of their subjects into two and only two groups, even though they often find more significant within-group difference than between-group differences” (1994:39). In fact, within-group differences have been rendered superfluous here even before the data are presented. By providing only means and standard deviations, the statistical norming of measurements is total. As Steven Epstein has noted in relation to the work of sex categories in medical research, “Most of the claims about sex differences are, once again, statements about differences between averages” (Epstein: 249).

Differences between the male and female groups were shown to exist in some instances, and not to exist in others. But Howard’s interest in sex-based comparisons in the *Atlas* was not a general one; he wanted to know how to quantify the particular sites of differentiation that his research in physical anthropology had identified. The UMGS *Atlas* provided the concrete specificity of millimeters to anthropologists’ relational indicators of craniofacial sex difference. These numbers do not simply guide his surgical plan; they prescribe the values that must be accomplished in order to meet the burden of the “female” face. These numbers travel with Howard as one of the essential items he brings with him into the operating room. Before beginning an operation, the patient’s frontal and lateral cephalograms are placed on the OR light board and illuminated from behind. In the negative space of the cephalograms, post-it notes display three sets of numbers for each procedure he plans to perform: (1) the measurements he took of the patient’s skull in the pre-surgical exam; (2) the range of the female norm for each skeletal feature, as taken from the UMGS; and (3) the amount of reduction that is required to bring the patient into that normal range. Although the “female ranges” are taken from the UMGS *Atlas*, it has been many years since Howard has actually had to consult the book to find them; he has long since committed them to memory. Once the patient’s skull has been measured, FFS becomes a simple process of subtraction.

In a presentation of his services to a group of attendees at a conference for transwomen and cross dressers, Howard explained how he uses the UMGS to plan patients’ surgeries.

The University of Michigan had these series of cephalograms over years and years, over 50-60 years. They’ve analyzed these, they trace them, and it’s the source of a lot of records and some averages, extremes, standard deviations. We can come up with, based on your skull size, exactly where I want to put you to go from a male to a female. I do reserve some engineering, some aesthetic use of my thumb in the operating room—a little here, a little here—but I like to put things on pretty much a mathematical basis where you’re going to be.

For Howard, this “mathematical basis” is the fact of female craniofacial structure. The UMGS standards are an essential part of his technical practice. Not only do they provide the exact definition of the female face that guides his surgical plan, but they do so through the authoritative language of mathematics. The figures in the atlas allow him to determine “exactly where I want to put you to go from a male to a female.” By invoking these numbers, Howard is able to identify female structure as a set of objective facts, rather than an ideal born of his own preferences.

Annemarie Mol has noted that, “The way individuals are diagnosed and treated depends on the reality of the population that is included when it comes to setting norms”

(2002:132). The UMGS included white, Midwesterners, mostly of northern European heritage. This is a group that displays more markedly sexually dimorphic traits than do other racial/ethnic/population groups. As such, the places and sites of sexually dimorphic skull characteristics are, in fact, indicative of the characteristics of Northern Europeans. The extrapolation is to say, in cases when sexually dimorphic characteristics are present, they will be located in the sites and take the forms of those seen in Northern Europeans. The methodological error is to allow the characteristics of this group to stand as the “universal” set from which all other racial/ethnic groups are simple variations (more on this in Chapter Two). The seemingly universal qualities of sex difference stand against the particularities of non-white racial and ethnic variation allowing bodily sex to stand as an ostensibly racially unmarked master category, something with the power to relate all other characteristics to its self.

Whereas in anthropological practices of sexing, the unknown sex status of a skull could be ascertained in part through the recognition of “feminine” and “masculine” physiognomies and thereby used to assign a skull a sex of “female” or “male,” in the UMGS the sex status of study participants is already known. Therefore characteristics used to describe and differentiate “female” and “male” subjects are read as “feminine” and “masculine” respectively. This sort of chicken-and-egg situation—in anthropological methods knowing what feminine look likes helps to identify which skulls are female, and in UMGS knowing which subjects are female means that information that distinguishes them from known males is by definition feminine—becomes problematic when it is invoked within a project of sex change. By stating his ability to move patients “from a male to a female” through facial surgery, the complex relationship between “female” and “feminine” disappears. Indeed in these two examples we see how “feminine” has shifted from describing the characteristics of a skull that look female, to the characteristics of skulls belonging to schoolgirls in a study. The collapse of these categories allows a very narrow—if not singular—female form to emerge. But even with this set of numbers, Howard still had to learn to see the sexed face in the way that Hrdlička and his contemporaries saw it: as a whole structure that gives a total effect of masculine and feminine.

Action: The Atkinson Library of Applied Anatomy

The final piece of research that Howard needed before undertaking surgical intervention was an examination of skulls themselves. After conducting research with the aim of feminization, he had to learn to see skulls—these objects that had been the focus of his intensive study and notable career—in a new way. This final phase of Howard’s foundational research took him to a private collection of skulls called the Atkinson Library of Applied Anatomy. The Atkinson Library is a collection of approximately 1400 dry skulls housed at the University of the Pacific Dental School in San Francisco. The collection was personally assembled by Dr. Spencer R. Atkinson (1886-1970), a renowned dentist and orthodontist who amassed the skulls over a forty-five-year period beginning in 1919 (Dechant 2000:18).²⁶ Like many of his contemporary collectors, Atkinson

²⁶ Dr. Atkinson was inspired to start the collection when as a graduate student studying orthodontics he was denied the ability to section university-owned skulls in order to better understand their structural

avoided the pitfalls and politics of collecting the bones of deceased white Americans and instead grew his collection with skulls from “bioavailable” (Cohen 2005) peoples whose bodies were deemed more appropriate for collecting. Through his own efforts and those of an extended network of friends and colleagues, he built a collection that included skulls from Africa, Australia, Japan, China, and native peoples from North, Central and South America (Pollock 1969).²⁷ This widely dispersed geographic sampling was not only prompted by the complexities of acquiring the bodies of white Americans, but also contributed to a research program that valued the supposed untouched development of so-called primitive peoples. The value of collecting skulls from “primitive regions,” Atkinson believed, was that they constituted “basic research” about how “natives lived and died in the same fashion as their ancestors, knowing nothing of sanitation, hygiene, or the blessings of medical care” (Atkinson 1963:591).

The aggressive collecting practices and sheer number of individual collectors who contributed specimen to this collection in its early years meant that there were no standards in terms of the kinds of information recorded about any particular skull. The kinds of provenance that are typically used in collections of this kind are simply missing in many cases. Atkinson’s colleagues traveling in Central and South America returned from their research trips with skulls about which they did not know even basic pieces of information such as sex, ethnicity, original site of burial, or age at death.²⁸ The only information that accompanied some skulls was the word MEXICO scrawled across the bones of the cranium in pencil. It is for this reason that the Atkinson Library is classified as a mixed collection. A mixed collection is one in which there is no distinction made between individuals of different racial/ethnic groups.

Taken in the context of the purpose of the collection, the omission of these demographic data is not particularly surprising. As an orthodontist, Atkinson was primarily interested in studying the growth of the skull as it affected dental and orthodontic anatomy and physiology. His interest in structural variation was not necessarily conditioned by statuses such as race or sex, though his desire to collect specimen from “primitive peoples” offers a glimpse into a more complex relationship to these categories than the classification of the collection suggests. Like the University of Michigan Growth Study, the goals that drove the production of the Atkinson Library were organized around the face as a much different object than the one that Howard went there to research.

components. Thus dissatisfied with the limitations of using other people’s collections in his research, he began his own.

²⁷ According to a 1969 article by H.C. Pollock commemorating the establishment of the Atkinson Library, “Indian examples from the West Coast of North America are included, as well as those of the Flathead Indians of Montana and the Pueblo Indians of New Mexico” (Pollock 1969:511). Pollock goes on to write that Atkinson himself “searched and unearthed several Indian mounds in California and on the islands off the California coast” (512). According to Dr. Dechant, the Library’s curator, the collection includes 15 skulls from Native Americans; this is unusual because most American collections contain many more. Due to the ethical and political complications of holding Native American remains since the 1990 passage of NAGPRA (Native American Graves Protection and Repatriation Act), Dechant does not acquire or accept donations of Native American remains in the collection. Dechant reported that she has not encountered any conflict over repatriation in relation to the Library’s existing holdings.

²⁸ This is considered by many researchers to be a significant shortcoming of the collection, and a main reason why the collection is used by only about ten researchers each year.

For our purposes, the fact that the Atkinson Library is a mixed collection is important because assigning sex is very difficult in this kind of sample. As noted earlier in the chapter, there is considerable variation in skull size related to racial/ethnic difference.²⁹ It is for this reason that the curator of the collection, Dr. Dorothy Dechant, is careful to classify particular specimen as “probably” male or female, based on the sizes and shapes of particular features. If a researcher’s project hinged on knowing for certain that x skulls were male and y skulls were female, Dechant said, she would be very hesitant to guarantee the sex of any particular skull. “The best we can say is probably,” she told me. Even if one did not know the sex of the deceased, Dechant offered, one could line up a series of skulls to get a sense of the gradation in morphology that is typically understood to distinguish sex. This is precisely what Howard did. It is when those differences in morphology are read independently as sex indicators that the interdependence of race, sex and age categories is erased. In this kind of seriation exercise, a skull that had been classifiable only in relation to others within its population group can now be independently evaluated against the observer’s ideas of masculine and feminine. Just as Ecker pronounced the handsome and womanly skull to be female, so Howard found what he took to be typical male and female specimen in the Atkinson collection, even while the curator herself was unwilling to name them as such.

When Howard visited the Atkinson Library in order to determine how the surgical project of producing female facial features might be undertaken, his interest was in seeing the structural constitution of male and female faces. Lacking definitive examples of those, however, the Atkinson collection did provide examples of feminine and masculine faces. What is crucial to see here is not that “feminine” skulls were identified because it is “feminine” features that FFS patients desire. Rather it is that “feminine” skulls were performatively produced as female, and the fact of their femaleness was used to underwrite Howard’s claim that he can surgically construct a distinctively female face. The gendered ideal of femininity became the fact of female sex—not only descriptively, but prescriptively, as well. It was transformed from a look, an effect on the viewer, into a surgical plan.

The “female face” that emerged as a result of this research process was quite a specific one, though its claims to efficacy and utility as a sex changing model relied upon—and continues to rely upon—its presentation as the form of generalized human craniofacial sex difference. The particular histories and contingencies in the forms of evidence from which it was derived have disappeared completely from the scene; they are absorbed by the surgical claims that opened this chapter: there are anthropological differences between the faces of men and women. Part of what accounts for the persistence and persuasion of this claim is its assumed stability as a total fact of the human species; it reflects both common sense and (now) scientifically backed understandings of the world. But the “femininity” that Howard and his patients were ultimately after, was itself not as consistent and determined as his mathematical formula to femaleness would suggest. “The face” that animated Candice’s initial surgery remained a structuring model in Howard’s practice for more than ten years. But then it changed.

²⁹ While age at death is also a factor in sex assignment, the presence of intact dentition provides a highly reliable indicator of age.

Numbers are Certain (But They Change)

Though numbers guide Howard's work—and his definition of the female is shored up by their legitimacy as objective indicators of fact—those numbers have changed over time. These changes are not the result of a new set of orienting figures, but instead reflect his experience and the experiences of his patients over nearly 30 years of performing FFS.

[Early on] I knew what the average female had and what the average male had, and where the extremes are. It was interesting: In about 1992 I did a forehead II on a lawyer from New York City. My end point at that time was different. She looked very good, but she came back in about 1995 or '96, and she brought a lot of pictures of models. You couldn't make measurements on them, but what was obvious was that the forehead was much further back than what I had been doing. She asked me if I could do her again. I did and it made all the difference in the world. She was a female before, now she was an attractive female. It changed my whole end result. It changed my approach. Everything changed. It's given, as a result, a much more beautiful patient.

I'm more aggressive now than I was even two years ago. Most of my aggressiveness has been caused by patients who come back and say, 'Can you take off a little more?' For example, the lower jaw. What I did in 1995 is quite different from what I do in 2010. I go much further. And I think my results are better because of that.

Howard learned *through practice* that average women were not magazine model material. Although this patient had, in his mind, been successfully feminized—in that her face had been reconstructed within the ranges of the female norm and she regularly passed as female—she did not look like a model. She was female, but not beautiful. This patient insight was a revelation. “Average women are not beautiful,” he told me pointedly during our first conversation, “and average men are not handsome. I had been making average women; now I could make more beautiful women.” Making patients “more beautiful” involves “going much further,” removing even more bony structure from their already newly “female” skulls. A narrower jaw. A more recessed forehead. As I have demonstrated, in Howard's research process, “feminization” was already reduced from a general “female” category to an extreme end of the spectrum of craniofacial morphology in which femaleness was a certain attribution, rather than a possible one. Now it is clear that this already circumscribed and particular notion of the “feminine” had tightened down even further.

Tightening down the “feminine” was not a product of the physician's research alone. Rather, like the impetus for the initial development of the procedure, the drive to move further was spurred by patient request. The recursive relationship between transpatients and their doctors is a crucial one. Whereas trans patients are often portrayed as passive recipients of the medical advancements made by physicians and surgeons (Talley 2010), in fact they are frequently active participants in shaping those advancements. Patients have continued to influence Howard's work by providing feedback on their procedures and by asking him to move further toward the extreme end of the ranges of femininity that guided his early practice. “Going further,” has been driven by his patients,

but it has also changed his perception both of the goal of the procedures and of the quality of his own work.

In addition to the guidance provided by patient feedback, Howard has also honed his own sense of female attractiveness—what he above called the “aesthetic use of [his] thumb”—but this, too, finds its form in terms of numerical values. He finds his source in “the golden mean,” a ratio from the ancient Greeks (attributed variously to Aristotle and Pythagoras) expressing the middle way between excess and deficiency. Howard explained the importance of this ratio to a group of prospective patients.

Proportions, I think, are really extremely important. The Romans did it one way but I think the Greeks really had it appropriately. It's said that Pythagoras did it, some say it's another Greek mathematician, but they developed the Golden Mean. The Golden Mean is the square root of 5 plus 1 divided by 2. It comes out to be 1.618 and goes on and on. It's interesting how pervasive this is throughout nature. If you put this [a caliper designed to calculate the Golden Mean] on your fingers, for example, adjacent fingers, this will absolutely fit your hand.³⁰ [It fits] successive rows of seeds in a sunflower, the chambers of a chambered nautilus. I think this is extremely important in female aesthetics. I don't think it's very successful in male aesthetics, but in female aesthetics I think it's an absolute winner. Much of my work is devoted to getting your face into these proportions.

It is not clear from this telling whether the statistically derived “female face” manifests the ratios of the Golden Mean, or whether the application of this figure is part of the “aesthetic use of [his] thumb.” It is clear, however, that these aesthetic standards are derived from a particular historical and racial origin that saw in its own form the ideal of natural beauty.

Though the ancient Egyptians took measurements of the body, the Greeks were the first to include facial measurements in their quantification of bodily forms (Vegter & Hage (2000:1090). Artists have paid attention to these differences for centuries. Indeed the reconstructive surgeon's insistence that his is both a scientific and artistic endeavor makes the structure of the gendered face an unsurprising site for the express intersection of these forms of knowledge and practice. Dutch artist and physician Petrus Camper (1722-1789) contributed the concept of the “facial angle” as one way to characterize the different groups he observed in the crossroads that was his contemporary Amsterdam (Schiebinger 1993).³¹ He defined the beautiful face as one in which the facial line creates

³⁰ This example, offered to illustrate a point, is a fraught one all on its own. Recent studies have used the ratio of finger length as a proxy for measuring the role of androgens on fetuses. These scholars take the presence of androgenizing hormones as impacting—if not determining—sexual orientation. Too little testosterone creates gay men; too much testosterone creates lesbian women (c.f. Lippa 2003; Rahman & Wilson 2003; Williams, et al., 2000). To offer the golden mean as a reliable measurement of the ideal hand, then, is to posit the lesbian hand, in the case of Williams, et al., as deviation from the ideal. In their text, at .96 the lesbian finger ratio falls directly between that of straight men (.97) and straight women (.95) (Williams, et al., 2000: 455). This is just one of many studies, past and present, searching the body for the origins of identities and behaviors that transgress gender and sexual norms.

³¹ The most widely applied use of facial angles was in ranking skulls: male to female, white to black. Camper used his “facial angle” in research beginning in 1768, and published its definition in 1791 (Spencer 1997:406). Camper suggested that the natural relationships between apes, Negroes and Europeans could be discerned through proper measurement of their skulls. “For him,” Schiebinger writes, “skulls revealed *natural* relations between humans, not cultural artifice” (1993:149). Though defenders of Camper claim

an angle of 100° to the horizontal—far superior to the Roman standard of 96° (Gilman 1999b:50). This was an ideal derived not from the study of human faces or even of human skulls, but was instead taken from the measurement of Greek statuary.³² This, according to Sander Gilman, is an exercise of the “Kantian idealization of high art as

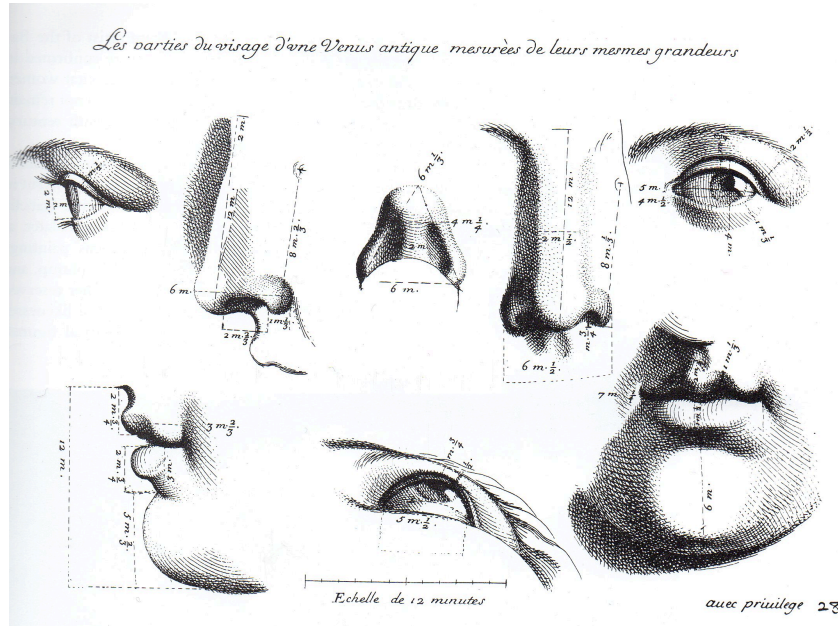


Fig 1.5. Measurements of the facial features taken from the statue of Venus (Romm 1992:59).

providing transcendent models for human beauty” (1999:50). The idealization of (already idealized) Greek formulae for the identification of the “classic female” reiterates the preference for—and power of—particular bodily forms to become models for the sexed body writ large.

I have a lot of patients who come to me and say, ‘I want you to do my forehead and nose and my scalp advancement. But if you look at so-and-so, she’s a good looking model and she’s got a nice, big, full lower jaw and she’s got a big masculine chin. Or maybe you want the chin done but you don’t want the jaw touched. I’m happy to do whatever you want. But I can guarantee you—or I can

that his was a wholly descriptive project and not one devoted to ranking the value and relative advancement of racial groups (Kemp 1999), the images he produced likening “Negroes” to orangutans have become iconic in discourses of “scientific racism.”

³² Gilman quotes Lorenz Oken, a German philosopher and naturalist who acknowledged that while “no face grows” at the most desirable angle, the Greek representations of perfection are the closest in existence.³² They surpass the works of Roman artists who rendered faces at an angle of 96° —still a significant departure from the angle of 80° observed in the faces of “beautiful” humans: “How come, that this unnatural face of the Greek work of art is even more beautiful than that of the Roman, even though the latter is closer to nature? The reason for this lies in the fact that Greek facial aesthetics represents even more the will of nature than those of the Roman; for there the nose is quite perpendicular, parallel to the spine, and thus returns from where it came. He who simply copies nature is a bungler, he is without inspiration and mimics no better than the bird, song, or the ape, gestures” (as quoted in Gilman 1999b:50).

tell you by experience—that almost all of those people will come back to me and say, ‘I’m being read, please get rid of it.’ ... I think these large jaws and these large chins are not classic female. I think they’re very much the result of the modeling agencies. They’re looking for someone that looks a little bit different, a little bit stronger in this, something striking. But it isn’t classic female.

Norms of beauty, in this telling, may change with time and fashion, but femaleness is an enduring category with stable and identifiable referents. Moreover, it is the instantiation of these referents that guarantees passing as female in the FFS project. Femininity can be beautiful, so long as it is first distinctly female.

These fundamental claims about the origins and forms of the feminine and the female continue to guide Howard’s work in the “feminization” of transwomen’s faces. They are, as I hope I have shown, claims that make complex and uncertain links between scientific and aesthetic forms of knowledge, finding their ground in historical and contemporary notions of sex difference across a variety of evidentiary sources. Archaeology, orthodontics, dentistry, radiography, ratios and Greek statuary are collapsed into mere triangulations of the same fact of the human world. The power of this story comes from the sure-footed effacement of these complexities: women look different than men.

As a (highly contingent) material property, facial sexual dimorphism is expressed and made accessible through a variety of always already differentially interested discursive regimes—gender, expertise, race, medicine, and experience among them. Contemporary critical thought has moved us beyond the modernist notion that the world is somehow available to us in an unmediated and pure state; we cannot understand bodies as somehow being prior to discourse. Nor can we think of them as being the exclusive products of discursive forms and moves. Bodies have material properties that both enable and constrain possibilities for actions and identifications in the world. In the case of FFS, the hard bones of the skull literally mark the limits of the body’s gendered possibilities.

It is useful to think of the facial sexual dimorphism that underwrites the concept and practice of FFS not simply as a reflection of the natural world, but as a process of its disclosure (Hekman 2008, 2010). Feminist philosopher Susan Hekman adapted the term and concept of *disclosure* from philosopher of science Joseph Rouse as one way to think about the material world through the interventions of the “discursive turn” of the latter half of the twentieth century. For Hekman, disclosure is a concept that acknowledges that perspectives, concepts, and theories matter. They are not simply abstractions, “they are our means of accessing reality. But disclosure also entails that we do not constitute that reality *with* our concepts, but rather *portray* it in varying ways. An important aspect of this understanding is that the reality... is agentic. It pushes back, it effects the result” (Hekman 2008:112). “There are,” Hekman writes, “Different material consequences to different disclosures” (ibid.). We need not think of this agency as conscious or self-asserting.³³ In the experience of the patients with whom I worked, and so the discourse of

³³ As opposed to other contemporary formulations of agential matter (cf. Barad 2003, Bennett 2010, Hird 2009).

FFS more generally, the face pushes back against the possibility of an endless play of gender. There are bodily features that foreclose bodily possibilities. The face reasserts itself in each encounter: it is there again, enabling and limiting the body's ability to be the vehicle for a subject in the world. The face is thus disclosed through a variety of discourses, the genealogies and stakes of which I have worked to represent here. It is (at least) a problem of history, of epistemology, of race, of time, of aesthetics, and of the market. These are the discourses through which the material fact of a particular set of bone and soft tissue structures become not only instances of a visage recognizable as (fe)male, but as the very instantiation of that category.

In order to think through the concept of disclosure, it is crucial that we begin from something small (not in size, *per se*, but in scope) in order to trace its conditions of being and the refractions from it. The human skull, as an icon of humanity itself, is a potent place to begin. This is the case because it has been used to ground so many theories of being and difference, and because it stands at the center of both contemporary and historical efforts to make difference and similarity, socially speaking, into a material form. The skull is an object that has stood at the center of a variety of claims—about life and death, about the line between human and animal, about the distinctions between races, and, as I have shown, the distinctions between sexes. These are, anthropologically speaking, divisions and distinctions that constitute forms of life as such.

The female face of FFS is the face of a 16-year-old, Northern European, Michigan schoolgirl, modulated by the ancient mathematic appeal of the Golden Mean. To state this plainly, and to rehearse the particular genealogy of this female face as I have done here is not to deny the existence of facial difference. Howard is certainly correct that we humans are generally very, *very* good at assessing the sex of faces we encounter. An overwhelming majority the time, we know males and females when we see them.³⁴ Attempting to deny or otherwise nullify this point would not only require ignoring a considerable body of evidence, but would also effectively undermine the patients who sacrifice a significant amount of money and personal comfort in order to undergo these procedures. These patients are not naïve and neither are these surgeons. What they want is the effect that comes from the category *feminine*. Examining how that effect is produced helps to shed light on the constitution of that category and the forms of knowledge—technical, historical, and aesthetic—used to produce it.

FFS is a set of knowledges and techniques that emerged from a very particular confluence of persons, desires, and modes of understanding the body. In this chapter, I hope to have shown how the ostensibly universal *category* of “female” was put through the mangle of very specific objects, biographies and forms of knowledge to emerge, on the other end as the same category, but now in a very particular *form*. Like the broader category female, the female craniofacial form is deeply entwined with notions of racialized gendered aesthetics as the biological category of female is shifted, displaced and rearranged by notions of desirable feminine beauty. The assumptions not simply of the existence but the political and epistemological valences of sexed and gendered difference preexisted Howard's goal of defining the female face. They helped to guide his initial research into the constitution of a distinctly female form, and have since continued to shape his practice in the form of patient feedback. Here, as elsewhere, it is the case that

³⁴ According to some studies of facial assessment, participants are able to correctly assess the sex of faces 96% of the time (Andreu and Mollina 2008).

while it may be transwomen who are submitting their bodies to a physician for modification, they are far from passive participants in the surgical scene. Patient desires and expectations continue to shape what “feminization” means, if not in concept then certainly in practice.

For patients, the contingency and uncertainty that I have recounted in this chapter is quite simply irrelevant. Whereas the ability of these women to change their faces had only been a fantasy some years ago, Howard’s research has this fantasy into reality. The certainty with which he describes the transformations—both physical and social—that these procedures produce is one that speaks powerfully to those who have experienced how certainly their current faces mark them as male. For these women who are motivated to pay the considerable financial and physical costs that this surgery requires, there is no question that their faces are masculine now. The particular physical characteristics that render them recognizably masculine are not as important as the fact of that recognition itself. The promise of FFS, like all specifically MTF medical interventions, is that what is now unquestionably male can be rendered unquestionably female. If the existence of a distinctly *male* form is one that patients inhabit bodily, then the existence of a distinctly *female* form is not only certain, but essential. This form doesn’t just tell a story about human sexual dimorphism, it comes to animate the desires and personal fantasies of those who believe that achieving this form will profoundly change their lives.

The Procedures

The Full Face

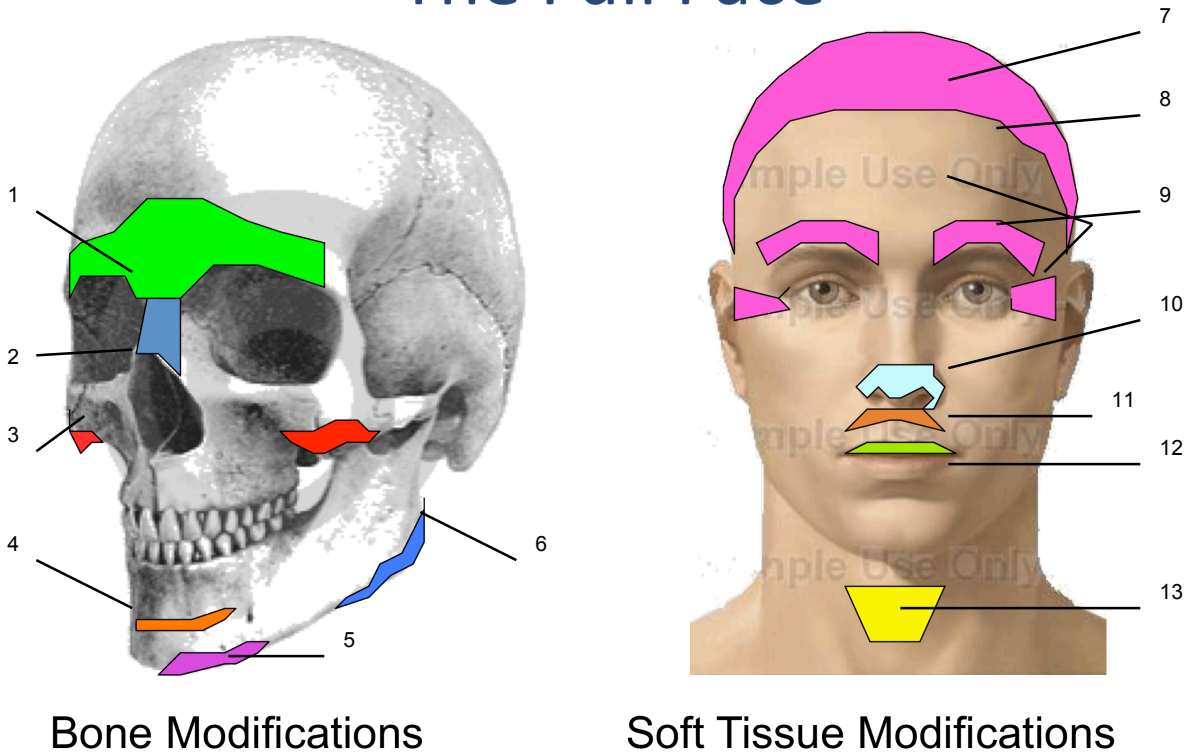


Figure 1.6. Sites of bone and soft tissue surgical intervention often involved in FFS.

Facial Feminization Surgery includes interventions in both the bone and soft tissues of the face. In general, the procedures involved in FFS are aimed at taking away or reducing particular features of the bones and soft tissue of the face. This focus on reduction and removal is based on a fundamental assertion that males are, on the whole, larger and more robust than females. This assertion applies both to the bony skeleton and to soft tissues such as skin and cartilage. Whereas the modification of the facial bones are guided, at least in Howard's case, by numerical norms, most soft tissue procedures are not. (The exceptions are the height of the upper lip and of the forehead; these assessments are guided by numbers and measurement). Instead, soft tissue procedures are often oriented toward and aesthetic ideal of feminine attractiveness.

Below are brief descriptions of the surgical procedures organized under the sign of Facial Feminization. Not every patient undergoes all of the procedures described here, though some certainly do. In Dr. Howard's parlance, a patient whose surgery includes all of these procedures gets, "The Full Face."

While one of the fundamental goals of this dissertation is to trouble the claims to absolute difference that often animate FFS, in the following descriptions I make use of the dichotomous distinctions that doctors use when characterizing the masculine features of patients' skulls.

Bone Procedures

1. Brow Bossing and Frontal Sinus: The prominence of the brow is one of the most distinctive and recognizable aspects of a masculine face. Some reduction of the brow can be accomplished through burring down the bossing (the thickness of the bones) just above the eyes. In other cases the anterior wall of the frontal sinus (the empty space just above and between the eyes) is removed (“unroofed”) and set back. The reduction of the frontal sinus is considered the most aggressive of all procedures involved in Facial Feminization Surgery (see Figure 1.7).

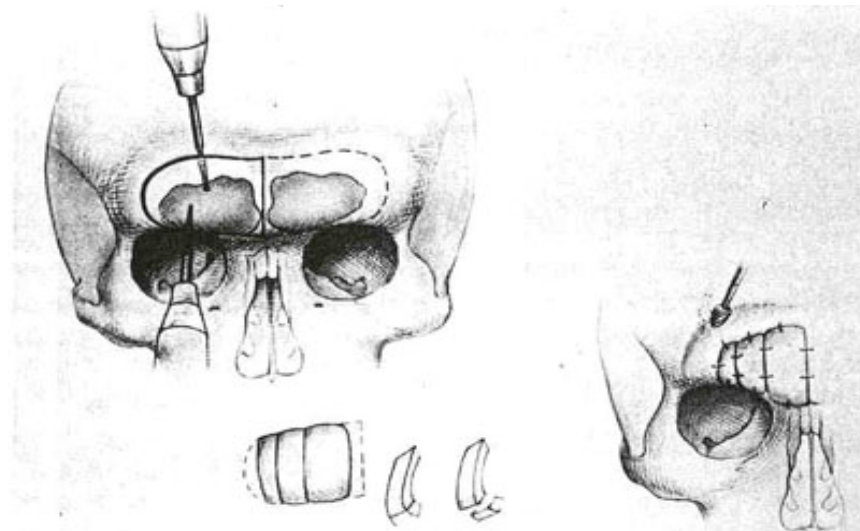


Figure 1.7 Cutting out the anterior wall of the frontal sinuses, sectioning into pieces, and wiring them in place after sinus margins (right) have been contoured.

2. Rhinoplasty (internal reshaping of the nasal bones): Rhinoplasty involves the fracturing of the nasal bones as well as the removal of cartilage. More radical bone fracturing and removal is required when frontal sinus reconstruction (1) is performed. When the forehead is “set back” through this procedure, the bones at the nasion (the depressed area between the eyes just superior to the bridge of the nose) must be reduced in order to create the desired relationship between forehead and nose.

3. Malar (cheek) Implants: In order to produce the desirable oval shape of the female face, implants may be placed over the malar bones to enhance the fullness of the cheeks.

4. Genioplasty (chin shortening): Based on the claim that female chins are shorter than male chins (as measured from the top of the bottom teeth to the most inferior point of the chin), a wedge of bone can be removed from the chin, and slid forward. Moving the bottom section forward also results in creating a more pointed chin (see note 5).

5. Reshaping mental protuberance (chin): A pointed chin is recognized as feminine, whereas a square chin is masculine. In combination with the advancement of the inferior portion of the chin, contouring is also done to enhance this characteristic.

6. Reduction Mandibuloplasty (jaw bone): Alterations of the mandible focus on the undesirable squareness of the masculine jaw. This squareness is attributed to two aspects of the mandible: mandibular angle and mandibular flare. The mandibular angle describes the angular value of the posterior and inferior portion of the jaw. The more acute the angle, the more masculine the jaw. This is best seen from profile. Mandibular flare describes the extent to which the squareness of the jaw extends toward the lateral sides of the face. This squareness is best seen when looking at a person from the front. In both cases, bone can be removed in order to reduce the appearance of masculine squareness.

Soft Tissue Procedures

7. Scalp advancement: By severing the tissue that connects the scalp to the skull, the scalp may be brought forward toward the face to help a patient compensate for a receding hairline. Excess tissue at the top of the forehead is excised. Scalp advancement as well as hairline reshaping and eyebrow raising (items 8 and 9) all occur through the coronal incision (from ear to ear just behind the hairline) required to alter the bony contours of the forehead (item 1).

8. Hairline Reshaping: In addition to bringing the hair-bearing scalp forward, the hairline itself can be reshaped. In this procedure, the M shaped male hairline is rounded out to reduce (if not eliminate) temporal baldness caused by a byproduct of testosterone.

9. Eyebrow Raising/Crow's Feet Reduction/Forehead lift: As noted above (see item 7), these procedures are performed at the site of the coronal incision after the bone work on the forehead has been completed (see item 1). When tissue is excised during scalp advancement (item 7), the position of eyebrows is raised up higher on the forehead. This is described as a feminine characteristic. The appearance of the eyebrows is also changed as a result of the changes to the bones of the brow and forehead beneath them. The pulling of the skin of the forehead generally produces the addition (and typically considered beneficial) result of eliminating the wrinkles around the eyes often called crow's feet. During this procedure, surgeons have access to the internal muscles of the forehead and may choose to perform a perforation of those muscles; this procedure is typically referred to as a forehead lift.

10. Rhinoplasty (reshaping of the cartilage and tip of the nose): The tip of the nose is given its shape by internal cartilage. After the bone modifications have been made (see item 2), the cartilage can be reshaped in order to achieve a "more feminine" nose.

11. Upper lip shortening: According to the surgeons with whom I worked, males have a longer upper lip (distance between the bottom of the nose and the vermilion part of the upper lip) than do females. This distinction can most easily be seen by observing how

much of the upper teeth are visible when a person's mouth is slightly open. This measurement is referred to as "tooth show." The length of the upper lip can be reduced by excising the desired amount of tissue just beneath the nose, raising the upper lip toward the nose, and applying sutures in the crease just at the base of the nose. This also results in increasing the amount of vermillion visible in the upper lip.

12. Lip Augmentation: Lips can be augmented through a variety of procedures including the injection of pharmaceutical products (such as Botox and Restylane) or fat taken from other sites in the patient's body. More permanent augmentation can be achieved by placing some of the tissue excised during the scalp advancement (see item 7) into the tissue on the underside of the upper lip.

13. Reduction of the thyroid cartilage ("Adam's Apple"): The Adam's Apple—or more properly, the thyroid cartilage—is considered to be one of the clearest indicators of maleness. Thyroid cartilage removal is often referred to as a Tracheal Shave (or just trach shave) despite the fact that it is neither the trachea being altered, nor a shaving motion used to reduce it. While a relatively simple procedure, the thyroid cartilage reduction carries significant risks. An inexperienced surgeon may remove more tissue than necessary, and inadvertently alter the site where the vocal chords insert. This can result in a radical modification of vocal pitch.

Chapter Two

“Facial Feminization Surgery Is Different”

We restore, repair, and make whole those parts of the face which Nature has given but which Fortune has taken away, not so much that they may delight the eye but that they may buoy up the Spirits and help the mind of the afflicted.

—*Gasparro Tagliacozzi (1546-1599)*¹

Considering their many commonalities in both discourse and practice, it is no wonder that parallels are frequently drawn between FFS and more mainstream plastic surgeries of the face. The ambiguous and shifting status of “feminization” at work in Facial Feminization Surgery (FFS) poses ontological as well as analytical problems. What kind of surgery is this? What, exactly, does it do? The aims of FFS are legitimized—and, by extension the methods used to meet those aims are justified—by a claim that FFS reproduces the “natural fact” of a distinctly female craniofacial structure, one that *literally* gives shape to the transwoman’s desire to transform her body. At the same time, however, the “natural fact” of the female face has been shown to be the product of an extraordinary amount of scientific labor, all of which has been influenced by gendered and racialized ideals of desirable female aesthetics. The expectations and demands of desirable femaleness helped to produce the norms that FFS in turn actively reproduces. This latter form of “feminization” is best understood not as an effort to produce femaleness, a biological category, but beauty, an aesthetic one.

FFS is undeniably similar to cosmetic surgery of the face in many ways. It works to make undesirable faces into desirable ones (variously construed) and it does so by operationalizing ideals of “feminine” aesthetics. The avowed commonality in desired ends of these surgeries—the production of “normative femininity”—does not mean that all procedures performed to that end are historically, ethically, and analytically identical. In other words, if we consider all surgical procedures intended to produce “normative femininity” as essentially doing the same thing, we ignore the particularities of their development and application, and the larger social, ethical and medical conditions within which these procedures are understood to make a kind of therapeutic sense, even if—and perhaps especially when—that sense is contested.

Whether it is considered as an operation that creates the beautiful or the female, FFS can be examined in relation to two distinct bodies of literature: that of cosmetic

¹ Tagliacozzi is known as “the father of modern plastic surgery.” This quotation appeared in Maltz 1936:18.

surgery or that of transsexual surgery. These literatures may share some adjacencies and common histories, but the points of their contact are often points of contention. In her 2007 book *Self Transformations*, feminist philosopher Cressida Heyes reads three projects of self-making—genital sex reassignment surgery, dieting, and cosmetic surgery—through a Foucaultian critique of discipline and normalization. In the introduction to the book she acknowledges possible critical responses to the project.

I anticipate the most poignant critique will come from transsexuals who object to the appropriation of their experiences for the purpose of gender theory and to any discussion of sex reassignment that falls within the same cover as a discussion of cosmetic surgery (12).

Further,

Some trans activists might be justifiably apprehensive... that any association between SRS and ‘boob jobs’ will serve to delegitimize even the current limited insurance coverage or the social understanding that accompanies transsexual transition (12).

Heyes’ acknowledgement of these potential conflicts is telling. She anticipates that transsexuals will object to having a discussion of sex reassignment surgery *under the same book cover* as any discussion of cosmetic surgery—as though the adjacency of the printed pages is itself a provocation (she avoids even this by putting the chapter on dieting between them)—and that *any association between SRS and boob jobs will delegitimize* the social understanding of transsexual transition.

I think Heyes is correct that associations between sex reassignment surgeries and surgeries that are classified as “cosmetic” are likely to draw criticism from those who assert that these procedures are essentially and *meaningfully* different. This assertion of difference is linked to the understanding of transsexualism as a unique condition that justifies its unique treatment. It also relies on and helps to reproduce a caricatured understanding of cosmetic surgery as only undertaken by vain people indulging their desires for superficial attractiveness.

In spite of—and perhaps especially because of—their multiple similarities, doctors and patients involved in FFS continuously assert a distinction between it and cosmetic surgery. Whereas cosmetic surgery is characterized as motivated by vanity and undertaken to produce beauty, FFS, it is asserted, is motivated by the essential longing that characterizes transsexualism and is undertaken to produce femaleness. Through this attribution of common ends, doctors and patients equate FFS to genital sex reassignment surgery. Both surgical interventions are intended to transform the patient’s sex from male to female; they are simply different kinds of sex. The vast majority of patients that I interviewed had prioritized FFS above other gender-related body modifications, asserting that changes to their face would enact a greater shift in their lives than would changing other sex aspects of their bodies (see chart on patients’ prioritization of interventions in the Introduction). Extending the *transsexual* treatment logic multiplies the location of sex in the body, framing the face and skull as distinctly sexed objects whose reconstruction does not stand in for genital sex reassignment surgery, but instead redefines how “sex” is changed.

This chapter is not an effort to resolve the multiple readings of FFS, but to situate them in relation to literature on the social studies of surgery broadly speaking, and to literature on the history of transsexualism and sex reassignment surgery. I show that the distinction between FFS and other kinds of facial plastic surgery is a critically important one to the patients and surgeons with whom I worked. They produced and defended this distinction by contrasting the serious and essential nature of transsexualism to what they construed as the capriciousness and vanity of other surgeries. I explore how this difference is produced and maintained, but am not concerned with investigating the veracity of the claims that structure it. What is most important to me is how doctors and patients act and relate to these claims, not whether they stand up to some mode of scrutiny external to them. The boundary work undertaken to separate trans-specific surgeries from other kinds of elective surgery has fundamental ontological stakes, as well as practical and personal ones. As is always the case, consistent discursive and rhetorical work is required in order to maintain boundaries that might crumble without this work. While FFS is certainly not reducible to cosmetic surgery, the distinctions between the two are not always stable and clear. Paying attention to how and when these distinctions are drawn can help make clear the stakes of these surgeries both to the patients and surgeons involved in them, and to the critical apparatus used to assess them.

Plastic Surgeries: Reconstructive, Elective, Cosmetic, Aesthetic

Though plastic surgery is a centuries old practice, it was not until the 1980s that it left the realm of exceptional practice and became a rapidly growing commodity available to the mainstream consumer market in the United States.² Over the last 30 years, scholars with a variety of disciplinary and political commitments have studied the social impacts of plastic surgery, especially plastic surgery of the face. As the title for this section suggests, several words have been used to describe plastic surgeries that are performed by patient choice rather than by medical necessity. These words are not simply categories for grouping different kinds of procedures. As historian of medicine Sander Gilman has explained, efforts to classify surgical interventions are fundamentally contests for legitimacy (1999a:3-20). Naming a given procedure as *reconstructive*, *elective*, *cosmetic*, or *aesthetic* surgery aligns that procedure—or refuses its alignment—with powerful rhetorics of necessity, validity, choice, vanity, authenticity and artifice. Just as surgeons and patients marshal these surgical categories in attempts to legitimize and justify surgical interventions, so do critics use them to describe and define their objects of study and to locate their work within a growing body of scholarship on this topic. In the following pages, I sketch the valences of these words—*reconstructive*, *elective*, *cosmetic*, and *aesthetic*—in order to think through how analytics from each of them might impact a critical reading of FFS.

² To be sure, elective plastic surgeries of many kinds were available before this time. By identifying this date I mean to draw attention both to the rapid expansion of procedures that began at this time, as well as to the emergence of a distinct body of critical literature generated in response to it.

Reconstructive Surgery: Making Normal

Reconstructive surgery aims to restore the body's anatomy and physiology following traumatic injury, the loss or deformation of a body part caused by disease, or as a corrective to a congenital malformation. Reconstructive procedures aim to establish healthful and normal form and function to the body where it is lacking. As such, reconstructive surgery carries with it the justification of medical necessity. Whereas it has become commonplace to gasp and joke about the surgical habits of celebrities such as Joan Rivers and Michael Jackson and to question the ethics of the surgeons who repeatedly operate on them, few find fault with doctors who replace the jaw of someone who has been disfigured by a car accident, or who repair the malformed bodies of newborn children. Though it could be argued that some such surgeries are undertaken in order to improve the body's appearance and serve no physiological function or necessity, the creation of "normal" anatomical structures generally determines a surgeon's plan of treatment.

Reconstructive surgery, of all types of surgery discussed here, carries with it the legitimizing power of its basis in anatomical and physiological normalcy. But certainly the idea of how the normal is constituted is a contentious one, and its production is not always as straightforward as its supposed basis in anatomical correctness. Recent reconstructive surgeries have drawn critical attention to the ethical and phenomenological concerns raised by surgical attempts to repair a body to the state of the normal through allografts, or donor body parts. In the cases of the first hand transplant, performed in 2001, and the first penis transplant, performed in 2006, both recipients rejected their new body parts and requested that they be amputated in spite of the fact that the transplants were successful.³ Ethicists have also raised questions of bodily integrity and identification in relation to newly developed "face transplant" procedures (Agich & Siemionow 2005; Strong 2004). Efforts to produce the normal by masking the visibility of congenital syndromes have also been contentious among doctors, ethicists and patients. Facial surgery to reconstruct the characteristics typical of children with Down's Syndrome (Strauss 1996) has come under critique regarding parental intervention and issues of consent (Suzedelis 2006) as well as those who claim such disability erasing practices as "backdoor eugenics" (Goering 2003). Questions of consent and the cost of "normalization" procedures on infants have been raised in relation to intersex "correctives" surgeries in recent years, as well (Chase 1998; Karkazis 2008; Fausto-Sterling 2000; Reis 2009).

The case of FFS certainly raises questions about the status of the normal. As is evident from the discussion thus far, the constitution of the "normal" female face is a product of a significant and varied research effort. In addition to prompting questions of what counts as normal, however, FFS also evokes a line of questioning that is frequently presented in relation to genital sex reassignment surgery and medico-surgical interventions for transpeople, more generally. Namely: it is ethical to transform a part of the body—here, the face—from one normal state to a *differently* normal state? It is not my purpose to debate this question. Here, I want simply to note that the answer to this question is usually deferred by recourse to another one: is FFS a necessary procedure? It

³ "Man Rejects First Penis Transplant." *The Guardian*, September 18, 2006.

is in this sense that the question of surgical necessity versus surgical choice becomes paramount.

Elective Surgery: ethics of choice

Elective surgery is used to describe surgical procedures that are not urgent and can therefore be scheduled in advance. Because *elective surgery* is a designation based on the lack of a procedure's urgency, it can be used to describe those that are medically necessary (such as a mastectomy to remove malignant breast cancer), as well as those that are not (such as a planned Cesarean section, or a facelift). The fact that choice characterizes these procedures—and indeed names them as *elective*—has itself emerged as a site of ethical critique. The choice and ethical enjoiners involved in organ donation (Cohen 2001; Fox & Swazey 1992; Kaufman, et. al., 2006; Sharp 2006), family planning operations (Cohen 2005; Guttmann 2005), and non-emergency Cesarean section (Bourgeault, et. al., 2008; Roberts 2008) for example, have been the topic of increasing critical attention in recent years. Central to these analyses is an interrogation of the notion of “choice” in contexts of economic, class, and kinship demands. What one “chooses” to do, in short, both reflects and helps to produce a host of social realities.

Work on elective surgery pushes us to think critically about the framing of FFS as a “choice” or “preference,” a framing whose power lies in the implicit contrast to procedures that are recognized as life saving. In this contrast, life-saving procedures are *necessary* while elected procedures are merely *desired*. The question of whether medico-surgical treatments for transpeople are necessity or desired is one that hinges on the institutional and etiologiical status of the “disorder” for which it is offered as treatment. As I will demonstrate later in the chapter, since even before the distinct diagnostic category of “transsexualism” existed, its status has been contested. If transsexualism is institutionally recognized as a psycho-medical disorder, then its treatment ought to be as accessible and routine as that of any other such disorder. If, on the other hand, transsexualism is construed as a non-disordered expression of personal identity, then its treatment is left up to the individual to procure, as is the situation for any other expression of personal identity. Though medical and mental healthcare providers increasingly recognize transsexualism/Gender Identity Disorder⁴ as a valid diagnosis in need of care, the question of its legitimacy is often raised in debates about extending health insurance or state-funded care to transpersons.⁵

The suspicion of and contempt for some “chosen” procedures exists in tension with an increasing trend toward what Robert Crawford (1980) long ago dubbed “healthism,” or the drive to individualize health problems. This dynamic has more recently been reframed as part and parcel of an ever-increasingly neo-liberal regime in

⁴ “Transsexualism” first appeared as a diagnostic category in the DSM-III (1980). This designation was renamed “Gender Identity Disorder” in the DSM-IV (1994). This change in nomenclature was intended to decouple the diagnosis from its medical and surgical treatment (Pauly 1992), though the underlying conceptualization of the ‘problem’ of Transsexualism did not change when its name changed (Becking, et. al. 1999).

⁵ Conflicts over whether incarcerated transpeople should have access to state-funded hormones and surgery have been the focus of recent scholarly and activist work (Spade 2003, Lee 2008, Smith & Stanley 2010). In July 2011, the ACLU won a suit that made the denial of hormonal treatment to incarcerated transwomen against the law in the state of Wisconsin. Similar suits are pending in other states at the time of this writing.

which each of us is responsible for cultivating the self-actualization that comes from living in “healthy” bodies (Briggs & Hallin 2007; Rabinow 1996; Rose 2007). In such a situation, when actively working toward our own health and happiness is not simply an expectation but is also increasingly an obligation, the status of “optional” surgery is an ambivalent one. Choosing to undergo surgery is just one of the ways in which we may demonstrate care for ourselves and the will to optimization that has come to characterize a life well lived.

This dynamic becomes further complicated in the case of trans-specific medical interventions by the fact that “passing” is often framed as a moral imperative and is frequently taken as the sign of a “successful” transition. It is often noted that transsexuals “disappear” as a result of transition, that process constituting a movement⁶ from a recognizably trans body into a transparently “normal” one (Bornstein 1994; Green 1991; Stone 2006). While the act of disappearing is sometimes a strategic one that ensures safety in potentially dangerous situations and is also frequently the goal of the individual person for other reasons, this kind of normalized disappearance is often framed as morally good and psychologically healthy. In her critique of this imperative, Sandy Stone described the stakes of passing this way: “The highest purpose of the transsexual is to erase him/herself, to fade into the normal population as soon as possible” (2006:230). This kind of disappearing meets a social need to be rid of transpeople as visible disrupters of the stability of hegemonic gender roles. It allows transpeople to be, well, just people unmarked by other exceptional qualifiers.⁷ In such a case, when we are exhorted to act as our own medical agents, when “passing” is framed not only as a desire of the patient but as a sort of social good, and when the face stands as the possibility of passing, reading FFS as a purely “elective” surgery becomes difficult.

The two types of elective surgery that have been most often critiqued are cosmetic surgery and aesthetic surgery. Scholars who write about cosmetic and aesthetic surgery critique their status as “chosen” within matrices of gendered and racial dynamics, respectively. Questions about the availability *to choose* these kinds of procedures frequently structure this research, as scholars draw critical attention to the differential values of beauty as a raced and classed property of the body.

Cosmetic Surgery: feminist focus on beauty

Cosmetic surgery generally describes non-medically necessary procedures intended to improve a person’s appearance. Such procedures may include facelift, blepharoplasty, rhinoplasty (nose surgery), tummy tuck, neck lift, and liposuction, among others. The term itself has its roots in cosmetic dermatology, a field that developed at the end of the nineteenth century, though the combination of cosmetics and medicine dates back to classical Egyptian and Greco-Roman writings (Gilman 1999a:12). In our

⁶ For a discussion on metaphors of motion in relation to transition, see Prosser 1999.

⁷ Stone was among the first critics of the imperative that transpeople “disappear” after transition. Bornstein (1994) later joined her in suggesting that instead of disappearing, transpeople should remain visible as such. Both authors argued that such radical visibility would constitute a form of embodied resistance to the hegemonic gender system, and make it possible for transpeople to “tell the truth” about their lives. Such an act would then help to ameliorate the damning reputation of transpeople as deceptive and ashamed.

contemporary parlance, *cosmetic surgery* carries the connotations of cosmetic products as those that are added to the surface of the face or body in order to improve its appearance.

Just as the use of cosmetic products is decidedly gendered, so too is the use of cosmetic surgery. Though the rate of male patients undergoing cosmetic surgical procedures is growing (as is the market for men's cosmetic products⁸), the vast majority of cosmetic surgery patients continue to be women. According to the American Society for Aesthetic Plastic Surgery (ASAPS), in 2008 women in the United States underwent over 9.3 million cosmetic procedures, accounting for almost 92% percent of the total cosmetic surgeries performed. The ASAPS also reported that the most popular surgery in 2008 was breast augmentation, accounting for more than 355,000 procedures.⁹ The fact that the overwhelming majority of cosmetic surgery patients are women—and that the most popular procedure is a distinctly gendered one—has been a consistent point of criticism for feminist scholars. Feminist writers use the designation *cosmetic surgery* to call attention to the gendered aspects of these surgeries, and to bring focus to the distinctly feminine and idealized notion of “beauty” that they argue motivates them.

Much feminist writing on cosmetic surgery interrogates the nature of the desire for surgery. In other words, these texts ask *why* women want to undergo cosmetic procedures and examine their reasons within a broader framework of social, political and ethical concerns. For some critics, female patients' desire for cosmetic surgery reflects a social reality in which the female body is portrayed as defective and in need of repair. Far from a solution to the problem of bodily unhappiness, Susan Bordo argues, cosmetic surgery “is a burgeoning industry and increasingly normative cultural practice. As such, it is a significant contributory cause of women's suffering by continually upping the ante on what counts as an acceptable face and body” (1997:43). According to this position, women are victims of a patriarchal culture in which they are always portrayed as inadequate. From this perspective, the desire for surgery is a form of internalized misogyny that leads women to take drastic measures toward an always-receding goal of perfection (Morgan 1991, Wolf 1991). These texts focus on the inherently harmful gendered aspects of cosmetic surgery, and seek to understand the forces that compel women to undergo it, rendering post-operative women as effects of social (and patriarchal) forces, variously construed.

For other feminist scholars, most notably Kathy Davis, the desire for cosmetic surgery is portrayed as an empowered exercise of agency in which women take charge of their own lives and navigate the often overwhelming medical complex on a mission for self-actualization (Davis 1995, 2003).¹⁰ Davis' is a sort of reclamation perspective in which the very surgical procedures that had been conceptualized as detrimental to women could instead be used to empower them. “In a gendered social order where women's possibilities for action are limited, and more often than not ambivalent,” she writes, “cosmetic surgery can, paradoxically, provide an avenue toward becoming an embodied subject rather than remaining an objectified body” (2003:85). Following a similar line of argument, Margaret Little has argued that it is unethical to deny helpful treatment to

⁸ “Men's Cosmetics Becoming a Bull Market.” Andrew Adam Newman. *The New York Times*, September 1, 2010.

⁹ <http://www.cosmeticplasticsurgerystatistics.com/statistics.html#2008-FACTS> (accessed 1/17/11).

¹⁰ Bordo decries arguments such as Davis' that she thinks blindly exalt “agency” as though it exists outside the social situations in which it is exercised.

people who suffer as a result of their appearance when the technology to alleviate that suffering is widely available (1998).¹¹

Whether construed as an effect of external forces or a the exercise of internal will, the 1990s era focus on women's motivation for surgery tends to flatten and generalize the overall picture of surgical patients. It also reflects a time in which cosmetic surgery was a less ubiquitous practice than it has become in the last ten years (Fraser 2003:3). In their 2009 *Cosmetic Surgery: A Feminist Primer*, Cressida Heyes and Meredith Jones assert that the radical change in landscape between when feminists began studying cosmetic surgery and the realities of its practice in the present day necessitates a shift in approach. "The political commitments or research methodologies that might have been a good match for the cosmetic surgical scene in 1988 may not suffice in 2008" (2009:2). Because of its exponential growth in popularity over the last few decades, the study of cosmetic surgery is no longer limited to feminist scholars engaged in its critique.

One part of this shift has been the extension of what is included under the rubric of *cosmetic surgery*. As notions of beauty have been linked in critical ways to ideas about race, class, and nation, what constitutes *cosmetic surgery* and what must be considered in its analysis has broadened considerably. It is no longer possible in this broader milieu—if indeed it ever was—to stage white, upper- and middle-class women patients (in this case otherwise physically healthy women) against doctors as though surgery is a one-way enterprise. "The effects of cosmetic surgery," Suzanne Fraser writes, "are not limited to those individuals who undergo it. Instead, cosmetic surgery redraws and/or stabilises certain aspects of culture and thus the production of our own subjectivities and materiality in significant ways" (2003:24). In order to think about the effects of cosmetic surgery as a series of interdependent discourses Fraser focuses, "not on cosmetic surgery participants themselves, but on cosmetic surgery as the circulation of gender" (24).

Many contemporary engagements with cosmetic surgery—feminist and otherwise—take a middle way between celebrating surgery as an exercise of women's agency, and condemning it outright (Gagné & McGaughey 2002). Elizabeth Haiken's excellent book, *Venus Envy: a history of cosmetic surgery* (1999), takes, as the title suggests, a gender-focused perspective on the history of elective surgery in the United States. In drawing powerful narratives through the centrality of military and combat medicine in the development of plastic surgical techniques, Haiken argues that cosmetic surgery has always been a gendered pursuit. From the rehabilitation of injured soldiers who were expected to play the role of providers for their families, to the ascendance of "self-esteem" as critical to both men's and women's successes in life, love and work, Haiken shows that notions of proper and ideal gender have driven the development of cosmetic surgery in the United States (see also Serlin 2004).

In addition to engaging a widening perspective on the constitution of surgical ideals in the United States, a growing body of work is focused on the specificities of cosmetic surgery outside of the context of its use among middle- and upper-class white American women. Like Edmonds's examinations of the cosmetic surgery industry in

¹¹ Little acknowledges that the origin of women's suffering may in fact be a misogynist society, but preventing women from accessing surgery only further denies them power to improve their situations. At the end of the day, she argues, the personal change of a facelift happens much more quickly than does fundamental and systemic social change.

Brazil (2007, 2009, 2010), Weiss and Kukla, for example, argue that analyses of cosmetic surgery must be situated within distinct political, ethical and historical realities.

We need to proceed by turning a critical eye to the origin and social meaning of the particular desires that are encouraged and gratified by procedures and in particular settings. The hard work will lie in unpacking the subtle differences between our possible relationships to various projects of self-transformation—the differences between complicity, creative co-option, resistance, inauthenticity, colonialism, and so forth (2009: 129).

These analyses recognize that desires for surgical modifications are not simple and transparent, but are rather shaped by and help to give shape to complex ways of understanding the body. For these scholars, forms of body modification must be situated in relation to dominant understandings of the gendered body that are themselves always informed by shifting notions of race, class, politics and place.

Aesthetic Surgery

Much of the literature reviewing the status of race as a surgical category was presented in Chapter Two. Here, however, it is important to note that in scholarly writing, the term *aesthetic surgery* is most notably used by historian Sander Gilman. “The name *aesthetic surgery* seems to be a label for those procedures which society at any given time sees as unnecessary, as nonmedical, as a sign of vanity. ‘Aesthetic’ surgery is the opposite of ‘reconstructive’ surgery, which is understood as restoring function” (1999a:8, emphasis in the original). For Gilman, the significant axis of this vanity is racial rather than gendered; he uses the term *aesthetic surgery* to signify this difference in focus. “‘Aesthetic’ procedures,” Gilman writes, “were and are those that enable individuals to pass into a category that they perceive as different from themselves” (1999a: 25). Though his focus is on the way that surgery enables passing as a member of a more desirable racial or ethnic group, it is clear that the emphasis on passing is central to the project of Facial Feminization Surgery, as well. Additionally, the focus on the racial work of aesthetic surgery would prompt us to ask which norms of the beautiful and feminine are being employed in FFS. As was demonstrated in Chapters One and Two, the unmarked category of “female” that underwrites the FFS project is, in fact, a white one.

Gilman argues that the history of aesthetic surgery has long been linked to notions of health and healing, though the site of the disease and its cure are not the same. In *Creating Beauty to Cure the Soul* (1999b), he traces the linkages made between the body’s surface and its interior in various psychological and psychoanalytic theories. The association of aesthetic surgery as a curative to disease and disorder was, he argues, a deliberate attempt to legitimize its practice and justify its performance as good medical science. “In creating an archaeology that places modern ‘aesthetic’ procedures in historical line with (and parallel to) ‘reconstructive’ procedures, aesthetic surgeons and their historians attempt to provide a ‘serious’ medical context for aesthetic procedures” (Gilman 1999a:15). *Reconstructive surgeries* are undertaken on the abnormal body, whereas aesthetic surgeries intervene in the normal body for purposes of enhancement (Naugler 2009:229). The constitution of the normal and the conception and location of disease are, however, not simple matters.

Frameworks for Writing About Surgery

My purpose in laying out these different classifications of surgery and the scholarly work that has been generated about them is to provide a basic context within which an examination of FFS might take place. Writing on reconstructive surgery asks us to examine the ethical and phenomenological issues that are raised by surgeries performed in the name of producing the normal, and emphasize the possibility that the normal may come at the cost of the good. Work on elective surgery encourages us to investigate the social, economic, and political conditions under which surgical procedures are framed as an exercise of choice. Indeed, it is crucial to remember that the costs of transsexual transition (from psychotherapy, to hormone therapy and hair removal, to various surgeries) puts it out of the reach of many, many people. Of all of the procedures listed above, FFS can be far and away the most expensive. (I address this topic more fully in Chapter Three.) Work on cosmetic surgery asks us to consider the overwhelming gender bias of procedures intended to “improve” or “enhance” a person’s appearance and, more broadly, how ideals of raced and gendered appearance (“beauty”) are created and put into action. Further, feminist critics of cosmetic surgery stress the need to consider the broader cultural impacts of these procedures as an ever-more-common way to live in a modern—and appropriately female—body. The body is increasingly disaggregated in late capitalism, making all its parts available for specific forms of care and improvement. As the sites of gender specificity proliferate, so too do their correctives. Work on aesthetic surgery acknowledges the importance of surgical interventions in the gendered body, but focuses our attention on the work that it does on bodily (mostly facial) characteristics that are recognized as signifying a person’s race and ethnicity. This work is also committed to understanding the political and historical circumstances by which the characteristics of particular racial and ethnic groups emerge as more valuable and desirable than others.

To categorize FFS as any one of these kinds of surgery is to call certain of its aspects to the fore, while others recede into the background. Under what conditions can FFS be characterized as a choice? What does the existence of it *as a choice available to some and not to others* complicate how we think about it as an elective procedure? To what extent do notions of beauty and of femininity constitute each other? What racial and ethnic categories form the basis of surgically produced femininity?

Insisting that FFS be considered in combination with the logic of genital sex reassignment surgery as opposed to any of these alone is to assert that FFS is about the creation of sex in a way that none of the others are. By doing so, advocates of FFS engage in a discourse of femininity that is putatively separated from notions of beauty. Even those patients who know that they cannot reasonably hope to be beautiful, fully expect to be feminine. This expectation is structured by the understanding that while beauty may be an effect, a subjective assessment, femaleness is an objective property of the body.

At the time of this writing, the only other social scientific accounting of FFS is a short article by Heather Laine Talley entitled, “Facial Feminization Surgery: The Medical Transformation of Elective Intervention to Necessary Repair” (2011).¹² As is evident from the title of this piece, Talley’s analysis focuses on the ways in which surgeons construe FFS as necessary and restorative surgery as opposed to the “elective cosmetic”

¹² Talley currently has a book manuscript under review that includes a chapter very similar to this essay.

intervention that Talley understands it to be. Her argument—based on observations of surgeons’ presentations of their work at trans- conferences, and the interpretation of a small number of promotional and explanatory materials distributed at these conferences and made available on surgeons’ websites—focuses on FFS as a promoted commodity. She levies an argument akin to many feminist analyses of cosmetic surgery in which she emphasizes the role of the surgeons in creating and promoting “the inadequacy of transwomen’s faces that inspires intervention” (201). FFS is, for her, the result of a “diagnostic strategy” that requires “a technology of repair” (190). Though a focus on physicians’ discourse is important—and indeed is one of my primary aims here—by leaving patients completely out of this story, Talley’s surgeons read like manipulators and hucksters “who stand to benefit commercially” (197) from their staging of the masculine face as “deformity.” She identifies surgeons’ practices as coercive, in that by identifying the differences between masculine and feminine faces, patients are given no alternative but to engage in the repair work that FFS offers. Following a well-trodden path of feminist and medicalization critiques, Talley argues that FFS is a “technology of normalizing gender variance,” that focuses on “changing the individual rather than the society that presumably makes living life difficult for transwomen” (200).

While I have several critiques of this reading, what is important to point out here is that when FFS is read simply as a cosmetic procedure whose only distinction is that it is being performed on a new group of patients and so relies on a new way to sell gendered inadequacy, one misses the manifold ways in which the history of trans-medicine bears on this growing contemporary practice. To leave out this history is to ignore the particular salience that this surgery has *as a surgery that enables a transition from male to female*. As a trans- specific intervention, FFS joins a long history of diagnostic disputes and therapeutic philosophies that has significant impacts on what patients and surgeons think FFS can do.

The Etiological and Treatment Paradigm of Transsexualism

The surgical scheme initially developed—and most commonly employed—in the name of sex reassignment is genital reconstruction: sex is assigned at birth through a visual assessment of the genitalia, and it is therefore *reassigned* through the reshaping of these organs. This system of sex determination is overwhelmingly concerned with the presence of the phallus as the marker of maleness (its absence does not necessarily meet the conditions of proving femaleness) (Kessler & McKenna 1978). In this system, the genitals stand alone as the location of physical sex. As such, it is changing them that enacts a change of physical and legal sex (more on this below). Framing FFS as a surgical alteration that changes sex, effectively multiplies (and sometimes wholly relocates) the site of bodily sex and therefore the project of sex change from the private subjectivity of the genitals to the public sociality of the face.

Anne Fausto-Sterling has chronicled the ways in which the bodily influences of the “sex hormones” estrogen and testosterone have been linked to a multiplicity of bodily characteristics and behaviors that have nothing to do with reproductive functions.

Now that the label of sex hormone seems attached with epoxy to these steroid molecules, any rediscovery of their role in tissues such as bones or intestines has a strange result. By virtue of the fact that so-called sex hormones affect their

physiology, these organs [and bones], so clearly *not* involved in reproduction, come to be seen as sex organs. Chemicals infuse the body, from head to toe, with gender meanings (2000:147).

While facial characteristics are clearly not recognized as primary sex characteristics, they are construed in FFS discourse as secondary sex characteristics. Because the masculinizing changes in facial morphology are linked explicitly to the effects of testosterone in the body during puberty, “masculine” characteristics are understood to be sites of sexual distinction. As Fausto-Sterling argues, this makes the bones of the face into sexed objects. Their alteration is, therefore, a means of changing sex.

The concept and category of *transsexualism* as a distinctly recognized pathological incongruence between body and mind emerged in clinical writings in the 1950s. Its short history has been a contentious one. Historian Joanne Meyerowitz describes the establishment of the *transsexual* diagnosis as characterized by turbulent disagreement about the nature of the new disorder, its possible causes, and its potential treatments. “From the start,” she writes, “the doctors and scientists fought among themselves about the explanatory powers of biology and psychology, the use and abuse of medical technology, and the merits of sex-change operations” (2002:6).

Ever since its emergence as a diagnostic category, those medical and psychological practitioners who advocated its treatment have had to work to justify their conception of transsexualism as a somatic problem (as opposed to a psychological or environmental one) that is best treated through an alteration of the body’s physical characteristics. Early on, the attempts to justify surgical intervention relied upon promoting the “theory of human bisexuality” (see Meyerowitz 2002:98-104). Because male and female reproductive organs emerge from the same tissue in the human embryo, proponents of this theory insisted, all human bodies contain natural—and structural—elements of both sexes. In this scheme, even abnormal manifestations of the latent sex could be understood as natural variations of a sexed body. Surgery was framed as a means through which an existing but latent form of the naturally occurring other sex could be confirmed. This framing of surgical intervention, Meyerowitz notes, gained traction from its association to intersex surgeries, as well. “The theory of bisexuality placed transsexuals in the same ambiguous social space as the more visibly intersexed, for whom surgery was already routine” (103). If materializing a “true” internalized sex was a legitimate—and even socially critical—medical objective for this group, then surely, advocates argued, such an intervention could be justified for transsexuals whose form of “intersex” was physiologically different but substantively analogous.

The rise of psychology and psychiatry following World War II made this battle a heated one. Oppositional treatment philosophies and approaches crystallized around the media sensation of Christine Jorgensen’s 1952 return to the United States after undergoing genital sex reassignment surgery in Denmark. Though she is widely known as known as the first American transsexual, the term *transsexual* was not in common use at the time of her operation. It was not until nearly 15 years later that physicians involved in caring for Jorgensen and others like her developed a definition for the disorder they called *transsexualism*.¹³ Jorgensen’s front-page-worthy surgery sparked debates among

¹³ Though a long history of scientific study preceded it, the first published description of what we now classify as genital sex reassignment surgery appeared in Niels Hoyer’s book *Man Into Woman* (1937). It

the public as well as psychologists and medical doctors. Some physicians and ethicists considered it wildly unethical to remove healthy body tissue on the basis of the demands of these new “transsexual” people whom they considered patently insane. Others saw surgery as the potential cure for a problem of gender variance that had not been successfully treated through any other means. At the forefront of this second group of physicians was Dr. Harry Benjamin.

Benjamin was a German-born endocrinologist practicing in San Francisco and New York City in the 1950s. Dr. Benjamin had been treating Jorgensen as well as several other patients with hormone replacement therapy because he believed that the physical changes enacted by hormone replacement could ease the psychological distress felt by his patients. After Jorgensen’s transition made headlines, Benjamin’s office was flooded with letters from people all over the country who wanted hormonal and surgical treatment. Benjamin called transsexualism a “much more severe syndrome of reversed gender-role orientation” than had been seen in cases of transvestism (Benjamin 1969). He claimed that the newly acknowledged disorder was a “unique illness distinct from transvestism and homosexuality, perhaps conditioned by endocrine factors, and *not amenable to psychotherapy*” (1954:219, emphasis mine). As is clear from Benjamin’s preceding—and foundational—quotation, transsexualism has always been an “illness” (later a “syndrome” and eventually a “disorder”) defined by its relation to particular treatment schemes. Transsexualism was defined by the medical and surgical interventions that Benjamin and his contemporaries argued were necessary to treat it. Then as now, it is the desire for these treatments that renders one medically and juridically legible as transsexual.

Like many of his contemporaries, Benjamin was interested in understanding the nature of the differences between men and women. In her history of the science of sexology in the United States, Janice Irvine argues that social and medical research in the mid-twentieth century was dominated by anxieties about shifting gender roles following World War II (Irvine 1990). One of the most influential medical researchers of this time was Dr. John Money who worked at Johns Hopkins University from 1951 until his death in 2006. Money was, and remains, a controversial figure.

While follow-up studies of Money’s early work have precipitated broad criticism in the last several years (especially among queer scholars, cf. Butler 2001; Califia 1997; Diamond and Sigmundson 1997; Fausto-Sterling 1997), his claims about the origins of gender identity—a term and concept he developed—remain the foundation of many understandings of gender, including that of the American Psychiatric Association (Becker, et. al., 1999). Money’s most influential claims were based on his 1957 study of 105 intersex children and adolescents in which he concluded that gender identity, like sex, is foundationally determined by prenatal hormone activity (Money, et. al., 1957; Money & Ehrhardt 1972). This hormonal development is further supported by social gender messages that are imprinted in the brain in a biological learning process occurring between birth and eighteen months of life. This is the window within which social gender is established—no matter what sex the child. In his estimation, once fixed, gender

relates the story of Lili Elbe, a male Danish painter who underwent surgical procedures to alter her genitalia. The particulars of those procedures are not known. Dr. David O. Cauldwell is credited with originating the term in his 1949 article “Psychopathia Transsexualis,” though Dr. Harry Benjamin has also claimed it, asserting that he was the first to use it in a public presentation and in a printed article.

identity is “extremely resistant to change.” While asserting the determinative biological influence of prenatal hormones,¹⁴ Money posited that the gender role in which the child was socially trained, rather than the genital morphology or chromosomal make-up, was the most influential factor in establishing gender identity (Irvine 1990a). He offered his now quite contentious reports of chromosomal males being successfully socialized as girls and women as evidence of his findings (cf. Colapinto 2000; Diamond & Sigmundson 1997).¹⁵

Conceptually bridging the nature/nurture divide, Money’s work provided a way to essentialize the social by suggesting ways in which social behaviors and experiences become physiological structures in the brain. With one foot in each camp, his work became very popular and influential in medical, psychological, sexological and technological fields in the latter half of the twentieth century. Money’s research was extremely influential in establishing the diagnosis and treatment of many “disorders” categorized as “sexual” and “psychosexual” (Duggan 1990; Erickson 1999; Irvine 1990b). In particular, this work provided empirical support for Benjamin’s claim that transsexualism was not a psychosis, but had physiological origins. In Money’s schema, transsexuals’ gender incongruity could not be cured through psychotherapy because their gender identity was, like that of all people, neurologically fixed and unchangeable since early childhood. As had been demonstrated by the rapidly growing field of plastic surgery after World War II, however, their bodies could be changed (Gilman 1998).

In his groundbreaking book *The Transsexual Phenomenon* (1966), Benjamin stressed the somatic treatment protocols that distinguished transsexuality from other so-called psychosexual disorders:

Psychotherapy with the aim of curing transsexualism, so that the patient will accept himself as a man... is a useless undertaking. Since it is evident, therefore, that the mind of the transsexual cannot be adjusted to the body, it is logical and justifiable to attempt the opposite, to adjust the body to the mind. If such a thought is rejected, we would be faced with therapeutic nihilism (116).

While Benjamin’s claim drew considerable criticism from many psychologists and psychoanalysts (cf. Restack 1979), Money’s work strengthened his position: transsexualism was, and still is, recognized as a condition that is not treatable through psychotherapy. Though not conceptualized as a “cure,” the currently accepted course of treatment is a medico-surgical one. Through hormones and surgery, doctors work to “adjust the body to the mind.” The critical point here is that in this schema, transsexualism is a problem of the body wherein the technologies of surgery render the body a mutable object as opposed to gender, which is construed as a property of the mind that cannot be changed. In this frame, the desired harmony between body and mind as simultaneously mutually exclusive but essentially linked (see Plemons 2010), can only be achieved through medico-surgical means. For forty years, those interventions consisted of

¹⁴ Prenatal hormone abnormalities have been linked to several intersex conditions but have not been conclusively linked to transsexualism or transgenderism. As some consider transsexualism to be a *psychologically* intersexed condition, prenatal dysfunctions remain among the most studied possible causes (Cohen-Kettenis & Gooren 1999; Gooren 2006).

¹⁵ Though Money is widely vilified by queer and feminist critics, he remains a luminary among many contemporary sex researchers (Coleman 1991).

genital surgeries (of a variety of types), chest/breast surgeries, and sex hormone replacement. In 1982, when Howard developed FFS, the alteration of the face was added to the index of distinctly sexed body parts that could be “adjusted to fit the mind.”

Critics of the medico-therapeutic model of transsexualism tell this history as a medical land grab. They characterize the medicalization of gender deviance as a process by which scientific methods were used to abstract and quantify what they define as the distinctly social problem of gender variance. Raymond (1979) has characterized this process as one in which patriarchal medicine ensured its ability to produce gender in the model it most valued. Irvine (1990) has stressed the financial gains won by physicians and universities that began offering services to transsexual people in the 1950s and ‘60s. Hausman (1995) has described this process as one of collusion between manipulative transsexual patients and doctors who were intoxicated by the medical challenge their transformations presented. Each of these critics concludes that the existence of transsexualism as a diagnostic category, and the possibility of bodily sex reassignment works to deepen the oppressive binary gender system (for a more contemporary rehearsal of this position, see Nanda 1999).

Transpeople and their advocates have been critical of this medical model on different grounds. Some have argued that the existence of *Transsexualism* and later *GID* in the Diagnostic and Statistical Manual marks them—and by extension people diagnosed with them—as pathological. Others reject the means by which the diagnosis is conferred and its treatment administered,¹⁶ identifying psychological, medical and surgical providers as “gatekeepers” who employ (and thus ensure) a very narrow and (hetero)normative model of gendering as the condition for access to hormones and surgery. The veracity of this claim is well documented (cf. Irvine 1990; Meyerowitz 2002; Butler 2001).

The treatment logic of transsexualism (a) establishes transsexualism as a *medical* problem that has existed in the patient’s body since birth; (b) asserts that this problem cannot be addressed through psychotherapy and is therefore only treatable through medico-surgical intervention; (c) posits a relationship between “self” and “body” such that each are fully formed but existing in juxtaposition to each other; (d) asserts that medico-surgical intervention can ameliorate this juxtaposition and; (e) identifies problematic “sex” as a series of bodily properties that can be located, quantified and changed to an opposing model of “normal,” thereby producing harmony where there was once discord. This constellation of assertions and assumptions animates the ways that doctors and patients talk about and think about Facial Feminization Surgery. It is, therefore, impossible to understand apart from this distinct etiological and treatment paradigm.

When patients and surgeons mark a distinction between cosmetic surgeries and the surgeries involved in transsexual transition, they reassert the classification of

¹⁶ The accepted model of care is outlined by the World Professional Association of Transgender Health’s (WPATH) Standards of Care (SOC). First drafted in 1979 when the group was known as the Harry Benjamin Gender Dysphoria Association, the SOC is now in its seventh edition. By adhering to the regimen outlined in the SOC care providers protect their association with WPATH, their reputation among other care providers, and protect themselves from lawsuits related to their care of trans- clients. Those care providers who disregard or “bend” the guidelines laid out in the SOC benefit by being very popular with transgender clients. Their names are traded within the community and they are guaranteed a steady flow of clients who wish to shorten the recommended times given in the SOC.

transsexualism as a medical condition in need of treatment through reconstructive surgery, in contrast to the superficiality of vanity-driven cosmetic procedures. This discursive move is a powerful one that works to align these surgeries with contrasting logics of health and define them as ontologically distinct. As is always the case, the boundary work required to maintain this distinction indicates that the line between forms and motivations for these surgeries would otherwise be quite blurry. It is crucial to see that the framing of FFS as reconstructive surgery has high political stakes, and not just for patients.

(Re)Producing the “Difference” of Facial Feminization Surgery

When the diagnosis and treatment for transsexualism were first established, the metaphorical explanation of being “trapped in the wrong body” came to stand for the radical disjuncture that characterized it (Stone 1991; Prosser 1998). The internal/external metaphor conveyed the frantic feeling of being trapped and unrecognizable as the self that resided within a false outer shell. Surgery was a means to “surface the body interior” (Taylor 2005), to bring the “true self” to the surface where it could be recognized by others. This disjuncture of body and mind as fully formed and stable but contrastive entities was unique to transsexualism at that time. Common cosmetic procedures such as facelifts and rhinoplasties were understood within a discourse of self-improvement and enhancement (Haiken 1997, Serlin 2004), where the self was always already coincident with the body. In these cosmetic discourses, a self could be improved through surgical alteration, but was not trapped inside a body that was its other.

Trans-specific surgeries are no longer unique in claiming that they enact a change in a patient’s core identity; neither are they alone in asserting that the changes produced through surgery enable patients to live more satisfying and authentic lives. Many patients who seek rhinoplasties, facelifts or blepharoplasties frame their procedures as transformations of their core identities, and as a means to bring an internal, “real me” to the body’s visible surface (Pitts 2006, Shilling 2003). Anthropologist Rebecca Huss-Ashmore (2000) has argued that it is the doctor/patient co-production of the “real me” narrative that helps to enact the changes attributed to surgical modification.

Both surgeons and patients speak of the process as creating congruence between the inner and outer self, or revealing the true self, the ‘real me.’ As one woman said of her surgery result, ‘I look more like me than I ever did’.

The idea that surgery can bring about “the real me,” is not exclusive to transsexual or cosmetic surgeries. For example, patients who undergo weight loss surgeries also describe their newly thin bodies as actualizing the “real me” that had been trapped inside the body of an overweight person (Throsby 2008). The rhetorical deployment of the search for bodily authenticity has become a powerful and far-reaching justification for surgical intervention.

Aiming to foreground the experiences and feelings of female patients, Kathy Davis (2003) interviewed women who had undergone elective surgical procedures. In contrast to claims that the plastic surgery industry is bent on creating idealized women whose faces and bodies incarnate male fantasies, Davis’ informants reported that they did not want to be “beautiful,” they just wanted to be “normal.”

Despite the differences in the specific circumstances that led to a woman's decision to have cosmetic surgery, the experience of suffering was the common feature of their stories. Thus, cosmetic surgery was presented as the only way to alleviate suffering that had passed beyond what any woman should 'normally' have to endure. It was an extraordinary solution for an extraordinary problem (77).

These patients, "Didn't feel 'at home' in their bodies; [a] particular body part just didn't 'belong' to the rest of her body or the person she felt she was" (66, emphasis in the original). These sentiments as well as those reported by Throsby (2008) and Ashmore (2000) above could have come verbatim from the FFS patients I interviewed. In fact, they contain elements of what has come to be considered the "master narrative" of transsexualism: a feeling of not belonging in one's body; a divide between the experienced body-self and person-self; and a pervasive suffering as a result of this disjuncture that leads one to seek a surgical resolution (Billings & Urban 1982; Mason-Schrock 1996).

The multiple similarities in technical procedures as well as discursive and narrative formulations has facilitated forms of analysis that blur the line between transsexual surgeries and other surgeries that participants claim enable a radical change in identity.¹⁷ Framed as simply one variety of identity changing surgical procedures, trans- and non-trans surgeries have come to inform each other in ways that were unthinkable 20 years ago. Once totally radical and distinct, forms of argument and explanation that take seriously patients' claims to use surgery as a technology that enables self-integration and self-actualization, FFS can be read as just another means by which a woman works to enact her feminine ideal.

What the transpatient wants from surgery may, therefore, be quite unexceptional (Prosser 1998:84). It may be the case that it is merely the bodily site(s) through which the desire for self-realization/actualization are manifest that marks trans- surgeries as so politically and ethically different from other surgeries that promise the same kinds of integration. It is not, therefore, the defense of an ontological distinction that drives doctors and patients to assert the differences between FFS and other surgeries of the face, it is rather one that reflects the distinct history of transsexualism itself. As a "disorder" and "syndrome" whose very existence has been disputed—and therefore whose treatments, including these same surgical interventions, have been under criticism—efforts to defend trans- identities as legitimate and worthy of treatment have high stakes indeed. Maintaining the distinct status of FFS (and GSRS, by extension) from "cosmetic" and "elective" surgery was very important to the patients and surgeons with whom I

¹⁷ Maria Frangos (2006) has used Jay Prosser's formulation of the role of narrativization in transsexual body modification to speak back to "many other forms of bodily transformation" (56) from cosmetic surgery to trans-species surgical modification. In addition to foregrounding of the role of narrative in enacting bodily changes, Frangos also makes recourse to the work of Didier Anzieu, a psychoanalyst whose theory of the "skin ego" were central to Prosser's analysis of transsexual subjectivity (in response to Butler). Frangos acknowledges that Anzieu's work "has been taken up by theorists to discuss the experience of transsexuality" (57), but she argues for its utility in analyzing cosmetic surgery makeover television programs. This is the first example I have come across of theories of transsexual embodiment and body modification being used to think through non-sex-changing body modifications. As opposed to being treated as an exceptional and distinct case, here trans surgeries offer the analytical tools to think through what are typically considered much more mainstream forms of surgery.

worked. This distinction was drawn by making a turn to GSRS as a therapeutic intervention, a reconstructive surgery undertaken by medical necessity as opposed to an often-caricatured explanation of who undergoes cosmetic surgery, and why they do so.

The image of the vain and preening cosmetic surgery patient is one from which nearly all patients and surgeons work to differentiate themselves. Sociologist Debra Gimlin calls these imagined patients “surgical others,” “that is, women, whether real or imagined, whose relationship with cosmetic procedures is at best, problematic and at worst, pathological” (2010:57).¹⁸ Whereas boundary work is often done to distance “reasonable” patients from the abject figure of the “surgical junkie,” (Pitts-Taylor 2007) FFS patients sought to assert a distinction between surgeries simply meant to improve appearance, and those meant to save lives.

Jill was a two-time patient of Dr. Howard’s and the most vocal of his proponents among the patients I interviewed. When we met for the first time in Howard’s office, she was not her usual, glamorous self. Still recovering from a jaw revision surgery five days prior, her lower face was taut and swollen, and she wore a light grey tracksuit with her short blond hair pulled back from her face. Still, her personality filled the office. When I asked her whether she saw similarities between cosmetic surgeries and FFS, she was quick to draw a distinction. For her, these were not at all the same.

People look at [Facial Feminization] surgeries as cosmetic surgeries. At the same time they’ll look at surgeries like cleft palates or deformed limbs or other anomalies—and I don’t like to call them defects because that continues to pathologize our existence—but what these things do is they minimize the opportunity to experience life or to involve yourself in life to your fullest extent. And to me, that’s why we’re here: to take part in life.

When a mistake or an anomaly has been made that prevents you from engaging in life that you can repair or that you can address, it’s much more about enhancing quality of life or enabling life than it is about something as simplistic as improving how you look. To say that I can now engage in life in the body—the case—in which I was originally meant to be thanks to the marvels of modern science, is the same as saying thanks for the ability to fix a cleft palate, or the ability to reattach tongues, or the ability to reattach limbs, or the ability to create artificial prostheses that then allow you to participate in life.

To me, that’s what this is about. This isn’t just about, “Well, I look better.” This is a fundamental change.... A breast augmentation for a genetic woman who happens to want larger breasts is not the same as having a breast augmentation for a transgender woman born into a male body that then enables them to exist inside of a casing that allows them to reflect who they are on the inside. There’s a huge difference. You can look at this as physical: purely cosmetic. I think if you do that, you do a disservice to the work that Dr. Howard

¹⁸ Talk shows and tabloids that feature “surgery junkies” (Pitts-Taylor 2007) and outrageous or botched celebrity plastic surgery results help to create an image of plastic surgery out of control. Although the vast majority of those people who undergo plastic surgery do not fit into any such category, the narrative of surgery’s blind power is a pervasive one. Meredith Jones has observed that “abject” figures such as Joan Rivers and Cher are critical to the production of the “normal” plastic surgery patient (Jones 2008). By having figures such as these to point out what “too much surgery for the wrong reasons” looks like, other patients can justify their desires for and relationship to surgical intervention as normal and right. FFS patients do this just as do patients undergoing more mainstream procedures.

does, to the bigger picture of the doors that this opens up and where this fits into the scheme of becoming.

Jill laid claim to the legitimacy of reconstructive surgeries by naming FFS as analogous to correcting a cleft palate, reattaching a tongue, correcting a deformed limb, or producing artificial prostheses that enable the recipient to “participate in life.” This rhetorical strategy links FFS to the medical exigency and assumed self-evident necessity of these procedures in direct contrast to “cosmetic” procedures that simply fulfill desires for beautification. Whereas in Jill’s narrative FFS is part of a “scheme of becoming” that allows the trans woman to “engage in life,” the genetic woman¹⁹ who “*happens to want larger breasts,*” is framed as simply wanting more of what she has already got, a desire presumably less crucial for her self actualization. While this point is a debatable one, its deployment here is meant to draw a sharp distinction: FFS is not about cosmetic improvement; it is about producing a body that enables a person to fully engage in social life. In this sense transsexual surgeries are equated with a deeper, more fundamental kind of transformation than are the superficial, interventions meant to restore the beauty and desirability of youth.²⁰ This distinction reasserts the surface qualities of the cosmetic and argues that something deeper is going on here.

The distinction offered between FFS and cosmetic surgery is one not just in degree but also in kind. By this I mean that FFS is not only presented as being a more radically interventive set of procedures, but also one whose goal is to fundamentally restructure the face rather than to enhance it (Holliday and Taylor 2006:189). When these patients do not pass—when they are read—they are not only read as men. They are, more importantly, read as *transsexuals*. Two kinds of misrecognition are at stake here. First, she is not socially legible as the woman she knows herself to be. Secondly, she is seen in the abject role of the transsexual. Transsexualism is marked by a stigma with much more severe consequences than that of being ugly, or old, or overweight. As such, we can say that the social stakes of the transformation at work in FFS are greater than those changes classified as cosmetic. Though a person undergoing surgery to ameliorate any of these

¹⁹ There is considerable disagreement among transpeople as to how the language that should be used when drawing a distinction between people who are trans- and people who are not. Much of this debate has centered around finding language that does not privilege the gender of non-trans people as somehow more authentic and does not pathologize transpeople as a marked group. Suggestions have included trans/non-trans in order to move the linguistic marker to the non-trans group as the exception rather than the rule. Descriptors of non-trans people have included: biological woman/man/boy/girl; genetic woman/man/boy/girl; natal woman/man/boy/girl; cisgender/cissexual. For an explanation of these terms, see Serano (2007: 23-34).

²⁰ Expressing a similar sentiment, actress and transwoman Aleshia Brevard classified her genital sex reassignment surgery and her cosmetic surgeries as completely distinct. When asked by interviewer Mary Weaver, “Do you see many similarities or differences between your SRS (sexual reassignment surgery) and the other nips and tucks you’ve had during your career?” Brevard replied, Well, there are no similarities that I can see.... To my way of thinking, the reassignment surgery was a lifesaving procedure. It was a surgery to correct an embarrassing, often threatening birth defect. Beyond that, any further nips and tucks were for pure vanity, and/or a way to continue working in film and television for as long as possible (Weaver & Brevard 2006:64). Like Jill, Brevard invokes the essential and medical nature of transsexualism in characterizing her GRS as a “surgery” that was a “lifesaving procedure” meant to “correct an embarrassing, often threatening birth defect,” as opposed to the other surgeries that she diminutively calls “nips and tucks” undertaken for “pure vanity.” The one was serious; the others were not.

other bodily conditions may debate this point, it is nonetheless a salient one for patients who desire FFS and the doctors who perform it.

Gimlin explains that doctors also use the figure of the “surgical other” to communicate ideas about patients, and about themselves. By identifying unreasonable expectations that “some patients” have, doctors are able to establish understandings of how reasonable expectations are constituted and to identify themselves as practitioners who perform reasonable surgeries. “Doctors employ references to the surgical other – or, at least, allusions to her – as part of their presentation of a professional identity, generally, and of their medical ethics and technical competence, in particular” (Gimlin 2010:70). Thus through invocations of the “surgical other,” both patients and doctors distance themselves from the mutually distained image of a vanity-driven cosmetic surgery.

Dr. Page operationalized this distinction when describing the differences between his trans- patients, who “really take care of themselves” and other women he treats. Of these other women he said,

They’ll drive you crazy. ‘This nipple is a little too low.’ Some of these women drive me nuts. All they care about is money. They have their Gucci bags. Some of them really do this because they want to take care of themselves, but others just care about looks. It’s funny that I feel this way because I *did* choose this profession.

Here, Page equates plastic surgery with the vanity and extravagance of conspicuously consuming fashion handbags. For him, picky patients are motivated by a concern with their surface appearance, whereas trans- patients are motivated by a desire to “take care” of a “self” rather than just a body. In counterposing care with consumption, Page recognizes the desire for FFS as essentially different from other forms of plastic surgery. Page also uses this difference to set his own motivations apart from those surgeons marked as merely succumbing to the demands of cosmetic patients. This desire to align oneself with the “right” and “legitimate” forms of plastic surgery is as old as the field itself (Haiken 2007, Gilman 1998). Surgeons distanced themselves from the image of the superficial quack by emphasizing the greater good that FFS accomplishes.

Facial Feminization Surgery Is/As Sex Reassignment Surgery

The unique motivation attributed to transpersons frames FFS as accomplishing a distinct result: a surgical change of sex. By shifting the project of sex reassignment from the private subjectivity of the genitals to the public sociality of the face, FFS does not *stand in* for genital sex reassignment; it redefines it. Both the surgeons who perform it and the patients who undergo it make clear that post-operatively, patients will not simply look different: they will be—or will be able to choose to be—women. The category of “woman” is defined here as a fundamentally social one, one based in the interactions and responses of others in daily life. By reconstructing what is arguably the single most important part of the body in constituting our unique personal identities, Facial Feminization Surgery aims to make women in the world. It was being recognized (and recognizable) as a woman that constituted *being a woman* in everyday life. Social identities are not developed—at least not in adulthood and not in everyday interaction—

based on the morphology of the genitals. And so, these patients told me time and again, changing their faces would change their lives.

Crystal explained that, for her, altering her face would make a much greater impact on her life than would GSRS.

I received a gift that I was going to put some money towards doing the [G]SRS surgery and I realized that after having transitioned over ten years ago, its [GSRS] really not going to change my life a whole lot more at this point. What would change would be doing face work.

Denise had not yet undergone genital reconstruction surgeries, though she did hope to do so at some point in the future. For her, too, FFS enabled a life change that was more important than what genital surgery would provide. “FFS will let me make the jump from man to woman, so I can live as a woman,” she said.

Alison had not yet begun taking estrogens when she had her initial surgical consultation in Dr. Howard’s office. Her plan was to begin hormones, wait until her breasts had begun to develop, and then undergo FFS. She planned to wait several years before undergoing any genital sex reassignment surgery; she hoped that the change she was seeking would mostly be accomplished through facial reconstruction.

I think that [FFS] will be the key marker where I stop being Robert and start being Alison. When I walk into the surgery room and I walk in with a Robert face and whatever body I have at the moment, I walk in with that, even if I had Robert face and some small breasts, I’d still be Robert. And when I walk out I’ll be Alison. The face will make that much difference to me.

For Jill, who had undergone FFS with Dr. Howard eleven years prior to our interview (and was in the office to consult on a minor jaw revision surgery²¹), facial surgery was the beginning of her transition.

Coming here and meeting Sydney [Howard’s assistant] and going through this process [FFS] was the single most profound experience of my entire life. It remains so. And I’ll tell anybody who asks. My facial surgery was very much the beginning of my transition.... [My] before [surgery] pictures are very much of a masculine kind of guy. Those pictures were taken the day before my surgery. In my case there was no process of being Jill and then Jill came in and had surgery and became a more attractive version of Jill. There was Joe and the life that I knew as Joe, and then there was this surgery that in my mind began this process of the opportunity to live a life as Jill.... The day I left my house I left a note for my wife: I’m leaving. I’m going to get my face done. I’m going to give this a chance.

²¹ Howard estimates that roughly 8% of his FFS patients return for revisions immediately following surgery. That is, these patients are unhappy with some aspect of the surgery and seek to have it repaired immediately. It is much more common that patients return for revision work many years following surgery if (a) some aspect of their “male face” has returned—like Jill who wanted her jaw narrowed 11 years following her procedure because some of the squareness had returned, or (b) after experiencing the effects of aging, patients return for facelifts and other soft tissue procedures to make them look younger.

For these patients, FFS enabled (or would soon enable) the achievement of a female social identity. Though most every patient I spoke with did desire some genital surgery at some point in the future, FFS was prioritized above these interventions (see Table 0.1). To have the genitalia of a female but be socially recognized and treated as a male would not fulfill their desire to be socially legible women. FFS was a mechanism for managing the unwanted stigma of being recognizable as transsexual. Stigma management, Goffman writes, “pertains mainly to public life, to contact between strangers or mere acquaintances, to one end of a continuum whose other pole is intimacy” (1963:51). FFS marks the ability of these patients to interact in the world as women. Like Alison, Jill uses her two names to demonstrate the profundity of this change: before FFS she was Joe; after FFS she was Jill. Though she did pursue genital surgery and breast augmentation soon after FFS, it was her facial transformation that constituted her change of sex.

In recent years, the centrality of facial reconstruction surgery has also been emphasized in medical literature on transsexual transition. In some schemas, FFS is part of Gender Reassignment, and in others it is something different: related, but complementary not constitutive. In an article entitled, “The Role of Nasal Feminization Rhinoplasty in Male-to-Female Gender Reassignment,” Nouraei, et al., indicate that facial surgery is an important part of “aligning the patient’s physical appearance with his or her perceived sex” (2007:318). Further, “The face is the most noticeable part of the human body, and facial feminization in male-to-female transsexualism is an important part of the gender reassignment process” (319). Dempf, et al, include FFS as a part of “gender reassignment” when the face of the patient warrants it. “In male-to-female transsexuals with strong masculine facial features facial feminization surgery can be performed as part of gender reassignment” (Dempf, et al 2009: 1). In these medical articles, surgeons recognize facial surgery as critical to the process of transsexual transition. No longer simply signifying genital reconstruction, “gender reassignment” indicates a total effect of bodily transformation, face included.

Common Logics, Practical Differences: GSRS, FFS and the State

The discourse of trans-specific surgeries focuses overwhelmingly on patients’ self-perception. Because diagnosis and treatment are driven by patients’ personal assessment of misembodiment, trans- surgeries tend to be read as individual transformations that change patients’ senses of themselves as individuals. While this is certainly the case, it is also true that individual bodies are regulated and recognized by the state in specific ways. Though FFS patients may contend that facial surgery constitutes a practical change of sex, it does not enact a legal change of sex. Legally, sex is located in the genitalia—mostly.

Meredith Jones has warned against thinking of patients and surgeons as working in what she calls a “simple binary relationship” (2009:174). She argues that to do so ignores the other kinds of players and forms of knowledge that inform this relationship and give it shape. “Not only do these lines of analysis risk recreating the dichotomy that they describe,” she goes on to write, “they also keep the action focused on the simple dyad of doctor/patient: there is a closed, two-handed relationship here at best, and at worst the patient is also obscured, leaving only the heroic doctor standing, sweating and

laboring for his own glory” (Jones 2009:186). It is clear that as powerful and often intimate as the relationships between doctors and patients in my fieldsite were, the surgery that they co-produce has material impacts on patients’ status as citizens who are legible (or not) to the law.

In most US states, in order to change sex on state issued documents such as birth certificates, social security records and passports, one must present a notarized letter from a surgeon certifying that sex reassignment surgery has been performed on the person in question.²² US courts have been inconsistent in their issuance of change of sex designation both from state to state, and in their different requirements of female-to-male (FTM) and male-to-female (MTF) transpersons. Whereas FTMs have been granted changes of sex after undergoing only chest reconstruction surgeries, MTFs are frequently required to provide evidence of genital sex reassignment surgery. Legal scholar Stephanie Markowitz attributes these different surgical requirements to the courts’ recognition of the “extraordinarily high costs and risks associated with [FTM] surgeries” (2008:707). While it is true that FTM GSRS surgeries are expensive and risky, these properties are not exclusive to them. MTF GSRS surgeries, while generally less expensive, are expensive nonetheless (usually running between \$8,000-16,000 depending on which surgeons are used and which procedures are performed) and carry the inherent risks of major surgery. Following Kessler and McKenna (1978) we might interpret the asymmetry in legal requirements instead as an institutional reflection of the asymmetry of morphologies in the determination of physical sex. The presence of the phallus on an MTF body conveys maleness while its absence on an FTM body does not necessarily deny it. Without a letter attesting to “complete genital sex reassignment, i.e., removal of the penis and subsequent labiaplasty and vaginoplasty surgeries to create a working vagina,” as Markowitz (2008:707) put it, transwomen may change their legal names, but cannot change their sex to *female* on these other important documents.²³ Because sex is identified by genital morphology, FFS does not count as sex change. As such, many crucial issues other than personal satisfaction and subjective identity confirmation are being achieved in the operating room.

If it is indeed the contention of many patients as well as surgeon that facial reconstruction *is* sex reassignment surgery, then what is the status of genital sex

²² Doctors are not required to give a detailed description of the procedures they performed. Therefore, what is actually meant by “surgical sex reassignment” is left up to the individual doctor to determine. Savvy and/or sympathetic doctors often construe “sex reassignment” broadly in order to allow patients who have undergone only chest and/or breast reconstruction surgery to register a legal change of sex.

²³ Rules regulating the criteria for changing sex on birth certificates and other government documents in the United States vary from state to state. Although the REAL ID Act, passed in 2005, has standardized some requirements at the federal level—for changing sex on Social Security and passport documents—birth certificates and drivers’ licences remain controlled by state and local governments using a patchwork of regulations. It is generally the case that a change in birth certificate can only be obtained—in cases when it can be obtained at all—with a letter from a surgeon attesting to the fact that some surgical sex changing procedure has been performed. After receiving the appropriate—and varying—forms of evidence they require, some states, such as Arizona, Oregon, Delaware and many others, will issue a new birth certificate to replace the original. Some, such as Alabama, District of Columbia and Massachusetts will amend an existing birth certificate with new sex and age but will not reissue the original. Some states, such as Idaho, Mississippi and Ohio do not allow sex to be changed on these documents under any condition. (This information taken from a website collecting all states’ policies on this matter: <http://www.drbecky.com/birthcert.html>. Accessed 4.11.12).

reassignment for these patients? In fact, the majority of patients whom I interviewed had prioritized FFS ahead of genital sex reassignment. Only 4 of the 19 patients surveyed had undergone genital sex reassignment surgery, though 13 of the remaining 15 patients indicated their intention to do so in the future (see Table 0.1). These patients emphasized the importance of the daily effects that facial reconstruction would have on their lives, over and above any personal or sexual satisfaction that would come from GSRS. Tracy explained this preference succinctly.

I am not one of those transwomen who has a very, very strong negative reaction to their genitals. It's more like indifference. So, I can wait. But from a practical point of view, on a daily basis, my face has a lot more to do with how I am treated. How I am in the world. It's both a practical and a personal kind of thing.

Rachel agreed.

For me, the most important thing I could do was change my face. If I had to, I could make peace with living with my genitalia the way it is. I wouldn't be thrilled about it, but I could.

Tracy and Rachel's explanations are an accurate representation of all of the patients with whom I spoke. Despite the fact that FFS costs upwards of two to three times the cost of genital sex reassignment surgery, these women valued the social changes that they felt would be enacted by changing their faces far above the more private and subjective changes that genital reconstruction would bring. Though the overwhelming majority of patients hoped and planned to have genital surgery in the future, contrary to dominant narratives of the body project of transsexualism, this was not their primary goal. They did not simply want to change their bodies; they wanted to change their lives.

One of the great appeals and pleasures of FFS is that it is not regulated by the same diagnostic schemes and treatment protocols that structure the delivery of hormones and genital surgeries. The accepted model of care is outlined by the World Professional Association of Transgender Health's (WPATH) Standards of Care (SOC). First drafted in 1979 when the group was known as the Harry Benjamin Gender Dysphoria Association, the SOC is now in its seventh edition. By adhering to the regimen outlined in the SOC care providers protect their association with WPATH, their reputation among other care providers, and protect themselves from lawsuits related to their care of trans- clients. Those care providers who disregard or "bend" the guidelines laid out in the SOC benefit by being very popular with trans- clients. Their names are traded within the community and they are guaranteed a steady flow of clients who wish to shorten the recommended times given in the SOC.

Patients who seek FFS are not required to adhere to the guidelines in the SOC the way that those seeking genital surgeries must.²⁴ A patient who undergoes FFS may be able Surgeons are not bound by any other standards than the ones that they apply to selecting and providing care to all of their patients. The logic for the exclusion of FFS

²⁴ The influence of the SOC, though ostensibly global, is not observed in a standard fashion around the world. One reason that many transpeople currently undertake international travel to undergo surgery is the avoidance of SOC guidelines for care. Financial considerations and technical preferences also contribute to traveling for surgery (cf. Aizura 2010).

from the SOC is that FFS is not thought to constitute an “irreversible” change of sex in the same way that genital reconstruction surgeries do. The problem of the “irreversibility” of the genitals is as much a surgical one as a legal one. Reversing a GSRS is very difficult, surgically speaking because the tissue and nerve reconstruction required in the initial procedure are complicated (and sometimes impossible) to undo. Reversal is impossible, legally speaking, when one of the medical procedures involved in the initial procedure is sterilization. Once sex—as defined by reproductive capacity—is changed, it cannot be undone. By contrast, FFS does not produce surgically irreversible results (characteristics can be built back on) nor does affect reproductive capacity or enact a legal change of sex, as we have seen. A patient who regrets facial surgery—for it is patient regret as well as physician culpability that the Standards of Care are meant to guard against—could either choose to have a revision facial surgery, or live as a man with a feminine face. The latter of these may be difficult for some people, but it is certainly not impossible. “If you open a magazine, Howard explained, “you’ll see models with big, square faces that look like they were carved by a hot knife through butter. But then you’ll also see male models with round, soft faces that make you look twice to see whether they’re men or women. You don’t see that same kind of variation with females. It’s just not acceptable.” In other words, masculinity can be put on or taken off within a much greater range of possibilities. Femininity, on the other hand, is either there or it is not. These transwomen could have feminine facial features while still being recognizable as males, but they could not have masculine features if they wanted to be recognizable as females.

At first blush, Facial Feminization Surgery shares a great deal in common with other plastic surgical procedures meant to produce normative femininity. Like cosmetic surgeries, FFS is animated by understandings of how “the feminine” face is constructed. As such, it is not immediately clear that FFS is somehow distinct from the cosmetic surgeries other women seek to enhance the feminine aspects of their faces. In spite of these commonalities, patients and surgeons involved with FFS insist that it must be understood in fundamentally different terms than cosmetic surgery. This claim is based on linking FFS to the treatment logic of transsexualism and genital sex reassignment surgery, and also depends upon casting “cosmetic surgery” as the superficial desire of a “surgical other.” Rather than interrogating the premises of this claim to difference, or attempting to assert my own ontological rendering of transsexualism and the forms of body modification associated with it, in this chapter I have attempted to hold the tension of the claim. My aim has been to understand how this claim is produced and maintained and the distinct forms of affective and historical relation that this maintenance engenders.

I have argued in this chapter that an analysis of FFS requires the consideration of scholarship on facial plastic surgery at its intersection with transsexual medicine. As an extension of the treatment logic of GSRS, FFS expands the location of bodily sex to the structures of the face. This expansion of sex to the craniofacial complex requires the quantification of the body and, by extension the constitution of femaleness, femininity, and what it means to transsex. FFS relies on the medicalized understanding of transsexualism that justifies GSRS, but it seeks to intervene in the problematic body in a

different way. This extension of the treatment logic is therefore also an extension of the location of sex, as well as a reframing of the transsexual surgical project. In the case of FFS, surgery is meant to enable ‘passing’ as a woman not only in intimate interactions (including the intimacy of personal satisfaction with the body), but in casual, everyday social interactions. This relocation suggests a need to consider the body’s practical materiality—the forms and shapes of the body that constitute its social life. I mean this distinction to stand in contrast with what I read as an overvaluation of genital morphology in discourse about the gendered body, especially as it relates to debates about the location of “real” sex.

During my fieldwork, it was the willingness and ability of FFS surgeons to regard sex in this way that helped to strengthen not only a doctor/patient relationship between themselves and the transwomen who sought their help, but a powerfully affective one, as well. It is to a consideration of that dynamic that I turn in Chapter Three.

Chapter Three

The Market in Beneficence

There is nothing clear about compassion except that it implies a social relation between spectators and sufferers, with the emphasis on the spectator's experience of feeling compassion and its subsequent relation to material practice.

There is nothing simple about compassion apart from the desire for it to be taken as simple, as a true expression of human attachment and recognition.

—Lauren Berlant¹

In November 2011, the *Miami Herald* broke a story about a “fake doctor” who had injected cement, silicone and other industrial materials into the hips and buttocks of a local transwoman order to give her “the derriere of her dreams.”² This story quickly became a sensation and appeared on TV news programs and websites across the United States and United Kingdom. In the following weeks, more victims came forward, including one who reported that this “fake doctor,” Oneal Ron Morris, had injected similar materials into her face two years before. The results were disastrous, producing, as one Miami news station put it, “acutely lumpy cheeks, [a] misshapen chin and a ballooning upper lip.”³ This client explained that she had heard about Morris through word-of-mouth in the transsexual community, and that she initially sought her services because she could not afford a licensed surgeon. She told reporters that, “It becomes so dire that you want to match your outside with your inside that you’re willing to roll the dice and take your chances. As a transgender person, you’re thinking, ‘Oh, my God, I can start to look like I want to look like and I don’t have to spend a lot of money.’”

A recent New York Times article⁴ also focused on the popularity—and risk—associated with unlicensed injectors or “pumpers,” like the one they call S. A transwoman who has self-administered silicone injections to feminize her face,

S. sees herself as helping the women she injects. ‘I try to help the girls because they want to look feminine,’ she said, caressing the contours of her face to demonstrate. Her overly plump apple cheeks and smooth pink lips are telltale

¹ Berlant 2004:1.

² <http://www.miamiherald.com/2011/11/18/2509172/doctor-accused-of-injecting-womans.html>

³ <http://miami.cbslocal.com/2011/11/28/new-victim-reveals-fake-docs-alleged-work/>

⁴ <http://www.nytimes.com/2011/08/21/nyregion/some-transgender-women-pay-a-high-price-to-look-more-feminine.html?pagewanted=all>

signs of the silicone injections she has given herself over the years. They dwarf her small, sculpted nose and dark brown eyes, which gleam under the thin eyebrows she carefully draws on. 'I try to guide them because the majority of these girls are young,' she continued. 'They come to me with holes, dimples; they don't have no cheeks, and their face is long.'

After three or four injection sessions, S. explained, she can help her clients achieve the looks they desire. Her methods may be unorthodox and labeled by physicians as extremely dangerous, but she claims that her results speak for themselves. On the day that the *Times* reporter visited her home office, 13 people were waiting to be "pumped."⁵

Stories of dangerous, backroom medical interventions for transwomen are not new. Take the notorious case of Dr. John Ronald Brown. Brown was an unlicensed surgeon who performed genital sex reassignment surgeries on transwomen from the 1970s until his imprisonment in 1998. By his own estimate, this amounted to roughly 600 procedures (Ciotti 1999, Meyerowitz 2002: 271-2). "Table Top Brown," so known for his reported willingness to perform surgeries anywhere on anyone who could pay (Denny 1992), was eventually convicted of murder after a patient-requested leg amputation went bad.⁶ Brown was reported to be a disheveled and otherwise strange man, sometimes eating and drinking during surgeries performed at his bare-bones clinic in Tijuana, Mexico.

But despite Brown's flaws, says Cheree [a former patient], there was a reason why so many 'girls' went to him—"He gives you a vagina at a fair price.' Whereas with other doctors you had to take hormones, wait up to six years, live as a woman, undergo psychological evaluations and then pay \$12,000 to \$20,000 or more, with Brown it was good old-fashioned capitalistic cash-and-carry. Anyone, says Cheree, could raise the necessary \$2,000 or \$3,000 Brown used to charge (in the '80s) by turning 'a couple of tricks.' The word would go out that Brown was coming to town. 'He'd shoot silicone anywhere you wanted it. For \$200 he'd do breast surgery. For \$500 he'd do cheeks, breasts and hips. After injections you had to lie flat on your back for three days so the silicone wouldn't go anywhere. He plugged the holes with Krazy Glue' (Ciotti 1999).

At the end of Brown's long and bizarre 1998 murder trial during which judge and jury were made to view gory homemade videos of surgical procedures, there was little doubt of his guilt. Sheldon Sherman, Brown's exasperated defense attorney, argued that though Brown may have been a terrible surgeon who had indeed killed someone, he ought to be lauded for his very willingness to treat transsexuals at all.

Sherman chose to portray Brown as a brave and caring man who tended to a segment of society no one cared about. 'No one else would deal with transsexuals,' he said in his closing argument. 'John Brown said, "I'll deal with them." Did he do this for money? No. He did it because he cared. And if you

⁵ See Kulick 1998 for a vivid ethnographic depiction of the practice of peer networked silicone injection in Brazil.

⁶ Self-demand amputation has a long and complicated relationship to transsexualism (Perpich 2005, Sullivan 2008, Stryker and Sullivan 2009). In this story, however, patients are unfortunately linked by the same poor practitioner.

don't believe that, then you have my permission—as if you needed it—to find him guilty of murder (Ciotti 1999).

These stories may be extreme in terms of the severe health risks that are involved, but they are not isolated incidents. And by no means are they the only kind of poor treatment that trans- people—both past and present—encounter from care providers (variously defined) in their efforts to transform their bodies.

Contemporary medical and surgical care for transpatients takes place in same milieu as the work of Morris, S., and “Table Top Brown.” The relationships between trans- patients and the surgeons with whom I worked are haunted not only by such past wrongdoings, but by present threats of opportunism, quackery and worse. It is against this very real and often brutal backdrop that the exceptional statuses of Howard and Page take shape. Howard and Page are competent and credentialed surgeons with years of education and experience. By this measure they are light years apart from Morris, S., and Brown. Their status as “good” surgeons is one that reflects their technical competence and professional ethics, and it is also one enabled by the exchange of significant amounts of money. Good care isn't cheap. As each of the above examples makes clear, one of—if not *the*—reason why transwomen continue to seek services from practitioners with questionable and even outright poor results, is that these practitioners promise to create the same desired bodily effect for a fraction of the cost. By some measures, the willingness to intervene at a low cost—whether within or outside of institutionalized medicine—is itself a measure of a “good” practitioner.

Despite the exceptional surgical abilities of Howard, Page, and the four other licensed FFS specialists in the United States, in FFS discourse, discussions of “goodness” are a measure of doctors' ethical commitments rather than their technical qualities. In other words, when patients describe what they look for in a surgeon and when surgeons describe the work that they do, the focus is on the value of the ethical and affective goods of FFS rather than the quality of the surgical interventions themselves. This focus helps to produce an intimacy between doctors and patients that foregrounds the emotional ties between them while diminishing the financial aspects of their relationship. This chapter examines how the market that mediates the relations between doctors and patients is structured and negotiated both in financial and ethical terms. Putatively distinct from economic considerations, it is within these ethical terms, or what I call the *market in beneficence*, that the physician's acts of surgical precision are fashioned as acts of “compassion” and “good will” among a population for which such good will is consistently framed as a scarcity.

Beneficence denotes a quality of feeling or act over and above what is expected or what is due. As such, it is ordinarily understood as something that is inherently and definitively not captured through the logics of the market. However, in this case, it is that supra-market value—the value of what is exchanged over and above its financial cost—that emerges as a commodity itself. The market that mediates the relations between transpatients and their surgeons is, therefore, a *market in beneficence*. Framing surgical skill as secondary to a motivating affect of care, or as an effect of it, casts the trans- patient as one in need of a special kind of attention. But this special attention is also returned to surgeons through patients' frequent expression of heartfelt gratitude and fierce personal loyalty. These relationships are a significant part of the story of FFS as they work through

relationships of markets, histories and affects to determine what kinds of gendered bodies are possible.

Through an examination of the means by which surgeons market their practices and the shared narratives of compassionate care that are organized, in large part, by the notion of the “desperate” trans- patient, I show how this constitutive “desperation” helps to characterize and then organize this particular market for surgical services. Doctors frame their work in relation to the definitive desperation of trans- people, and position themselves to respond emotionally as much as technically. This desperation is brought to the fore through frequent reference to the history of suicide and other forms of self-harm—including the solicitation of unlicensed and amateur providers like those described above—that contemporary treatment is understood to prevent. The focus on desperation helps to both justify surgical interventions and to stage them as compassionate acts.

But it is crucial to see that the patients are not the only ones who benefit from this relationship. Surgeons explain their work with trans- patients as being motivated by these patients’ by a sincere “gratitude” that differentiates trans- patients from other patients that they see. Their work within this small and well-connected group of patients earns them affectionate nicknames and the honor of being called “friends of the community.” Many patients are very defensive of their surgeons and referred to them as “angels” and “miracle workers.” Both Drs. Page and Howard cite the effusive gratitude of these patients as a primary motivation for their work with trans- people.

After examining the characteristics of the market in beneficence, I return to the financial aspects of this market, and examine the ways that patients think about and finance the high costs of surgical procedures. Irrespective of the emphasis on beneficent care, patients still must find a way to pay for Facial Feminization Surgery as well as many other costly interventions. Here I explore the issue of the financial and other resources that characterize this group of patients and examine how the significant cost of this surgery organizes priorities of medicalized self-actualization.

This Market Is an American Market

In order to situate the market in beneficence, it is crucial to recognize that it is, in fact, a market. As opposed to other models of healthcare delivery that are mediated by insurance companies and/or various forms of state management, trans- surgery in the United States is a pay for play market system in which individual doctors in private practice work to differentiate themselves and grow their own businesses. They do this both through skillfully delivering surgical services, as well as cultivating a reputation for an affective and ethical commitment to the wants and needs that they see as particular to trans- patients.

The expansion of the internet over the last two decades has meant that this market is an increasingly global one in which patients are not only negotiating the particular surgical outcomes they desire, but also the regulatory context within which each potential surgeon works. Surgeons’ work is regulated by the legal and political economic structures of the countries and localities in which they practice, and as physicians performing trans- specific procedures they are also bound (in various ways) to the guidelines of the World Professional Association for Transgender Health. The WPATH’s Standards of Care recommend the means by which physicians across the world should

diagnose and treat (both medically and surgically) people who identify as transgender and transsexual. These Standards are not legally binding, but they do inform the practice of those physicians who wish to be seen as adhering to internationally recognized best-practice models (more on this at the end of the chapter).⁷

Howard's individual charisma, capability and interest in a challenging surgical problem were what led him to develop FFS. He was the right person at the right time, fielding the right patient request. And while it is undoubtedly the case that his individual reputation for producing good outcomes is what has fueled his FFS practice over the years, it is also true that his availability as an American surgeon for hire has also played a significant role. Though Page has yet to grow his reputation to the size of Howard's, as a surgeon in private practice in the United States—where the only things mediating between himself and his patients are his medical ethics, personal judgment and considerable sums of money—he may one day be the destination of patients from around the world, as well.

Heleen had had a Full Face FFS with Dr. Howard nearly six months prior to our interview and had returned to his office for a facelift. I asked her whether there were surgeons closer to her home in The Netherlands who performed these procedures.

There are surgeons but they do not have the reputation that Dr. Howard has. There was no hesitation. I was not picking who would do the job. I heard of the reputation of Dr. Howard and came here.

The Netherlands is often imagined by trans- people in the United States as being a fantastic place to get medical and surgical care. They have a well-known gender team that, along with the team in Belgium, are recognized experts in caring for trans- people. As opposed to the private practices of physicians and surgeons working in the United States, the Dutch and Belgium practitioners utilize a university-based team model incorporating psychological, medical and surgical services in one coordinated unit. The Dutch team has been performing Facial Feminization for over a decade and has published significantly on the topic. With that reputation, I wondered, why had Heleen come all the way to the United States to undergo surgery—not just once, but twice. “I have a strong opinion on that,” she said.

We have sort of a monopolist gender team operating from the Free University in Amsterdam. They have a virtual monopoly because there's no one else doing these things in, let's say, all disciplines combined. And also you have to go through them to get any costs reimbursed through your insurance. They have an incredibly long waiting list. They are not very service minded. The way they communicate with people I think is just plain rotten. It's very bad. They do not treat you as someone who is in need of help. I had an intake after eight months of being on the waiting list. After the intake you get to the diagnostic phase with the psychiatrist. It's been another eight months and I'm still waiting for it. So I just skipped it all. I'm of independent means so I can spend the money I need. I had a

⁷ Patients who find the guidelines laid out in the Standards of Care to be onerous often seek out practitioners who do not adhere to them strictly. This is a significant reason why Thailand has become a major destination for trans- people seeking genital surgery. Thai doctors, I have been told by many people, do not require the kinds of waiting periods that Euro-American doctors typically do.

different psychotherapist who had been working with the gender team in the past. After that I got my hormones from an endocrinologist. I'm now with a gynecologist. So I'm patching it together all for myself.

Despite their international reputation for quality multi-disciplinary care, Heleen described the Dutch team as one steeped in a government bureaucracy that limited its effectiveness and responsiveness. Because she had financial resources, Heleen's choices were not dictated by insurance provider or national healthcare system policies. Rather than waiting at the end of the "incredibly long waiting list" she opted to purchase the services she desired directly. Since she had the money to spend, she could get the surgery she wanted from the surgeon she wanted in the United States.

In addition to avoiding the long cue of other potential patients, by paying for surgery with Howard, Heleen was able to avoid the long therapeutic process required by the Dutch system. Whereas access to FFS is not technically governed by the WPATH Standards of Care (more on this below), the Dutch system that Heleen described would have required that she undergo the same long and awkward stages of hormone and "real life" therapy that the WPATH Standards require prior to genital reconstructive surgeries.

As for the Dutch medical profession, the gender team which is apparently famous world-wide, especially for what they do with children, I think they're not up to standard. Also because one of their principles—this is a protocol that is followed world-wide I think—but, after you've had the diagnostics and the outcome is that sex reassignment would be the best solution, they require you to live as a woman, to dress as a woman for a year. That's also when they start with hormone therapy.

Not only would this extended process prolong the time before she was able to make the physical changes to her body that she desired, she felt that it would have severely complicated her professional life. Dressing as a woman before making physical changes, she explained, "would not have worked in my case."

I'm a professional lawyer. I'm working with multi-nationals. I'm a partner. I have all my equity partners around me. If I would start dressing as a woman while looking like a man, that wouldn't have worked. [That system is] too rigid. It may work for some people. A lot of people in my situation do not have family anymore; they do not have work; they're just sort of dancing around in the social circuit for the rest of their lives. But this is not *my* life. I have a professional life. I have a family. I have a social network, and I just want to have this in order. I feel like a woman. Okay.

Monika, who had traveled from her home in Germany to have surgery with Howard, told a similar story about why she had chosen to come to the United States as opposed to seeking care in Germany or elsewhere in Europe. As a person with the financial means to carry private insurance rather than the state healthcare, she was able to navigate her transition outside of the regulations that the state system required. Her experience with German physicians, she said, had been, "Quite good."

I live in a big city where there are even specialized doctors for trans- people. Just a couple, but still, it helps a lot. If you're on a private healthcare scheme, there aren't many regulations. If you're on the state healthcare scheme you need to have therapy for more than one year, then have the real life test for more than one year. Then you can start hormones. For me, [with private healthcare] I could just go there, have psychological examinations for five or six weeks, and then I could start. This was easy.

In addition to avoiding the regulations required by state healthcare, Monika also felt that the quality of American surgeons in general, and Howard in particular, were superior to what she could find in Germany. There were surgeons offering FFS in Germany, she explained, but it was not the same.

It's mostly just the cosmetic stuff that they also do on biological women. But trans- women also go there. The results? I saw a lot of them, and they're not near as good as here in the States. My doctor told me that some patients went to Dr. Howard. If you can afford it—it's more expensive, the aesthetic surgery here—I think it's much better.

Monika had plans to travel to Thailand for her genital sex reassignment surgery. “You can see the world as a trans- person!” she said with a wide grin.

These stories certainly don't account for the worldwide popularity of American surgeons performing FFS, but they do make it clear that there are a variety of reasons—both individual and structural—that influence the dynamics of this market. With so few practitioners in the world, the market for FFS—like that for genital sex reassignment surgery—is always an international one in which local policies and practices literally give shape to how trans- people imagine and work to create their bodies.

The Market

Finding a Surgeon

With very few exceptions, medical and surgical procedures involved in transsexual transition are not covered by insurance in the United States.⁸ Therefore, persons interested in these services must seek out providers, evaluate their capabilities and skills, and pay for services without the financial or institutional assistance. There are few surgeons in North America who perform the specialized procedures most frequently involved in transsexual transition.⁹ At the time of this writing, there are five surgeons in

⁸ The City of San Francisco provides transgender health benefits to its employees. Some trans-organizations are working to frame this exclusion of transgender-specific care as discrimination, a move that depends upon the diagnosis of transsexualism as a medical condition for which hormonal treatments and surgical interventions are medically appropriate treatment. While this tactic may be important for gaining insurance benefits, other members of the trans community agitate against the medicalization of transsexualism as they see this designation as perpetuating the stigma associated with illness.

⁹ One prominent genital sex reassignment (GSR) surgeon estimated that approximately 25 currently practicing US doctors had ever performed genital sex reassignment surgery, but only six do so on a regular basis.

the United States who specialize in Facial Feminization Surgery.¹⁰ Surgeons in the United States do not receive training in trans-specific surgeries as part of their formal training. As such, these procedures are learned through apprentice relationships with doctors who have established a specialization in them. Considering that genital sex reassignment techniques began to be practiced in the United States in the mid-1950s, and FFS was developed in the mid-1980s, this skill set has only been passed between a few generations of practitioners.¹¹ Among people in the market for these procedures, these few practitioners are well known and in high demand.

Because of the self-direction required in the identification and procurement of services, as a group trans- people in the market for surgery tend to be quite well educated. Rachel explains self-education among trans- people as a life-long search for understanding their experiences.

I think one thing that most trans- people are is incredibly well read about trans-issues because we've spent most of our lives trying to figure out why we are who we are and we're always looking for an answer. I started trying to figure this out when I was a kid. Anytime I came across a scrap of material that had anything to do with crossing the gender divide I wanted to know about it. I was hoping it would give me some clue as to where I was going.

This drive for information is thus motivated by a desire to understand and give sense to one's feelings, and then to explore the treatments options available, if indeed treatment is desired. Much like the AIDS activists described by Steven Epstein (1996) and the parents grappling with fetal diagnostic tools described by Rayna Rapp (1999), trans- patients navigate patchwork and ad hoc sources of information as they develop ways to relate medical technologies to their own bodies and feelings.

The wide availability of the internet has significantly changed how people access and share information about their own life experiences as well as their experiences with care providers. As Patricia told me, "I didn't even know that facial surgery, as it's done today, was even available until probably about seven years ago when I started actively looking into the internet and... understanding that there was a much larger community than I thought." Nearly everyone I spoke with had learned of and/or researched Drs. Howard and Page through online resources that have emerged in recent years with the express purpose of educating trans- people about legal, medical and other practical aspects of transitioning. Though Howard had been performing FFS since the mid-1980s, it did not become the majority of his practice until roughly 1995. Sydney, Dr. Howard's long-time personal assistant, attributes this shift to the growth of the internet and the ubiquity of the home computer at that time. Like many previously dispersed and isolated groups, trans- people used the internet to connect and share information in ways that has

¹⁰ This count reflects the number of surgeons who market their services explicitly as Facial Feminization Surgery and whose techniques include bone as well as soft tissue modification. Many surgeons advertise what they call Facial Feminization procedures, but these are no different than the procedures they offer the general population. As one FFS surgeon explained, "Really, all plastic surgery is facial feminization."

¹¹ At the time of this writing, Dr. Howard, the developer of Facial Feminization Surgery, has not trained a protégé. This is not for lack of interest. Several doctors have approached Howard with a desire to learn his techniques. While Howard is open to training interested doctors, he requires that they undergo the same lengthy training that he has had—fellowships in craniofacial surgery, maxillofacial surgery, and aesthetic surgery—before they begin working with him.

had many profound effects, the growing knowledge about and popularity of FFS among them.¹²

A few of these sites¹³ dedicate considerable space to allowing users to share photographs of their surgical results. This kind of website photo sharing is a primary means by which people who are interested in a particular surgery can shop for the surgeon—and results—they are looking for. Sites such as transbucket.com and (the now defunct) transster.com make photos searchable by type of procedure and by the names of individual surgeons. Users are able to create a page for their results that can be updated with new photos as they progress through the healing process. They can also add a few lines of text to describe what is seen in the photos, as well as things that cannot be visually depicted such as the quality of post-operative physical sensation and their own satisfaction with the results. These photo sharing sites provide crucial opportunities for prospective patients to see what is out there and to set expectations. Such an opportunity is especially important because these surgeons practice in distant cities and traveling to multiple consultations is often prohibitively expensive. Outside of trans- conferences, where surgery show-and-tell gatherings provide the opportunity to see a surgeon's work in the flesh, these photo-sharing sites are the only way most people get to see the work of multiple surgeons in one place. Potential patients look at photographs of post-op bodies to consider what kinds of results they desire. It is clear from the growing demand for FFS that people accessing these sites (and sharing information in other ways) are pleased with the results that they see. The before and after photos featured there become images of inspiration and promise that what worked for others can work for them. When I asked patients how they had decided which surgeon to use, they almost always cited some online source where they had been able to evaluate surgical work for themselves. It is this means of comparing and contrasting, of seeing one's own possibility through the faces of others that makes FFS so powerful.

In addition to viewing post-surgical photographs, many patients learned about their options by participating in internet chat rooms devoted to FFS. Several patients cited peer recommendations found on these sites as their primary source of information. Reena made the decision to have surgery with Dr. Page based on chat room recommendations alone. She had such faith in the information she received there, that she did not schedule consultations with other doctors (in spite of living near another doctor's practice) and scheduled surgery with Dr. Page following her initial appointment with him. Doctors know that managing their reputations among this small group is crucial to the success of their practice. They are concerned with how and to whom photographs of their surgical results travel—often because they are not able to comment on what is shown in the photographs and cannot count on patients to describe or assess outcomes accurately—but also about descriptions of their demeanor and that of their staff toward trans- patients.

Prior to the expansion of the internet, patients learned about surgeons almost exclusively by word of mouth. This mode of communication remains essential to these doctors' practices, as several patients told me that friends had referred them to a particular surgeon or care provider. Informal personal networks as well as more formal

¹² Many patients told me that they had learned about FFS and about Dr. Howard in particular on tsroadmap.com, a very popular site run by long-time activist Andrea James.

¹³ For example, www.annelawrence.com and ai.eecs.umich.edu/people/conway/TS/SRS.html. Many surgeons also feature photographs on their professional websites.

organizations—such as support groups, patient groups, social and activist groups—share information about experiences with particular surgeons. It was common during my fieldwork to hear that a new patient had been referred by a past patient. On a few occasions, these former patients accompanied their friends to consultations or pre-operative appointments, and were identified as the person who would help in post-operative recovery.

Conferences for trans- people are another important site of information gathering and exchange. There are seven major conferences held in the United States each year and several smaller, regional conferences. Doctors who provide specialized surgical (and other medical) services to trans- people give lectures at these conferences and offer clinical evaluations to prospective patients. For doctors, these conventions are important places to disseminate information about procedures while at the same time marketing their expertise and growing their businesses. Convention attendance and on-site surgical consultations generate a significant number of new patients in a surgical practice. For attendees these conferences are sites for the acquisition of otherwise far flung resources. Attendees benefit from learning about newly available procedures directly from the surgeons who developed them. Many patients have indicated to me that they learned of the existence and availability of particular procedures by attending such conventions. As such, these conferences are critical spaces in which surgico-mecial forms of transgender and transsexual personhood become imaginable.

By the time most patients arrived in surgeons' offices they had already undertaken significant research of various kinds. Many who visited Dr. Howard's office had bought and read his recently published book, and a few had read papers he published in surgical journals. Darla explained that her 3½-year research process involved developing a working literacy in a number of specialist discourses.

I'd researched it, dug a bit deeper, went into a few medical journals and some other related things and just got as much knowledge as I could. And then I took that research and, with my limited biological knowledge I'd done a bit of study there, but enough to have a reasonable idea about the whole procedure. My instincts from the onset were telling me that Dr. Howard would be my choice. I then spent at least a couple of years researching beyond that—everywhere in the spare time I had.

Like most patients, Darla had used the guidelines set forth in these publications to assess the problem areas of her own face and had come into the office with a basic understanding of the information her consultation would yield. Even patients who had not spent years considering the procedure had devoted considerable time to learning about the surgeons who performed FFS and the options available to them.

While the network of care providers who work with trans patients is growing, the number of surgeons who specialize in this work remains quite small. Obviously the market here is a peculiar one; patients who desire these specialty procedures must choose among a limited number of physicians. While the economic conditions of this market are determinative—and will be discussed at the end of this chapter—I want to turn now to a discussion of the ethical terms by which this market is structured and negotiated by surgeons and patients alike.

Thinking Through Compassion

Surgeons are frequently portrayed as heroic figures. Ethnographer of surgery Joan Cassell likens surgeons' behavior to the edgy heroics of fighter pilots, astronauts and racecar drivers (1991, 1998). "Like [Chuck] Yeager, the successful surgeon takes risks, defies death, comes close to the edge, and carries it off" (Cassell 1986:13). The surgeon's heroism is often linked to his role as a performer operating in the surgical "theater" but also to an imagined active and decisive personality that is propped up by masculinist language. "Surgery," writes Charles Bosk, "is a contact sport" (1976). Metaphors of competition, battle and conquest are often used to describe the stages of an operation (Hirschauer 1991, Katz 1985). These sorts of heroics are opposite to the ones that are used to characterize FFS and GSRS surgeons; they are heroes not because they are macho and tough, but because they are exceptionally compassionate, caring for a group of patients that is often maligned.

In light of the very real experiences of discrimination against trans- people both past and present, it is no wonder that the doctors who work with them are often recipients of high praise from trans- patients and their advocates. These doctors provide quality medical services to a group whose relationship to physicians is one of dependence—in that surgical and hormonal interventions are undertaken in the care of physicians—that has often come at the cost of humiliation and degradation. To be sure, competence and respect are qualities that all people deserve from care providers, irrespective of what situation has led them to seek that provider's help. By the same token, doctors, as much as anyone, deserve to feel good about the work that they do. The sense of fulfillment that one gains from "good work" is not to be denied or discounted. But the market in beneficence structured by patients' desperation and extraordinary gratitude extends the moral valence of "good work" beyond kindness and the desire to help. A dynamic such as this one in which physicians are recast as "shamans" and "gods" (more on this in a moment) requires rethinking, irrespective of the marginalized status of the patients they treat.

In the introduction to a volume she edited called *Compassion: The Culture and Politics of an Emotion* (2004), Lauren Berlant explains the conceptualization of compassion as an "emotion in operation."

In operation compassion is a term denoting privilege: the sufferer is *over there*. You, the compassionate one, have a resource that would alleviate someone else's suffering. But if the obligation to recognize and alleviate suffering is more than a demand on consciousness... then it is crucial to appreciate the multitude of conventions around the relation of feeling to practice where compassion is concerned (4, emphasis in the original).

The compassionate relationship is premised on inequality (Garber 2004:23), though that is not typically the dynamic that a discussion of compassion is meant to emphasize. Compassion is, after all, generally understood to be a laudable and honorable emotion, one that enables the extension of generosity between those who suffer and those who can alleviate that suffering. This is a quality that we value and as such, Berlant notes, is one that may be thought of as better left alone.

But scholarly critique and investigation do not necessarily or even usually entail nullifying the value of an affirmative phrase or relation of affinity. It is more likely that a project of critique seeks not to destroy its object but to explain the dynamics of its optimism and exclusions. If we challenge the affirmative forms of culture, it is not to call affirmation wrong, but to see how it has worked that forms of progress also and at the same time support destructive practices of social antagonism. Social optimism has costs when its conventional images involve enforcing normative projects of orderliness or truth. This kind of bargaining demands scrutiny, in that desires for progress in some places are so often accompanied by comfort with other social wrongs (5).

In calling attention to the affective dynamics that structure that patient/surgeon relationship here, I do not mean to discount or discredit the work that these surgeons do. Far from it. Instead, I mean to call attention to the ways that histories of desperation, the corresponding emphasis placed on patients' personal gratitude, and the motivating value of that gratitude for surgeons work to create a dynamic in which caring for trans- people is an extraordinary act. If the doctor is a god, then what does that make the patient? What kinds of "social antagonisms" are recreated here? John Ronald Brown's attorney argued that treating transsexuals at all—even brutally—was worthy of praise. In such a situation, surgeons' respectful and competent care for them is framed not simply as appropriate and expected, but as beneficent.

More than once during the course of this research I have been chided by transfolks who have reacted defensively to the notion that I might question—or even ask questions about—the ethical commitments of these surgeons. "Well, they *are* friends of the community," one transman pointedly reminded me during an afternoon barbeque. As a transman, I understand that position. I do. But as an anthropologist, I don't think that means that they're above examination. When I made that point to my friend, it didn't go over very well. The power and prevalence of terrible medical outcomes is a powerful corrective (and counterpoint) to any examination of the work of reputable surgeons' among transpatients. This connection to and defense of "*their* surgeon" helps to establish the efficacy of that surgeon's expertise, and becomes itself a means through which surgical authority—in this case on the constitution of the feminine—is produced.

Marketing Beneficence

For nearly 15 years, Dr. Howard was the only surgeon in the United States—and one of very few in the world—who specialized in Facial Feminization Surgery. His renown as the developer of FFS has contributed to his reputation as a capable and compassionate surgeon; for many people Howard and FFS are synonymous. In the past ten years, a few other US doctors have begun to offer the procedure. A quick internet search for FFS produces a considerable number of aesthetic and cosmetic surgeons who advertise FFS among their services. Upon further investigation it is clear that the "FFS" procedures offered by the vast majority of these doctors are simply standard facelifts and rhinoplasties that they claim have a feminizing effect. Rosa characterized the distinction between "plastic" surgery and FFS succinctly:

Other doctors just do plastic surgery. They'll give you Botox in your forehead or change your nose, but no one does the real work that we need except Dr. Howard. Other doctors like Boondech [a Thai surgeon who is well-known for GSRS and who is beginning to offer FFS] and Lubbock do 'facial feminization surgery' [said while making air quotes] but they only do plastic stuff.

At the time of this writing, I count five surgeons in the United States who perform FFS as it is defined as a set of surgical procedures altering bone and soft tissues with the express purpose of creating feminine features. In addition to differentiating themselves from other surgeons by intervening in bony structures, these five surgeons also take up the discourse of transsexual transition as part of their marketing effort.

When surgeons market their practice, they frequently distinguish the services they perform for trans- people from other kinds of elective surgeries. This is the case for FFS surgeons as well as those who perform genital sex reassignment. In differentiating procedures for trans- patients, surgeons reproduce fundamental distinctions between the desires and effects of particular forms of body modification. Virginia Braun notes that, "Surgeon website discourse... contributes to the ongoing construction of experiential as well as material bodies, to the production of desires, and practices around these desires" (Braun 2009:136). In other words, when surgeons market their services, their communication of technical practice carries strong affective messages about desirable bodily forms and how we should feel about those forms.

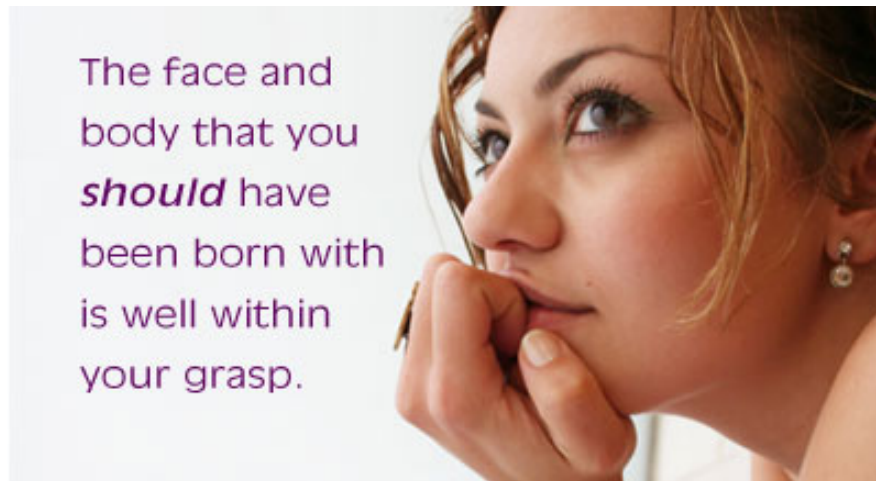


Figure 3.1 Image from the website of an American FFS surgeon

The image above comes from the website of Dr. Lubbock, a surgeon in the American Midwest who specializes in FFS. The text that accompanies the image of the hopeful and pensive young woman reproduces a core trope in trans narratives: "The Face and body you *should* have been born with is well within your grasp." Jay Prosser has discussed the recuperative language of "what should have been" as a form of nostalgia, "a literal and figurative re-membling" (1998:83). This language reimagines the history of the body as one that existed in the desired form from the very beginning, one that never required surgeries, sutures and the injection or ingestion of hormones. As Jill explained in her extended quote in Chapter Two, FFS surgery produced her body as the

one in which she was “originally meant to be.” The notion of a body wronged from birth reinforces the essentialist transsexual ontology and positions the attainment of the desired body as both an accomplishment that is deserved by the person who has suffered a wrong, and the restoration of a long overdue justice: it should have always been so. This text/image promises that that face and body is no longer something to be wistfully desired; it is “well within your grasp.” An East Coast FFS surgeon, Dr. William Gold emphasizes the gender work that FFS accomplishes over and above the techniques performed.

Facial feminization surgery (FFS) is commonly defined as “a group of surgical procedures that alter the face to increase its femininity”. While the definition is accurate, Dr. [Gold] defines FFS as procedures that provide patients with the face they should have been born with.... Dr. [Gold] often thinks of Facial Feminization Surgery as Gender Confirming Facial Surgery, as the goal of the procedures is to provide you with all of the major and subtle facial features that support your true gender.¹⁴

When surgeons market services to trans- patients by reproducing the rhetorical structure of trans- narratives, they mark themselves as understanding the personal and historical stakes of the procedures involved. This text/image is not just a promise of bodily improvement; it is a promise of bodily reintegration, a making right.

Dr. Page maintains two separate websites: one for his mainstream aesthetic surgical practice and one for his Facial Feminization practice. The mainstream page is very sleek, with photos of beautiful and nearly naked women framed in hues of bronze and copper. The Facial Surgery page on the mainstream site opens with the following passage:

Facial plastic surgery includes a range of procedures that can help patients achieve everything from reshaping the nose, jaw and chin, to removing fat or loose skin. As a leading [West Coast] plastic surgeon, Dr. Page has extensive experience helping patients seeking to rejuvenate their facial appearance and meets with each patient to develop a plan to achieve their goals.

In contrast, Page’s Facial Feminization site performs “feminine” in a much more stereotypical way. It is formatted in shades of violet and purple and uses brightly colored daisies to mark its menu options. The words, “beginning of a vision,” “transition to femininity” and “a holistic approach” run across photos of beautiful women’s faces. These are, ostensibly, the faces of post-operative transwomen, but that is never stated explicitly. The site includes links to the pages of an affiliated endocrinologist specializing in feminizing hormones and a preeminent American sex reassignment surgeon. There are also links to several trans- conferences around the United States, non-medical gender

¹⁴ Gold’s use of the term “Gender Confirming Facial Surgery” in this quotation is another example of how he is attempting to establish his ethical relationship to FFS—as well as *Transsexualism* and GSRS more generally. GSRS is referred to by many different names, each of which carries distinct political stakes. Other than GSRS, the two most common terms used are Gender Reassignment Surgery (GRS) and Gender Affirmation Surgery (GAS). By calling his facial surgery “Gender Confirming Facial Surgery” Gold is asserting that facial bone and soft tissue reconstruction is essentially an intervention in gender and that this intervention is a confirmation of a gender that already exists is simply being substantiated in the new face.

services such as a femininity coaches and shopping assistants, and a business that makes custom corsets for atypical feminine bodies. On this site, the description of facial procedures begins like this:

Our goal and vision for you is to provide a method to attain optimal emotional and physical health in all endeavors of your life while having a team to support you. Feminization surgery of the face or body is the beginning of a vision for transgender patients. It is not unusual to have undergone a life, or at least, a period of time of desiring to transition towards femininity.

Whereas the mainstream site lists the parts of the face that can be modified and assumes that the goal of this modification is “to rejuvenate [the patient’s] facial appearance,” the FFS site begins by describing FFS as “a method to attain optimal emotional and physical health in all endeavors of your life.” This language indicates that FFS alters more than the face; it is a means to altering the entire life.

Maintaining two different sites, I argue, serves a number of purposes. First, having different sites masks Page’s trans-specific work from mainstream patients. Viewers of Page’s mainstream site would never know that he specializes in Facial Feminization Surgery and that nearly 30% of his practice’s revenue is generated by his specialized services to trans- clients. They would never know that Page is affiliated with an endocrinologist and OB/GYN who specializes in sex reassignment surgery. The mainstream site does not contain any trans-specific content, nor does it provide a link to access the FFS site. In contrast, patients can link from the FFS site to the mainstream site, and text and photos describing non-trans-specific surgeries (such as liposuction, tummy tuck and breast augmentation) appear on the FFS site just as they do on the mainstream site. In other words, Page’s trans-specific services are masked from mainstream patients, but not the other way around.

Though masking his FFS site assumes a negative connotation attached to FFS, Page has found that sometimes non-transwomen who are seeking surgery are impressed by what he is able to accomplish in FFS. “If you can make her look good, you can certainly help me!” The category of “the tranny”—the transwoman who is visibly recognizable as such—has become an accessible touchstone by which to stage conversations about masculine and feminine bodies. Celebrity blogs and gossip columns sling accusations of transsexualism at women whose features they deem too masculine. One such blog, *Citizen Renegade* posted the following copy above a series of celebrity photos.

Something is afoot in the land. An ossified pall hardens like cement over our Western women. Armies of bony, chiseled, jutting mandibles of maxillofacial transsexuality following in formation behind blitzkrieging boffo chins are mowing down reserves of beauty and femininity.¹⁵

Rather than calling these celebrity women men, the blogger makes use of the figure of the visible transwoman; it is her failed effort at femininity that makes her conspicuous. And if she can be successfully feminized, Page’s patients presume, then certainly their already female faces can be improved through some of these same surgical practices. He has yet to embrace this as a marketing strategy, however.

¹⁵ <http://roissy.wordpress.com/2010/04/08/attack-of-the-manjaws/>

Maintaining a trans-specific site can also help to produce a feeling of exclusivity and privacy for potential trans- patients. This site is entirely dedicated to feminization procedures for transwomen. This exclusivity frames Page as singularly committed to helping trans women realize their feminine selves. From the color schemes to the grand statements about patients' life experiences, this site is one way that Page demonstrates his special care for transwomen. The affective language of "care" in these sites—that, as you'll see below is reproduced by surgeons directly—is not meant to portray the doctor's surgical ability. It is not the same as saying that he is a good care provider. Rather, it is a way of acknowledging that Page not only knows *what* trans- clients want, he knows *why* they want it. This recognition validates their desires to feminize their bodies and faces, and affirms that he understands the effect they hope these surgeries will produce. Presenting this kind of care is central to the market by which prospective patients find the few surgeons who specialize in the procedures they desire.

Dr. Howard has placed the maintenance of his online reputation solely in the hands of his patients. He does not maintain his own site, nor does he review or otherwise authorize what is written about him on patients' sites. He is confident that his work speaks for itself, and that the interpretation of this work is significantly informed by his status as the pioneer of FFS. Through his long-term involvement with trans-specific charities, advisory boards and conferences, Howard has earned a reputation that helps prospective patients to *see* the surgeries he has performed in a particular way. As the person who made Facial Feminization surgically possible, his results are often interpreted as the epitome of the feminine, as the best results possible. This is *in itself*, recognized as an act of beneficence.

Desperate Patients, Heroic Surgeons

While patients and doctors frame FFS as a reconstructive—and therefore therapeutic—intervention, it is also one that carries with it a past in which its status as "therapy" has been ethically and medically contested. In short, transsexualism has baggage. This baggage informs how doctors and patients view each other and themselves in their relationships to one another. At the time of this writing there are no clinical means by which to measure or establish transsexualism, nor is there conclusive evidence that surgical or hormonal treatments for trans- people are clinically efficacious (Cohen-Kettenis & Gooren 1999, Spiegel & Ainsworth 2010). Lacking clinical indications, surgeons who perform services for trans- people have to *believe* that the condition of transsexualism exists and that its existence is severe enough to warrant their intervention (Draper & Evans 2006:103).

The question of belief raised by Draper and Evans is an open one. Whether or not personal belief is the condition of surgeons' acts does not particularly matter. What does matter is that this formulation of the clinical dynamic puts the power of ontological invention and of action in the person of the individual doctor. Each doctor chooses based on a personal rather than a clinical basis, whether he or she will provide care to trans-patients. Thus this decision is a moral as well as a medical one. The doctors with whom I worked justified their care for trans- patients in terms of how they *feel* about the patients who come to them for help. As such, an individual doctor's willingness to treat trans-patients is interpreted by patients and explained by doctors as a humanistic or

compassionate act rather than one of duty. Jill described Dr. Howard's work with trans-people as an intimate and personal engagement beyond the ordinary expectations of a medical care provider.

He has always been a friend to the community. He has given back. He has given his soul. He has given his work. He has made it his life to give other people life. The fact that other people can't or won't recognize that is more than a shame, but those of us who have been fortunate enough to know him, know better.

This framing of Howard's surgical work as "friendship," the giving of his "soul," and "his life" to "the community" is one that patients frequently repeated to me. Reading surgical procedures as acts of care from the "soul" creates a powerful affective dynamic between patient and surgeon. As I will show, this dynamic both depends upon and reproduces the surgeon as savior to the desperate and misunderstood trans- patient.

Patients reminded me time and again that these doctors do not *have* to help them. Drs. Page and Howard had successful careers before they began working with trans-patients and could—like the vast majority of their peers—work with patients with other kinds of medical issues. The fact that these doctors are willing to apply their expertise to helping transsexuals despite the ethically, morally and medically contested status of their "condition" indicates to patients that there is something special about these doctors. And, according to these doctors, there is something special about these patients.

From the very earliest identification of transsexualism as a distinct condition for which medico-surgical intervention was the appropriate treatment, trans- people have been portrayed as a desperate group.¹⁶ Part of this portrayal is a direct reflection of the way many trans- people describe their subjective experiences. It is frequently stated that anyone who is not trans- simply "cannot know what this is like." That inaccessibility is demonstrated, in part, by foregrounding the desire for particular forms of surgery as a measure of radical disjuncture. Acts of medical compassion and care gain status against the backdrop of this pervasive and constitutive desperation.

There is no shortage of literature documenting the discrimination that transgender and transsexual people experience in all aspects of their lives. This ranges from, employment and housing discrimination (e.g., Flynn 2001, Namaste 2000; Storrow 2003; Whittle, et.al., 2007), to family conflicts (e.g., Cochran 2002; Isreal 2004), to suffering from physical violence (e.g., Lombardi, et. al., 2001; Wyss 2004) and homicide. Scholars have drawn particular attention to how experiences of discrimination and violence play out in scores of problems related to health and medicine. Public health researchers have

¹⁶ The kind of radical difference that constitutes this desperation is also a central condition by which non-trans people produce the authority to write about them (Heyes 2007:41). In other words, the authority to speak about trans people to other ostensibly non-trans people is predicated on the fact that the speaker is outside the group. The "I am not transsexual, but..." position marks the author/commentator as the normative observer who has extended his or her understanding into a mode of bodily experience that is described as impossible for non-trans people to understand. Trans people are portrayed as suffering a sort of misembodiment that is unimaginable to those who do not experience it and, as such, are not accessible through a relation of sympathy or empathy.¹⁶ ¹⁶ Trans authors often defend the particularity of their experience. The first rule that C. Jacob Hale lists in his "Suggested Rules for Non-Transsexuals Writing about Transsexuals, Transsexuality, Transsexualism, or Trans ____" is "Approach your topic with a sense of humility: you are not the experts about transsexuals, transsexuality, transsexualism, or trans ____." Transsexuals are" (Hale 1997).

documented the high rates of HIV seropositivity among male-to-female trans- people (Bockting, et. al., 1998; Clements-Nolle, et. al., 2001; Pang, et. al., 1994), citing chronic unemployment and homelessness as reasons why many turn to sex work to survive. These problems are exacerbated by a general lack of health care providers who are willing to serve trans- patients and possess the medical knowledge to do so.¹⁷

One way this desperation is demonstrated is by a frequent foregrounding of what trans- people are willing to do if they do not get the medical and surgical help that they desire. Stories of self-mutilation and suicide—both attempted and achieved—are ubiquitous in medical and popular literature, as well as the discourse of the doctors and patients with whom I worked.¹⁸ In this dynamic, sex reassignment surgical procedures are framed as life saving interventions.

This measure of desperation has a powerful effect on the relationship between surgeons and patients. Dr. Harry Benjamin was the first to argue for surgical intervention explicitly as prophylaxis against suicide in 1966, and he quickly gained the support of some of his contemporaries (Walinder 1967). Historian Joanne Meyerowitz has reported that a UCLA urologic surgeon who performed sex reassignment surgeries in the 1950s described himself as having, “a strong sense of compassion for these poor devils.” He was “‘a softie’ who found it hard to turn away desperate patients” (Meyerowitz 2002:146). Harry Benjamin has also been lauded for the “compassion for his patients” (Rudacille 2005:86) that compelled him to treat those who many of his contemporaries considered delusional and insane (Allen 1962, Brown 1961, Restack 1979). At the same time, Benjamin was aware that sympathies could also be dangerous for physicians.

The patient who is constantly on the verge of a reactive psychosis or is in danger of suicide or self-mutilation cannot be turned down with an unequivocal ‘no.’ On the other hand the physician’s sympathy should not tempt him to give in too easily to the patient’s persuasive arguments and thus obscure his sound clinical judgment (1954: 228).

Benjamin felt that doctors’ clinical judgment could be swayed by the strong feeling of sympathy for patients whose intense distress led them to seek surgical intervention and to hold suicide or self mutilation as a viable alternative to it.

Although surgery is a much more commonplace and even casual part of our contemporary world, surgeons are still aware that trans- people’s desire for surgery has very high stakes. Surgeons often discuss their work with trans- patients as the only intervention that will prevent these patients from killing or otherwise harming themselves. In a recent article in *Archives of Facial Plastic Surgery*, four surgeons introduced their study on feminizing rhinoplasty by explaining that, “The overwhelming desire to be a member of the opposite sex has profound consequences for the physical

¹⁷ A 2011 article published in the Journal of the American Medical Association reported that of 132 North American medical schools studied, 33% reported 0 hours of GLBT health-specific curriculum during clinical education. The median reported time dedicated to teaching LGBT-related content in the entire curriculum was 5 hours (Obedin-Maliver, et al., 2011).

¹⁸ For example, one study on transgender needs assessment in the Philadelphia area found that in their sample of 182 trans participants, 30.1% had attempted suicide. That compares to a .002% reported rate of attempted suicide in the general population of the United States (Kenagy 2005). Other studies report similar findings (Grossman and D’Augelli 2007).

and psychological well-being of the patient, and untreated, it could lead to self-harm and suicide” (Nouraei, et. al., 2007:318). A 2008 article about Facial Feminization Surgery noted that, “If untreated, [transsexuality] can lead to automutilation and even suicide” (van de Ven 2008: 293). During our conversation in Dr. Howard’s office, Zoe explained to me that, “[Surgery] was a last ditch effort. I could explore ending my life, or explore transition.... Surgery is not fun, but if it is between surgery and suicide, FFS is the least horrific of all options.”

In calling attention to the ubiquity of suicide in discourse describing trans- people’s desperation, I do not mean to suggest that that the threat of suicide is merely a tactic by which doctors are manipulated into performing procedures that they do not wish to perform (as has been suggested by Hausman 1995). Nor do I mean to diminish the fact that rates of suicide *are* disproportionately high among trans people. This is a serious and severe problem that needs critical attention. My purpose in discussing the prevalence and possibility of suicide in narratives of trans people’s relationship to medical providers is to consider how the mutual awareness of this alternative shapes the relationship between trans- patients and the surgeons who treat them.

Dynamics shaped by desperation are unequal, to say the least. While inequality characterizes virtually all doctor/patient relationships, when the market for physicians is quite limited and the stakes for the patients is high, that inequality produces what Charis Thompson (2005) has called a “monopoly of desperation.” In her work on assisted reproductive technologies, patients turn to doctors with a desperate desire to become parents.

The conditions of desperation—drawn from the intersection of private struggles, the imperatives of the private sector, and autonomous medical research that must perfect treatment—work together to produce extremely focused patient demand for treatment. In a sense, a monopoly that is imposed at least in part by the consumer is a very good market. It ensures demand and consumer loyalty, forces rapid innovation and efficiency, and pushes to internalize externalities such as the social and moral costs of unequal access to treatment (241).

Thompson’s assessment of the desperation that gives shape to the market for reproductive technologies is instructive here. Doctors frame their work in relation to the definitive desperation of trans- people, and position themselves to respond to this desperation emotionally more than technically. The discourse they produce about this need also helps to produce the need as such. It is surgeons’ ability to present their work in ways that both mirror the uniqueness of transsexualism and provide its remedy that makes them special.

A Team of Caring Professionals

In 2005 I mingled through the exhibition hall in a hotel lobby at the biennial meeting of the World Professional Association for Transgender Health (WPATH). The WPATH brings together a variety of mental, medical, and surgical health care providers and is, as an organization, the worldwide authority on care practices for people known variously as transgender and transsexual. Surgery presentations given at this conference were by surgeons, for surgeons. Presentations were followed by questions about procedural protocols, research outcomes and technical practice. Outside of these

workshops, however, surgeons spoke about their practice in a much different tenor. In the exhibition hall, sipping wine and socializing, these surgeons continuously framed their work in GSRS not in terms of the highly specialized skills involved in performing the operations, but in terms of the special sensitivity required to work with trans- patients.

Dr. Stuart Crabtree is a prominent American sex reassignment surgeon and perennial attendee at this and other trans- conferences. I managed to work my way to the front of the small swarm of people surrounding Crabtree and Lana, his long-time assistant. Lana was handling the onslaught with practiced poise and when I introduced myself as a former patient (I had chest surgery with Crabtree four years before), she graciously indulged my questions. Crabtree had specialized in working with trans-patients for many years, and so Lana had seen a lot about the industry throughout her career. She spoke disparagingly about a group of young surgeons who she characterized as trying to get into GSRS for the money it brought in or the technical challenges it presented. “These young surgeons have a long way to go,” she told me. “They need to work on compassion.” She emphasized the special need for sensitivity that makes GSRS more than just another surgical procedure. Calling attention to the special care that is required in dealing with “this population,” Dr. Phillips, a Canadian surgeon, asserted that the only “right reason” to go into GSRS as a specialty is because “you care about these people.” This ethical and compassionate engagement with trans- patients is made evident in superior surgical results, but is also framed as the condition for working with them at all.

Historian Joanne Meyerowitz (2002) describes the early years of medical and surgical treatment for trans- people in the United States as ones marked by intense negotiation between patient desires on one hand, and surgeons’ wills on the other. But doctors are not the only care professionals involved in surgical services, and the place of the surgeon’s staff emerged early on as a critical one in the relations between patients and surgeons. Early transsexual autobiographies such as those by Canary Conn (1974) and Mario Martino (1977) describe the poor treatment they received from hospital staff and the staff in physician’s offices. When seeking help from physicians in the 1960s, these patients confronted rude and aggressive nurses, and were made to feel like oddities on display. Surgeons recognize that in order to create an image of themselves as caring for trans- patients in a special way, they need to have a special staff.

Denise had had a facelift two years before coming to meet Dr. Howard. She had hoped that looking younger would also help her to look more feminine. Her experience with that surgery was bad for a variety of reasons, one of which was that neither the surgeon nor his staff would honor her choice of female pronouns because she had not yet changed her name on her state identification. Despite her repeated requests that they use feminine pronouns when addressing her and call her by her chosen name rather than her legal name, they would not honor her appeal. To them, she was a man named John who wanted a facelift to appear younger. Denise experienced their refusals as utterly demeaning and disrespectful. Though she equated youthfulness with femininity and perceived her facelift as a feminizing procedure, the doctor and his staff did not see it this way.

Each of the surgeons I have met—those who perform FFS as well as SRS—have dedicated personal assistants who perform vital functions in the running of their practice. Many patients mention these assistants in the same breath as the surgeon when discussing

their experience with surgical procedures; they go together. With one exception, the assistants I have met are all beautiful women who demonstrate a fierce loyalty to the surgeons for whom they work. Patricia, a patient I interviewed, pointed out the oddity of the exception. Dr. Lubbock, an FFS surgeon in the Midwest, has an assistant who Patricia described as a “big, Guido of a guy,” with an overwhelming handshake. When we were discussing her experience of meeting Dr. Lubbock at a trans- conference, she specifically mentioned how strange it was that he would choose such a person as his assistant. According to Patricia, a guy like this just could not make her feel as safe and welcome as the other doctors’ assistants had. I would argue that the seeming oddity of Lubbock’s large male assistant has to do with more than his ability to make patients feel safe and welcome. Beautiful female assistants also perform a powerful role as arbiters of gender in these offices. They, along with the surgeons, see the feminine woman beneath patients’ masculine appearance. While the doctors are ultimately responsible for the production of a feminine aesthetic, these assistants do a considerable amount of gender work with patients as they interact with them “like girlfriends.”

Howard’s personal assistant, Sydney, has worked with him for more than twenty years. Sydney is a striking woman with a cosmopolitan fashion sensibility. Her mode of interaction is one focused on making whomever she is talking with feel good: she is a casual forearm toucher, leaning in when she talks as though every conversation is a shared secret among friends. She agrees a lot, laughs a lot, and offers a seemingly endless stream of affirmations. Each time I arrived in the office she greeted me as though my arrival was at once eagerly anticipated and a wonderful surprise. Even though I knew that everyone she spoke with was her “angel,” her “darling,” her “dear,” when she was talking with me I somehow felt like she really meant it. Her energy was astounding. She complimented shoes, she laughed at jokes, she found something to “love” about everyone and made sure they knew it.

Sydney is responsible for a variety of office and patient logistics, including transporting patients to and from the hospital, helping them with travel plans and arranging for translators when necessary, overseeing Cocoon House (the private convalescent facility for patients), and handling all of the office financial matters. She also performs some light routine medical care such as removing sutures and changing bandages. More crucially, though, she performs emotional labor (Hochschild 1983) as she works to create a distinct kind of experience for patients, and acts as the mediator between patients and doctor, all the while gushing over Howard’s abilities, skills and successes.

When Dr. Page prepared to give his presentation at a trans- conference, I watched his assistant, Hannah, walk into the room carrying a bouquet of flowers so large that it obscured her face. After she carefully positioned the flowers on a table among pink and purple brochures and pink sprinkled sugar cookies cut in the shape of butterflies, she turned and flashed a smile at the small but eager audience. She was dazzlingly beautiful. Hannah’s role in the office is similar to Sydney’s, but she goes about her work with a much more casual affect. Her slow and easy movement gives her a feeling of confident elegance. She, like Sydney is a people person. I first met Hannah at a conference. That evening I shared a dining table with her and Dr. Page, along with several other people. We drank wine, complained about the overcooked salmon, and watched a truly entertaining talent show produced by the conference participants. Hannah moved quickly

and easily between conversations with everyone at the table. She leaned close to Dr. Page throughout the meal to remind him of people's names and other personal details that helped him appear engaged and invested in each person with whom he spoke. These conferences are a significant marketing opportunity for these doctors, and it is important that they make a good showing. Hannah played an essential role in helping him produce this image.

Assistants like Sydney and Hannah also serve as walking symbols of what these surgeons can do. A surgeon who specializes in the aesthetics of femininity benefits from having an aesthetically pleasing woman as his assistant. At the beginning of a presentation of his techniques at a trans- conference, Howard introduced Sydney to the audience. "This is Sydney, she's been working with me for over twenty years. Can you believe it?" To which Sydney replied in what seemed like a joke they'd done a hundred times, "I *do* travel with a plastic surgeon." She got some laughs. Howard added, "Yeah, she's really an 85-year-old guy. Doesn't she look great?" That drew the big laughs. Though this last comment was clearly meant as a joke, the comedic value of the first statement is less clear. Howard has performed facelifts on all three of his wives, and it would not be terribly surprising if he had worked on Sydney, as well. The fact that she is beautiful is an important part of the gender work that she does in his practice.

Certainly every doctor—and especially those in private practice—has an interest in making patients feel good, though some do a better job at working toward that than do others. What is happening in these offices is a very particular kind of "good." In a "testimonial" to Dr. Page, one patient wrote,

When calling around to look for surgeons, I was met with a surprising degree of off-handed cluelessness and thoughtlessness by surgeons of high repute. A number of them simply said "we won't work on men"¹⁹ (isn't a nose a nose?). Others jerked me around. From the second I walked into [Dr. Page's office], I was treated like a princess. Nobody questioned my sanity, or patronized me in any way. Of course, the offices are nice and clean, and everyone has a sunny disposition, but it was in the little details that I was allowed to feel genuinely cared for. When I was waiting for my slot in the OR, one of the nurses even went out of her way to get me a copy of *Vogue* to read – a minor issue, but a sign of being considerate. This was by far [and] hands down my best experience of any sort with the medical profession.

This patient describes her experiences in Dr. Page's office through a series of (trans)gendered devices. First, she describes the "clueless" and "thoughtless" responses of "surgeons of high repute" who would not take her as a patient because they do not "work on men." The nature of their gendered refusal marks the ways in which they are both clueless and thoughtless: they do not recognize her as a woman and do not treat her as the "princess" she was acknowledged in Page's office to be. In this context her question, "isn't a nose a nose?" is one that her desire for surgical feminization seems to confound. The patient has conceptualized her nose as a gendered object and has sought surgery to alter its gendered characteristics. If a nose can be masculine and can be feminine and the condition for its metamorphosis from one into the other is the ability to see them as distinct, then no, a nose is not a nose. In contrast to doctors who could not see

¹⁹ Howard also told me that he does not perform rhinoplasty on males. "They don't know what they want. They want to look different, but they don't know how."

her nose the way that she saw it, and could only see her as a man on whom they would not perform surgery, in Page's office she was "treated like a princess." She read this treatment as sincere and emphasized this point by stating that, "nobody questioned [her] sanity, or patronized [her] in any way." These points become exceptional—and worth mentioning—only in contrast to expectations or experiences of their opposite. Page's staff did not make her feel crazy. They did not seem to be condescending when giving her the "princess" treatment. One staff member made her feel "genuinely cared for" by bringing her a *Vogue* magazine while she was waiting for her turn in the operating room. This highly gendered exchange—of one woman giving another woman a fashion magazine—stood out for this patient as a mark of "being considerate." I suggest that this is consideration and recognition of the patient *as a woman by a woman* in the office. In contrast to the "thoughtless" and "clueless" doctors who made her feel like a man, Page's staff was thoughtful and knowledgeable. They saw her and treated her as the woman she knew herself to be.

Though Howard and Page conceptualize the procedures they perform as different kinds of therapeutic interventions, the work that Sydney, Hannah, and other staff members perform is a crucial part of this therapy. Arthur Kleinman (1988) has suggested that the relationship between patient and doctor—and, I would suggest, patient and doctor's assistant—is an essentially moral one. By this he means to draw attention to the fundamental act of caring between humans that constitutes—or should constitute—the interaction between doctors (and assistants) and patients. Kleinman aims to show that the work of a successful physician is not just in treating the biological and physiological aspects that constitute a patient's "disease," but also in caring for the psychosocial and personal experience of living with that disease, or what he calls a patient's "sickness." The gender work that physicians' assistants and support staff do is part of what helps to transform the surgical work from technical to affective. Staff members acknowledge the "sickness" that leads trans- patients to seek surgical intervention by conferring particularly gendered forms of recognition between women, bringing them fashion magazines, calling them "darling" and "love," telling them that they're beautiful. This powerful work is an extension of the "care" Kleinman references: a distinctly gendered recognition of the gendered "sickness" that has led patients to these offices, that helps to frame the "disease" of their masculine faces as one that can be cured.

Gratitude

Considering the very small number of surgeons who specialize in transsexual body modification, I am always interested in how they chose this particular specialty over (or in addition to) the others available to them. This was one of the first questions I asked Dr. Howard during our first meeting.

While he did not set out with the intention to work with trans- patients, he had made a concerted effort to grow FFS as the focus of his private practice since he began performing the procedures in the mid 1980s. He explained this decision in very simple terms: his trans- patients' sincere and effusive gratitude for his services made them extremely rewarding patients with whom to work. "Transgender patients are even more grateful for what I can do for them than are the parents of children whose skulls I've rebuilt," he said. This is no small statement. Earlier in his career Howard had headed up

the pediatric craniofacial program at a major research hospital. His patients included infants and children with devastating deformations of the face and skull, many of which required a series of major surgeries to correct. While these correctives were always undertaken with the aim of producing “normal” appearance, they frequently also enabled essential functions such as breathing, eating, swallowing, vision and adequate space for brain growth and development. Without the reconstructive surgeries that Howard and his colleagues performed, these children would have endured the terrible stigma that accompanies radical facial deformity. Having recently become a parent myself, I was especially struck by this measure of gratitude. Even more than the parents of these children, transwomen were *grateful* for the surgeries he performed. “Before, it was the parents of the children who loved me, now it is the patients themselves,” he said. And this love and gratitude mattered to him.

Dr. Page echoed these sentiments. He frequently reminded me that he preferred working with his trans- patients to most other patients he sees in his practice for this reason.

If FFS could be my whole practice that would be great. I love these patients. They’re nice. They’re respectful. They’re happy to have someone pay attention to them. They care about taking care of themselves, and they’re thankful. It’s nice to have someone who appreciates you.

The frequency with which doctors mentioned the gratitude of their trans- patients made it clear to me that this characteristic set them apart from other patients. Page’s points of why he loves these patients are implied contrasts to other patients who are not nice, not respectful, and not thankful. His comment that “they’re happy to have someone pay attention to them,” also underscores the affective component of his relationship to his trans- patients. These patients who have come to expect poor or hostile care, appreciate being paid attention to.

Trans- patients’ appreciation took many forms including direct statements of praise to the doctor and to others, letters, cards and gifts for the surgeon and his staff. Rosalind came into Dr. Howard’s office for her five-day post-operative appointment with a cast on her nose and bruised and blackened eyes bearing a gift of a beautiful purple orchid. “I collect orchids!” Sydney exclaimed as she took the offering from Rosalind’s hands. “Every time I see this I will think of you!” Patients often expressed their thanks immediately following their procedures, but measures of gratitude sometimes continued long after. It is not unusual for patients to send photos of themselves to the doctors’ offices years after their surgeries. Dr. Page showed me a photograph that a former patient had sent him. She was posing in front of a wooded waterfall with a huge smile on her face. “You’re not going to get that from a breast aug,” Page said with a smile. The understanding that gives sense to this statement is that there is a fundamental difference between a breast augmentation—and the patient who requests and undergoes it—and facial feminization surgery. A patient who gets a “breast aug” may be grateful to her surgeon, but her gratitude will not likely form a long-lasting emotional link between them. The face produced through FFS enables a kind of radical shift—predicated on a radical realization of a desired life—for which this patient’s gratitude endured. For Page, that waterfall photo said a lot.

Howard's many certificates of professional affiliation and academic diplomas hung in a tiny (eight by eight foot) room in the office where I conducted most of my patient interviews. Interspersed among these were awards from trans- organizations, activist groups and host committees of nationwide conferences for trans- people. These brightly colored—and often rainbow adorned—certificates of appreciation stood out against the muted parchments and calligraphies of diplomas and professional awards. The overall effect of the variety and sheer number of these commendations hanging in such a small room was overwhelming. Several patients gestured to these awards when explaining why they had chosen Dr. Howard to perform their surgeries. A small plaque hung on the wall that listed a patient's name and the date of her procedure and read, "Thank you Dr. Howard. Now I can 'face' the future."

Patients' gratitude to Dr. Howard sometimes verged on adoration. His global reputation for FFS made him a kind of celebrity among transwomen who visited his office, as well as many who I met outside the office. Conference participants who were leery of my presence as a researcher immediately softened when I they learned that I was working with Howard. Even people who were not interested in having FFS knew his name and spoke of him with great reverence. As I waited in the examination room with Darla before her initial consultation with Dr. Howard, she fidgeted and chatted nervously about how excited she was to meet the doctor in person. She could hardly believe it was about to happen! Her excitement was about finally getting the face that she wanted, but also about meeting Howard in the flesh. He had a kind of rock star status, as surgeons go. Patients frequently asked the doctor to pose with them in photographs, sometimes before surgery and sometimes after. Rosa, a patient who had traveled to Howard's office from Italy asked to have her picture taken not with the doctor, but with the nameplate on his door. He was routinely asked to autograph copies of his book that patients brought with them to their consultations.

In addition to his international renown, Howard is considered by many to be a larger than life figure. On the website postopliving.com, Kayla described the anxiety and excitement she felt when visiting Howard's office for the first time.

I have to admit that I was nervous the first time I met him. I had been reading and dreaming about having surgery with him for about 5 years before I was able to afford it and meeting him was like a dream come true.

She goes on to write,

I was pleasantly surprised with how nice and down to earth of a guy Dr. H was. I mean I didn't expect him to be a tyrant, but with his prestige and the fact that every transsexual worships him, I expected him to be curt and guarded. I couldn't have been more wrong. Some people idolize sports heroes, I idolize Dr. H.²⁰

In her online "testimony" to Dr. Howard and his work, one former patient named Diane said that Howard, "has touched my heart in a way few people ever will." She goes on to write that Howard "does change peoples lives, to me he is my private god, the person that has given me another chance in this life and not having to wait for the next one which we

²⁰ <http://www.postopliving.com/index.php/userblogs/authors/62?view=lyftenbloggie&start=10>. Accessed 3/31/11.

don't know if we get." Diane's profound gratitude led her to convey upon Howard the status of a god who had the power to give her a new life. Kathy attributed the same power of creation to Dr. Howard in her online description of her experience with FFS. In describing her initial consultation, she writes,

Then a minute later He comes in. Ok, I don't really need to capitalize the H. He's not God. Then since God apparently didn't quite manage to get things right with me and he's going to do some major repair work, maybe I should capitalize His name rather than god's?²¹

These statements demonstrate the profound change that FFS represents in these patients' lives. They attribute to Howard the power to do what God had not done correctly for them the first time. He is "going to do some major repair work" that will give "another chance in this life." While the surgical interventions will enact the change, it is Howard himself who is deified. As Jill stated succinctly, "He is possibility."²²

This kind of gratitude expressed by trans- patients was deeply rewarding to Howard and Page. They often spoke of the profundity of changing their patients' lives for the better. Surgeons felt good about the work that they did, and truly felt appreciated by the trans- patients with whom they worked. Being appreciated mattered a great deal to them. The technical work of FFS was not particularly challenging, and there were potential personal and professional drawbacks associated with working with a stigmatized population. Indeed fear of negative professional response had made each of them initially leery of working with trans- patients. But both Howard and Page found the personal and emotional rewards extremely valuable. Part of this came from understanding themselves as helping a group that few other surgeons were willing to help. As Page mentioned above, his trans- patients are "happy to have someone pay attention to them," and he gets a lot of personal satisfaction from being that person.

Money & Other Resources

It is vital to note that this small group of patients is not a representative sample of transgender and transsexual people in general. Not only have these patients self-selected facial surgery as a medical necessity in relation to their projects of transition from male-to-female, but the patients I met in these surgeons' offices also had access to resources that enabled them to actualize this desire. In addition to financial resources, these patients

²¹http://www.kathygnome.com/index.php?module=pagemaster&PAGE_user_op=view_page&PAGE_id=3&MMN_position=3:3 (accessed 2/28/11)

²² Patients are not the only ones who describe doctors in superlatives. In the Introduction to *Principles of Transgender Medicine and Surgery* (2007) Dr. Randi Ettner writes that practitioners who provide care to gender-variant individuals are more like shamans than physicians. According to Ettner, a board member of the WPATH, those who work with gender-variant individuals, "must offer help and support for wholeness and authentic identity—a modern-day version of the [shamanic] ritual and community that welcomed the returning soul part home" (2007: xxiii). Of the psychotherapists, family physicians, endocrinologists, and surgeons who authored chapters in the book she writes that, "Each has emerged as an expert based on years of listening and bearing witness to narratives of those who long for identity alignment. Ironically, it is the regression to this fundamental mode of communication—listening—and the most evolved level of consciousness—compassion—that trump technology in advancing this burgeoning field" (2007:xxiv).

also had educational and cultural capital that facilitated their journeys to these doctors' offices.

Earlier in this chapter, Rachel explained that her loneliness and isolation as a young person pressed her to learn about gender difference, and so she turned to books as sources of expertise. Certainly this refuge in information is not available to everyone. Rachel's position as a member of an educated family living in New York City gave her access to these resources, and the inclination to turn to them for the answers she was seeking. Darla was a university professor and though she taught on topics far removed from anatomy, physiology, and surgery, she was equipped to take on and develop a working understanding of these forms of knowledge. With this knowledge to hand, Darla was comfortable engaging Dr. Howard in a discussion about her surgery, and she was not alone in this regard. The fact that so many patients were well researched in surgical literature spoke to their access to these specialty materials and the fact that they possessed the educational background to read and understand them. Many patients were able to speak quite astutely about historical and contemporary writing on transsexualism from a variety of fields, commenting on texts from Janice Raymond's polemic *The Transsexual Empire* (1978) to a somewhat controversial article suggesting a neurological basis for cross-sex identification (Zhou, et. al., 1997).

The vast majority of research on trans- people suggests quite a different demographic profile. Public health studies frequently report the high rates of homelessness, unemployment, and survival sex work among transwomen. This research often stresses the negative impacts that inadequate and unfriendly healthcare have on the trans- population as a whole. While these kinds of studies play an integral and essential role in efforts to improve access and quality of healthcare for many, many trans- people, there are many other trans- people whose experiences they do not represent. The FFS patients I met in these offices were entrepreneurs, doctors, lawyers, engineers, Hollywood directors and business owners. Howard told me proudly that of the nearly 1,600 FFS patients he has seen, 14 have been Nobel Prize nominees. Patients whose occupations were not as high earning—such as flight attendants, municipal employees and teachers—still interacted with care professionals from a relatively empowered position. They used online and personal resources to seek out referrals for friendly therapists, physicians and surgeons, and knew that if one provider was not meeting their needs, they could at least *look* for another one who could.

Shannon had seen the same general practitioner throughout her 25-year career as a police officer. After she retired from the police force, Shannon decided to pursue her desire to transition and began to change her appearance by growing her hair long, losing weight and undergoing laser hair removal on her face. In preparation for her operation with Dr. Howard, she needed to get her primary doctor's clearance for surgery.

I went in there two weeks ago and looked different than I did, and you could just see the wheels were turning in his head. He kept asking me, "Why do you need an EKG? What's this for? Who's the doctor?" After I gave him the name he went out of the room for a while. His male nurse came back who had been really friendly to me prior, and he non-personed me after.... The doctor's whole attitude changed and he was a little bit weird about the whole thing. The following day I had an appointment with the hormone doctor and relayed the story. She said, "I do GP too and I can be your doctor if you want." I thought, Cool. I'm coming here from now on. So that worked out.

Shannon knew that she did not have to work with the doctor who treated her poorly. Through resources available in the major metropolitan area near her home, Shannon had been referred to a “trans friendly” therapist who in turn had recommended the internist that first provided Shannon’s hormones, and is now her primary care physician. Because Shannon had financial resources and had a long history of interacting with physicians and insurance companies, she was able to find a doctor who could meet her medical needs and was also respectful of her personal choices. She worked between Dr. Howard and her primary physician to obtain the tests that Howard required, and was able to travel to his office from a distant city first for a consultation and later for her operation and recovery.

When transsexual transition involves medical intervention,²³ it is often a very expensive undertaking. Although there has been an increase in the number of clinics offering subsidized care to trans- patients—often including free or low-cost hormone prescriptions—in many major metropolitan areas in the past several years,²⁴ these primary care and drug costs often represent only a fraction of the total cost involved. Transwomen can spend thousands of dollars on electrolysis and laser hair removal on their faces and bodies. Access to pharmaceutical and surgical interventions are frequently conditioned by the endorsement of one and sometimes two mental health practitioners. These preliminary costs can be a barrier to accessing desired surgeries, especially for the uninsured. And surgery is not cheap.

Financing Surgery

In all of the discussions of intimacy and surgical magnanimity that surrounded Drs. Howard and Page, one topic that neither patients nor surgeons ever addressed directly was the role that money played in structuring the doctor/patient relationship. In addition to being “friends to the community,” “geniuses,” and “compassionate souls” these doctors were also making a very handsome living from the procedures that they performed.

The topic of money was a very delicate one throughout my fieldwork. Though I was allowed access to examination rooms and operating rooms, and took part in casual conversations about patients and the practice more generally, the only times I was asked to excuse myself from a conversation was when finances were being discussed. Howard asked specifically that I not include the fee for his services in any of my writing on this project.²⁵ In fact, he almost never spoke of money. Neither did Dr. Page. After

²³ Many people who consider themselves to be transsexual undergo transition without the help of medical interventions. Their transition may involve practical changes such as a legal name change and alterations in dress, clothing styles and comportment. There is no set definition of what it means to “transition,” though this process is often imagined to culminate or to be “complete” only after genital sex reassignment is performed. People who transition without medical intervention, or whose opt for some forms of intervention but not others, do so for many reasons. These include (but are not limited to) limited access to medical interventions—as determined by geography, educational or financial resources—and the belief that their transition *is complete* without them.

²⁴ At the time of this writing, I am aware of such clinics in San Francisco, Boston, New York City, Minneapolis, Washington DC and Philadelphia. For a reading of “metronormativity” in queer life and thinking about the possibility of that life, see Halberstam 2005:33-45.

²⁵ The estimates included here are ones that patients reported to me.

performing extensive patient evaluations in which they described surgical procedures in great detail, doctors took patients to their assistants' offices to discuss the cost of these procedures. "I give you the good news," Howard would say, "Now Sydney will give you the bad news." Sydney and Hannah did give the patients the bad news. They also handled deposits and payments. There are many reasons why this division of labor makes practical sense. In a private practice that depends on a steady stream of new patients, the doctors' time is better spent seeing patients than discussing finances. And since it is the assistants who ultimately handle payment, it is simpler to have the same person dealing with the money from the beginning of a patient interaction until the end. That said, this division of labor also allows the doctor to keep his hands clean, as it were. There is a break—a literal change of scenery—between the place where the doctor works and where the money changes hands. In both cases, after the doctor escorts the patient to the assistant's office, he then leaves the room to allow the discussion of money to happen without him present. This helps to create a separation between the service rendered and its monetary value. The doctor works on the face. The money is something else altogether.

The cost of FFS is significant, ranging anywhere from a few thousand dollars for minor procedures to over \$60,000 for significant reconstructive surgery. The wide range in fees reflects a variety of factors. Most significantly, doctors have varying opinions as to what kinds of surgical interventions a patient needs in order to be "feminized." The more procedures performed in one operation, the longer the operation and the greater the cost. The total fee includes the cost of the supporting surgical and medical staff, as well as time in the operating room and the medical equipment and pharmaceuticals required. Dr. Howard works in a major hospital (that figures the cost for OR time in 7½-minute increments) while Dr. Page works primarily in an ambulatory surgical center (ASC) adjacent to his office-park practice. Procedures performed in ASCs use only minimally invasive procedures and do not require hospital admission for recovery. Avoiding overnight stays in the hospital significantly reduces cost to the patient. Second, the doctors themselves charge different rates for their services. These rates are typically figured as flat fees for particular services, and not billed by time spent.

To put the \$60,000 price tag in perspective, at the time of this writing the cost for male-to-female genital sex reassignment surgery ranges from around \$21,000 in the United States to \$11,000 in Thailand.²⁶ So a patient who pays \$60,000 for Facial Feminization Surgery is paying roughly three times what it costs to have GSRS in the United States, and six times what it costs to have GSRS in Thailand. Patients with limited access to financial resources—which at these price points is virtually everyone—have to prioritize some procedures over others (see Table 0.1). Consider, as well, the cost of ongoing hormone therapy, facial and body hair removal, and other surgical procedures such as breast implants or vocal pitch modifications. Of course not everyone who identifies as transsexual or transgender desires all of these body modifications. And even if a person does want all of these things, they are sometimes quite simply financially out of reach. I met several transwomen at conferences and social events who said that they would like to have FFS but they simply could not afford it.

²⁶ These estimates were reported to me by FFS patients who had either recently paid these fees for genital SRS or received quotes after consultations with genital SRS surgeons.

I had expected to hear at least a few patients express frustration or resentment at the cost of these surgeries, but this sentiment never came up in interviews. Not once. Instead, patients took these costs as a matter of fact and worked to find ways to finance them. Many patients I interviewed in the doctors' offices were aware that due to their financial resources, they had access to options that many other people did not. Rachel acknowledged this when I asked her about her decision to seek out and under go FFS.

At a certain point I just said to myself, really, the truth of the matter is I just want to look as female as I possibly can.... If I can pull together \$50,000 I'm not going to feel guilty about it. There's all this thing of not everyone can afford it. Obviously. It does create a certain kind of a divide in the community. There are certain people who can't afford it. Some of it has to do with age. I'm 55 years old. I accumulated a little bit of capital. I couldn't have afforded to do this when I was 25. I didn't have \$50,000 in the bank. And there are probably plenty of 25 year olds who have a million dollars in the bank. So, it's all relative. But all of these things run through your head when you're considering it.

Jill commented on the same dynamic of differential access.

People can say, "Yes, but not everyone can afford it." I agree and that's a shame. My dad passed away and left me some money and I was fortunate enough to be able to afford what [Howard] could do for me. That being said, what [Howard] did is he opened doors that never would have otherwise been open.

Jill's acknowledgment of the limitation imposed by the high cost of these procedures made it clear that she had been presented with this argument before. She was quick, however, to bring the focus away from the criticism that FFS was only available to an elite and resourced group, and focus on the positive changes the procedures produce.

Like Jill, Beth was able to pay for FFS through money that came from her family. Beth was in her early 20s and talked a lot about how her parents felt about her FFS. Her parents' feelings and reactions were a big source of anxiety, but they were also the source of funding for her surgery.

I have an investment fund. My dad used to be an investor and he set up a fund for each of us kids when we were born. I'm using a good chunk of it for this. Obviously I don't like the fact that I'm using a good chunk of my money for this, but I think this is easily important enough. My dad was saying that he didn't like that I was using it for this because he was hoping I'd use it to put a down payment on a house. But this is far more important than that, I think.

While patients such as Rachel, Jill and Beth had money available to them through savings and inheritance, this was not the case for everyone. Zoe paid for her FFS by borrowing money from Care Credit, a credit issuing company dedicated to financing medical and dental services that are not covered by insurance.²⁷ She was in Howard's office to get a consultation on some revision surgery that she wanted following the major FFS that she had undergone several months before.

²⁷ <http://www.carecredit.com/about.html> (accessed 11/15/2010)

My problem now is that I am here in [town] visiting my lawyer because I am getting ready to file for bankruptcy. I've spent about \$60,000 in the last year for surgery [FFS and GSRS] and now I can't even make the minimum payment to Care Credit. I have a brother and a sister who both have money, and I tried to get loans from each of them. They refused. They told me that they wouldn't finance the worst mistake I could make with my life.

The fact that many patients had family sources of money—whether or not they came through—indicates that they come from a socio-economic class with access to significant economic resources. This was not the case for all patients I spoke with.

Rhonda—whose feeling of overall anguish about her life as a transwoman I recounted in the Introduction—had had her mandible contoured and upper lip shortened a few days before I met her. She wore a Philadelphia Eagles knit cap on her head and her chin and jaw were very swollen. She had dimples in her chin that were caused by internal sutures that would dissolve in time. Rhonda cried gently during much of our interview, but insisted that our conversation continue. She dabbed at her tears and the saliva at the corners of her mouth as we spoke. When I asked her if she intended to have more surgery on other parts of her face, she replied,

I would like to have more but the money issue is a big issue. The money is so hard to come up with. My mom cashed in her life insurance policy. That's kind of dramatic because she's up in age. I want to work on paying her back.... I wish I was a millionaire. I'd have them work on me for 24 hours. I'd have them pluck this, insert this. Other than that, I'm happy. I think it's going to all be good.

Rhonda had had genital sex reassignment surgery performed by the renown Dr. Stanley Biber nearly 30 years prior. She was very happy with her genital surgery and was optimistically looking forward to healing and reaping the benefits of her FFS. Even still, she fantasized about the body that would be available to a millionaire.

Gretchen had borrowed money from friends to finance her Facial Feminization Surgery and she was very anxious about paying that money back as soon as she could. When I asked how she was feeling about her surgery that was scheduled to take place the following morning, she said

I feel absolutely nothing about it. I'm just worrying about paying back very, very soon the people who were kind enough to lend me the money. It's very difficult to find that. I have another priority [she planned to travel to Thailand for genital sex reassignment surgery] and I want to do it as soon as possible.

Gretchen had factored her FFS into her plan to earn money to pay for her genital SRS.

G: I will probably work seven days a week to pay off everything and save for the next surgery [SRS] for quite a long time. I do hope—it's not an expectation, it's a hope—that I will look good enough to attract enough paying customers that want to chat with me on the net so that I can pay [the money] back very quickly.

EP: Are you doing that now?

G: No, obviously not. I can't. With this face, I can't. I tried last year but the company who is doing that in Japan [where she lives] told me, "Sorry you're still looking too much like a guy." Yeah. I understand. I agree. I will do something with that within one year.

EP: What does the company offer? What do they do?

G: You're staying at home and the time you want, you just plug in the camera with their server. You're waiting for their customers to choose your photograph and chat with you for a few minutes. I've got a friend who is a genetic girl who is doing chat hostess when she has some free time. It's pretty much talking with lonely guys. "Hey, show me your boobs." Okay. Satisfied? And that's all. That earns a bit. It would be enough to speed up [my savings], if it works. I will try that.... That's for a very short time, but it is absolutely not the goal of having this [surgery]. I want to live normally after that.

Gretchen hoped that FFS would render her face feminine enough to earn money chatting online with "lonely guys." While she ultimately wanted FFS in order to "live normally"—i.e., not as an online sex worker—the face created by FFS animated her strategy to save money for GSRs. This plan helped her to prioritize facial surgery above genital surgery, despite the fact that FFS is far more expensive than that the GSRs she planned to have in Thailand as soon as she could afford it.

Gretchen's story represents the reality of most patients: they must strategize and prioritize in order to finance the surgeries and other forms of intervention that they desire. The ultimate form that these strategies take is influenced by their financial and professional situations, as well as their personal and familial relationships and obligations. Several patients told me that their decision to transition had led to the end of their marriages and, in some cases, estrangement from their children or other intimates. Denise said that "this transition has cost me my marriage and my children." Alison was in the middle of a divorce, and her plans for surgical interventions depended upon the financial settlement she would eventually reach with her ex-wife. Brenda's decision to transition brought her long-term relationship with her male partner to an end. "He was a gay man, after all, and wasn't really interested in being with me if I was a woman," she said. Like Alison, the end of this relationship left Brenda's surgery plans somewhat up in the air. "I'm on my own now," she said, "all of this stuff [FFS and her plans for GSRs] just depends on how my investments do."

Shannon's marriage to her wife of 18 years was going to survive her transition. This meant that she had a consistent source of love and support, and it also meant that she was not alone in deciding how and how much money would be devoted to her physical transition. After she had had her initial consultation with Howard, Shannon and I discussed her plans for surgery. "I'm only having certain parts done," she said. "I'm not doing my jaw and chin yet. Possibly later. I'm married and we're debating whether we want to spend that money. I'm going to do as much as I can. It's spending the money—because this is not cheap. I kind of owe it to my wife not to blow everything we have."

The money that changed hands between patient and surgeon (or, surgeon's assistant) was enabled by a sometimes very complex set of connections and interactions between work, family and personal desire. Patients considered the cost of different

surgeons, and of the different procedures the desired within a network of financial and personal demands.

Other Surgeons' Pocketbooks

While the patients who came to these surgeons' offices acknowledged—and sometimes struggled with—the cost of their operations, none of them ever expressed resentment about the high figures of their own doctors (though they sometimes cited the high prices of other doctors as one factor that impacted their selection of a particular surgeon), nor did they ever insinuate that the FFS surgeons were taking advantage of them or were out to get rich. In fact, the only time I heard such accusations made were when surgeons themselves criticized the work and motivation of their peers. These accusations were focused on surgeons' perceptions of a patient's "need" for particular procedures.

The first of these instances occurred in the operating room. Dr. Howard was performing a few minor revisions on Shelby whose "full face" FFS he had done several years prior. According to Howard, Shelby had been quite pleased with the results of her initial surgery.²⁸ Some years later she had accompanied a friend to the offices of Dr. Stuart Crabtree, a leading American genital sex reassignment surgeon who had recently begun performing Facial Feminization Surgery, as well. During her friend's consultation, Crabtree remarked to Shelby that she could benefit from the addition of cheek implants as well as some revision work on her nose. Shelby agreed with his assessment and underwent the procedures he recommended. As soon as she healed from the surgery—Howard told me as he removed the implants from her cheeks—she regretted having it done. She returned to Howard to have the implants removed and to have her nose (re)reconstructed into the shape that Howard had made during her initial FFS. Howard shook his head as he dissected her nose in preparation for the rhinoplasty—a process that is made more difficult when another doctor has performed surgery on these same tissues. He told me that he could understand why Crabtree had wanted to re-do her nose; noses are a matter of aesthetic taste. But "the only reason to put cheek implants in someone who doesn't need them is to line your pocket book."

The second occasion in which one doctor accused another doctor of operating out of greed rather than a patient's interest occurred over dinner at a trans- conference. Dr. Page and I shared a table with several other people at the back of a large banquet room. Despite our distance from the stage, the musical numbers being performed at the conference talent show were loud enough that we had to lean in close to each other to talk. He was describing what he thinks makes his approach to FFS different from the other American surgeons who are currently performing it. As opposed to the standardized approach that he attributed to other surgeons, he described his approach as one that takes into account the specific needs of each patient. "Not everyone needs everything," he stressed. "A doctor who does every procedure on everyone is doing it for their pocketbook and not for the patient."

²⁸ I was not able to interview Shelby. Howard's reports of her feelings are the only information I have regarding her assessments of her surgical results. Judging by the fact that she returned to Howard for revisions after seeing Crabtree, I take his characterizations to be reasonably accurate.

These accusations call the motivation of “other doctors” into question by foregrounding the financial rewards that come with performing multiple procedures. Despite surgeons’ acknowledgement that different practitioners have different ideas about what patients “need,” there is still an imagined standard of appropriate and inappropriate practice in this regard. In claiming that “other doctors” are motivated by selfishness and greed, Page and Howard located themselves in the position of beneficent caregiver. Performing “unnecessary” surgical procedures that patients do not “need” is what Crabtree’s assistant called “wrong reasons.” The specter of financial gain threatens the purity of beneficence that surgeons claim motivates *them*—though it may not motivate the other guy—and by locating the desire for gain elsewhere, they shore up the steadfastness of their commitment to benefit “the patient” and not themselves.

In this chapter I have explored the unique market between trans people and the surgeons who offer the procedures they seek. My aim in this chapter was to show that the history of *transsexualism* as a contested diagnosis has shaped the way that patients and surgeons interact with and understand each other in this market. As a result of this unique history, surgeons’ work is recognized more for what it means about their character than for what it shows about their abilities as skilled practitioners. Trans- patients negotiate the market for surgical care with a focus on surgical character in the forefront of their minds—and surgeons know it. As such, surgeons market their practices by emphasizing beneficence over technical proficiency and contribute to a foregrounding of patients’ desperation and concomitant gratitude for services rendered. Though these surgeons’ actions can be understood as strategic—in that they emphasize certain characteristics in order to appeal to prospective patients—recognizing them as such does not necessarily mean that they are manipulative or disingenuous. Of course, all of these things may be true at once. By this I mean that surgeons may be compassionate, sincerely invested in helping trans- patients, and also want to be venerated, adored, and make a lot of money in the process.

Though the market in beneficence that I have described is putatively defined by surgeons’ “belief” in the problem of transsexualism and their “commitment” to helping this marginalized population, the actual beliefs and commitments of surgeons is hard to know. In the end, I argue, it does not matter what truly motivates these surgeons’ work—be it compassion or money or some combination of those things. What is critical to see about this market is that ideals of belief and commitment are made real through the actions they animate. This reality works for patients in that they get “good” care, and it works very well for surgeons. When an individual surgeon is exalted for his work, the story of that work becomes about *him* as an individual person. *He* is exceptional. *He* is beneficent. He is both capable and kind. He acts on the body not only as a skilled technician, but as the embodiment of good will. Through his actions he is not only able to restore a misaligned gender history to a patient, but is able to recuperate a past of inadequate healthcare and physician hostility to “the community.” This is a powerful act that helps to locate particular forms of knowledge in the exceptional individual surgeon, as well.

In the next chapter I turn to an examination of how surgeons' produce the facts of masculinity and femininity in the clinical examination. Their ability to authoritatively represent these gendered differences continues to both constitute and be enabled by their reputations as doctors who help trans- patients for all the right reasons.

Celebrate!

Celebrate! is an annual conference for cross dressers and trans- women that has been held in the same rural northwest town since 1990. There are only a small handful of these conferences held each year in the United States, and many attendees identified these conferences as their main opportunity to dress in public (though this is a very particular kind of public) and to talk openly with other cross-dressers and transwomen.

I was not sure how I would be received in the space of the conference. Other than four physicians and a police chief (who were conference presenters), I was the only masculine presenting person there. When I first walked in one of the organizers approached me and introduced herself. I told her that my name was Eric. She asked me if I had a femme name. I responded that I was a transman, and the conversation immediately changed. Someone near by told me that the fact that she could not read me as a transman was a compliment to me. Many people responded that they would never have read me as a transman, and often followed this with (mostly) playful complaints about how transwomen have a much harder time passing than do transmen. I responded to these complaints with a quiet smile. Apart from these (mostly) friendly little jabs, I was invariably met with kindness and often with sincere interest and enthusiasm for my research.

I met Molly before the “Crossdressing 101” workshop. Molly was a cross-dresser and first-time conference attendee. When I asked her about FFS she responded quickly: “I like everything I’ve got, just how it is.” Molly did not pass as a woman and was not concerned about that. Cross-dressing was an occasional practice that she really enjoyed, but she had no interest in transitioning or changing her body in any way. She compromised on altering her physical appearance with her wife: Molly was allowed to shave her chest and body hair during the winter months as long as she allowed it to grow out for the summer swimsuit season.

With only one exception—Rene, who was attending her first-ever trans-conference and was generally blown away by everything and everyone she saw—everyone I spoke with throughout the weekend had some knowledge of Facial Feminization Surgery. Many knew of it from personal experience; they had either researched it for themselves or knew someone who had researched or undergone the procedure. Without exception, everyone who knew of FFS also knew of Dr. Howard by name, though the extent of knowledge about him and his work varied. When describing the work he had done on one of her friends, Karen said, “He is a miracle worker. It is amazing what he does for people.”

Just because people knew about FFS, however, did not mean that they were necessarily interested in undergoing the procedure themselves. During the second night of the conference, I joined the official evening event at a town bar hosting a locally famous cover band that specialized in pop songs from the 80’s and 90’s. Their conference draw, though, was that the band was all cross-dressers. The small bar was packed with an amiable mix of town residents and conference attendees, making it a people-watching event for all tastes. In between beers and sweaty dances I struck up conversations with transwomen who were leaning against the walls or seated at the bar, watching the scene. “Yeah, sure, faces are a big deal,” Gina told me, shouting against the volume of the

music. “But the real tell is the hairline. You can have a beautiful face, but if you’re bald, no one is buying you as a woman.” I heard these kinds of rejoinders a lot. Another woman told me that the voice is the key. Another, the hands. For these transwomen, FFS might have been desirable, but it would not have made the difference between passing and not passing. For them, that line was located somewhere else on the body. As such, FFS was simply irrelevant.

Sophia personally knew two people who had had Facial Feminization Surgery. She told me that she thinks “they really do look much more feminine,” and that her friends considered it to be the most important thing they’d done in their entire lives. While she completely acknowledged the transformative power of FFS, Sophia was not interested in it herself. She gave two reasons for this. First, “I’m six foot three,” she said, “and there is nothing I can do about that.” Like the women I met at the bar, Sophia understood other characteristics of her body—her height—to be more determinative of her perceived sex than was her face. “More importantly,” she said, “I have this.” She picked up the walker she used to help her get around. “Once people see the walker, they really don’t look at anything else about me.” Dressed in a skirt and blouse wearing a short-cut grey wig and leaning against a walker, Sophia passed most of the time. This was immediately picked up by others in the conversation as an ingenious passing strategy. They joked that it was a great prop and that they should go out and buy walkers for themselves, too. Sophia played along, “Oh yeah, I’ve got it all worked out.”

I met only two people at *Celebrate!* who had had FFS themselves. They were both patients of Dr. Howard’s and couldn’t say enough positive things about him and about the results of their procedures. One of the former patients, a physician and conference presenter, told me matter-of-factly that there really is a difference between what Howard does and what other FFS surgeons do. “Surgeons are different,” she said, “even those with the same training. It’s like artists: some draw portraits on the sidewalk, and some are Michelangelo.” Both of these former patients joined the luncheon table I shared with Dr. Howard, his assistant and a person who had recently booked a surgery to take place in the following months. There was a great deal of laughing and conversation during lunch and it was clear that all of the patients—past and present—had congenial feelings toward Howard.

In addition to the personal investments people had in Howard’s surgical work, he had established a positive relationship with many people here through being a long-time sponsor of scholarships for first-time conference attendees. In short, he provided money so that people who had never attended a conference such as this one would not be prevented from doing so owing to a lack of funds. He was recognized for his ongoing financial contributions during a lunch-time event. The announcer thanked him for being a “long-time friend” of the conference. The room full of diners turned and applauded. While I had hoped to talk with someone who had a negative or at least ambivalent attitude toward FFS in general and Dr. Howard in particular, I just didn’t find that to be the case. For the eighteen people with whom I spoke at length, FFS was a miraculous thing, and Dr. Howard was the miracle man.

Dr. Page was at the conference, too. In fact, this was the place where we first met. He and Howard were the only two FFS surgeons at this conference, and many people attended both of their presentations in order to compare approaches. Their ability to attend both sessions was a point of contention for Page. He had coveted Howard’s prime

Saturday mid-morning slot, but had to settle, instead, for a Friday afternoon time. These kinds of prioritizations were an uphill battle for him as he tried to build his name and his reputation.

By the end of the weekend, it became clear to me that “the feminine” is an ongoing achievement. For some people, the first and most important thing to do in order to achieve femininity is *x*. For others, it is *y*. But, in any case, *z* comes next for everyone and becomes the most important thing that is standing in the way of one’s happiness. It is one thing, and then another, and so on. For many folks at the conference, the first necessary step to begin their pursuit of femininity is learning to see it. She knows that she is not doing feminine right, but she does not know in which ways she is failing, or how to correct them. She does not know how to get from where she is now to “femininity” over there, though she may know it when she sees it. Various forms of expertise on the subject of femininity were offered over the course of the weekend. How to recognize—in order to reproduce—the feminine walk, talk, make-up, hairstyle, dress, affect, and so on. In important ways, then, Howard and Page’s FFS presentations fit in with other “learning to recognize the feminine” kinds of trainings. Whichever doctor does the best job of training people to see the feminine in the same way that he sees it, will have that person as a patient. It is a question of whose approach most resonates, who can *communicate* femininity most clearly in such a way that it becomes a thing that can be achieved—in general terms— and in the face of the person watching and desiring a path to it.

Chapter Four

The Clinical Examination

Coordination into singularity doesn't depend on the possibility to refer to a preexisting object. It is a task. This is what designing treatment entails.

—*Annemarie Mol*¹

The contested status of “feminization” as signifying both the female and the beautiful is not only a philosophical difference, but a practical and technical one, as well. Though the sites of FFS interventions were initially developed with reference to scientific practice and series quantifications, it is clear that these ostensibly objective measures are not the only ones that guide surgical practice. In fact, while many doctors invoke Howard’s research and general approach to FFS, others take a significantly different approach to the project of feminization. Dr. Mitchell Page is one such doctor. His difference of approach does not stem from a definition of the female that contrasts the one that Howard established in his 1987 article. Indeed there has never been an explicit challenge to the characterization of male and female skulls upon which Howard first developed FFS. Dr. Page does not disagree about what the “normal” female looks like. Instead, he disagrees with the notion that creating “normal” females ought to be the goal of FFS at all.

Through comparing initial patient examinations in the offices of Dr. James Howard and Dr. Mitchell Page, this chapter demonstrates that surgical “feminization” is not a single set of procedures performed by different doctors. Instead, it is a contested process animated by divergent forms of expertise, and aimed at producing qualitatively different results. In short, these doctors—both recognized as FFS specialists—have fundamentally different views about what “feminization” means in practice. This disagreement is not merely a matter of aesthetic tastes. Rather it is the product of their understandings of the role of surgical intervention (as informed by their training and orientation to distinct surgical specialties), and fundamentally different understandings of what their patients want from surgery. Dr. Howard performs scientific expertise through recourse to statistics and measurements; it is based on the facts that he established that he promises results that will produce the certainty of femaleness. Dr. Page co-produces knowledge with his patients and relies on popular images of famous

¹ Mol 2006:70.

women to communicate desirable facial features. Based on this supposed shared understanding of “what women look like,” his results aim not for the certainty of the female but for the possibility of the beautiful.

In the space of the clinical exchange, the relationship of femaleness to beauty at work in “feminization” emerges as a problem of practice. For Drs. Howard and Page, these two properties—beauty and femaleness—exist in causal relation to each other, but the order of that causality is inverted. Let me explain. For Howard, beauty is a possible effect engendered by the scientifically certain instantiation of “the female face.” For him, “feminine” describes an essential and sexually dimorphic property: because the face is female, it can be beautiful. By contrast, for Page, femaleness is a possible effect engendered by the aesthetic and celebrity-driven possibility of beauty. Here, rather than something that the face *is*, “feminine” describes something that it does: because the face is beautiful, it can be female. These orientations to the practice of feminization set clinical priorities, and are manifest in the means by which surgeons identify and communicate characteristics of gender to patients—*what* and *how* they see masculine and feminine in the clinic.

Practice and Specialty

Broadly speaking, the principles that guide Howard’s and Page’s clinical practice can be characterized in reference to a distinction that Meredith Jones (2009) has drawn between thinking of those undergoing elective surgery as “patients” or as “consumers.” As *patients* persons undergoing surgery are subject to the doctor’s assignment of diagnosis and determination of cure; they are receivers of information. As *consumers*, persons undergoing surgery engage in a dialogue with the surgeon to determine what is to be done; they are the co-, if not primary, producers of information. Jones attributes the growth of the consumer model to the now widespread accessibility of information and increasing demystification of medicine in general and surgery in particular. Surgeons who were once the arbiters of knowledge about their discipline, must now respond to and incorporate the desires and demands of their clients who often come to the clinic well informed and empowered by their roles as consumers. Though in the case of trans-patients the consumer model is complicated by the historical and ethical complexities I have explored in earlier chapters, the description of self-educated and self-directed patients is an apt one here. Employing the myth of Pygmalion, the sculptor, and the statue Galatea whom he creates and then falls in love with, Jones describes this new doctor-patient/consumer relationship.

The contemporary cosmetic surgeon is a Pygmalion figure who operates as a decentralized figure in a web where he plays lover, father, salesman, aesthete, medical expert, competitor, artist, advertiser and technician. Galateas of the contemporary world may be unfaithful to their origins, may turn on their creators, may actively employ doctors’ expertise to their own ends. They are likely to be discerning shoppers, canny ingestors of research, and knowing consumers (186).

To be sure, the dynamic that Jones characterizes here affects the ways that both Page and Howard run their practices. To characterize the work of these surgeons using Jones' dichotomy, I would argue that Howard sees patients and Page sees consumers.

This distinction can be attributed, in part, to the fact that Howard and Page are different kinds of surgeons. As a cranio-maxillofacial surgeon, Howard spent much of his career repairing severe deformities of the face and skull caused by accidents and congenital abnormalities. One surgeon described this aim succinctly: "Reconstructive surgery has the objective not only of helping an abnormal individual achieve a kind of normalcy, but of ridding, if possible, society of a visible, uncomfortable exception" (Goldwyn 1996:86).² Though Howard is board certified as a cosmetic surgeon and does plenty of procedures that fall within its purview—such as facelifts and breast augmentations—his primary training and orientation are to facial surgery as a reconstructive project. In order to accomplish the stated—and ostensibly shared—goal of feminization, his task is to intervene in the structures of the face that are considered to be objectively male in order to reconstruct them as female. From the perspective of this approach, there is not much co-production of knowledge or negotiation of procedures to be done. The face is a series of facts that altered in one way can produce the feminine, and altered in any other way can produce some other result. If feminization is what the patient wants, then Howard knows the path to its production. The justification for this change is bound irrevocably to the therapeutic logic of GSRs, a logic that fixes both the degree and the kind of desire that motivates it. Howard accepts his part in corporeal transformation, and the entire bundle of meaning that comes with it. In practice this means that he recognizes that surgical care is not the only kind of care he provides: this surgery is deeply and fundamentally transformative.

Dr. Page is a plastic surgeon by training—though he completed a fellowship in craniofacial and reconstructive surgery. Like the surgeon described in Carol Spitzack's essay, "The Confession Mirror" (1988) and the contemporary Pygmalions that Jones describes, Page lets his patients guide the clinical process, telling him what they feel needs to be changed about their bodies and faces. Rather than an orientation toward identifying and intervening in bodily structures whose pathologies are constituted by their objective divergence from the healthy norm, Page allows his patients' experience of dissatisfaction and their vision for an improved body determine where and in what ways he will surgically intervene. His practice is therefore built on responding to patients' feelings about their bodies, more than the bodies themselves.

For Page, FFS is a name that characterizes a particular set of *desires* more than a grouping of surgical procedures or outcomes. Like all of the surgeries he performs, feminization is, for him, ultimately left up to the patient to define. As such, he does not frame his work as enacting a change of the face's sex, per se, but is instead interested in giving the patient the face she wants—or the best approximation of it that he can produce. While Page may suggest sites of intervention, it is ultimately the patient who decides which parts of her face are unacceptably masculine and is, therefore, responsible

² One of the timelines that helped to structure Howard and his colleagues' surgical plans when working with children was the goal of having them healed from their procedures in time to take their senior yearbook photos. This example makes clear that "normal" is not only a morphological category but a centrally a social one, as well.

for the direction of her own surgery. In this way, FFS is the same as all other surgeries he performs: he produces a desired appearance from an undesired one. These differences of approach and understanding of the problem of femininity and masculinity do much to determine how Page and Howard *see* these characteristics in patients' faces, and thus how they determine what patients *need*.

The Initial Consultation in Two Offices

From his private offices within a large hospital, Howard can walk to the surgical wing—where operating rooms and surgical recovery rooms are located—in less than a minute. Upon entering his office from the hospital corridor, one enters a warm but unremarkable waiting room: carpet and walls in shades of neutral brown, upholstered armchairs separated by low coffee tables offering a selection of news and fashion magazines. In addition to personal and administrative offices, the practice has three small examination rooms, each equipped with a large examination chair (somewhat like a dentist's chair, it defaults to an upright but gently reclining position), a rolling stool (on which Howard sits during most of the exam), a small side chair (where I sat while observing exams), and a counter at the back of the room that contains a hand-washing sink and a light box for illuminating x-rays.

There are few decorations in the exam room dedicated to initial consultations and pre-operative appointments. To the right of the patient seated in the exam chair, a silver and bronze toned image of a naked and reclining woman hangs on the wall. Her long hair flows down her back and shoulders but leaves the side of her breast exposed. On the wall facing the patient—and so behind Howard as he conducts the exam—is a magazine rack that holds several fashion magazines. For months, Fergie from the Black Eyed Peas looked over Howard's shoulder from her enviable place on the cover of *Allure* magazine. She watched as he assessed the undesirably masculine faces of his patients, baring her midriff and being otherwise sexy.

When I entered the room, Tracy was seated in the reclining exam chair, hands folded in her lap and looking nervous. Howard urged her to keep her seat as I introduced myself and shook her hand. With Tracy, as with all other patients whose consultations I observed, Howard began the appointment with a few minutes of friendly conversation. He enquired about the Canadian city in which she lives. As a person who has done a considerable amount of traveling throughout the world, Howard often has a personal story to tell about the patient's hometown. Though he tends to speak rapidly as a norm, these exchanges do not seem to me to be perfunctory or rushed; people's stories sincerely fascinate him. After having seen this routine enacted a number of times, it is clear that Howard uses these first moments to establish a friendly rapport with new patients who are frequently very nervous—and in some cases could be best described as star struck. While this moment may be the culmination of many months or years of a patient's personal and financial work, for Howard, this is another day in the office.

After the brief exchange of pleasantries, Howard moved into questions about Tracy's medical history: height, weight, medications, prior surgeries, and so on.³ When Tracy stated that she was actively losing weight and would like to get down to 180 pounds, Howard made his first recommendation of the appointment. "I'd like to see you down to 160," he said. "The best results I see—not surgically but in terms of overall femininity—are in patients who get down to a female weight for their height. When you get down to 180, just keep on going." While completely unrelated to the craniofacial surgical consultation underway, Howard's recommendation on "overall femininity" signaled his understanding of FFS as both part of a larger goal of corporal feminization, but also as just one part of achieving that goal. In addition to signaling a holistic understanding of the project that brought Tracy to his office, this shift from conversation to recommendation marked the beginning of the exam;⁴ he is the expert with information to give. Howard did not ask why Tracy was in the office to see him. He did not ask what her goal was for surgery. He assumed in Tracy's case and in all other consultations I observed, that a person whose paperwork indicates that she has come to the office for an FFS consultation is doing so because she wants to have her face reconstructed to take on female proportions. I have not heard this assumption corrected. It is with this assumption that directly following the medical history, he began making measurements on Tracy's face.

Page's office, located in an office park in an affluent suburb of a major West Coast city, shares a building with accountants, attorneys, and dental offices. The Ambulatory Surgical Clinic where he performs most of his operations is attached to his office, though it has a separate entrance at the back of the building. In the waiting room, leather armchairs and a long couch are arranged around a low coffee table covered in fashion magazines. The walls are covered in an ivory-toned wallpaper that in combination with the light coming in through a large window makes the space bright, though somewhat impersonal. The dominant feature of Page's waiting room is a mirror-backed, top-lit curio cabinet featuring branded cosmetic products such as Juvederm and Botox, the presence of which makes it impossible to forget that this is not a neutral space; there is something for sale here. The reception desk is located in the front waiting room and is staffed by a few different young women. On two occasions the stillness of their faces and the shape of their lips have made me quite aware that they have "had some work done."

The two exam rooms in Page's office are considerably larger and more brightly lit than those in Howard's office. Here too, the reclining exam chair is the largest and most central object in the room. A small chair (where I sat during observations) is positioned just to the right of the exam chair, and a full-length mirror hangs on the wall next to it. A counter with a small sink occupied the left wall of the room. A model of a

³ The medical history that Howard takes is part of assessing a patient's medical suitability for surgery. By beginning appointments in this way, Howard gives the impression that his initial consultations are also pre-operative exams.

⁴ "If the history-taking is still a realm of the self, though one in which the self is becoming detached from the body, the physical examination is a realm of the body, and one in which the body is rendered an object" (Young 1997:26).

human skull sat on the counter, looking directly at the exam chair. When Page invited me in to observe the consultation, Leanne was seated in that chair.

Leanne was one of the few patients I encountered during my fieldwork who arrived for an FFS consult in what was referred to in both offices as “man mode” or “male mode.” She had taken the opportunity to visit Page’s office while traveling through town on business and looked every bit the businessman: short-cropped sandy blond hair graying at the temples, a crisply pressed pale blue shirt, navy blue necktie, grey trousers and black oxford shoes. Page habitually opens the conversation by asking patients how they heard about him and his practice. This sets the tone that the patient is a consumer who has shopped around, and it helps to identify him as a businessman who is eager to grow his practice. After a bit of small talk about Leanne’s hometown and learning that this was her first visit to the region, Page began the exam not by taking a medical history, but by prompting a personal conversation. “Tell me about yourself, about your transition.”

An examination is frequently understood to consist of two parts: the history taking and the physical examination (Young 1997:23). It is immediately clear that though Howard and Page each “take a history” from their patients before beginning the physical exam, what constitutes relevant history is different for each of them. Howard asks his patients about what are traditionally understood to be medical issues: their height, weight, current medications, previous surgeries, and overall physical health. This information helps him to assess whether the patient is physically well enough to be a candidate for surgery. It also signals that his primary interest is in the physical properties of the patient’s body, an interest that is born out in no uncertain terms in the examination that follows. Page, on the other hand, does not ask such questions of his patients during their initial appointments. Instead, he elicits a “history” of the patient’s feelings about herself and her transition, more generally. Because the appointment begins with the disclosure of personal—and often quite emotional—information, the examination that follows is framed as one directed toward the realization of personal and emotional goals more than physical ones.

As the consultations progress, the distinctions between Howard and Page’s approaches become clear. Howard’s meeting with Tracy appears in the left-hand column below. Page’s meeting with Leanne appears on the right.

H: Now I'm going to take some measurements and we'll look at your x-rays.

Howard washed his hands and came back to sit down in front of Tracy. She was sitting in the exam chair and he rolled up to her on a small, wheeled stool. He took a small white flexible plastic ruler from his coat pocket and measured the distance from the cornea of her eye to the most forward prominence of her forehead.

Your brows are down a little bit.

He felt the brows and temples on both sides of her face using both hands. He pressed the sides of his thumbs up under the bones at the top of her eye sockets in order to get a sense of the shape of the bone.

Look at the top of that light switch.

Howard directed Tracy's attention to the switch on the wall directly in front of her. Looking at this object helped to make her head level.

Open your mouth just slightly.

Howard measured the distance from the bottom of Tracy's nose to the inferior ends of her front teeth.

Bite down on your back teeth.

Howard bit exaggeratedly on his back teeth to show her what he meant. Looking away, he felt the muscles on either side of her jaw with his hands. He turned to me and explained to the patient that we had been talking earlier about how he decides whether or not to remove some masseter muscle when he does jaw tapering. Talking to me: She has a fairly prominent jaw, but the muscle is not that large. I won't even consider removing any muscle on her.

Howard runs the pad of his thumb up and down the center of Tracy's throat.

Have you got one of these things?

Settles on the patient's Adam's Apple.

L: I began dealing with my gender issues at 50, when my wife and I became empty nesters. I have already been cleared for hormones but I am waiting to take them until after my daughter's wedding in a few months. I am a manager—I mean, that is what I do for a living but that is also who I am. I like to have everything figured out before I start. That is why I am here. I don't really know how hormones will affect me and what changes they might make to my face, but I do know that the face is the most important thing to me. I can do things with clothes, but I can't hide my face.

P: Making changes to your face can make you more feminine appearing.

As she spoke, he sat quietly, almost motionless. Like a practiced interviewer, he allowed her short silences to linger unfilled, and it turned out that she had a good deal to say.

L: I know that if I proceed with this my marriage will be over, and I understand that. My wife didn't really sign up for all of this and I can't force her to feel better about it. I am here because I want to manage my expectations; I need to know realistically where I might end up, instead of going forward with all of this and then finding out that you can't do what I think you can do. I don't want someone to give me all of the classic female things.

This is a clear reference to Howard's approach.

I was interested in talking to you because you said that you work *with* features not totally remake them. It is not a clean slate. Given the face that I have, I want to know what to expect. Right now, I don't look like a woman; I look like a man in a wig.

I haven't gone out much; I only wear women's clothes when I go to counseling. But when I go out I worry about my face. I just don't want to attract attention. I want to fit in.

Page did not verbally respond to any of Leanne's personal and emotional disclosures; he simply began the physical assessment of her face.

Yes you do. That's got to go. If you have this done by someone else don't let them put a scar at the middle of your throat.

Tracy lives in a country that has a national health service and Howard makes explicit reference to this since he knows that by using that service Tracy could save a considerable amount of money on this procedure. As he describes the potentially problematic placement of some other surgeon's scar, he draws a line across her thyroid cartilage with his index finger to mark the cut.

If I do it I'll put the scar up here...

He draws his index finger just under the point of her chin to indicate where he would place the scar.

...so no one can see it. Plus if you put the scar here [in the middle of the throat] it can stick to the cartilage and then it moves every time you swallow. It looks like the dickens.

Let's look at your x-rays.

Howard walks to the light box behind the exam chair and invites Tracy to join him. They stand shoulder to shoulder in front of the light box looking at the cephalograms that Tracy brought with her to the exam.

First I look to see that you're brushing your teeth, and it looks like you are (laughs). When I was measuring here before...

Uses his finger to show the measurement he took from the forehead to the cornea.

...I was looking at the maximum prominence of your forehead to the cornea of your eye. In you it was 15mm, which is average for a male of your height. As far as I know, this measurement is not taken anywhere else in the world. It is not a standard measurement. Once I am in there and I begin to contour the forehead, I can't tell where I am. This measurement helps me locate myself in space.

By this he means that because the cornea does not move as a result of any bone reconstruction in FFS, he can use it as a constant reference

He took a handheld mirror from a small drawer and handed it to her. She sat, holding the mirror, looking at her face as he spoke.

P: We'll start at the top and work our way down. These are only suggestions, to let you know what is possible, and how I think of things. We think of the face in three sections: forehead, midface and lower face. One of the most feminizing effects happens in the forehead. We can move the hairline forward. Bone work is required to make a feminine skull.

Page rolled his stool backward to retrieve the model skull sitting on the counter behind him. He held the skull in his left hand and used the index finger on his right hand to show Leanne how the frontal bone could be reduced.

By burring down this area [above the eyes] instead of removing the bone, we can retain the angle from your forehead to your nose. Patients with 'the works' often look worked on. That is not what I want to give you. When you lose the natural transition from the forehead to the nose you don't look good as a man or woman.

This is a direct defense of his surgical approach against Howard's more aggressive style. Page runs the pad of his thumb across the orbital ridge above Leanne's left eye as she looks at her face in the mirror.

Reducing this will give you the feminine appearance. It gives you sex appeal. That's the approach we're going for. Passing as a woman takes more than what I do: it's about hormones, behaviors, dress, makeup, voice. What I do is just one piece of the pie.

Now, when I'm in doing the forehead contouring I can remove some frown muscle, which would be nice for you. At the same time I can take away the peaks at the hairline.

Page uses the wooden handle of a long cotton swab to trace along the temporal baldness of Leanne's hairline.

L: I'll need a wig anyway. I had hair transplants all through there but they failed.

point against which to measure how far he'll bring the forehead back.

This dark space is the frontal sinus.

He points at the sinus on the x-ray using a yellow wooden pencil.

In my mind, the most desirable female forehead is convex horizontally and vertically; it is not vertical. I could take you back 8mm. The 15mm you currently are minus 8 equals 7mm. That is where I want you. If you had an x chromosome rather than the y you were born with, that is where you'd be. You got this...

indicating the brow prominence of the frontal sinus

...when you were 14, 15, 16 years old.

You have what I call a type III forehead.

Explains how he'll remove the frontal wall, and form patches to wire back into the exposed sinuses.

When taking out the frontal sinus you have two holes left: if you sneeze you make a bubble and if you sniff you make a dimple. That is good at the first cocktail party, but not the second. I take the bone I removed and make two small patches and wire them into place to close those sinuses. If someone just burred this down, they could only go about .5mm to 1mm.

This comment acknowledges the common approach by other surgeons to burr the bone rather than unroof it. It is both descriptive and defensive. Tracy is being educated about what Howard will do and why it is the best approach.

T: How far can you go back?

H: The most I've gone back is 9mm.

T: Let me rephrase. How far can you go back safely?

H: I could go all the way back here.

Pointing to the posterior wall of the frontal sinus on the cephalogram.

T: What happens to the sinuses?

H: They go away. As far as we know, the only

P: Okay. Your nose is really necessary to do. We can take the hump out of the dorsum and decrease the projection some. The upper lip could be shortened. That is really common in feminization surgery. It'll be like when you were younger.

Page presses the wooden handle of the cotton swab just beneath Leanne's nose, causing her upper lip to rise on the surface of her teeth and allowing more tooth to show.

In terms of the jaw, I would leave it alone.

L: Really?

P: Beautiful women have a strong jaw line. For you, brow lift, cheek implants possibly to give you some more fullness in the midface, and nose for sure. If you'd like to see what this would look like, we can image you and give you a better idea of what I am talking about.

Page led Leanne to a small, dimly-lit room attached to the exam room. There was space for only two distinct positions in this room, so I observed in the doorway, looking over Page's shoulder as he worked. Page was seated at a laptop computer equipped with a special trackpad that allowed him to move a stylus along the pad controlling the computer display. His laptop was connected to a digital camera mounted on an adjustable stand. Leanne sat at the opposite end of the room in front of a grey backdrop. Page took six digital photos of Leanne's (non-smiling) face: (1) looking straight ahead at the camera; (2) turning her whole body such that her face is in 3/4 view; (3) profile; (4) 3/4 view facing the other direction; (5) opposite profile; (6) facing forward but looking straight up, a 'worm's eye view'. Page invited Leanne to pull her stool up beside his so that she could watch as he altered the photos he just took.

purposes of the sinuses...

He indicates with his fingers where the sinuses are located on the cephalogram.

...is to reduce the weight of the skull.

H: Now, the jaw.

Howard looks at Tracy's jaw, and then down to the x-ray.

Do you grind your teeth?

T: I know I used to.

H: You've got some wide angles here. Feel your jaw.

He places Tracy's hand on her jaw.

Feel how it flares out? We can get rid of the bowing that males have in the mandible that females don't have.

T: How do you do that?

H: We use a bur instrument on the sides here...

Indicating anterior portion of the lateral mandible on his own face.

...and then we have an oscillating saw that we use to take out the larger parts of the bone here

Indicating posterior section on his own face.

T: You actually take out parts of the bone?

H: Yeah.

T: Okay.

H: Can I borrow a finger?

Howard reaches down and grabs the index finger of Tracy's left hand. He places it on the side of his face in the medial section of his mandible.

Feel my teeth?

He presses her finger into his cheek and moves it back and forth so she can feel the texture of the bone below his bottom teeth.

Feel that ridge? That is what we take away. For some people, a thin layer of blood that forms on the bone becomes bone. I am one of

P: I try to do things with imaging that I can do during surgery so that it's not unrealistic. One thing would be to decrease projection. Come over here and I'll show you what I mean.

Leanne got up from her seat in front of the drape and sat beside Page in front of the computer. Using the stylus on the trackpad, Page selected the areas that he could reduce: frontal bossing, orbital bossing, and nose projection. He circled each of these areas on the profile image because this image produces the most noticeable contrast. Once these areas were selected, Page drug the stylus back and forth across the trackpad. As he moved from left to right across the pad, the nose, forehead, and orbital bossing all reduced in unison. As he moved back to the left, they 'grew' back to their original (current) size.

Leanne watched this in silence for a few seconds. It was clear that she was not seeing all that she hoped to see. Page was quick to step in.

P: I am kind of limited in what I can show here. I mean, you have to imagine what it would look like once your facial hair is gone [*she had a day's growth of beard*]. You've also got some skin damage that you should really work on. I'd say the most important thing you can do for yourself between now and any surgery would be to start a skin-care regimen. Work on that sun damage and some of the brown areas, the wrinkles around the eyes.

Page indicated these problem areas on the computerized image of her face.

I work with an esthetician right upstairs. I can set an appointment for you if you want. I really do think that is really important. You know, beautiful women have beautiful skin.

those people. I was hit in the head with a golf ball when I was 13 and I got this big bump.

He feels the bump on the top of his head.

I've still got the bump because the blood that formed there turned into bone. If you look at an x-ray you can see it plain as day. If you are a person like that—and I don't know how to know that in advance—it is possible that some of that ridge may come back. But it won't all come back.

The chin. I measured from the top of your bottom tooth to the end of the bone and that is 50mm. That is average for a male of your height. I want to take out 8 mm of chin height. I can't do that by shaving it off the bottom, because then the muscles and tissues that attach to the bottom of your chin have nothing to attach to and they just sag down. ... Instead, I take out a wedge of bone that is 8mm thick, and stabilize the bone with titanium plates and screws.

Howard explains that medical grade titanium comes from recycled Russian atomic submarines. He makes a joke that the addition of this Russian material may make Tracy fond of vodka after surgery.

T: You cut a wedge out of the bone and then rotate it up?

H: Yeah. Have you seen my book? Maybe you want to buy one. There is a lot of information in there about all of this stuff. And some stuff that you don't need. It can answer a lot of questions.

We want to get rid of the sublabial sulcus at the base of your chin. I think of this as a very male feature.

Now, what to do. The brow. Right now the distance from your brow to your hairline is 7cm. I want 5.5cm. The average male has a distance there of 5/8 of an inch longer than the average female. This is the case in 16-year-old males, even before they've experienced hair loss. You have a type III forehead. We talked about that. We'll do your nose—if we do the forehead we have to do the nose. Do you

L: Yeah, I spent almost 20 years in Arizona. I have a lot of sun damage.

P: Here are some other patients I have operated on. Maybe these will give you a better idea of the changes I am talking about.

Page opened a file on the laptop with several pre-op and post-op images of his patients. He flipped through the images, describing the procedures involved.

Here you can see I did the nose.... Here you can see the reduced bossing; that really opens up the eyes... Here you can see the difference that a brow lift really makes. She looks great....

This didn't seem to alleviate Leanne's sense of disappointment with her own images.

L: These people look much more feminine than what I see when we look at me. I have my wig with me. Can I put it on and you can take the pictures again? That might give us a better idea of how this is going to look.

She crouches down and pulls her wig out of her briefcase. It is a bit disheveled and needs brushing. Leanne does her best to place the reddish-brown shag cut wig on her head, but there are no mirrors in this room. In addition to the contrast produced by her businessman's attire, the wig is not quite on correctly. To my mind, this photo session has just changed quite radically.

Page appeared somewhat reluctant, but he agreed to take a new profile photo on which to make the digital modifications. One of the qualities that made the wig desirable is particularly problematic during the photo shoot: it obscures her forehead and brow.

remember Dick Tracy? His nose went straight out like a shelf? You probably won't like that. Upper lip. Now your upper lip has a vertical height of 2.5mm and drops 2-3mm below your upper teeth. If you look at me when I talk, you don't see my upper teeth unless I smile.

He smiled to demonstrate.

Women show their upper teeth when they talk. We'll want to move you up to get some good tooth show. So. We'll do your chin, your lower jaw, the thyroid cartilage. If I do all this at one time—and most patients choose to do that because it saves them a lot of time—I know this will take almost exactly 10 ½ hours.

T: Everything?

H: Yes.

Howard went on to describe the risks associated with these surgeries, the recovery process, and necessary pre-operative preparation. When he'd answered Tracy's questions, he led her down the hall to talk money with Sydney.

P: Could you pull your hair back so I can see your forehead?

Page took the photo. Leanne resumed her seat beside him at the computer and watched as he made the same alterations to the new photo as he had to the previous set. The addition of the wig did not produce the effect she'd hoped for. Page reiterated the importance of starting a skin-care regimen and beginning electrolysis on her face.

I think those changes could make a big difference for you. Let's go talk to my office manager, Hannah. She can give you a better idea about prices and we can look at some more images.

The pair left the room and began flipping through a photo album in Hannah's office.

L: Do you think I could ever look this good? I'm worried about going through all of this and looking as ridiculous as I do now.

It is clear from these two representative appointments that though these doctors putatively share a common goal—the “feminization” of their patients—what “feminine” means to each of them is quite distinct. Their approaches to the project of “feminization” determine both *what* each doctor identifies as the problematically “masculine” and the desirably “feminine” and *how* they do so. Howard understands the goal of FFS to be the creation of the “female face” which is, for him a discrete thing; it is a form that exists and is knowable through the methods of mathematics and scientific observation and can, therefore, be reproduced with certainty. As was made clear in Chapter One, this certainty is not one born from the supposed divorced objectivity of scientific methods alone, although it is crucial to see that it does borrow its claims to legitimacy from its association with these methodological conceits. For Howard, “female” is a category defined by measurements and numerical values; it is a material fact of the facial skull. As such, his consultations involve measurements of both the patient's face and of the radiographs of her craniofacial structure. He evaluates these measurements against the figures from the University of Michigan Growth Study in order to determine the exact quantity of reductions required.

Page, on the other hand, conceptualizes “the feminine” as an aesthetic category, a total effect produced not through the creation of distinctly sexed characteristics, but through the creation of desirably beautiful ones. Beauty, for Page, is not a sexed

category; it is a category populated by exceptional things. Of course, what counts as exceptional is not static; it changes across time and place; it is a matter of taste. Rather than using a particular set of “normal” figures to determine sites and degrees of intervention, Page hopes that his surgeries will produce the overall look of a woman. It is a look that, he explains, he understands intuitively rather than through the taking of measurements. He explained that his training and experience as an aesthetic surgeon had enabled him to see these patients’ faces in a particular way, to see what they could become. He did not rely on statistics or measurements to determine his surgical plan. “You know what you need to do. You just have to do it,” he told me. For example, just before observing surgery I asked how far he planned to reduce the patient’s frontal bone/sinus. “There isn’t really a number. It’s like a mountain: you see it, you take it down,” he explained. Beauty is, by definition, not a thing that is certain. It has no formula, but rather is something that you know when you see it. It is this quality of beauty—the unknowability but recognizability—that guides Page’s orientation toward the possible.

We could read Howard’s discourse of science and Page’s discourse of aesthetics as analogues to some other familiar dichotomies: sex/gender, nature/culture. To do so would be to reassert the distinctions between sex and gender, between nature and culture that this analysis of FFS had attempted to complicate. The doctors’ deployments of scientific and aesthetic discourses find their sense in the seemingly discrete and self-evident divisions between the figures of these dichotomies and simultaneously make clear that these divisions are impossible to maintain. Here as elsewhere, the categories of sex/gender, nature/culture, science/aesthetics—both their constitution and instantiation—are irreducibly connected. Rather than reading Howard’s approach as one that produces sex and Page’s approach as one that produces gender, I want to suggest that a more salient (and productive) reading is one that examines their approaches as ones oriented to the production of certainty and possibility respectively. In one sense, certainty and possibility could just as easily be placed in our chart of dichotomies, where certainty is on the side of nature/science/sex, and possibility is on the side of culture/aesthetics/gender. The future orientation and internalization of the perceptions of “society” that animate the promises of FFS complicate this potential parallel. Howard and Page’s differing ideas about “feminization” are not only technical and epistemological. They also reflect different understandings of what the project of FFS is meant to accomplish for patients, and the role of the face itself in accomplishing it.

Making the Face a Common Object

In order to discuss appearance-altering surgery, surgeons help patients to relate to their faces as external objects rather than intimate and fundamental identity bearing parts of themselves. This is especially important when surgery is intended to facilitate a central change in the patient’s personal and social identity. Page and Leanne sat shoulder to shoulder examining her face on the computer screen in much the same way that Howard and Tracy stood together examining Tracy’s cephalogram on the light table. Each of these technologies provides a means through which doctors and patients can look at and talk about patients’ faces as disinterested and common objects. “By jointly reducing patients’ bodies to a series of parts and focusing on the parts that require

‘correction,’ surgeons and patients forge a mutual basis for evaluating patient’s complaints, determining what should be done about them, and assessing post-operative results” (Dull & West 1991:63). In this process, surgeons not only help patients to see their bodies as discrete parts—a process that those seeking surgery have inevitably already begun at some level—but they also teach patients how and within what constraints those body parts could emerge from surgery differently.

The cephalogram is a very important resource during Howard’s consultation. By focusing attention on the cephalogram, Howard is able to help Tracy see her face in the way that he sees it: as architecture. When Howard incorporates the cephalogram into the exam, it becomes a common object shared between doctor and patient, providing a means through which Tracy can think differently about her face. As an image that is both familiar and strange to her—it is her face, but in a way that she has never seen it—the cephalogram facilitates disinterested conversation. Because it is not a version of her face that she is affectively connected to, any changes that Howard proposes to make to it are purely abstract; the pencil mark across her supraorbital bossing cannot help her *see* what her brow will look like post-operatively. In this sense, the cephalogram is a medium for visualizing technical and material capacity. It makes visible a set of structures that can be disassembled and reassembled ad infinitum.⁵ In such a view, feminization is simply a question of design. Through the invocation of hard numbers in his descriptions of procedures, Howard speaks of Tracy’s transformation into female not as possible, but as certain. He knows *exactly* what to do.

Page produces quite the opposite effect through digitally manipulating photographs of Leanne’s face. The imaging technology that Page employed in his consultation—a software program specifically designed for plastic surgeons called *Canfield Mirror*—made a powerful impact on Leanne. Whereas the cephalogram facilitated a disinterested gaze for mutually assessing the structures of the skull, during the manipulation of the digital photograph of Leanne’s face, only one member of this pair viewed the face on the screen as a set of structures. As Page selected and altered parts of Leanne’s face this way and that, she sat motionless, waiting to find out what she had come to this office to learn: *what was possible*.

The possibility that Leanne was witnessing on the computer screen was of a fundamentally different kind than what Howard showed Tracy by marking the bony structures on a cephalogram. As Page moved his stylus back and forth across the trackpad, the alterations he proposed were being enacted in the photograph of Leanne’s face. Her brow and nose were growing and shrinking, right before her (our) eyes. Though Page ostensibly uses this technology in order to help patients set expectations for their surgeries, it is also clearly a very powerful motivator.⁶ One thing that struck me while watching this back-and-forth display was that when her face was “growing” back to its actual size and shape, it seemed not simply to be going back to its original proportions, but to be getting *bigger*. It was as if during each “growing” motion I could

⁵ Indeed Dr. Howard explained to me in our first meeting that when it comes to feminization surgery, he is “virtually unlimited” by a patient’s skeletal anatomy. (After having seen photographs of previous radial craniofacial surgeries that he has performed, I believe him.)

⁶ Surgeons have noted that this sort of digital imaging is an “impressive” and “sophisticated method of communication” that is a “marketing tool that should not be underestimated” (Mülhbauer and Holm 2004: 2102).

not predict when it would stop growing, even though I had been looking at the original photo just seconds before, and Leanne's actual flesh and blood face was no more than three feet away from me. The excessiveness of her masculine features had the potential to exceed even their own limits, rendering hers a grotesque body in need of management and constraint (Bakhtin 1984).

Leanne was looking at her own face as she is accustomed to seeing it, the surface and skin. Though Page may have been talking about bones, he was not *showing* her bones—not literally, at least. As her face grew and shrank on the computer screen, Leanne was confronted with the limitations of surgery. In order to imagine her face with a more feminine structure, she was being asked to look past what was there—past the stubble and the collared shirt, past the skin damage, past the bonework that is not captured well by this kind of imaging technology. And she was not seeing what she hoped to see. My heart broke as she reached for her wig. It seemed that she hoped the wig would somehow change her face in ways that this imaging technology could not. Or at least show her the version of “what is possible” that she hoped to see. But it didn't. Instead, she was faced with the limitations of surgery, of what it simply could not do. The fantasy of her face's potential had found its limit.

In these acts of pre-surgical bodily disaggregation, the “problem” of masculinity is translated from the abstract concept of “gender” into the material substance of the face. Masculinity is no longer an effect produced by the face as a whole; the sizes, shapes and textures of discrete aspects of the face emerge as its constitutive elements. Part of what is at stake in rendering faces as objects is helping patients to see their faces not only material facts, but as *gendered* material facts. In the clinical exam, patients' generalized anxiety and dissatisfaction with their faces (often as metonyms for a gendered identity that they read as foreclosed by their bodies) become itemized and individualized. Fault is found not in the structures themselves, but in what those structures signal to others: maleness. In the examination, it is maleness that is visible to surgeons. The ineffable and elusive complexity of corporal gender is rendered intelligible in, as Howard wrote, “contours, angles, plains and textures.” In the initial exam, doctors make it clear: Your problem is real. We can both see it. I can fix it.

Foucault has ascribed to the clinical gaze the power of creation: what is visible to the doctor is made real. Maleness is taken to be a pure fact of human difference, as preexisting the political circumstances of trans- identities and as more stable than the vicissitudes of aesthetic tastes. These things change but maleness does not. It is there in the bones. *And you can see it.* Foucault writes,

...the observing gaze manifests its virtues only in a double silence: the relative silence of theories imaginings, and whatever serves as an obstacle to the sensible immediate; and the absolute silence of all language that is anterior to that of the visible. Above the density of this double silence things seen can be heard at last, and heard solely by virtue of the fact that they are seen (108).

The presence of male features as manifest to both patient and surgeon helps to make this clinical scene an especially potent one. While it may require a special mode of surgical sight to see these features as sites of structural intervention, their existence is (problematically) visible to a much wider audience. “By showing itself in a repetitive form,” Foucault goes on, “the truth indicates the way by which it may be acquired. It

offers itself to knowledge by offering itself to recognition” (110). The repetition and predictability of male forms makes them into truth.

In the clinic, making masculinity real is the first step to making femininity possible. Once the presence of problematic material is established, its removal—and concomitant reversal of gendered signification—is not only possible; it has a real and precise location. Julien Miravel (2008) has argued that this “making real” is a crucial aspect of the interaction between plastic surgeons and their patients. In describing initial consultations between plastic surgeons and patients seeking liposuction, he writes,

In and through his hand activities, the surgeon collects information about the nature of the patient’s bodily landscape, but also evidences to the patient, who is gazing at the excess tissue that is being manipulated and experiencing the touching, squeezing, and jiggling of her own body by an expert plastic surgeon, that there is “fat.” The manual activities, thus, confirm (prove) that there is excess fatty tissue on her body; that it exists and is a “real” problem (158).

In measuring and touching the patient’s face, directing the patient to touch her own face (or his own face, in the case of Dr. Howard) and talking together through images of the face, doctors work to make masculinity real. It is visible and palpable—once one has learned to see and feel it. Because masculinity is a problem of excess—of too much bone and soft tissue—it is *there* to be grabbed and felt. The surgeon can see it and the patient can see it, too. Masculinity is a “real” problem.

Howard and Page establish the problem of masculinity through different means. In both cases, however, external objects help to facilitate this process. Howard employs his own face as a model of the masculine in his clinical exams. He points to his face when explaining which section of Tracy’s jaw would be burred down during surgery, and places Tracy’s hand on his face to allow her to feel a ridge of bone beneath his teeth that cannot be observed visually. In doing this, he establishes points of common masculinity between his face and hers. The fact of a distinctly male structure is materialized in this process; if the male doctor has particular characteristics, then those ought to be removed in the course of feminization. Howard’s masculinity is real, too.

Rather than offering his own face, Dr. Page makes use of a dry skull that sits on the counter in his exam room. This skull becomes a resource when Page explains how and where he will alter Leanne’s bony structures. Whether it is the surgeon’s face or a skull model, the incorporation of faces other than the patient’s has the effect of universalizing and externalizing sex-specific characteristics to all human skulls. It is not that Leanne and Tracy’s faces are somehow abnormal. Quite the contrary; theirs are absolutely normal male faces. This makes their problematic characteristics expected and easily “diagnosed.” What they hope to do about these problems is another matter.

Seeing the Possibility of Femininity in the Faces of Confirmed Beauties

Not surprisingly, the evidence Page uses to underwrite his claims to beauty are quite assuredly not the same kind of evidence that Howard uses to ground his claims to the female. Instead of cephalograms and skulls, Page locates his version of the feminine in the photographs of Hollywood’s leading ladies. It is based in large part on the power of these photographs that Page makes it clear that the feminization he aims to produce is

one driven by an aesthetic of aspiration, of possibility. Though both Howard and Page encouraged patients to bring photographs⁷ of faces they liked to their appointments, Page made central use of these photos in communicating to patients how to see the femininity he described.

In the context of aesthetic plastic surgery, Virginia Blum (2005) has argued that the act of selecting images is much more powerful for the patient than anything for which a surgeon might later use those images.

For the patient, the very process of picture selection functions as the ultimate lure toward surgical change. You go to his office, [a picture of] Gwen [Stefani] in hand, and announce, ‘This is who I want to be.’ If the surgeon is even a little honest (and doesn’t want to spend the rest of his life working on you), he will admit to his limitations. But by that time it doesn’t matter. You have already cast yourself into the future of your new look. You are wearing different clothes in your mind, maybe shorter skirts to show off your newly liposculptured thighs and knees. Gwen is wearing the new bronzes in makeup for the summer. So will you (125).

Just as in the dynamic that Blum describes, there is more communicated to FFS patients through these photographs than the structures of bones and soft tissues. Indeed, Suzanne Fraser has noted that in this “intertextual relationship” between medical and pop-culture discourses, doctors encourage patients look to “fashion models and celebrities for their aesthetic ideal” (Fraser 2003:125). In the case of FFS, where the motivating aspiration is not only for a “better look” but also for a desired gender attribution, the search for celebrity and model photographs helps to laminate notions of “the female” to “the beautiful” and desirable.⁸

Denise brought tabloid photos of Kate Hudson and Catherine Zeta Jones to her initial consultation with Howard, though she did not have a chance to present them during the appointment. During our interview following the appointment I pointed out, with interest, that these women, while both beautiful, looked quite different from each other. Denise remarked that she really wasn’t sure what she could ask for, since she didn’t know what was surgically possible. She knew she would like to be beautiful and glamorous, so why not shoot for the moon, whatever it looked like?

For her initial consultation with Dr. Page, Reena brought a publicity headshot of Piper Halliwell, an actress who plays a powerful witch on the WB television series, *Charmed*. Reena said that she had chosen Halliwell not for her aesthetic, but because the character she plays on television, “is an inspiration to young girls... and to me!” It is clear that what patients and surgeons *see* in these photographs can diverge quite significantly. Anatomical structure, celebrity and even dramatic role are collapsed in

⁷ In spite of this request, and the fact that many patients did bring these photographs, I never saw the surgeons engage them with much interest.

⁸ Howard encouraged patients to search for pictures of noses that they liked in the *Victoria’s Secret* catalog. He explained that the structure of noses is best seen in photographs taken from a profile view. These views are not typically featured in magazines, but they are common in the *Victoria’s Secret* catalog. It is not clear to me whether there is something special about the artistic direction of this particular iconic catalog, or catalogs in general. In any case, he identified this one by name

these images and what patients see when they present them as prototypes for their own surgical reconstruction.

When celebrity photographs are offered as examples of male and female craniofacial form, it is not simply their faces that are on display. What we know of them as individuals, as beautiful, successful and often sexually desirable impacts how and what we see when we look at them. Photographs of Grace Kelley and Burt Lancaster are used to demonstrate facial sexual dimorphism on the UK-based website, VirtualFFS (Fig 5.1).⁹ Much more is communicated through these faces than would be through the demonstration of craniofacial dimorphism using two non-celebrities.



Fig 4.1. Photographs featured on Virtual FFS site to demonstrate facial sexual dimorphism.

The pairing of George Clooney and Michelle Pfeifer appear on a Belgian FFS surgeon's website as examples of "male" and "female" cheeks (Fig 5.2). While it may be the case that these faces exemplify the anatomical variations relevant to FFS, their facial structures are not the only things visible here. We cannot look at Grace Kelley and Michelle Pfeifer apart from what we know of them as desirable, successful and glamorous women. And Burt Lancaster and George Clooney invite the same associations as sexy, powerful, handsome men (the fact that Lancaster is shirtless and dripping wet in this particular photo certainly fuels the fire). The essential sexual differences of the face are represented in these photographs in the same forms and sites in which Howard first identified them. It is important to note, of course, that all of these people are white. Kelley and Pfeifer look directly at the camera, inviting and enticing the viewer's gaze by directing their own. Their slightly open mouths and upturned eyes signal their sexual desirability and availability. By contrast, Lancaster and Clooney look away from the camera, with closed mouths and the slight smirk of confidence; they are not available to the viewer in the same way. When these photos are invoked as exemplars of essential difference, there is a kind of performative gendering happening

⁹ www.virtualffs.co.uk. "Alexandra," the site's operator, offers to help those interested in FFS understand what kinds of surgical procedures they "need" and how those procedures would change the look of their faces. Clients submit a series of digital photographs and receive a written assessment of their faces and an explanation of "what makes it look masculine" (\$30US) as well as a series of photographs that have been digitally altered to show what their faces would look like if they had undergone FFS (\$30US/each). The site has been in operation since 2002 and has been growing in popularity ever since.

beyond the supposed representation of dichotomous facial sex. These are decidedly not anatomical representations of difference; they are showing us something more. If the



Fig 4.2. These photographs of George Clooney and Michelle Pfeifer appear on a page entitled “The Gender of the Cheek” on the website of a Belgian FFS surgeon (<http://facialfeminization.eu/>) (accessed 6/15/11).

viewer can only see these faces through their celebrity, then this celebrity is part of what constitutes the distinctive sex of their faces as such. Here we learn that sexed faces are exceptional and beautiful. They make us, as viewers, *feel* something: it is the structure of gender itself.

Dr. Page made frequent use of celebrity photographs in order to demonstrate his claims about feminization surgery. Crucially, though, Page used photographs of beautiful women in order to demonstrate that “beautiful” and “female” are not always the same characteristics. In a talk entitled “Aesthetic Subtlety With Feminization Surgery” presented at a conference for transwomen and cross-dressers, Page made use of several photographs of celebrities to illustrate his points about particular facial features. Jennifer Aniston has an “enlarged lower face and a strong chin.” Gwyneth Paltrow’s “forehead is enlarged.” Angelina Jolie “has an enlarged forehead, a recessed hairline almost. She has a broad jaw. She has a protruding chin. Yet she’s considered to be one of the most beautiful women in the United States,” he explained while standing in front of a projector screen filled with these women’s faces.



Fig 4.3. Angelina Jolie’s masculine face.

Page used Angelina Jolie’s face as an example of the “masculine yet beautiful” several times in conference presentations and in his office. The implied message is that Jolie’s masculine features—like Aniston’s and Paltrow’s—are an asset to her, not a liability. Her face may be masculine, *but it is not manly*. Though few would argue for the necessary “feminization” of Jolie’s face, it does not stand to reason that it is a bad idea to change enlarged foreheads, recessed hairlines, broad jaws and protruding chins on those who desire to be recognized as female. Page uses Jolie’s face to make the point that masculine can be beautiful—*not* that masculine can be feminine. Prioritizing the beautiful over the female

allows Page to work outside of the prescribed ranges of the osteologically female and to instead make subjective alterations in pursuit of an aesthetic of beauty. Page is in search of a look rather than a structure. Or, as he told Leanne during her initial consultation, he is going for “sex appeal.” Page feels that it is this look—the effect of the feminine rather than the structure of the female—that patients ultimately want from FFS.

The following excerpts from Page’s FFS website help to make his approach clear.

The many components of a face, especially an attractive face, will vary on the scale of masculine to feminine. In spite of the statistics, there are no easy rules to apply when it comes to recommending surgery. People are often attractive because they DON’T conform to statistical norms.

When arguing the benefit of a square jaw (as he did during his consultation with Leanne above), Page’s site features the following text beneath an image of Gwyneth Paltrow.

This type of jaw may be more common in males, but in females it is a highly prized feature. Because the less common mandibular shape is the one found on beautiful women, reliance on statistical prevalence of sexually determined features can lead to unnecessary or irrelevant changes. Diminishing the angularity of the mandible may make a more typical woman, but it is unlikely to make a more attractive one. The contribution of the “masculine” mandible to the beauty of countless women is hard to underestimate [sic]. Why do transgender patients consider surgery to “feminize” the mandible? Would anyone suggest Gwyneth Paltrow “feminize” her jaw?

This text and photo combination—and the many others like it on Page’s website—does a lot of work. First, it names the constitutive distinction between “typical” women and “attractive” or “beautiful” women: beautiful women are by definition, not typical. If “statistical prevalence” is used to identify the characteristics of “typical” women, this same method cannot possibly be used as the basis for producing “beautiful” ones. If given the choice, as FFS patients are, why would one choose to be typical when they could instead choose to be beautiful? Gwyneth Paltrow is not statistically common; it is her exceptionality that makes her beautiful, makes her famous, makes hers a face that can settle arguments. If Gwyneth wouldn’t make the decision to be average, why would anyone else? Page’s site goes on to make this rhetorical question into an enjoiner:

The wide mandible is attractive in men or women regardless of its statistical prevalence between the sexes. Facial feminization surgery should not be used to “normalize” features that contribute to beauty.

These passages define femininity not as the origin of beauty but as its effect. This method of defining the beautiful both rejects the “statistically normal” female and relies on its stability in order to identify itself as an exception. Angelina’s forehead can only be named as *enlarged* in reference to this normal. Page’s efforts to inspire the possibility of the beautiful thus stands in a negative relation to statistical measurement while Howard’s efforts toward the certainty of the female are constructed through a positive

relation to it. It is not the accuracy of Howard's measurements that Page is debating; it is the utility of their application.

Statistically, women have more pointed chins than men, but this does not mean that pointed chins are prettier. They are just more common.

"Commonness" here is a thing to be avoided in favor of "prettiness." As I argued in Chapter One, Howard's ability to name a distinctly female face was enabled by the expanding and contracting of the word "feminine" such that sometimes it denoted femaleness, and sometimes it denoted a particularly desirable aesthetic. The collapsing and expanding of the female and the beautiful that silently facilitated Howard's development of FFS, is here made explicit. Common is ordinary—even statistically average—not beautiful.

When Page argues that feminization is more about beautification than it is about creating recognizably female features, beauty becomes a quality that is decidedly not reducible to sexed or gendered characteristics. While a square jaw may have made physical anthropologists unsure about the sex status of a particular skull, in Page's estimation such an unusual feature is an asset whose uniqueness defines the beautiful. In other words, single characteristics of the face cannot be defined as male or female in isolation. Sometimes beauty is quintessentially female as Howard defined it, and sometimes it is not. In explaining the value of a square jaw he related a new trend in plastic surgery in which implants are being placed to accentuate the angle of the jaw and thereby enhance the profile.

When you go to the big national events for plastic surgeons, a lot of the facelift surgeons—who are the most famous facelift surgeons—they actually put angle of the mandible implants in to give their patients more of a nice neckline. These are in women, most of them.

The implication is clear: don't replace the desirably wide jaw you already have. Though you may think it is masculine, "women" (read: non-trans women) find it so attractive that they're having surgery to have that exact same jaw produced. In this example Page offers a reformulation of the problem. Rather than seeing their faces in terms of male and female—a pair of normal forms, neither of which is more inherently desirable than the other—Page reframes patients' options in FFS as a choice between being beautiful and ordinary—a pair of terms that he thinks more accurately reflects patients' desires for surgery.

Page's emphasis on the value of possibility that the atypical represents is an explicit argument against Howard's numbers-driven and systematic approach to the project of facial feminization. He explained his position on standard measurements at a conference for transwomen and cross dressers.

One of the things I talk about is conforming to a standard. There are some positive things and some negative things [about conforming to a standard]. What I don't try to do is to give the same operation to every single person. What I try to do is individualize things. When you do conform to a standard at least it's a systematic approach; it's trying to identify a statistically common appearance and then replicate it over and over and over. The down side to that is that statistically common appearances are not always beautiful as you see in the

photos that I had originally. Angelina [Jolie] doesn't have the narrow jaw, the short forehead, the less prominent chin. If you were to operate on her and give her more feminine characteristics I would bet that she's not going to look as good. So why change an outstanding feature to a common and ordinary one?

In emphasizing his “individualized” approach that doesn't “try to do give the same operation to every single person,” “over and over and over,” Page worked not only to describe his philosophy of care, but also to differentiate himself from Howard who, in this specialty, casts a very long shadow.

Professional politics notwithstanding, Page is telling a story about his practice that is not simply a difference in epistemological grounding and surgical approach. The conference talk from which the above quotation was taken was a marketing opportunity, to be sure. In advocating this non-standard philosophy, Page is responding to a particular understanding of what he thinks transwomen patients want when they want FFS: like every other woman who comes to his practice with a concern about her appearance, they are motivated by the possibility of becoming beautiful. The question that ended his pitch above does not have a simple answer in the case of FFS. “Why change an outstanding feature to a common and ordinary one?” The answer to this question depends on what you think the project of FFS is about.

Certainty, Possibility, and What the Face Can Do

If “passing” is the goal of FFS, then the answer to Page's provocation—“Why change an outstanding feature to a common and ordinary one?”—is simple. Passing is, by definition, about *not* being outstanding; it is a project based on a desire to blend in, to go unnoticed—or, only to be noticed in a particularly desired way. This is what the ideal of the normal promises. In light of the instability inherent in the definition of “feminization” at work in FFS, it stands to reason that what patients hope to *pass as* following this feminization is also unclear—at least to doctors and sometimes to the patients themselves. The success of these doctors with contrasting approaches makes this plain.

Each surgeon has loyal patients who come to him typically being quite aware of their alternatives. In the clinical examination recounted above, I noted several places in which Howard, Page, and their patients made reference to the existence of other ways of approaching and accomplishing the effect of “feminization.” Howard and Page made comments about their means of both assessing and producing the feminine that were at once meant to inform and persuade the patient, but also to defend and differentiate their practice from those of their competitors. When discussing their approach to forehead modification, for example, Page told Leanne,

By burring down this area [above the eyes] instead of removing the bone, we can retain the angle from your forehead to your nose. Patients with ‘the works’ often look worked on. That is not what I want to give you.

When Howard described modifying Tracy's forehead, he said,

I could take you back 8mm. The 15mm you currently are minus 8 equals 7mm. That is where I want you. If you had an x chromosome rather than the y you were born with, that is where you'd be.... If someone just burred this down, they could only go about .5mm to 1mm.

More than simple marketing differences, these kinds of direct contrast indicate a difference in what these two versions of FFS can do and, therefore, the kinds of change they can enact.

Howard and Page—and other doctors—who work to reconstruct and regender the face frequently emphasize the effects of this reconstruction as though it works in isolation from the rest of the body. I have come to think of this as “the floating head phenomenon.” The floating head phenomenon is a framing of the face as the sole location of embodied sex, as though the head floats through the world unattached to and unencumbered by a body that may signify sex characteristics in other ways. When publicity headshots and magazine portraits become evidence for sexed facial features or are used to guide aspirations and the possibility of exceptional beauty, the itemization and atomization of the body that animates the floating head phenomenon is exacerbated. Let us provisionally agree that Angelina Jolie and Gwyneth Paltrow have some facial features that are classifiable as “masculine” in reference to statistical norms. Those features are *exceptions*—and therefore exceptional—on their otherwise feminine (magazine cover) bodies. The claim that they are masculine but still beautiful is one that reads their faces in isolation, apart from the rest of their bodies. By isolating the face in photographs and in conversation—and in cephalograms and computer imaging technology—it is atomized from the body and left, like the genitals, to stand as a metonym for bodily sex. But faces do not move through the world as independent things.

Sometimes the interdependence of bodily characteristics and personal comportment were made clear, as above when Page reminded Leanne that, “Passing as a woman takes more than what I do: it’s about hormones, behaviors, dress makeup, voice. What I do is just one piece of the pie.” Howard similarly emphasized the importance of thinking about passing as a total project. He explained in a conference presentation that, “It’s not enough just to feminize your face. You’ve got to walk appropriately, you’ve got to talk appropriately, you’ve got to dress appropriately. You’ve got to do all the other things to be appropriately female.” At the same time, these doctors assert that without the FFS, none of these other efforts will elicit the gender attribution that patients desire. After all, most patients have made these other changes in their lives to no avail. They are seeking surgery because they hope it will make the difference that these other changes have not.

By invoking the certainty of the biological category of female, Howard asserts that the certainty of the female face can even overshadow the gender markers of clothing and comportment. Alison recounted the way that Sydney, Howard’s assistant, explained the power of the post-operative face.

Sydney says, after you get your face done—and it’s really done—you go out as a guy and they’re going to see you with your long hair and they’re going to see you with the feminine face and they’re going to say ma’am. I said, ‘Okay.’ She said, ‘You know, another woman puts on man clothes, they still look like a girl.’

You're going to have a girl's face and you go out and put guy's clothes on, you're still going to be the girl in the guy's clothes.'

This is the effect of certainty; of surgically (re)producing what scientific research has proven to be the normal female—pushed even further into the narrow margin of the feminine. In Howard's opinion, making exceptions to this narrowed norm comes at the cost of certain femaleness.

I have a lot of patients who come to me and say, 'I want you to do my forehead and nose and my scalp advancement. But if you look at so-and-so, she's a good looking model and she's got a nice, big, full lower jaw and she's got a big masculine chin. Or maybe you want the chin done but you don't want the jaw touched. I'm happy to do whatever you want. But I can guarantee you—or I can tell you by experience—that almost all of those people will come back to me and say, 'I'm being read, please get rid of it.' ... I think these large jaws and these large chins are not classic female. I think they're very much the result of the modeling agencies. They're looking for someone that looks a little bit different, a little bit stronger in this, something striking. But it isn't classic female.

Norms of beauty, in this telling, may change with time and fashion, but femaleness is an enduring category with stable and identifiable referents. Moreover, it is the instantiation of these referents that guarantees passing as female in the FFS project. Femininity can be beautiful, so long as it is first distinctly female.

As was clear in his consultation with Leanne, Page is not expressly concerned with the project of passing. By this I mean that he does not describe surgical procedures in terms of what a patient needs in order to pass as female. Instead, he emphasized to Leanne several times that he was not inclined to make drastic changes but wanted to “soften” the face so that when she was “dressed up” she would be read as female, and when she was not she could still be in “male mode.” In this sense, the post-operative face is imagined as beautiful in a gender-neutral sense. One might dress it up and dress it down, as it were. Page's approach depends upon the extension of gendered adornments and behaviors across the body. The exceptional status that he describes is one that leaves the face as a vehicle able to carry the signification of other physical and social gender markers produced around it. Beauty is this thing, a total effect in which gender takes a backseat to aesthetics. For a masculine characteristic to be exceptional as such, it must exist in contrast to an otherwise feminine body. The sense and efficacy of retaining a “masculine jaw” as part of “feminization” surgery depends upon the cultivation of a coherently gendered feminine body. Otherwise, there is nothing exceptional about it; it fits neatly with other bodily signifiers and is part of a total effect of maleness.

Page's story is a compelling one not only because he offers the allure of famous and beautiful women, but because the narrative of beauty contrasts to its alternative: passing as “an ugly girl.” This is an aspiration that is frequently cited as an alternative to surgery. To the extent that one can hope to pass as female, she can only hope to pass as “ugly,” the limitation of the face is one that forecloses the possibility of attractiveness. If one must choose between being recognized as female and being recognized as beautiful, the choice is an excruciating one. It is no wonder that Page's approach is one that some (prospective) patients find so appealing. It is not enough to be any woman.

These patients hope that surgery can give them something that they have never had: a body that feels like home, one that looks—to others and to themselves—like the person they know themselves to be. The certainty of the biological and the possibility of the beautiful are two ways of practically enacting “woman,” a category whose constitution has been seen to shift across registers of knowledge and value. Through their different approaches, Howard and Page crystallize and thus come to stand in for what they think women are, and what they think transwomen want.

Chapter Five

On Race and Resemblance

Facial aesthetics is the aesthetics of race.

—Sander Gilman¹

As I explained in detail in Chapter One, sex determination of the skull is complicated by the wide variation of facial characteristics attributable to distinct racial and ethnic (or “population”) groups. This variation destabilizes any claim to a universally “feminine” facial form. While the power of the “feminine face” in FFS comes from its presentation as a natural fact of human difference, it is clear that that fact is itself the production of an extraordinary amount of medical, scientific and experiential labor. When the particularities of this labor and the distinct forms of knowledge upon which it is based recede into the background, a particular “natural” female form is left standing in its place. If it is the case that surgical feminization involves particular points of intervention based on a distinct idea of what “woman” looks like, then it stands to reason that FFS patients are not simply made to look like *a* woman. Instead, they are made to look like *a certain kind* of woman. The ideal form that animates Howard’s work in FFS is one that reflects racialized ideals of aesthetics, as well as the ideal of youthful beauty. Each of these aspects helps us to better understand the constitution of the category of “woman” at work in FFS, as well as the projected expectations of the audience who can/will convey this attribution.

While in Chapter One I explored the entanglements of race and gender in the research by which FFS was developed, in this chapter I want to think through the ways in which this ostensibly universal form of the feminine is marked (and left unmarked) by racial and ethnic specificity in FFS practice. In other words, how this particular history bears on the present in which “femininity” is not a conceptual category but a clinical problem. In point of fact, during the course of my fieldwork, the face was very rarely discussed in terms of its racial and ethnic characteristics. Nor were concerns or observations about the racially particular sites and kinds of surgical interventions typically applied in FFS ever named as such. Instead, feminine—complex and shifting as the term may be—was left as a racially unmarked category. As Judith Butler has

¹ 1999:50.

stated succinctly, “To claim that sexual difference is more fundamental than racial difference is effectively to assume that sexual difference is white sexual difference, and that whiteness is not a form of racial difference” (1993:182).

Beyond a concern with the material practices and aims of the surgery itself, the pervasive silence on the topic of race also implicates a particular understanding—on the part of both patients and surgeons—of the audience of the post-surgical face. In other words, if we understand “passing” to be a social project, then we must also think through the kind of “social” that is being imagined and actualized by the promise of FFS. Attending to the specificities of racial difference in formulations of gendered aesthetics invites an engagement with the long history of “passing” as a project that has been both motivated by and helped to reflect the stakes of racial differences and inequalities, particularly in the United States. In terms of “passing,” the visibility of race has been staged in opposition to the supposed invisible nature of “sexual preference.” As Jewell Gomez wrote pointedly, “I can pass as straight, if by some bizarre turn of events I should want to. Or I can pass as a compliant woman who accepts the patriarchal hegemony. But I cannot pass as white in this society” (1986). As a problem of the visual, race is, in Fanon’s terms, “epidermalized” on the surfaces of the body (1967:11). In terms of FFS, we might call sex a quality that is ossified; the sex-specific structure of the bones is visible on the surfaces of the body, displaying an inner truth thought to reside there.

Excesses

FFS rarely involves the addition of materials such as implants or transplants. Instead, it is almost always a project of subtraction. As a result, male features—and masculinity itself—are coded as problems of excess; their removal reveals a feminine form within. As opposed to formulations of sexual difference that imagine the female body to be an inferior or derivative version of the male body,² in FFS discourse, the female body—and more particularly, the female skull—is the fundamental structure from which the difference of masculinity can later emerge through addition. Just as masculinity is a problem of excess, so, too, are (non-white) “ethnic” features described as being layered on top of the racially unmarked “normal” female skull within. Construed in this way, beneath the overabundance of the unwanted, the feminine—and white—ideal waits to be freed from its overgrowth. Like gender, race is therefore represented as a *thing*: a quality of the facial skull that is discernible (diagnosable) in particular structural sites. I do not mean to name FFS as an “ethnic surgery,”³ for neither patients nor surgeons spoke of it in these terms, nor are “ethnic” features targeted as such. Instead I aim to show that Howard’s number-driven model of the “normal” female is one that reifies the particular characteristics of a white racial aesthetic as the “classic” and “typical” female form. This is not particularly surprising considering the body of research upon which Howard’s norm was based (as are the norms of most medical practice [Epstein 2007]). What is perhaps more surprising is the persistent power of this “normal” female in helping to reify a single version of the story of craniofacial sex

² From Aristotle to Freud and beyond (cf. Shiebinger 1993).

³ Add citations here.

difference as universal and ahistorical, and as immediately visible to all who (will) see it.

There were only two clinical occasions throughout my fieldwork in which the racial and ethnic specificity of facial features were explicitly discussed in relation to gender. As clear as it is in the discourse of FFS that faces are never seen outside the matrix of sex and gender, so is it true that they are never seen outside the matrix of race and the politics of belonging and exclusion, desire and difference that it animates. The dynamic relationship between the face that is viewed and the audience viewing it implicates racialized understandings of sex and of beauty in complex and shifting ways. The question, *To whom does one pass as a woman?* is always already a racialized question.

Cela

Cela had had FFS with Dr. Howard in 2005 and was back in the office six years later to consult about a jaw revision. She suspected that the squareness of her jaw had returned somewhat, but wanted it more tapered, in any case. Howard might also remove a bit of the jaw muscle to further narrow the width of her face.⁴ Cela was “very pleased” with the results of her initial surgery. While her FFS had been “life changing,” the change it enacted was quite different from the total gender transformation that patients and surgeons typically described as the goal of surgery. Whereas every other patient I met during fieldwork sought FFS in order to pass as a woman, Cela had no trouble passing before the operation.

I’ve always been passable. You know, I think at that time [of the first surgery] I just had way too much disposable income to waste. I think I had the extra money and I found this surgery and I go, ‘Let me improve myself.’ You know, because I have girlfriends who are born female and they look good but they still want surgery. I think it’s not really the fact that I felt like, ‘Oh, I look like a guy.’ I never felt like I looked like a guy. I never thought [FFS] would really change my life, because I was still feminine. I’m short. I’m 5’3”. I don’t have broad shoulders. So I pass anyway.

For Cela, FFS was a cosmetic rather than a sex-changing surgery. FFS *improved* her appearance without changing the way that others recognized her gender. The fact that she passed before FFS was, for her, a result of the already “feminine” aspects of her body. Her short stature and narrow shoulders contributed to her overall femininity, and so did her facial features.

For some reason I feel like because my face before [surgery] always fit in with my race, I never really got spooked [read as male]. Back then—with the strong jaw and stuff like that—I still passed because, you know, Filipinos we don’t have the Northern Asian face so we’re a bit more harder looking.

In attributing her ability to pass to her racially specific facial features, Cela identified two very critical things about FFS. First, that features defined as feminine and masculine

⁴ It is not uncommon that muscle is removed when a narrower jaw is desired.

with reference to a white standard do not translate simply to faces of different racial and/or ethnic origins. Secondly, Cela's comments help to make clear that, as a social project, the success (or failure) of passing depends upon the audience—actual or imagined.

For Cela, the “strong jaw” that differentiates Filipino faces from “Northern Asian” faces has implications both for ethnic distinctiveness as well as connotations of gender. Indeed through explaining the effect of her “strong jaw” as one that makes her (and other Filipinos) “harder looking” she narrates her face as one marked by an ethnicity that is inherently masculine. But because the “strength” of this jaw is, in her telling, a characteristic that all Filipinos share, it is no longer a site of sex distinction. Its “ethnic” character evacuates it as a signifier of masculinity. The claim made by both lay persons and FFS experts that a “wide” or “square” jaw is a tell-tale sign of maleness applies to some faces—certainly the white faces upon which the claim was formulated—but it is not a universal site of sex distinction. The sex-distinctive aspects of Cela's face—if indeed they exist—must be located elsewhere. But, luckily for her, the American audience of Cela's face is less able to recognize these redistributed signs of facial sex difference; they cannot “spook” her.⁵ This makes passing a project that implicates her audience in very particular ways.⁶

[Before surgery, my face] never bothered me. I think being Asian helped. I know some transsexual Asians that still look very masculine. But I think I look kind of feminine anyway. I think it's just that I wanted more. I think at that time I had an obsession with perfection.

It's amazing how people respond to what they perceive as attractive or exotic or something. Especially in San Francisco [where she lives]. Everybody there has an Asian fetish for some reason. They all like the Asian girls. Like the guys seem to like Asian girls a lot. And then it's like they respond very well to me. They stare at me. It's kind of weird. Not that I have an ego.

Cela's racial difference already made her an object of interest for non-Asians who “exoticized” and eroticized her. This metric of sexual attention was a significant one by which she explained how FFS had changed her life. When I asked if she noticed a change in people's response to her after surgery, she waved her hand above her head in a wide circle and declared, “Oh yeah!”

It's kind of hard to explain because before a lot of people really thought I was attractive anyway. But now I feel like they're like, ‘Wow, you're *really* attractive.’ I feel like if 20 guys would hit on me a day [before], it became

⁵ The use of the term “spook” to describe being seen (or not) as a transwoman, is one with a complicated racial past. Ralph Ellison's *Invisible Man* says, “I am not a spook like those who haunted Edgar Allen Poe.... I am invisible, understand, simply because people refuse to see me. Like the bodyless heads you see sometimes in circus sideshows, distorting glass. When they approach me they see only my surroundings, themselves, or fragments of their imagination—indeed, everything and anything except me” (1952:183). Cela remains invisible as a transwoman because people do not see her, a thing she attributes to what they can and cannot see about themselves in her “exotic” face.

⁶ A considerable body of social psychological literature documents and variously attempts to quantify the ability of individuals to assess the characteristics of those outside their racial group (cf. Zhao and Bentin (2008).

double [after surgery]. It became double! I have less women friends now because I feel like they got more competitive. They feel like, ‘Oh god, she’s like *attractive*.’ Other women don’t like attractive women. So I feel like I’ve been kind of alienated by some of my friends. It’s like they want to stop hanging out with me. If we would go out in a bar, all the guys would gravitate towards me. And I guess I’m exotic. But in their minds they think, ‘Oh, no.’ But I feel like it changed my life. I get more free stuff [laughing.] I get a lot more things. Seriously. Like, wow. All I have to do is make certain faces and I get away with, like... blowing up the world. So I feel like the surgery made me prettier, like more attractive. A lot of people thought that I was attractive before but I feel like it got more refined. It helped me.

Though FFS had cost her some female friends, Cela viewed the fact that these women disliked her as an unfortunate consequence of her increased attraction. It was a small price to pay for the extraordinary advantages of men’s attention. Though she had always been seen as a woman, after surgery she felt—and she could see through the responses of others—that she was a more attractive woman. “Sexual desire,” writes Rosemary Wiss, “is posed as the standard by which femininity may be judged, and underneath all of this, the body is taken as the essential statement of feminine difference” (Wiss 1994). Cela was threatening to women and more attractive to men. Part of that attractiveness came from the surgical removal of the characteristics that made her distinctively Filipina.

[Before surgery] I wasn’t really thinking, ‘Oh, I look like a boy.’ But then after he did the surgery I was thinking, ‘Oh my god, he really took out a lot of the hardness.’ I think it made me look younger. It made me look more kidlike. So without make up on I look really young. So I’m like, ‘Oh, it took out years!’ I think the brow bones made it look older.

After Howard removed the “hardness”—that characteristic that she marked above as the common look of Filipinos—Cela looked not only more attractive, but also younger. The bone and soft tissue that were removed from her face took away the physical signs of her age to leave her looking “kidlike” and, removed her distinctive racial characteristics leaving looking less racially marked (read: more white).⁷ Instead of naming the racial specificity of her post-surgical face, Cela described her results as “refinement,” that she got in the process of her search for “perfection.” FFS had not made her more recognizable as a woman than she had been before surgery, but it did make her recognizable as *a different kind* of woman. In looking younger and less Filipino, she was more “attractive,” “prettier.”⁸

Despite the fact that Cela consistently passed as a woman before she entered the surgeon’s office, she ended up undergoing a Full Face FFS. Her forehead was set back,

⁷ Though Zane (1998) has cautioned against the reading of all Asian plastic surgeries as attempts to imitate whiteness by reminding us of the huge range of physical variability within “Asian” groups, in this case, I think the claim to a white facial structure is born out by the ethnographic evidence. The research upon which FFS interventions are based used young white children from the Upper Midwest as the models for craniofacial anatomical norms. Thus, their application in turn reproduces these as norms, though their racial specificity goes unmarked in FFS discourse.

⁸ Something here on the idealization of white beauty, taking care not to flatten this. See note 5.

she had a rhinoplasty, her jaw was narrowed, her chin was shortened and her upper lip was raised.⁹ Cela's ability to pass as female was a product of her Filipino-ness. Though she is no less Asian now than she had been before FFS, she is perhaps less Filipino and more like the "Northern Asian" faces that she described. The matrices of *how*, *as what*, and *to whom* she is passing now are quite complexly layered. The assessment of her masculine features and resultant schedule of treatment was made possible by Howard's application of a universal notion of facial sex distinction that is, in fact, based on the facial characteristics that differentiate young, white women from young, white men. The sites and kinds of difference between these groups become the very definition of craniofacial masculinity and femininity, resignifying the meaning of other racial and ethnic features in relation to themselves.

This is not completely lost on Dr. Howard; he is quick to note that the skull is a site of primary racial and ethnic differences. When referring to a slideshow image during a conference presentation he explained that,

A Japanese gal and a Chinese guy have differences in their skull and it's important for me to know these things. They're both very attractive, beautiful people but there are some things that are different. It's important for me, if you happen to be Chinese, Japanese or Black, to understand these differences and preserve them.

This assertion of the importance of preserving what he called the "ethnic aspects" of a person's face is in line with a dominant trend in facial plastic surgery (more on this below). What is crucial to see here is that "Chinese, Japanese or Black" are variations from the norm whose preservation requires a special mindfulness from the surgeon performing feminization surgery. The implication is that without such special mindfulness these "ethnic aspects" may be removed in the process of feminization and so must be actively protected.

But some "ethnic aspects" are simply at odds with the process of feminization itself. In such a case, a determination of priorities must be made. This is the case, as Howard explained, with Korean women.

I don't know if you have any Korean friends, but a lot of Korean women have very square faces. Boy, I'll tell you, they want to get rid of that so fast. They want a classic, tapered lower face. A typical female face. Korean women with big lower jaws are attractive, but they've got a very masculine lower face, if you think about it.

The assertion that a Korean woman's square jaw amounts to an atypical and masculine face is one that finds its sense in relation to a very particular version both of what counts as "classic" and "typical," and how these categories give shape to ideals of gender and of beauty. In this formulation, all Korean faces are masculine. The distinction between gender and race collapses completely leaving only one aesthetic profile of the feminine.

⁹ She did not need alterations made to her hairline and did not have a significant thyroid cartilage prominence (Adam's Apple).

The “classic” and “typical female face” become synonymous with the mathematical norms by which Howard’s FFS Face was created.¹⁰

Dana

The second clinical occasion on which ethnically specific characteristics were named in relation to femininity happened during Dana’s initial exam. Dana was shy and soft spoken. She had cultivated an aesthetic of introversion and privacy through an all-black wardrobe of draped and layered fabrics and long, jet-black hair. Dana had decided two years prior to her visit to Howard’s office that she wanted FFS. She wanted, “the works: the forehead, the nose, the lift of the lip, the scalp advance, and the tracheal shave.”¹¹ She was not sure that she would be able to pass as a woman after all of this surgery, but she did think it would greatly improve her chances. In the few moments of conversation before the exam began, Howard inquired about her distinctively Greek surname. As a life-long Canadian, Dana did not profess to have any meaningful connection to her family’s Greek origins. Not one that she knew of, anyway. As Howard worked his way through each of her facial features in the course of the physical exam, he stopped to discuss her nose.

Howard: You have a nice male Greek nose there. Can I make it feminine?
[laughing]

Dana: Yes. [smiling]

Howard: Okay, I didn’t know if there was an ethnic thing you wanted to protect here.

After this quick comment, the exam continued, and there was no more mention of the specifically marked character of her nose. In this interaction, the Greekness of Dana’s nose is at odds with the femininity she desires. In order to feminize her nose, its ethnicity must be removed.

“The [male] Greek Nose” has long been a symbol of beauty and civilization, its distinction marked by the ancient Greeks’ love—and embodiment—of beauty. Whereas the Greek statuary discussed in Chapter One provide a material example of the Golden Mean as a celebrated form of feminine aesthetics, the Greek nose stands as the form of masculine aesthetics and refinement. In his 1852 treatise entitled *Notes on Noses*, Richard Bentley defined the shape and character connotations of the Greek nose this way:

The Greek, or straight Nose, is perfectly straight; any deviation from a right line must be strictly noticed... It should be fine, and well chiseled, but not sharp. It

¹⁰ As Ian Hacking argues, the word and concept of *normal* “became indispensable because it created a way to be objective about human beings. The word is also like a faithful retainer, a voice from the past. It uses a power as old as Aristotle to bridge the fact/value distinction, whispering in your ear that what is normal is also right” (1990: 160).

¹¹ “Tracheal shave” or “trach shave,” are commonly used terms to refer to the removal of the Adam’s Apple. This is a misnomer of unknown origin. Neither is it the trachea that is removed, nor does it involve a shaving procedure. In practice, to get rid of the Adam’s Apple, the surgeon removes the thyroid cartilage in small pieces.

indicates Refinement of character; love for the Fine Arts, and *Belles Lettres*; astuteness, craft, and a preference for indirect rather than direct action (43).

The author notes of people with Greek noses that,

Beauty is their highest excellence, their chief praise. Exquisite melody, ethereal fancies, felicitous expression, a fine perception of the Beautiful, as distinguished from the Sublime, whether on paper or canvas... are their best attributes (47).

These characteristics do not belong to anyone with this nose, however; they are only associated with men—indeed Bentley names several characters as examples of them (Byron, Shelley, Rubens, Voltaire, and more). Women, he tells us, on the other hand, have relatively little character and so have smaller and less differentiated noses.

In judging the Nose feminine, therefore, comparison must not be made with the masculine, but with other feminine Noses. All the rules and classifications apply to the one as well as the other, but allowance is to be made for *sex* (110, emphasis in original).

Even after this allowance is made, Bentley asserts that that fine characteristics indicated by the male Greek Nose are there, in modified form, in women.

The most beautiful form of Nose in woman is the Greek. It is essentially a feminine Nose, and it is in its higher indications that women generally excel. This Nose will not carry them out of their natural sphere [as a Roman Nose which indicates strength may do], and it is for this reason that it is so beautiful (113).

The feminine Greek nose is the ideal of beauty and, as the one taken from statuary and thus indicated by the Golden Mean, is the model for Howard's female nose. In FFS discourse, and in the above exchange in Dana's exam, the Greekness of this model nose is actively crossed out. She—and other patients may in fact *get* a Greek nose *in form*, but it is not marked as a Greek nose *by name*. As an ethnic category, Greekness is essentially masculine. In planning her surgery, Dana must choose between them. The beautiful and the feminine—here presented as one and the same thing—are self-imitating: they carry only the sign of their naturalness and self-evidence.

In both Cela and Dana's cases, ethnicity, like (and as) masculinity, is identified as a problematic excess that has literally grown on top of the feminine form within. It is not simply that male features and "ethnic" features are bigger, it is that they are *too much*. While FFS is the only case that I know of in which the excesses of masculinity are an explicitly surgical problem¹², masculinity itself is frequently described in this

¹² This is generally not the case in MTF genital sex reassignment because in that operation, the genital structures are repurposed in the construction of the neo-vagina and neo-vulva. A relatively small amount of tissue is excised and discarded. In the case of MTF GSRS then, we might say that maleness is problematically external, but not necessarily excessive. Also something about those (natal) men who come to Howard hoping to have their "aggressive" features reduced. To the extent that we understand femininity to be the constitutive opposite of masculinity, these, too, would be feminizing. But that doesn't quite get it.

way.¹³ The conception of the non-white body as one marked by its excesses of anatomy (and of appetite) has a long and sordid history, as well.¹⁴

Surgical efforts to isolate—and render “correctable”—racially distinctive morphologies have focused overwhelmingly on the face (Gilman 1999). While a number of scholars have critiqued what they see as the overvaluation of “Western” or “white” facial characteristics (Dull & West 1991, Kaw 1993, Hunter 2011, Perry 2006), others have argued that to read all surgeries undertaken by non-white women as mimicry is itself a move that perpetuates “whiteness” or “Westernness” as an assumed aesthetic ideal (Zane 1998, Heyes 2009). Promoted as a good of multiculturalism, “ethnically appropriate” cosmetic surgery, or surgery that looks to improve aesthetics while retaining (or, as Howard said above, “protecting” or “preserving”) ethnic identity, has been one response to these critiques. “Ethnically targeted cosmetic surgery,” writes Victoria Pitts, “now aims to rethink Eurocentric beauty ideas in order to preserve the ethnic features of the person, and to ‘honor’ her or his racial heritage” (2006:39). It should be noted that in this literature, too, “ethnicity” is solely the property of non-white bodies—and, more specifically, non-white *faces*—whose distinctively marked features are in danger of being effaced in the act of beautification. Several feminist scholars have identified the double standard that emerges in the assertion that whereas white women undergo cosmetic surgeries in order to be beautiful, when women of color undergo similar surgeries their intervention is a more essentially identitarian and political one (Davis 2003, Heyes 2009).

While these and other critical and surgical efforts are working to decenter “Eurocentric” notions of beauty, this is a beauty understood to “enhance” or “improve” a face that is already recognizably female. Here again, the nominally biological category of the female is defined by a particular aesthetic of beauty. I am not suggesting that FFS is an “ethnic surgery” in either the express effort to erase or to preserve “ethnically” specific features. Rather, the equation of femininity to whiteness renders these acts simultaneous.

While it may be the case that white norms guide the surgeries of a mostly white patient population, this does not mean that racial specificity is a non-issue in most FFS procedures. To assume that the act of tuning to a white (mostly Nordic) ideal is only relevant when considering the surgical plans of non-white patients would be to once again equate and flatten “white” and “feminine” as a self-evident and single form. As has been made clear in both Howard’s and Page’s clinical examinations, the desirable femininity of particular facial characteristics draw on racially and ethnically specific features. Howard’s do this by citing the norm of the Northern European ideal; Page’s do this by idealizing exceptions to this rule. The idealization of particular forms of the female face as “feminine” is racially coded for all patients, even for those such as Dana, who is recognizably white. By removing the “ethnicity” of her nose, Dana is rendered white in a different and ostensibly more feminine way. As Cressida Heyes writes in her critical assessment of feminist appraisals of ethnic cosmetic surgery, “Even when surgeries arguably aim to make already white people whiter (refining a nose that carries the implication of Mediterranean or Middle Eastern ancestry, for example), there is

¹³ As in too much energy in young boys, too much sex drive, too much aggression, etc.

¹⁴ On the Hottentot Venus, for example, see Gilman 1985, Gould 1981, Sharpley-Whiting 1999, Schiebinger 1993, Somerville 1994.

something to be said about their ethical implications” (2009:203). As the site of the body that often bears the most visible racial and ethnic characteristics, any reconstructive surgery of the face that is bound complexly with femininity and beauty is also always an issue of race.

Excess as a Surgical Problem: The Asian Jaw and the Ethnic Nose

One way to examine the homology (and isomorphology) of masculinity and ethnicity as excesses of the facial skeleton is to note the surgical procedures that their removal shares in common. Surgeries that are performed on the facial bones for the express purpose of removing or reducing “ethnic” features often target the same parts and characteristics of the face as those surgeries intended to feminize it. Following the examples of Cela and Dana above, I focus here on surgeries that reduce the “Asian jaw,” as well as the ethnically marked nose. (While for reasons noted above, the Greek nose is not named problematic as such, other forms of ethnic distinction frequently appear in surgical literature. I focus here on noses marked as excessively African-American, Jewish, and Indian.) In all of these cases, ethnicity is a property that can be removed or reduced through the literal removal or reduction of bone and/or cartilage.¹⁵

The Asian Jaw

Though a considerable amount of critical attention has been paid to the steadily growing demand for blepharoplasty (eyelid surgery) among Asian people (primarily women) (Kaw 1991, Gilman 1999, Heyes 2009, Zane 1998), relatively little has been paid to the bone reconstruction work performed on the “Asian face.” The most invasive of these procedures involves the reduction and/or removal of the “wide” and “flared” mandible responsible for what is described in surgical literature as a distinctly Asian squareness of the face. In a 2006 article, Ying and colleagues site, “hypertrophy of the mandibular angle” as “the most common lower face deformity in Asian women” (2006:67).¹⁶

The lower face remodeling operation has recently become more popular for patients with mandibular hypertrophy in Asian countries especially in South Korea and China recently. The main reason is that girls in Eastern countries who have an oval face are regarded as pretty (ibid).

We might read the authors’ situating of the standard of “prettiness” in “girls in Eastern countries” as simple reportage of patients’ desires, or as a deft preemptive defense against reading these procedures as “Westernizing” young Asian women, an act that has

¹⁵ While ethnically marked overabundance in other areas of the face—of fat in the “Asian eyelid” (Kaw 1991, Ying, et. al. 2006) or overfullness of the “African-American lips” (Gilman 1999)—are other sites to examine excessiveness, these soft tissue parts are not named as gender-changing procedures.

¹⁶ Study authors were explicitly interested in the skeletal structure of patients’ faces, and did not consider those whose lower faces were “over-wide” due to obesity or large masseter muscles (Ying, et.al., 2006:67). Thus ostectomy—or removal of the offending bone—was required to make the mandible less wide and less acutely angled.

come under considerable criticism of late. Nonetheless, as demands for certain forms of “oval faced” prettiness increase, more and more jawbones are being cut out.

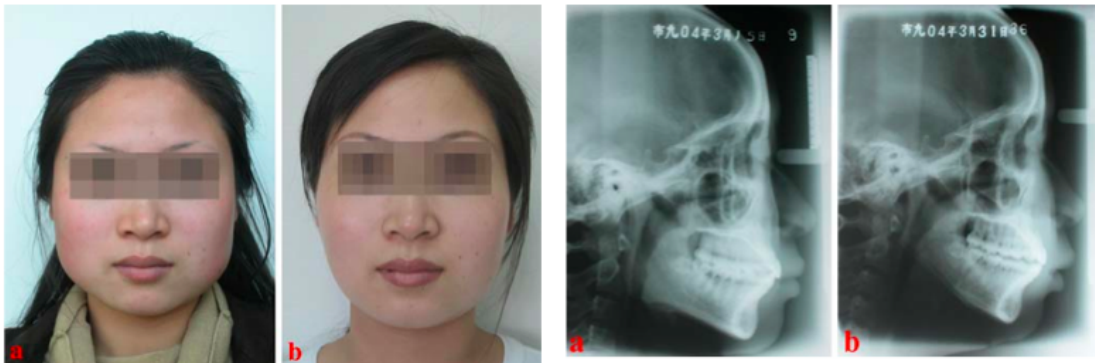


Fig. 2 a Cephalometric X-rays of her profile view. b After the operation, the prominent mandibular angle had been resected

Fig. 5 a Cephalometric X-rays of her profile view. b After the operation, the prominent mandibular angle had been resected

Fig 2.1. Ying, et. al., 2006:69.

In a 2005 article in *Facial Plastic Surgery*, plastic surgeon Dr. Samuel Lam stated that, “mandibular angle reduction” is “unique to Asian plastic surgery” (2005:320). It is clear, however, that it is not; mandibular angle reduction is often a key part of FFS. Lam notes, in relation to the Asian¹⁷ face that, “wide, flared mandibles are often deemed masculinizing in appearance” (321). He goes on to state, however, that demasculinization is not the only reason that these “wide, flared mandibles” are reduced. According to Lam, “men are also desirous of reducing both the cheekbones and the mandibular angles, as the thought is that these features render the face wider and thereby flatter and more ethnic in appearance” (321). Here, as in Cela’s story above, the wide jaw signifies doubly: it is both masculine and ethnic. Its removal, therefore, enacts two kinds of change: what is left is both less ethnic and less masculine. If *less masculine* means, de facto, more feminine, then what does *less ethnic* mean? To what extent might the reduction of the mandibular angle signify a departure from one gendered and/or racial category without implicating an arrival in another?

The Ethnic Nose

Historian of medicine Sander Gilman has written extensively about the nose as a body part that conveys information about ethnic and racial identity, and one that thus emerged as a common site of early aesthetic surgical intervention. Gilman’s analyses of the Asian, the African and the Jewish nose have shown how these body parts have come to signify “otherness” and how their surgical alteration has been oriented toward erasing the difference that they represent (1985, 1991, 1998). “In the world of nineteenth-century science, the great chain of being that was seen to stretch from the most human to the least human was also a chain of beauty. This idea of beauty was measured by the

¹⁷ Lam notes that, “The term ‘Asian’ refers to the Mongolian ethnicities of East China, e.g., Korean, Chinese, Japanese” (2005:317).

shape of the nose” (Gilman 1999:49). Standing for the normal and typical, in this literature the white body is a transhistorical constant from which other ethnic and racial groups are understood as deviations (and deviants). Chronicling 19th and 20th century European and American anxieties that found their focus on the “hooked” Jewish nose, the wide African nose, and the inadequate Oriental nose, Gilman shows that, “The original nose, the normal nose, the healthy nose is that of the European, which may be altered through cultural interventions, but remains a sign of the universality of all human beings” (1999:52).

The language of excess used to describe the troubling width and over-prominent dorsum of noses in Gilman’s historical material persists in contemporary surgical literature. In a 2007 plastic surgery article, for example, the African American nose is characterized by the following excesses: a wide dorsum, excessive alar flaring, sharp nasolabial angle, ovoid, wide nostrils, and a wide alar base (Patrocino and Patrocino 2007:561). If this excessive width, flare and sharpness are removed, something of the distinctively ethnic character of the nose is gone, too. But it can be put back, through addition. In 2006, Romo, et al., published an article on revision rhinoplasty to “reestablish ethnic identity.” They open by summarizing a problem in contemporary plastic surgery: while the number of non-Caucasian people in the United States undergoing surgery has grown, facial analysis and the surgical procedures on which it is based continue to use standards and practices based on research on Caucasian people.

Applying Caucasian-based principles of facial analysis to people of different ethnicities can result in dissatisfied patients, who feel they have lost their ethnic identity (2006:679). Typically, many Caucasians in the United States undergo dorsal reduction-based rhinoplasty. Application of these Caucasian-based principles to people of different ethnic groups can result in patients feeling disconnected with their ethnicity (681).

The authors report on the cases of two patients, an Indian woman and a Jewish man, both of whom wanted their “ethnicity reestablished” following a rhinoplasty. Their ethnicity had been removed in the primary procedure when, as noted above, they underwent a dorsum reduction (as is common for Caucasians). The patients felt—and the surgeons confirmed through the naming of these procedures as ethnicity reestablishment—that their Indianness and Jewishness, respectively, had been resected away through the literal removal of bone and cartilage. If it had been removed, it and could be restored by building back on top of the Caucasian noses they’d been left with. (The diagram above shows the various grafts and structural elements through which the patient’s ethnicity can be reestablished [2006:681].) With this

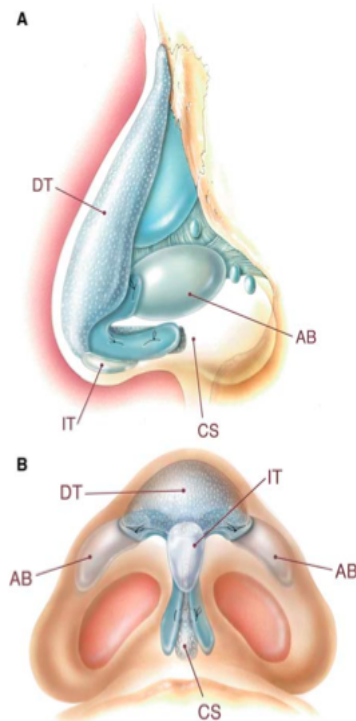


Fig. 2. Lateral (A) and basal (B) diagrams demonstrating the placement of various porous polyethylene grafts. DT, dorsal-tip graft; AB, alar batten graft; IT, infratip graft; CS, columellar strut graft.

Fig 2.2. Romo, et al., 2006:681.

extra material re-added, these patients felt that their ethnic characteristics had been restored.

The recognizability and signification of racially or ethnically specific facial features is not simple, nor are the categories of belonging in any of these groups mutually exclusive. To say, therefore, that the use of Caucasian-based anthropometric norms as a guide for plastic surgery does, in effect, turn patients white is to simplify and flatten “race” or “ethnicity” into an index of noses and jaws. That is not my intention here. Rather, my effort is to show ethnographically and through the reading of practice-oriented surgical texts how masculinity and race/ethnicity become synonymous as deviations from femininity defined as an unmarked white norm. It is clear from these examples that though ethnicity and gender are described as separate aspects of a facial skull, they are always read through each other.

Passing In/And The Racially Marked Body

When a transwoman speaks of passing, she is not only talking about passing from man to woman. When she is read, she is read not simply as a man, but as a man trying (and failing) to look like a woman, as a stigmatized and degraded man: a transwoman. What is visible in her failure to pass—what is read—is not the stability and viability of maleness beneath, but the artifice of an effort toward passing itself. The failure occurs at the moment the try becomes visible, undermining her status as both a man and as a woman; she is something else. *What* spectators can see in her bodily presentation depends both upon the material shapes of her body, and upon who is doing the looking.

The material limit of the sexed/gendered body is not a property of the material itself; it is a product of how that material is understood by others. It is through the gaze that the body’s sex is constituted; in order for femaleness to be attributed, the face must be seen. Howard and Page speak of the audience of the post-surgical face as a general one: its audience is *everyone who will see it*. Their understanding of what *everyone* sees is, of course, conditioned by their own visual understanding facial sex as a perceptible and recognizable quality. The power of the surgeon comes, in part, from his ability (or, at least, willingness) to stand in as the universal viewer of an ostensibly universal form of difference. As situated social actors, Howard and Page’s understanding of the perceptively female is conditioned by their own personal experiences and aesthetic preferences. Whether it is the white norms that guide Howard’s practice or the models whose faces Page uses to define and communicate the feminine—Angelina Jolie, Jennifer Aniston, Gwyneth Paltrow, Ashley Judd, and so on—there is a particularly raced notion of the feminine being presented by each of them.

Though Foucault identified the “medical gaze” as a shift in the practical and epistemological basis of medicine, broadly conceived, it is also the case that the medical gaze is operationalized in the clinical encounter by discrete individuals. As charismatic actors—both in this ethnography and in the market and practice of FFS—Howard and Page distinguish themselves by distinguishing their mode of clinical sight: they see differently. In the case of aesthetic and reconstructive surgery, it is the individual surgeon’s *taste* and *aesthetic eye* that differentiates him from his competitors. His vision for desirable feminine aesthetics makes him more than a technician; it makes him an

artist (Schlich 2007). In this sense, the surgeon is able to apply the ostensibly “common knowledge” of female aesthetics *as seen* uniquely through his eyes.

The conceptual transformation from the art of medicine to the measurability of science, Foucault writes,

“was decisive: it opened up to investigation a domain in which each fact, observed, isolated, then compared with a set of facts, could take its place in a whole series of events whose convergence or divergence were in principle measurable. ... It gave to the clinical field a new structure in which the individual in question was not so much a sick person as the endlessly reproducible pathological fact to be found in all patients sufferance in a similar way...” (1973: 97).

While the clinical encounter organized around the mitigation of masculinity may constitute the patient on the table as one in a series of duly diagnosed bodies, it also important that she is one in *his* series. In her discussion of the gendered dynamics of physician interpretation, Kristi Malterud noted the role of a physician’s personal experience over purely clinical information. “The doctor’s inner images, constructed by previous medical science and history, are the templates toward which the clinical signs are read by the medical gaze” (1999:282). Personal and clinical sight become entwined.

The doctors’ claims to authority on the constitution of the feminine are critically dispersed into the powers of science and popular aesthetics, but that authority also individualizes the surgeons themselves. Their understandings of what it means to “look like a woman” are, therefore, universalized and particularized at once. When a surgeon says—as they often do—*she looks good to me*, that *me* is not only an expert practitioner, but also a situated social actor.

It is frequently asserted by those advocating “ethnically appropriate” plastic surgery—which is *always* facial surgery—that a surgeon of the same racial or ethnic group as the patient is required in order to truly understand not only the patient’s needs and desires, but also to understand the very structure of the patient’s face (cf. Lam 2005, Pitts 2006). This sentiment was voiced by two patients during my fieldwork. Gretchen and Krista had both prioritized their FFS above genital surgery, though they each named genital reconstruction as a future goal. Though they were each still evaluating which surgeon they wanted to do these procedures, foremost in their minds was a Thai surgeon with a strong reputation for quality work in genital sex reassignment surgery. This surgeon, Dr. Boondech, had recently begun offering FFS among his suite of sex changing surgeries, but neither Gretchen nor Krista considered going to him for their facial surgeries. Gretchen noted that though she respected his work in genital surgeries, she would not be comfortable going to him for FFS. “He seems to be doing a lot of Asian faces. So, I’m a little bit afraid of asking an Asian guy to do work on me that he usually does on Asian faces.” Though she was perfectly willing to consider traveling to Thailand for genital surgery, Krista found the prospect of getting FFS done there “really iffy.” Part of Krista’s skepticism about Boondech’s FFS was due to the fact that he had only recently begun performing these procedures. But, like Gretchen, she also worried about an “Asian specialist” working on her face. While the genitals emerge as non-raced body parts in this discussion—or at least ones whose differences do not adversely effect

the ability of the surgeon to adequately reconstruct them—feminization of the face requires a kind of in-group sight in which patient and surgeon are matched pairs.

In her marvelous essay, “It Takes One to Know One: Passing and Communities of Common Interest,” (1994) Amy Robinson interrupts the typical dyad of the “passer” and the “dupe” that populates most representations of passing (her essay focuses on those passing as white and passing as straight) with the triangulating figure of the “in-group clairvoyant.” “What may be available to the in-group,” Robinson writes, “is the visibility of the apparatus of passing—literally the machinery that enables the performance. What the in-group sees is not a stable prepassing identity but rather the apparatus of passing that manufactures presumption (of heterosexuality, of whiteness) as the means to a successful performance” (ibid:721). While the passer is working to create an effect and the viewer constitutes that effect by reading it as a visually confirmed reflection of reality, the in-group sees the effort itself as a social and corporeal technology. In the clinical relationship, the surgeon plays the role of this “clairvoyant” figure.¹⁸ His role is not so much to interrogate the beginning and end points of the patient’s identity—though these are certainly stabilized as byproducts of the narrative of transformation—as it is to see the means of the artifice. These include both the aspects of the patient’s body, but also an understanding of the cultural norms into which the patient will be passing, the presumptions of femininity that, as an audience member, he himself shares. His status as one who can see the apparatus of passing even while he is not a member of the group who is working to pass, helps to consolidate his image as an exceptional figure.

Looking Alike: Kinship of the Common Form

Feminizing via a set of standardized norms raises problems related to anxieties of commonness, or “looking alike.” If the claim that one can be made to look like a woman holds true, then it must be the case that everyone recognizable as a member of the category *woman* shares some common characteristics. Identifying those characteristics, however, is a different story. This kind of commonly-held-but-impossible-to-name quality is how Evelyn Brooks Higginbotham has described race in America: “When we talk about the concept of race, most people believe that they know it when they see it but arrive at nothing short of confusion when pressed to define it” (1993:253). Howard and Page have arrived at very different forms and means of defining femininity. As individual surgeons engaged in series of patient interventions, their philosophies become born out in the forms of their patients’ faces.

A few months after I began visiting his office, Dr. Page hosted a cocktail party to welcome a prominent genital sex reassignment surgeon to his practice, a boon to be sure. The event was held in the foyer of the building that housed Page’s office, and seemed to be as much a celebration as a marketing event. The invitation encouraged guests to

¹⁸ It is also often played by other transwomen. Several patients mentioned that other transwomen had told them that FFS could be helpful. Generally interpreted by the patients I spoke with as helpful advice, this information sharing was also a form of community disciplining of bodily forms. Once equipped with the knowledge of masculine and feminine facial forms, transwomen diagnose and make recommendations for each other—as did Caitlin and Brooke in the exchange at Page’s cocktail party.

“Come dressed to impress on the red carpet in your best cocktail or evening wear,” to welcome “one of the most famous GRS surgeons in the world to [Page’s] practice.” A DJ played club music from a small table in the corner of the white marble foyer as guests huddled near tall cocktail tables and watched the door for new arrivals. Most of the guests were either current or past patients of Dr. Page’s who were also interested in meeting the GSRS surgeon. With the addition of this surgeon and the recently acquired services of an endocrinologist and affiliated aesthetician, Page was well on his way to establishing the “hub of transgender medicine” that he’d been envisioning. Though the overwhelming majority of the offices services were oriented to transwomen—the GSRS surgeon is an Obstetrician/Gynecologist and so specializes in male-to-female genital reconstruction, and the aesthetician helps transwomen feminize—Page was also eager to perform more chest reconstruction surgeries for transmen. He knew that his online marketing efforts that focused exclusively on feminization were stymieing this effort.

During the cocktail reception, I struck up a conversation with Caitlin as we worked our way through hors d’oeuvres and plastic cups of cabernet. Caitlin had undergone FFS with Page nearly five years earlier and she was happy to share her enthusiasm and appreciation for him as a surgeon and as a person. A few minutes into our conversation, Brooke joined our circle. Brooke was an international petroleum engineer who had earned enough money to have some flexibility in her schedule. Though her FFS surgery wasn’t scheduled to take place for another week, she had decided to extend her trip so that she could attend the party. Page had encouraged her to talk with Caitlin if she had any questions. After a few traded compliments between them—“Honey, you look great!” “If you just take a little off of that forehead you’ll be in good shape. You don’t need much work at all”—the conversation shifted to an assessment of surgeons. In this conversation, Page and Howard were the only names mentioned. “In the early days,” Caitlin told us, “a lot of working girls went to Howard. They figured out that they could make a lot more money with a pretty face.” Roughly ten years prior, Caitlin had spent some time as a sex worker and was aware that facial surgeries could have been helpful to her. She had seen Howard for a consultation and knew a few friends who had had surgery with him, but she opted not to undergo FFS at that time. Though she acknowledged his contributions as the pioneer in the field, Catlin did not like Howard’s approach. Brooke had never met Howard personally, but she had very strong opinions about his approach as well as the price tag on his services.

Like Page, both Caitlin and Brooke were critical of the “standard” approach that they attributed to Howard. For them, this approach is both too radical, medically speaking, and produces common and recognizable results that they referred to as “cookie cutter” faces. There is no question amongst surgeons or patients that Howard’s surgical approach to feminization is the most aggressive one currently practiced. He believes that bone reconstruction is absolutely essential to the production of the female face. “You *must* change the underlying skeletal structures in order to look female,” he explained to me emphatically. In his estimation, if a patient’s desired effect is to be recognized as female, then certain things simply must be done.

Less is not more. We’ve had over the years not more than four or five patients probably, who came in and said, ‘You were going to set my forehead back 8 millimeters, just go 4.’ Or, ‘You want my chin to go up 6, just do 3.’ ‘You’re going to move it forward 8, just go 4.’ Fine. I’ll do that for you, but you’re not

going to be happy. They say, ‘Oh it’ll be perfect because I just want a little female.’ Every one of them has come back and said, ‘go ahead, fix it’ because they still look masculine. You’ve got to go there. It’s crazy, but you’ve got to do all these things.

Of course, not everyone agrees with this approach. Dr. Page has a different philosophy, and so do the patients who chose to have surgery with him. “I’m not letting anyone take a buzz saw to my face,” Brooke blurted out. To her, the mere suggestion of such a thing was laughable. Her comment construed Howard as a mad doctor wreaking havoc on women’s skulls as opposed to the restrained subtlety that Dr. Page promised.

The second objection that Caitlin and Brooke voiced to Howard’s approach was that it produces a common result. In other words, after surgery all of his patients’ faces look alike. Caitlin emphasized that Howard’s cookie cutter effect was so evident that it wasn’t only visible to discerning, in-group transwomen (Robinson 1994). “I have *straight* friends in [the *suburbs*] who can spot one of his faces from across the street!” Caitlin said incredulously. Brooke echoed these sentiments. “It was fine when there were just a few of us, but now that he has done like 15,000 people you could be walking down the street and see someone who looks like you and say, ‘Hey, are you my cousin?’”¹⁹

Caitlin and Brooke’s concern with recognizable similarity—looking alike—engages networks of kinship through the material fact of family resemblance. The notion of “cookie cutter faces” evokes images of an assembly line stamping identical shapes out of soft dough. Despite the comical, if a bit macabre, image of this metaphor, Howard’s patients do not emerge from the operating room as a series of copies, each of the other. The application of a common model does not produce identity, but it might produce forms of resemblance that are themselves powerful markers of connection, as evoked by Brooke’s question: *are you my cousin?*

In their study of the importance of family resemblance in adoptive families in Catalonia, Marre and Bestard claim that, “Perceived physical resemblances between family members are an ethnographic window through which to analyse the different ways in which nature and culture are mobilised when people refer to their relatives” (2009:66). Though “nature” and “culture” operate as very different signifiers in the context of Marre and Bestard’s research, their multivalent work in the scene of kin making through FFS is equally potent. To the extent that family resemblance describes physical characteristics (as opposed to behavioral or mimetic ones), it is understood to be a thing that one inherits. This inheritance typically comes through genetic material, but in Brooke’s hypothetical scene of familial recognition, it is an inheritance of a particular, racially specific model of the feminine.

“It is not enough to find family resemblance through genetic connection,” Marre and Bestard write. “Rather it is a way of constructing relations in a network of already existing relatives, a way of placing the new body into the group of the family body and constructing the new individual body as a family member” (ibid:65). While the recognizable look of a face that has “been worked on” has been said to erase signs of pre-surgical “familial intracorporealities” (Gibson 2006:15), it is equally important to

¹⁹ Though Brooke’s estimate of Howard’s surgeries is overshoot (his actual number is closer to 1,500), her point is clear.

consider how new modes of relation may be created through the application of a common post-operative form. The frequent practice among trans- patients of naming themselves as the “girls” of their surgeons—saying, as Jill did, “I’m a Jim girl,” or as Rhonda did, “I’m a Stanley²⁰ girl”—marks their inheritance and common form as originating from an individual surgeon’s practice. He becomes a progenitor of a very particular sort.²¹ As the link by which a family is formed and thus family resemblance conferred, the question of race in relation to surgical practice emerges again. Kinship as a network made visible through bodies is always a question of race.

Brooke had offered the scene of potential cousin recognition as a means to demonstrate and render ridiculous the overdetermination of a common surgical model. As a patient of Dr. Page’s, she implied, she would not have FFS cousins. But Howard’s patients will. Though Howard contests that his approach does not make “cookie cutter faces” this sentiment was the one most frequently raised by his critics. The logic underlying this claim makes sense: he does have a set of procedures that he recommends, and he does have a narrow range of desired “female” measurements that he attempts to produce.

Howard contends that the impression that he does “the same thing to everybody” comes from a misunderstanding that he addressed directly during a presentation at a trans- conference.

If two of you come to see us today and we give you a consultation and you walk out you don’t look anything like each other and [our assessment] says, ‘scalp advancement, forehead III, rhinoplasty, upper lip, chin, jaw, thyroid cartilage.’ You might think, well jeez, we don’t look anything alike and he’s doing the same thing. Yes, I’m doing the same thing because those are the things you’ve got to get rid of to go from male to female. But what I *do* on you is absolutely individualized. I might move your chin 2 millimeters, I might set yours back 6. Whatever I’m going to do is individualized to you. Everybody is that way.

The perception that he does “the same” procedures on every FFS patient is therefore both true and not true. If it is the case that most males have masculine skulls, then it stands to reason that most males will need interventions in these same areas. In this sense, his characterization of the masculine is consistent. Insofar as the definition of the racially unmarked female rests in the transformation of those characteristics, every male who wants to be made female must undergo a particular set of modifications. For Howard, it is as simple as that. Jill agrees with his philosophy and raised the issue of “cookie cutter faces” very defensively.

²⁰ Brenda is referring to the legendary Dr. Stanley Biber who performed her genital sex reassignment surgery many years before.

²¹ Patricia described the relationship between a surgeon and his former patients in another way. She described her experience of visiting a surgeon’s hotel room during a conference in order to get a quote for FFS with him. “His people love him. In his room—which was a little strange, I have to say—when you went in there he had five or six gals in the living room area of the suite that he had worked with. At one level that was good so you could talk to them, but I felt a little creepy because it was kind of like his little harem or something. They were supposed to be there to talk to new people, but they really just talked to themselves. And drank champagne.”

I have always envisioned Jim—and I'll call him Jim because he's a friend—as an artist. Our skulls are canvases upon which he can work. I am his biggest supporter against those who would argue that he creates cookie-cutter faces, that somehow or another over the years everyone is the same and you can tell. I got three words for that: bullshit on that. Don't come to me with that crap. Jim has made it possible. Jim is a golden age. Those of us who are fortunate enough to see him will forever be a minority of people who have changed the world of opportunity for transgender people. I don't care and I will argue that with anybody, anytime, anywhere.

Jill did not respond to the criticism that “everyone is the same” by arguing that they are not. Instead her turn was to the ethical and heroic status of Howard himself. As a “friend of the community” who “changed the world of opportunity for transgender people,” Howard is absolved from any criticism about the ways in which he “has made it possible,” or indeed *what* he has made possible.

The Erotics of the Male Gaze

Pamela, a transwoman, with whom I talked at length during a weekend-long conference, had been unsure about whether she wanted to undergo FFS. She was a self-described hippie and farmer with an established, if unorthodox, spiritual practice and deep commitment to parenting her teenage sons and nurturing her relationship with her wife of 20 years. Pamela was one of the most open people I had met in my life; her green-blue eyes seemed to always be on the edge of watering as she looked and listened intently. She spoke as though she revered not just what she was saying, but the act of speaking itself. We talked for hours. Though she was fairly certain that she wanted genital sex reassignment, she described herself as being, “30% interested in FFS, but 70% disinterested.”

There are times that I look at myself and want to smash the mirror. Then I think about FFS. But I don't know what it is about my face that I don't like in those moments. I pass pretty well, and I'm not interested in living stealth anyway. I get a charge out of coming out. But when I look at myself in the mirror I look most often at my face.

Out of curiosity, Pamela attended talks by both Howard and Page at the conference, but left more uncertain than before. A few months later she decided to consult with Dr. Lubbock. She and her wife traveled to his office and had such a positive experience there that they decided that Pamela would undergo a “full face” FFS. She described her decision to go with Lubbock as one informed as much by her interpersonal dynamic with him as it was by her impression of his practical techniques. She described her meeting in an email:

I had expected a ‘used car salesman’ type, but for whatever reason I just enjoyed him; I admit I was somewhat romantically/sexually ‘titillated’ by his very confident manner, which is odd for me, as I have traditionally run from such men. I guess I felt his (I suppose) attraction to me and responded to it... strange business.

The dynamics between surgeons and patients are undoubtedly shaped by the gender differences between them. Just as surgeons' assistants do important gendering work by being patients' "girlfriends," as heterosexual men Howard's and Page's assessments of patients' attractiveness must always be read through a dynamic of sexual desirability. Sometimes this is overt, as in the experience that Pamela described, and other times surgeons' assertions of attractiveness stand in for the male gaze that patients imagine in their future.

Most patients desired the sexual attention of men following transition (more on this below), and the surgeons who performed their operations were, in effect, their first male audience. As Pamela makes clear, messages of attractiveness and desirability communicated by surgeons can become very powerful modes of reassurance. Typically cordoned off as an area in which sexualized acts or communications are taboo, when sexual attractiveness itself is identified as a surgical goal, however informally, these kinds of assessments become not only relevant, but crucial.

Though Pamela was quite clear about her "utter fidelity" to her wife, she enjoyed exploring—if only through fantasy—the sexual dynamics that she imagined would shift as her body became more feminine. Like the overwhelming majority of patients I interviewed, Pamela had been in heterosexual relationships prior to transitioning. Part of what it meant to her to "become a woman" was to reorient her relationship to men as an object of their sexual desire—even if they were not the object of hers. She wrote,

It's entertaining to be feeling an increased 'male attractedness' — but that's not quite it, it's more like an awareness of what I, as female, do to them, and enjoyment of that, and a willingness to someday succumb to that desire they (will/do?) have.

Patients often expressed their desires for post-surgical life in terms of what they hoped would be their increased potential for sexual and romantic relationships. The patients understood the audience of their post-op faces as being, at least in part, one that would see them as objects of desire. While some patients had wives who planned to stay with them throughout their transitions and so were learning to renegotiate their sexual and romantic partnerships within a new physical and social dynamic, those who expressed the desire to find a new partner after surgery always spoke of male partners; they anticipated a male gaze. In these moments, it is clear that "femininity" can sometime signal both the female and the beautiful for patients as well as surgeons. The assessment of both of these categories is left to the desiring and scrutinizing masculine eye.

Denise hoped her FFS would be a radical change. "My hope is to walk up to my daughter and she'll say, 'May I help you ma'am?' She won't even recognize me. None of my kids will." Restaging Howard's doorbell stranger scene with an intimate family member raises the stakes on the degree of transformation she anticipated. Though Denise did not have a particular idea in mind of what she would look like after the surgery, she was clear about her desire: "I want to be beautiful. When I told Dr. H that, he said that he couldn't make me beautiful but he could make me good looking. That sold me." For Denise, FFS was mostly about increasing her confidence and removing the "major distraction" that she felt about her appearance. "FFS will enable the jump from man to woman, so I can live as a woman. Maybe I'll find a man. Living in the

middle is just kind of neutered.” During our conversation, Denise received a text message from her ex-wife. They had recently been divorced, another major life change that Denise said was a direct result of her decision to transition. “That decision also cost me my children,” Denise said as her thumbs busily typed out a return text message. She didn’t want to say anymore on the subject of her kids, but the fact that it was her children’s (non)recognition that she used as a measure of the success of her FFS felt especially raw and poignant.

Rosa, who I described in the Introduction as wanting a face that would make a man turn red, was especially vocal about her desire for men’s attention following surgery. When I asked her how she thought her life might be different after FFS, she replied, “When I am out with a boy I can just be with him and not worry about keeping my hair perfect and my make-up perfect and wondering what he is thinking.” Though Rosa was not sure precisely what form her face would take following surgery, she knew what she wanted from it. “I know what I want,” she said. “I want a man like to you see me and your face turns red. That is what I want.”

In this chapter I have tried to draw critical attention to the complexity of surgeons—like anyone’s—claim to know what others see when they look at someone. “Woman” is always a category inflected by understandings of race and ethnicity, and of sameness and difference. What may be visible to me may not be visible to you. Still, femaleness is not a totally local category. Its general stability is both maintained and reproduced through the disciplining norms of desirable beauty, and the incredibly powerful discourses that help to shape a particular body as normal and as right.

My Adam's Apple

Pronunciation: /,ad-əm-'zəp-əl/

: the projection in the front of the neck that is formed by the thyroid cartilage and is particularly prominent in males

It is often said that Adam's Apple takes its name from the biblical story about Adam, Eve, the Serpent and the apple. A piece of the forbidden fruit stuck in Adam's throat and created the anatomic Adam's apple. So the story goes.¹

On the night before my first surgical observation, I leaned against the desk in Howard's office as he scrolled through patient photographs on his computer. He wanted to show me photos of some facial masculinization procedures that he'd been working on. Though he had never received a request for facial masculinization from a transman, he was interested in investigating whether there might be a market for such a thing. He had performed "masculinizing" facial surgeries on two males who wanted more masculine faces, and he showed me their before and after photographs. The differences in one of the patients were pretty astounding. Howard had given this guy a big wide jaw, a square nose, and a more deeply cut hairline. He explained that the patient was a very well built gay man who wanted his face to match his masculine body. When Howard told me that he wanted to begin marketing these facial masculinization surgeries to FTMs, I asked him why.

H: Why not? I love to do this and I'm good at it. Do you want me to give you an Adam's Apple?

He spun in his chair to look up at me.

E: **No, thanks.**

H: I'll do it for free.

Never in my life had I thought about an Adam's Apple being—or not being—in my throat. While I could see why a transwoman might want to be rid of hers, as I transman, the absence of an Adam's Apple didn't carry the same corporeal meaning. But now he we was offering to make me an Adam's Apple. For free. The offer of a free surgery was, I suppose, intended to tip the scales, but into whose favor—his or mine—was not clear.

E: **No, thanks.**

H: Why not? Are you chicken?

¹Others argue that this is a misinterpretation of the Hebrew "tappuach ha adam" meaning "protuberance on man" used to denote this anatomical part. The late Hebrew word for protuberance is very similar to the word for apple, and Adam in Hebrew can refer to "man" in general as well as the biblical figure. *Merriam-Webster's Medical Dictionary*. Merriam-Webster, Inc. <http://dictionary.reference.com/browse/Adam's apple> (accessed: 2.27.2011).

E: No, I really don't need one. I never get read as trans.

H: Yes, but if someone sees you at a bar and you've got an Adam's Apple there'll be no question if you're trans.

This is essentially the inverse of the explanation for why MTFs need to have their Adam's Apples removed. If that Adam's Apple in MTFs is a tell, then for me, the logic goes, it must perform the opposite function: it must be a trump card. I'm not sure who this observant stranger in the bar might be, but one look at that Adam's Apple and they'll know I'm the man they're looking for. At this moment, maleness is—or could be—located right in the middle of my throat.

E: That's true. But I still don't need one. (Anxious to change the topic away from my throat and toward throats in general.) How would you do it?

H: I'll take a piece of cartilage from the base of your ear.

He tugs on his own ear to show me where he means. Without thinking, I mirror his grab and tug on my ear. It is a satisfying tug; now I know just what he means. All of the sudden that hunk of hard cartilage that I'd never really noticed before has incredible potential.

Or a piece of cartilage from your rib...

Yes, he is literally offering to make my undisputable maleness of out one of my own ribs. He can turn my Eve into Adam. I am autogenic.

...suture it once on either side. I think it should work.

He smiles so playfully that I can't help but smile back.

You don't want it to move down...

He points at his throat, and slides his finger down toward his chest. Of course, the only throat this wayward hunk of ear cartilage would be sliding down is mine.

...or end up pointing to the side.

His smile grows as he describes this even more absurd image. Laughing, he points a thumb out the side of this throat to imitate a tracheal cartilage sticking out the side of his neck.

You sure you don't want it?

E: Thanks, but no thanks.

Of course I had wanted other things: more than ten years of bi-monthly testosterone injections and chest reconstruction surgery that included a bilateral mastectomy and nipple replacement. I needed that surgery and I continue to need hormones in order to give me the body that makes me recognizable as a man in the world. I worry sometimes about what might happen to me if I were to

lose access to my testosterone prescription. I know what the physical effects would be, but I really can't imagine how I would deal with that new body emotionally. For the last ten years I have been a man in every sense but the genital. I have grown accustomed and very attached to this masculine body and the social life made possible through it. Though Howard's offer of a free and unquestionably masculine Adam's Apple did not appeal to me, it was not an absurd offer. Nor was the proposition of performing a free surgery a simple gesture. I wonder, if by some unfortunate set of circumstances my testosterone were gone and my body were to begin to feminize once again, if I might regret having so blithely turned him down.

Early the next morning I stood next to Howard in the surgeons' locker room as we got out of our street clothes and into blue scrubs. I was feeling very anxious, trying to pay close attention to what was required of me as I prepared to enter the OR for the first time, and deeply concerned that I would make some sort of compromising mistake. I could get lost in the seeming maze of ORs and scrubrooms (these non-public areas did not have friendly signs for the uninitiated). Worse yet, I could faint during the procedure. Utter humiliation. As I leaned down to pull the scrub pants up over my underwear, Howard gestured for me to lean in close. It seemed like it was going to be something important.

H: Have you had a hysterectomy yet?

E: **No.**

What?!

H: Have you had your chest reconstruction yet?

E: **Yes.**

I look down at my own chest wondering how the occurrence of my chest surgery could be in question as I stood there in a white undershirt. And, more importantly, why was he asking me this? My mental focus that had been concentrating on watching Howard's body in the OR, thinking about the patient's body during surgery—and fundamentally thinking about how to do this through occupying the anthropologists' body—was snapped quickly back to my own sexed body. Already introduced to Howard as a trans- body, mine was an object of potential intervention. It could be made to do its sex better.

H: Oh. Because I was thinking if they were doing your chest it would be really easy to just get some rib cartilage and do that Adam's Apple.

E: **Yeah, I already had that done.**

The subject dropped and was never mentioned again.

Chapter Six

The Operating Room

I don't care if you're [in the operating room]. I won't really be there anyway.

—Beth

For most patients I interviewed, the anticipation of and preparation for surgery had given significant shape to their personal, professional, financial and emotional lives for many months. For others, many (many) years. By the time they'd made the trip to the surgeon's office, they had come to think of Facial Feminization Surgery as the event that would mark the difference between the life they had and the life they wanted. It would, they hoped, be the end of a deep longing for transformation. Structured by the future goal of surgery, for these patients the present had collapsed into a seemingly interminable time *before* surgery. It was a continuation of the past experience of bodily dissatisfaction and disaffection into the *almost*, the *can't wait*, the *before* to which every day following surgery would be the *after*.

1. Dr. Howard pointed to a chair in the hallway outside his office. "I'll walk by that spot at exactly 7:25am. If you're there, you're welcome to join me in the OR. If you're not, you're not."

Rosalind—whose surgery is described in the interstices of this prose—had traveled from Wales to undergo surgery with Dr. Howard. When we met on the afternoon before her surgery, she was feeling very anxious. When I asked her about the source of her anxiety, she said that it was not the operation itself that worried her. Rather, she was nervous about the postoperative recovery period.

I'm scared to death. A week before my plane ride I started praying for British Airways to go on strike. I saw a patient at the Cocoon House [Howard's private recovery and convalescent facility, all gendered and natural metaphors intended] all bruised and bandaged and I've been walking around trying to think, 'Why am I doing this?'

Rosalind had hoped to make this trip five years before, but financial issues had delayed her plans. For her, as for all patients who shared their stories with me, arriving in this office was the culmination of a long process of self-discovery.

At 25 years old my hair started to fall out and I thought, ‘Oh no! I haven’t decided whether I want to transition!’ I tried topical creams and things to try to keep my hair and I became pretty obsessed with it. Then I started thinking, ‘Wait, is the problem that you’re going bald or that you’re transgendered?’

She began feminizing hormones in 1999, and hoped that their effects would be enough to ease the anxieties she had about her appearance. She was not ready to commit to surgical alterations at that time because, she explained, she simply could not accept the idea that she was a transwoman. “I still thought I could cure myself of being transgendered,” she said. In spite of this desire to be “cured,” she began taking tentative steps toward “accentuating the feminine in [her] face.” She underwent facial electrolysis that had produced permanent pockmarks on her cheeks and chin, only exacerbating her self-consciousness about her appearance.¹ In 2002 she had surgery to remove her thyroid cartilage (Adam’s Apple) and, shortly thereafter, a surgery to reduce the size of her nose. “That only made my brow look bigger,” she lamented.

My brow is my major concern. I need my nose to match my brow. I have a kind of Neanderthal brow. I want to do my jaw too, but I may have to skip that for now depending on whether I can get the money together. I was kind of hoping he wouldn’t say that I needed to do my jaw, but I know it needs to be done.

Rosalind knew that her decision to have surgery would cause complications in her work and family life. She presented as male at work and at family events, and planned to continue doing so at least until her elderly father passed away. The thought of disappointing him with the fact of her female identity was unthinkable to her. She worked in the building and construction industry in a fairly small town and, for her, living full-time as a woman was simply not an option. Worries about work and personal consequences had kept her from making many changes both to her life and to her body, but she had finally decided that such concerns could no longer determine her choices.

If I have to think too much about what others think, I’ll never do it. I have to do this for me. I’ve spent 25 years of my life thinking about not looking like I do now. I want that to go away. Constant thinking about that ruins the mind. After this I’ll be able to think of other things, everyday things.

Rosalind told me, as did many patients, that it was during puberty that she began to hate her face. As she watched her “button nose” give way to the oversized nose of a pubescent boy, she taught herself how to wash her face and brush her teeth in the dark. “My mum would go into the bathroom after me and always wonder why the blinds were closed,” she said. It was easier for her to re-learn these daily habits than to deal with the look of her changing face in the mirror. This was the beginning of the long story that brought her all the way from Wales to have surgery with Dr. Howard some 25 years later.

¹ This is not an inevitable result of facial electrolysis. Pockmarks are produced by inexperienced or unskilled technicians.

2. I was tired and anxious when I joined Howard the next morning. We walked briskly down the hallway to the surgical wing, he in a shirt and tie covered by his long white coat, me in my canvas jacket and shoulder bag. I saw the loafers on his feet and felt like an idiot in my running shoes—I thought they'd be best for endurance.

After so much discussion of looks and numbers and desires and abilities, it is in the operating room that faces are reconstructed. It is here, as they say, that the rubber meets the road. While for surgeons the operation is an event that has been routinized and repeated hundreds or even thousands of times over, for the patient, the operation is something absolutely singular—assuming all goes well. Over the course of the surgery (up to nearly eleven hours in the case of a “full face” operation), the patient’s skin, bone and cartilage is pushed, pulled, burred, sawed, cut, cracked, tucked and sutured. In the end a strikingly new face may emerge; one whose production is guided by the hope that its new form will enable a coincidence of the patient’s self and body for perhaps the first time in a very, very long time. Facial Feminization Surgery is guided by a hope for phenomenological integration—the creation of a body that (re)presents the self. Though the technical work of surgery is something that patients do not experience in real time, its effect animates their anticipation of a better life through the body as a better and truer thing.

3. He brought me to the charge nurse’s desk. I was to register my name in the vendor’s logbook. Dr. Howard offered me a pen. “You can keep it,” he said. “It’s got my name on it.” I signed in quickly and was given a sticky nametag. I followed Howard into the physicians’ locker room where I was shown for the first—and last—time where to find the supplies I would need to enter the OR. I slid my bag and jacket into an open locker.

For those who desire physical transformation, the operating room is place that symbolizes corporeal change and all the attendant hopes of what that change will bring. In addition to the physical transformations enacted here, the operating room is also the scene of an encounter between patients and surgeons that is structured by a common conception of the body or, more specifically here, the face. For these two people in this place, the patient’s face is a material thing. It is not the irreducible site of personhood, the distinct shape of which makes us individuals; it is a series of structures whose problematic characteristics can be rectified. These structures do not necessarily map onto or even remotely relate to the social or personal identity that the face is typically taken to be. That is just the point: *this face is not her face*. Not yet at least. The pre-operative face is simple, disinterested material for the surgeon who cuts into and reshapes its parts, and it also is this for the patient whose experience of her face as something disloyal—as non-coincident with her self—has motivated her arrival here. This is a distinct vision of the body shared between the surgeon and the patient, two people who have arrived together in the operating room precisely in order to alter it.

4. We grabbed blue paper caps from a shelf near the door to the hallway. He folded the bottom rim of his cap upward in order to pull it down snugly before tying the white paper straps behind his head. I did the same. We were ready. Howard swung open the door and we headed to OR 3, his regular room. He handed me a surgical

mask as we walked through the scrub room and into the OR where Rosalind was laying on the table being prepped by the Circulating Nurse (CN).

She's Not There: surgery without patients²

Ethnographies of surgery have been beset by a problem of presence, both in the physical and metaphysical senses. Physical presence has been the focus of those who write about the action and objects of the operating room—its machines (Hirschauer 1991; Prentice 2005), its repetition and ritual (Katz 1981), the decorum and ego of surgeons (Bosk 1976; Cassell 1986, 1991, 1998; Katz 1999), and the dynamic sort of presence between a teaching surgeon and her medical student (Prentice 2007). These scholars have taken great care to call our attention to how objects, actions and relations make the operating room into a unique place where human bodies are cut open and sewn shut, all in a day's work. The at once familiar-and-strangeness of the surgical scene allows a vivid ethnographic rendering. We consumers of the one-hour television medical drama are drawn to the scene and these texts bring us into the operating room to see how meaning is made in action.

5. I stood near the wall and tried to stay out of the way as I received my instructions once again, this time from the anesthesiologist whose distaste for surgical masks was made evident by the way his hung loosely around his chin: Do not touch anything draped in blue cloth. If you are not sure whether you can touch something, ask first. Since this is your first time in the OR, start out in your seat with both feet on the ground. If you get queasy, put your head between your knees. Once you're sure that you can stand up without us having to pick you up, you can come and observe at the table. You may stand behind the surgeon to observe, but do not come near his elbows.

The metaphysical problem of presence³ has taken the form of ontological explorations of the doctors and patients in the space of the operation (Cassell 1986; Goffman 1961; Hirschauer 1991; Young 1997). These authors have approached surgery as a “special situation” (Collins 1994) in which fundamental rules of social behavior are violated in approved ways. Their analyses work to understand how, in the focused interaction of the operation, persons are transformed into “surgeons” and “patients” and back again. For doctors, they agree, the transition from person to surgeon (if one is required at all) is accomplished through the process of dressing and scrubbing for surgery. For patients, the line between person and object is the hazy one drawn by anesthesia.

² *She's Not There* is the title of Jennifer Finney Boylan's (2003) autobiographical account of coming out as a transsexual woman and undergoing sex reassignment surgery. The phrase was originally made popular as the title of a hit song by the 1960s British pop band *The Zombies*—named for a group with its own problems of absence and presence.

³ Think more about “metaphysics of presence” in Derrida; also “Of course, we say, for something to be, no matter what it is like, it must be present at some moment of time which was, is, or will be the present, even if its manner of showing up is very different from ordinary objects” (White 1996:147).

6. Dr. Howard went immediately to greet the patient. He caressed her forearm and assured her that everything would go well and that she would look beautiful. I couldn't stop staring at her fingernails: cotton candy pink against the blue and white striped blanked that covered her. Howard stayed by her head until she was under anesthesia. The moment the patient was unconscious, the feel of the operating room changed. With the presence of a guest no longer observed—I certainly did not count as such—everyone in the OR began their tasks in haste.

Mine, too, is a problem of presence that is informed by both of these literatures, but reflects the particularity of FFS as an intervention in the body intended to bring about a change of sex and sexed identity. Like the authors above, my observations in the operating room made it clear that the questions *who is in this room* and *what is happening here* are difficult ones to answer. The problems of who and what is present in the operating room are complicated in this case by contested ontologies of transsexual being and embodiment. If it is the case that the “self” (usually represented under the sign of “mind”) and “body” of transsexuals is figured as non-coincident (Benjamin 1966), then the dynamics of personhood and objecthood that have typically structured critical readings of operating room practice have to be reconsidered. This is especially the case if the act and promise of FFS is predicated on bringing these two—self and body—into congruence through the surgical reconstruction of the face.

7. Howard announced the plan for the day. “This is Rosalind Mitchell, 37 years old. We’re doing her forehead and nose today. She wanted to do the chin and jaw but her credit card didn’t come through. Says she’ll be back for those in the fall. This should take four and a half hours. She has no allergies and is on no medication.” Confirming that all parties were in agreement, he began to prepare the first site: the forehead. Sitting on his stool at the end of the table, he began to comb and gather Rosalind’s long hair in rubber bands. Once the site was isolated, he shaved a one-inch wide track through her hair, combed out the loose pieces and dropped them into a biohazard bucket. He injected the incision site with local anesthetic and then left the room to scrub in. While he was out, the CN sterilized the forehead site with soap and water and then with iodine that dripped in deep brown-yellow drops through her hair and into towels on the floor. The doctor returned with his clean and dripping hands held at chest level. The CN helped him into his gown and gloves.

The process of making a masculine face into a feminine one only rarely involves addition (of bone substance or implants). Instead, making feminine is almost always a process removing that which is masculine to reveal the feminine beneath. The masculine is a problem of excess: the jaw is too wide, the forehead too long and too prominent, the chin too square, the upper lip too long. Whereas genital sex reassignment involves rearranging and repurposing body parts in order to make new ones, like mastectomy for female-to-males, Facial Feminization Surgery is essentially about taking parts of the body away. For this reason it can quite literally be read as carving away the outer unwanted body to reveal the self within. The metaphorical representation of “a woman trapped in a man’s body” is, in other words, rendered quite literally here. In this OR scene, the ontological and phenomenological statuses of the body and self are radically uncertain.

8. The surgeon further isolated the incision site by draping sterile blue towels over the patient's hair and securing them in place with skin staples. Fully draped from head to toe, only the patient's face was showing. One stitch was placed in each of her eyelids—sutures are necessary to keep her eyes closed (and thus moist) because her face will be tugged and moved quite a lot throughout the procedure. All was ready to proceed. Dr. Howard announced the time of the first incision, the CN recorded it on the whiteboard on the wall, and the operation began.

Ethnographers of surgical practice have described the preoperative preparation of the patient's body as a process through which persons are rendered into objects (Goffman 1961, Hirschauer 1991, Katz 1981). The routine practices used to create and maintain a sterile field, the isolation and preparation of the surgical site, the induction of anesthesia and the handling of and interaction with the anesthetized body have all been examined as means by which a surgical patient's personhood is suspended during the course of the operation. Much of the patient's body becomes, in short, a table for holding instruments, sponges and hoses. "Anesthesia ensures this absence during surgery," writes Katharine Young. "As the patient draws away into depth disappearance, the surgeon is witness to a transformation: the body is drained of subjectivity" (1997:88). These analyses focus on the actions of surgeons and other medical professionals and argue that rendering a patient's body as a mute object may be necessary for the execution of surgery, but it is also a form of violence and violation. Objectification is, here, assumed to be an exceptional and undesirable state because persons and bodies are presumed to be irreducibly integrated outside the operating room. Objectification, we are told, may be necessary for the surgeon to accomplish his aims, but it is not a good thing in relation to the patient's status as a person.

9. This forehead procedure has earned Dr. Howard the reputation of being the most aggressive of the FFS surgeons in the United States. In addition to producing an instantly recognizable difference in appearance, this procedure is the most dramatic to watch. It requires the biggest incision and reveals a considerable area of the skull below—in contrast to the other procedures that are done through the nose or transorally. To reduce the frontal sinus that accounts for the "male brow," an incision is made beginning at each ear and meeting at the center of the head, just behind the hairline. The skin of the forehead—from hairline to orbits (eye sockets)—is folded down over the eyes, revealing the smooth and very white frontal bone below.

"When the body is unconscious," Katherine Young observes, "its sheer materiality becomes prominent" (1997:89). Young's account of this objectification assumes a normative phenomenology of the body, one in which the body and self are irreducibly integrated. But for trans- people who experience themselves as profoundly *misembodied*, the sense of disjuncture between the physical body and the sentient self preexists the anesthetic transformation. A distinctly trans- subjectivity is characterized by a disconnection and corporeal alienation—a feeling of not-likeness and non-coincidence with one's body (Prosser 1998). I read this not as *disembodiment*—feeling separate from and outside one's body—but rather as *misembodiment*—feeling firmly located in a body that is somehow misrepresentative. Young's (and others') assertion

that the materiality of the body becomes prominent when the patient is anesthetized, is one that may convey the perception of the body held by the doctors (and anthropologists) in the room, but not necessarily by the patient herself. Anesthetization, in other words, is not the only condition in which the body's material form is ascendant.

10. The long, thin wooden handle of a cotton swab is broken in half, dipped in methylene blue and used to mark the frontal bone on either side. The periosteum (a membrane that lines the outer surface of bones) is cut at these lines and scraped forward into the orbits at the top of the nose bridge. Glancing at the cephalograms illuminated on the wall-mounted light board, the doctor marks the frontal bone with a yellow wooden pencil.

In moments of pain, distress or directed concentration the body's "sheer materiality" becomes evident not to observers, but to the subject herself. This sort of unrelenting and aching bodily self-awareness—or what philosopher Drew Leder (1990) has called *dysappearance*—is one way of understanding transsexual experience. Leder describes the body as a thing that often disappears or recedes from consciousness. When one is healthy and well and engaged in familiar activities, Leder argues, one's body functions largely without one's awareness or active intent.⁴ This is, in Leder's terms, a "latent" or "absent" body; its actions enable everyday living but the body itself fades from our attentions. This body can be made to reappear with astounding and compelling force, however. Leder calls this sort of pathological or troubled reappearance a "dys-appearance." By adding the prefix, *dys-* Leder calls attention to the appearance of the body as a distressing event. When the body dys-appears it becomes the center of consciousness. This may result from a physical experience—an unnoticed and therefore absent toe becomes huge and all encompassing when it is painfully stubbed against a table leg—or a social one.

"Social dys-appearance" occurs when the body is perceived as the target for unwanted attention from other people. A catcall, an epithet, or a critical or objectifying gaze may cause the body to dys-appear as an abject thing, bringing the fact of its sex, race, size, or ability into painful relief. "Social dys-appearance" results in both a break in social interaction and produces in the recipient of that aggressive gaze (whether received from an other or produced by the subject herself) a kind of corporeal self-consciousness: one *feels* one's body in an unwelcome way (96). A dys-appeared body is "that which stands in the way, an obstinate force interfering with our projects" (84). In such a moment the "whole body is forcibly reoriented" (73) toward alleviating this conflict; the division between body and self that occurs in dys-appearance compels us to act in order to allow the body to recede into latency once again, to reestablish a state of "absent presence" (86).

11. The burr tool whirs like a dental drill as it grinds off the undesirable bony prominences above the orbits. Bone particles fly off the burr as it spins. They catch in the cloth and paper that covers the patient and in the folds of my scrubs as I lean in.

⁴ Take tying shoelaces as an example. When a child first learns to tie her shoes, she directs great attention and focus to the movements of her fingers. Once such a skill is acquired, Leder notes, its performance "comes without conscious effort, allowing... focus to be directed elsewhere" (1990:31). I can tie my shoes while carrying on a conversation, for example.

By the end of the procedure they will become dry chalky dust. An oscillating saw blade replaces the burr tool and a cut is made along the pencil drawn lines. The cut bone is pried up out of its place, making a dull cracking sound as it is dislodged from the skull. The Surgical Tech (ST) collects this irregular oblong piece (about two inches across at its widest point) and sets it in the white plastic lid of a sample cup for safekeeping. The frontal sinus is revealed. Everyone's frontal sinus (95% of us have one) is structured differently. Rosalind's is internally asymmetrical, divided by thin walls of bone into three distinct cavities. Frontal sinuses are usually empty, but sometimes brain matter has protruded into them. "Is that brain or sinus? Not sure. Let's go slow."

Social "*disappearance*" is one strategy for dealing with social dys-appearance (1990:97). In other words, blending into social life and thereby becoming unnoticed by others is a means to facilitate the body's absence, its recession to relieving latency. This, I argue, is precisely the state that patients hoped FFS could produce. They felt that their faces—and perhaps other things as well but especially their faces—caused them to painfully dys-appear in ways that impeded their everyday lives. Zoe explained to me that in spite of the many feminizing effects of hormones and the fact that she had DD sized breasts, her face continued to mark her as a male-to-female transsexual. "It is really difficult to be pegged as an MTF from 20 feet away," she said. She told me that her face frequently draws unwelcome attention, making even a trip to the pharmacy to buy cough syrup a humiliating and self-scrutinizing event.

A few days ago I was in Walgreen's and a guy turns around and says, 'You're hot. I saw you in Starbucks yesterday. My friend and I are wondering if you're a man.' I said, 'You're staring at my breasts, you tell me.' He said, 'I think you're hot but my friend thinks you're a dude.' Even though I know I shouldn't care about stupid shit like this, it really hurts me. I wanted FFS in order to avoid these kinds of situations.

Rhonda and I met for the first time a few days following her FFS with Dr. Howard. When I asked her how she thought that FFS would impact her life, she replied,

Not in a big way, but in a subtle way. I'll feel like I blend in a little more. I'll melt in more with the crowd. That's all I want. I'm not looking for no Marilyn Monroe thing. I know that's not going to happen. Realistically, I'm looking to blend in.

Darla also hoped to "blend in without it [her transsexualism] becoming known." Tracy said that she hoped FFS would result in "fewer stares." "I don't want to scare small children," she said and then began to laugh uncomfortably. When I began to laugh with her, she stopped me short. "Don't laugh," she said flatly. "I do."

12. Fortunately for all, there is no brain matter in the frontal sinus. The blood filling the otherwise empty sinus is suctioned away and its internal walls are removed. The burr is used to smooth the bone at the site of the cut, and to ensure the symmetry of the previously burred sites above the orbits. Howard looks away as he feels for symmetry with his fingertips and burrs, feels and burrs, until he is satisfied. The skin

of the forehead is pulled up to its original position, instantly turning the site from skull to face. The doctor looks at the face, feeling and rubbing roughly through the skin for ridges in the bone beneath. He tips the head from side to side to look at it from profile. Tip. Feel. Tip. Look. "Looks different."

13. The skin is pulled forward again and saline rinses bone particles away from its raw underside. The large piece of bone that was removed is refashioned into a pair of patches to cover the sinuses that its removal exposed. Each piece is held over its corresponding hole. Excess material around the edges is marked with a pencil. The excess is trimmed away with the burr. This process is repeated until the patch fits the hole exactly. *Exactly*. Howard jokingly reminded me that, "You have to patch the hole completely because all of the sinuses in your skull are connected. If the bone is not properly patched, each time you blow your nose you'd make a bubble [under the skin of the forehead]. Each time you sniff, you'd make a dimple. That's fun at the first cocktail party, but not the second."

Debra Gimlin (2006) has argued that a desire for the kind of "absent presence" that these and many other patients described to me is precisely what motivates people to seek surgical intervention. After exhausting other possible means of rendering their bodies less conspicuous, surgery emerges as a promising option.

Cosmetic surgery provides a tool for self-expression because it alleviates intrusive bodily self-awareness. That is, cosmetic surgery is sometimes used to make the body less problematically central to consciousness, thereby allowing individuals a greater degree of volition in focusing on the body or beyond it (700).

Gimlin argues that surgery focuses on the body as a site of self-making, "a body project" (Shilling 2003)⁵ whose goal is to allow the body to recede from consciousness. For Gimlin, this move also facilitates a (re)alignment of the previously misaligned body with the self.

Just as efforts to move the body out of problematic awareness do not eliminate the body's significance for identity, tacit embodiment does not imply a division between body and self. Rather, it is the dys-appeared body which is experienced as 'other'; thus, efforts to alleviate bodily dys-appearance can be seen as efforts to restore the body/self connection (2006:713).

Surgery, thus imagined, is capable of producing a change far greater than its material and corporal products. It is this promise that underwrites surgery not just as a project of body making, but of identity making.

14. A yellow pencil marks the location where corresponding holes will be drilled in the frontal bone and in the bone patch. Stainless steel non-magnetic wires are

⁵ Shilling disagrees with Leder's central thesis and sees their approaches as being contradictory (2003: 183-189). Gimlin's effort in this article is to reconcile these approaches through showing their value in interpreting the words of her informants in long-term research on cosmetic surgery.

placed and spun down tight. The ends of the wires are trimmed and turned inward. The bone work on the forehead is done. Rosalind's forehead has been set back 5 millimeters.

Surgical Vision Also Disaggregates Body from Self

Harry Collins has noted that while it is true that surgeons do, in fact, routinely depersonalize and objectify their patients, they do not require anesthesia or the other accoutrements of the operating room in order to do so (Collins 1994:317). Surgical sight is oriented to the body's structures; it is structures on which they operate—skin, bones, nerves and arteries—not persons. Page and Howard view the face—and other parts of the body on which they operate—with distinct attention for each of its structures. This mode of seeing is itself a surgical technique—perhaps its most vital (Foucault 1973, Hirschauer 1991). It is the stuff of the body—its fleshy excesses or deficiencies—that the surgeon reaches for, and it is the stuff of the body for which he is ultimately responsible. Though this technical action may be animated by his hope that the patient's post-operative form will allow the prominence of the material to recede into its rightful place—as the faithful vehicle for a subject recognizable *as herself* to herself and to others—that is an effect that will (hopefully) come later.

15. The periosteum is pulled up and sewn together. A small, hexagonal piece of scalp is excised in the center of the head at the main incision. This will pull the forehead and eyebrows up and has the "added benefit" of reducing "crow's feet." In order to advance the hairline to a feminine position, the scalp must be moved forward. "This," Howard explains, "is just like the Indians did it." Tugging on the scalp he uses a scalpel to cut the connective tissue that binds scalp to skull. They come apart with very little effort. With the forehead skin still pulled forward and the scalp pulled back a considerable amount of the skull is visible. The skin and hair look fake, like latex Halloween masks wrapped around the white bone. The scalp is pushed forward toward the face and secured in its new position by a suture pulled through a shallow hole drilled into the frontal bone. The recessed hairline has been remedied. For now.

The ability of the surgeon to see the face of a woman—even where the patient herself cannot—is extraordinarily powerful. The patient does not feel that her face represents her. And the surgeon does not think so either. For Facial Feminization surgeons, the face is not (at least not *only*) a fundamental site of personal identity. Faces are simply structures: bones, muscles, fat and cartilage through which surgeons make masculinity and femininity into palpable quantities. To hear one's face described in this way is disarming, at first. When Howard and Page looked at my face as they spoke to me, I felt as though I were being literally dismantled by their gaze. But then the same "tools" of sight by which my own face was taken apart became mine to wield in the world. I came to personally understand the ways in which surgical sight enabled surgeons to evacuate the identity that is typically taken to reside in an individual's face, and at the same time enabled patients (and me) to see their faces as objects that could be controlled so that a new identity could be made visible to all.

16. The dermis is sutured. Because the incision runs through the hair, the epidermis is closed with skin staples. This ensures that no hair will be lost at the site. The hair is combed through coarsely. A plastic garbage bag is placed under the patient's head to catch water as the blood and bone particles are rinsed from her hair. Her wet hair gives off the sweet, fruity scent of tropical conditioner. The CN finishes rinsing and then squats down to observe the patient from profile. "The forehead looks great. Good job. She looks really nice." Local anesthetic is injected into the patient's nose and upper lip. The surgeon leaves the room for a 30-minute lunch break.

Though the surgeon and the patient may theorize and experience the "wrongness" of a given body part in radically different ways, their shared understanding of the thingness of the body and its troubling parts allows for a uniquely shared recognition between them. This recognition is, I argue, an important aspect of the affective connection of trans- patients to their surgeons. Far from being her destiny, in the operating room, the transwoman's body is malleable potentiality. Here, surgical sight becomes surgical action. With the help of anesthesia, the patient's body cannot only be conceived as a material object, but treated as one. This shared perspective of the body as an object enables a crucial communication and shared vision between patient and surgeon, but the valence of its object-status is another question.

17. The rhinoplasty is the single longest procedure in a "full face" operation. To begin, the doctor packs the nose with cotton strips soaked in liquid cocaine the bright green color of mouthwash. The nose hairs are trimmed with small scissors. A sponge called a 'throat pack' is placed to keep blood from running down the throat. The nose is off the midline and has a fairly rare double septum. Interested in this feature, the anesthesiologist gets up from his chair to look at the cephalogram. He calls the patient "he". The ST corrects him under his breath, "she." There is no notice made of the correction.

Bringing Her In: Surgeons Do Personification

It is not easy to get into the operating room. In order to reach the OR at Crestview Hospital one has to pass through four closed doors. First, the door marked *Authorized Personnel Only* that separates the surgical unit from the rest of the hospital. Next, the *Restricted Access* door separating the bustling desk of the charge nurse from the long hallway of operating rooms. Once in the hallway, one must pass through the door to a scrub room, and finally through the door to operating room itself. The location of the operating rooms deep within the hospital is not incidental. Rather, it reflects attitudes about the contemporaneous rise of surgical and laboratory science as privileged and protected sites of knowledge production (Adams & Schlich 2006). Surgery is a specialized mode of controlling objects that is enabled, partly, through the control of physical spaces like the OR (Schlich 2007).

18. An incision is made across the nasal septum, and dissection of the nose begins. I remember that yesterday in our interview Rosalind spoke with fond nostalgia of the button nose she had before puberty set in and produced the nose that was currently being unmade. Once the front tip is dissected and pushed back (reminiscent of a pig

snout), instruments can be inserted under the skin all the way up to the nose bridge. I felt a pang of hope for her button nose.

The physical barriers to the OR parallel its safe keeping behind boundaries of hierarchy and propriety (Bosk 1976). The operating room is a decidedly ordered space. But so long as fundamental rules of spatial management are followed, it is, at the same time, very casual. While the action of surgery is what organizes this entire situation or “focused interaction” (Goffman 1961:7), the surgical acts underway do not always require the undivided attention of the participants. As Collins (1994) reminds, the OR may be a “special situation” for outsiders, but for surgeons and surgical staff, it is ordinary and even mundane.

While the operating room is, in many ways, an impersonal place, I also found that at times it could be an extraordinarily intimate one—for better or worse. This intimacy was not only a projected effect of my feeling for the patients. While I certainly hoped along with them for the production of a face that would meet their expectations, I was also privy to the effect that these surgeries had on the doctors and other staff who worked in the operating room. Stefan Hirschauer has noted the unique perspective of the observer in the operating room: “As an observer, I was neither under anaesthetic [*sic*] like the patients, nor like the surgeons, whose concentration on the area of the operation and dull daily routine seem to have put them under local anaesthetic [*sic*] towards many sensorial impressions in the operating theater” (Hirschauer 1991: 282).

The operating room is undoubtedly a place structured by routine. Methods, protocols, and procedures guide most everything that happens there. But despite the routinization and replication of costuming and other forms of depersonalization, the operating room is also animated by people who do more than merely occupy the roles of doctors, nurses and patients. The controversial and transformative nature of FFS makes its enactment a site in which the commitments and beliefs of individuals are sometimes made quite clear. Forms of relations and thoughts about what gender is and how it gets (re)made, create a dynamic interplay between the body on the table, the actors in the room and the technologies that mediate between them.

19. “Now that we’re done with the dissection, we need to decide what to do.” The removal of the frontal sinus necessitates reducing the nose bridge otherwise the patient “would be left looking like Dick Tracy” with a sharp, bony shelf at the top of the nose, just above the eyes. An osteotome (chisel instrument) is inserted beneath the dissected skin of the nose and slid upward in order to reach this place. The doctor holds the osteotome in place. Each time he says “mm-hmm,” the ST taps the end with a small hammer. The doctor moves the instrument to see if the bone they’d been tapping has dislodged. He bears down on the handle of a long rasp as he pushes and pulls it across the site of the bone break. The patient’s head nods, as if in agreement.

As a non-emergency procedure, FFS is scheduled according to the preferences of the surgeon and the availability of the surgical facility. Both Drs. Howard and Page worked regularly with a small number of nurses, scrub techs and anesthesiologists. During long procedures, these three or four people spend upwards of twelve hours together—from the pre-operative preparation of instruments and patients to the post-

operative clean up—in very close quarters. They know each other well—in a collegial, work relationship sort of way, at least. And while there are moments throughout the procedure when one or more of the parties require intense and silent concentration, these moments are few and far between. Instead, each person goes about his or her job in a professional but very practiced sort of way. And they talk. Howard’s OR was a very conversational place. In my first few surgical observations I heard the same jokes made over and over again. We listened to classical music from a local radio station via an online connection and the doctor and scrub tech guessed at the names and composers of the pieces. The anesthesiologist and circulating nurse used this computer to check their personal email in the middle of the operation, and I was sent to Wikipedia to settle disputes often arising from the discussion of classical music: When was the trumpet invented? All of this routine made my presence in the OR a welcome one. I was a new person with potentially interesting—but at very least, new—things to add to conversation.

In contrast to Young’s observations in which the anesthetized patient’s personhood was suspended—as marked by the OR staff no longer referring to the patient by name while they were unconscious (1997:88)—the patients in Dr. Howard’s OR were often the center of conversation.⁶ In these moments the line between surgical practice on a body-object was blurred with identity work on the patient as a person. More critically, I think, this talk bridged the gap between before and after surgery, keeping the formation of patient identity as a foregrounded and explicit event. While rebuilding Rosalind’s forehead, Howard mentioned that she was from a small town in Wales. His interest piqued, the anesthesiologist got up from his station and walked over to the computer to find information about this town on the internet. We spent the next 30 minutes talking about Rosalind’s hometown as the anesthesiologist rattled off historical facts about it and drew our attention to photographs of its low stone walls and rolling green hills. We speculated about life there and watched Howard suture as he told a story about traveling through Wales once in his early 20s.

As he worked, Howard told stories about patients’ lives that he had learned during pre-op conversations. He talked about them in a very general sense—where they were from, what they did for a living—but also in more particular and personal ways. Patients often shared incredibly personal stories during clinical interactions because they felt these stories were relevant information for the care they were receiving. Because *transsexualism* and *Gender Identity Disorder* are conditions evinced through narratives, patients’ stories of gender non-conformity constitute evidence for diagnosis in mental health settings, and come to constitute “symptoms” of the problem that FFS is meant to treat. Their personal stories were, in some senses, explanations for what had led them to seek FFS and how they expected it would change their lives. Howard’s examination of their bones, cartilage and soft tissue made sense to them within the context of these “illness narratives” (Frank 2000, Kleinman 1989).

20. The doctor feels through the skin between the eyes for smoothness of the bone beneath. Bruises are already beginning to form there. Bone rongeurs (cross between scissors and pliers) are used to remove the broken bone and cartilage. Excised pieces

⁶ This patient talk can be explained in part as the surgeons’ self-celebratory discourse that I described in chapter three.

of cartilage are set aside because they may be needed to restructure the tip of the nose. I am alarmed by the amount of material that is removed. The inside of the nose is stabilized by two plastic pieces, the size and shape of large kidney beans. They will remain sutured in place until the nose is “unpacked” five days later.

During quiet times—and no doubt due in large measure to the novelty of my presence as an anthropologist—OR staff spoke not only about the patient, but about their understanding of what the operation was about. The medical staff in Dr. Howard’s OR shared his understanding of FFS as a physical means of enabling transwomen to realize their desire to be recognizable as women. As Rosalind lay on the table, Jeff, Dr. Howard’s Scrub Tech began to talk about the transformation that was taking place. “She’s really lucky to live in a time when we can do something about this,” he said. “I think that my grandmother would have been trans, if she could have been. Of course she never said that, but looking back I think it’s true.” I watched his face as he spoke through the blue mask covering his mouth, his hands fastidiously reorganizing instruments on his table. “It is amazing what we can do now. She [referring to Rosalind whose mouth was held open while Dr. Howard placed an incision between her cheek and gum to begin the internal aspects of the rhinoplasty] can look like the woman she wants to be.” “I think the next big thing will be genital transplants,” Howard offered. “I think there is a documentary about attempts to do that in China.” The anesthesiologist chimed in that there were still far too many problems with immuno-suppressants, but that nevertheless it seemed to him that there was a growing recognition of transgenderism as a natural phenomenon. He had read an article in *New York* magazine about gender transgressive behavior in albatross.

While each of these professionals diligently worked in their roles to manage the anesthetized body on the table, they also spoke of Rosalind, the woman on the table. They attempted to understand and make sense of her life project, a central part of which they understood themselves to be enacting. The OR was a space for them to think about the patient and also about themselves as taking part in a shifting understanding of the gendered body and of the technologies for its achievement.

The OR is not always this kind of space.

21. The doctor opens the patient’s mouth and tilts her head back. He makes an incision where the top lip meets the gum line, on either side of the center of her mouth. A long osteotome is inserted through the mouth incision and slid up under the skin to access the bone and cartilage that must be broken and removed in order to reduce the width of the nose bridge. “Mm-hmm.” Tap-TAP. “Mm-hmm.” Tap-TAP. Until all of the desired material is broken and removed.

The Refusal to Recognize

Dr. Page’s medical staff worked with trans- patients far less frequently. A relative newcomer to the practice of FFS, Page was not as reflective about the specificity of FFS: his trans- patients, like all his patients, wanted to look better (variously construed) upon leaving the OR than they did when they entered it. Based on my observation, he had not required that his operating room personnel adopt discourse or

procedures that demonstrated even a basic understanding of who his patients were or what they hoped this operation would achieve.

On the morning of Reena's surgery, I met her and her wife Grace in the waiting room of the small ambulatory surgical center adjacent to Page's office. It was not a planned meeting, but the waiting room is a small space, and we were the only ones there at 7am. As Reena filled the ten minutes we shared in the waiting room with nervous explanations of how she had chosen Dr. Page and what she expected from the surgery, Grace sat quietly with a timid smile, glancing from my face to her folded hands and back again. "I decided to go with Dr. Page because he just moves shades," she said. "I just want to move in that direction, to pass most of the time. Maybe I won't be able to pass if people are really looking. But I've learned that the ones who aren't really paying attention are the ones you need to worry about anyway." I didn't ask many questions as I sat there. I just listened. It was clear that Reena was anxious and wanted to talk about what was about to happen to her.

As we talked, Dr. Page walked in through the front door of the center wearing a red Adidas tracksuit. He paused briefly to shake my hand and walked directly into his office to change into his scrubs. Moments later, Jessica, the Circulating Nurse, came to the waiting room to get Reena prepared for surgery. Grace grabbed her by the arm and got a quick kiss before Reena followed the nurse behind the receptionist's desk and into the prep room. "Reena has a background in theater," Grace explained to me. "She studies people, and sees their differences in ways that I don't. But since we've been thinking about this, I've started to notice faces a lot more. The brow and jaw are the male markers, you know. You really start to notice that if you look for it."

Jessica came back to the waiting room carrying Reena's black backpack. "You might need to hold on to his backpack," she said, handing it to Grace. "He tried to put it in one of the lockers, but it is too big to fit." Grace accepted the bag and set it in the chair next to her. She looked at me apologetically. "Pronouns are really hard," she said and looked down at her hands again. This was one of the many moments during my fieldwork when I wanted to out myself as a transman as a gesture of understanding, or at least of fellow feeling. But this time I decided only to hurriedly assure her that she did not have to explain anything to me. I wanted her to be sure that I was not sitting in judgment of her or her partner, or of the choices that they were making.

It was clear that Grace did not know how to respond to the nurse using male pronouns to refer to Reena. Of course Grace understood what the nurse meant when she said that *his* backpack would not fit and that she would need to hold it until *he* was out of surgery. It did not seem to me as though Grace was a person who would have made a scene in response to an offense such as the incorrect assignment of pronouns, but even if she were, this small waiting room where she would pass the next six hours while her partner underwent surgery would have been neither the time nor the place. Already feeling incredibly vulnerable, there she sat in the waiting room, apologizing to me because the nurse called Reena *he*.

Once we were in the operating room, Jessica interacted with the anesthesiologist Dr. Hahn, all the while referring to Reena as "he" and "him." Though Hahn emphatically corrected her at one point, repeating back what Jessica had just said but with feminine pronouns—"I gave HER... SHE needs...."—Jessica continued to have a problem both using and understanding *why she might* use feminine pronouns to refer to

Reena. Feeling frustrated, Jessica turned to the patient and asked directly, “Do you want to be called he or she? Did you mind when I called you he?” To which Reena responded, “I like to be called Reena. If all else fails, revert to Steven. I was Steven for a lot of years. But I like to be called Reena.” This answer seemed to satisfy both Dr. Hahn and Jessica. Each had her actions validated and her responsibility to the patient was somehow met. At this, Dr. Hahn quickly changed the subject and asked Reena to discuss what she does for a living. In midsentence, Reena trailed away and succumbed to the anesthesia.

Later Jessica explained the pronoun confusion to another nurse. “I was saying ‘he’ and they were saying ‘she’ and I didn’t know which was right, so I just started writing ‘it’ in the chart.” There was no audible response from the other nurse; it was just a piece of information shared between coworkers. I admit that I was shocked. My eyes darted around to look at the other people working in the OR—Dr. Hahn, the Scrub Tech and Dr. Page—and, if they heard this comment, they did not respond to it. When the time came to rouse Reena, Dr. Hahn leaned in close and said, “Reena? Reena? Steven? Steven? You can wake up now, Steven?”

It was difficult to watch Reena come to consciousness while being addressed by a name that she had worked hard to leave behind. It had been offered as a token to the nurse who could not (or perhaps, would not) see her as a woman prior to her surgery, and then was used to deny her the transformation that surgery had promised, precisely at the moment that that promise could have been realized. This refusal to recognize Reena’s transformation marked her FFS as a failure already: her face’s first audience did not view it as a woman’s.

Routine as it may be, FFS is always a deeply transformative procedure that enables conversations and reflections on what that transformation is about, what it does, and what it cannot do. In these moments, the OR can be both a forum for the reinscription of essentialist narratives of embodiment and a site for radical challenges to them, a space for transformations of many kinds. I share these scenes from the operating room to make clear that though anesthesia occasioned the treatment of patient bodies as objects, they were still objects haunted by subjects. Absence is a category whose sense is derived from its opposite: presence. To speak of absence already imputes an expectation of proper placement, an assumption that something *should* be there.

22. The skin is pulled down over the nose to assess its appearance. Seeing that more cartilage support is needed to avoid a step down appearance from the bridge of the nose, the doctor uses a scalpel to sort through the pile of excised cartilage and finds a piece that will do. He cuts it into the proper shape and thickness. It is provisionally placed in the nose. He presses and pinches to achieve the shape he desires. With a hand under the patient’s chin, he turns her face from side to side. “I think I got it.” The blunt end of the scalpel is placed between the patient’s two front teeth in order to establish the midline of her face and assure that the new nose is centered properly.

FFS is itself an attempt to make present, to make manifest. But it does not *guarantee* that coincident presence it promises will be recognized. Just as surely as Rosalind’s efforts to be recognized as female were explicitly advanced by the people in the operating room who literally had a hand in her transformation, Reena’s efforts were

denied. It is critical to think about not only what is being accomplished in an ontological or metaphysical sense through these surgical interventions, but *how* it is being accomplished as well.

Patients recede from consciousness in the operating room in order to be relieved of the excesses of their masculine bones. This is a relief that works across registers of material and feeling. They had to go away in order to come back more firmly into themselves and, ultimately, into a body that itself recedes from awareness.

23. The sponges are counted and the sutures are placed. The surgeon stands and the table is raised. He wipes the blood from the patient's face with wet laps (gauze pads) The nose is packed with wet gauze. The CN calls recovery to notify them that the patient will arrive soon. Howard applies a pine resin adhesive to the skin and then a layer of tape. He bends the pink hard casting material over the barrel of a syringe to achieve the proper shape. Ointment and tape cover the scalp incision and a layer of gauze covers them. A dry gauze wrap is wound around the entire head. The doctor shakes his head when he sees the pockmarks on the patient's cheeks and chin. "No one tells them that facial electrolysis will leave pockmarks. No way to get rid of those." The sutures are removed from the eyelids as the patient begins to stir. She is coming out of anesthesia.

For me, what was most critical to see in the operating room was the way in which foregrounding the body's materiality through surgical discourse, patient and surgeon were able to articulate a common project around identity production. As Jay Prosser argues, "Transition may be the very route to identity and bodily integrity. In transsexual accounts transition does not shift the subject away from the embodiment of sexual difference but more fully into it" (1998: 6).

When the body in question is the one laying anesthetized upon the table, ego projections and phenomenological notions of the body are no longer available. And when the patient has herself removed her self from the room, there is little left of the body than its *thingness*. The problem of subjective inhabitation of this body may be what has brought the OR scene into being, but in the operation event, that problem is radically refigured. It is no longer a question of how the patient experiences or comes to understand her body; instead this work is taken up by the cast of players in the operating room. They tell stories about her even as they are bringing her face to the surface. Such an accomplishment is both subjective and surgical.

I am not suggesting that trans- subjectivity is reducible to the trans- person's relation to medicine. This is the problematic position acrimoniously taken up initially by Raymond (1979) and rehashed by Hausman (1992, 1995) as part of the 1990s wave of writings that centered on the transsexual body. These text and others (Daly 1978, Millot 1990) argued that transsexuals were the creation of ethically unchecked physicians whose "production" of transsexual bodies participated in the misogynist devaluing of women's bodies (they focus almost exclusively on male-to-females). It is crucial to see that the scene of the operation is not the result of a patient who has surrendered her agency; instead it must be seen as a willful submission of it. This giving over is not passive, but is itself an agentive act (Mahmood 2005). Rosalind had flown halfway around the world to have this surgery. She had weighed the risks of losing her job and alienating her family that this surgery entailed. She *wanted* to be there. She did not

surrender to Howard, she left herself with him in order to come back into a body that was less and a body that was more.

24. The anesthesiologist leans over and speaks loudly in Rosalind's ear: You did a great job. Surgery is over. Just relax. Let us move you.

Chapter Seven

And After

The discursive condition of social recognition *precedes* and *conditions* the formation of the subject: recognition is not conferred on a subject, but forms the subject.

—Judith Butler¹

When a patient first encounters her new face after surgery, it is covered with bandages and dressings. Much of the skin that is visible is taut, swollen and discolored. Her nose may be packed and casted. There may be drains pulling blood from around her newly contoured jaw. She must suction saliva from her mouth because the throat pack placed during surgery will make it uncomfortable to swallow. For the first several days following surgery she may need to manually stretch the muscles of her jaw to keep them from clamping tight in a gesture of defense.

Even if the procedure is considered medically successful—in that the surgeon was able to meet the goals that he set for himself and there were no compromising complications—there is no way to know how well the surgery went, or whether the desired effect will actually be produced. That effect is, after all, not a property of the face itself. It is, rather, a response that the face will (hopefully) elicit. Such a measure of success cannot be clinically assessed, nor can it be known right away. Depending upon the particular procedures performed, it may take up to a year for all of the swelling to subside and for the face to “settle down,” as surgeons say. Though new structures of bone and soft tissue were created in the event of the operation, the face itself is never a fixed and stable thing; it is always a thing unfolding in time.

After all of the waiting she has already done—waiting for self-acceptance, for surgery savings funds to grow, waiting for consultations, for travel arrangements—now the patient must wait to heal and find out whether the face she wanted is the face she’s got. Surgery is the quintessential anticipatory regime (Adams, et. al., 2009). It is forward looking, oriented to a future post-surgical life that will be somehow better than the life that would have happened without it. Surgery is about intervention: the imagined and undesirable future can be changed through the event of the operation. Once that event has occurred, there is nothing to do but wait. And hope.

¹ Butler 2003:225-6.

I first met Rachel five days after her surgery. She had had her forehead, hairline, nose, thyroid cartilage, and jaw done. In addition, her upper lip had been shortened and enhanced. When I was introduced to her by Heleen, a Dutch attorney who was back in town to see Dr. Howard for some jaw revision work, I had to stifle a sympathetic wince. Rachel's eyes were ringed in deep browns and purples, and the sutures beneath her nose drew contrastive attention to the thin red incision line where the length of her upper lip had been reduced. Though the packing had been removed from her nostrils earlier that day, the cast on her nose remained and was held in place by a large X of tape rising up above her eyebrows and down across her cheeks. Her thinning hair and receding temporal baldness left sutures and staples visible across the crown of her head. I felt sore for her, like neither of us should move too quickly. She, on the other hand, said she was feeling better than she had in days and was light on her feet as she led me to the back garden where we could talk.

As Rachel spoke—with the marked accent and dry humor of a life-long New Yorker—she dabbed saliva from the corners of her swollen mouth with a white cotton handkerchief. We talked for more than two hours in the garden behind Howard's private convalescent facility, with only one break: the unseasonably strong sun was heating the staples in her scalp and demanded that we move into the shade of a leafy tree.

Rachel, now in her mid-fifties, had first decided that she wanted FFS fifteen years earlier, as soon as she saw before and after photographs posted online.

From the moment I knew it existed, I thought, 'Wow.' I knew that I didn't have a pretty face. I'd get dressed up but I knew I didn't look like a woman. I could put all the makeup in the world on and nobody was going to mistake me for a girl. Maybe when I was like 16. Essentially, I would say that from the moment I knew people were doing it, I immediately started thinking to myself, 'Wow, I could do that, too.'

When I asked her what it was about her face that she had wanted to change, she had trouble locating the problem that she hoped surgery could fix—though she could quickly recount the list of the procedures that had just been performed. "If I was sitting here with a friend and just talking," she said, "I would say, 'Beauty is like pornography, you know it when you see it.' And it's the same thing with a feminine face: you know it when you see it." Though she noted that her, "rather large nose," was "a male trait in [her] family," the nose by itself was not the problem. Neither, necessarily, was it her "fairly prominent forehead." It was something greater than these, and something more diffuse.

I was a handsome man, but I didn't want to be handsome. I wanted to be pretty. I guess, in a certain sense, I wanted to have all the things that I enjoyed in women that I liked. The way they looked. The way their lips looked. What their hair looked like. How all the features went together. I think it's kind of a simple answer: I wanted to be a pretty girl. One of the great things that Dr. Howard did was define this whole notion of feminizing in entirety, as opposed to just doing one thing. One thing in and of itself is not going to do it. It's got to be a holistic approach.

On account of this "holistic" transformation, Rachel did not really have an idea of what she would look like once her face had finished healing. More than any particular ending

point, what she most wanted her face to be was something other than what it had been for her entire adult life: masculine. The particular form that that femininity would take was not something that concerned her.

[When considering having FFS] I would say to [my friend], ‘Do I really want to do this? Because what if I don’t really look good?’ She would say to me, ‘Well, you know what you look like now. Would you rather go through the rest of your life looking like you look now, or looking like somebody else? Maybe you’re not drop-dead beautiful or even pretty, but you’re not going to look like a man.’ And the answer to that is the latter. I knew how deeply dissatisfied I was. To the point of it being painful what I looked like, and having to look at myself in the mirror everyday. That got worse as I got further into my transition. That just got worse and worse. The disconnect between what I felt and how I looked just became more and more pronounced to the point where I just didn’t want to look in the mirror. I just hated it.... [Someone] asked me, ‘Are you going to look very different?’ And I said, ‘I sure hope so.’ That’s the whole point. It wouldn’t bother me if nobody recognized me. That wouldn’t bother me at all. If I look good. If somebody said, ‘You look fantastic, but I can’t quite place you,’ that would be wonderful.

Her new face—still tender, bruised and cut—held, under its bandages, the possibility of a radically new identity in which she was not recognizable to anyone she knew. While to me such a prospect seemed as if it might be quite frightening, for Rachel, the potential of this total change was “wonderful.”

As Rachel sat healing, she recounted the promise that the facial change would be a total one through a personalized version of Howard’s early morning doorbell scene.

My goal, my ideal is that I could go out on the street dressed like I’m dressed right now—just a pair of pants and a t-shirt and some sneakers—and no gender markings other than I’d be wearing earrings, which I always wear, and that when I went into a grocery store the person would say, ‘Can I help you miss?’ That’s really what I want. I want to read as, accepted as, and reacted to as a woman. So that is what I was hoping he would say he can do, and that’s what he does say he can do. That *is* what he promises.

Becoming “accepted as and reacted to as a woman” would be the actualization of a truth about herself that Rachel traced back to her earliest childhood memories of dressing in her mothers lingerie and heels. Her knowledge of her gender as being somehow “not right” had persisted throughout her life. “I’ve essentially been feeling ashamed of myself probably since I was five years old—or probably more like four,” she said. “Living daily with a sense of shame about who I was. And not only living with it but hiding it, because I was also hiding the source of my shame.” Rachel had undergone years of therapy with various psychologists and psychiatrists.

I had met someone very early on in the therapeutic process that I interviewed with and he said to me, ‘Look, this is the way you are. You’re not going to change. This isn’t going to go away.’ And I just refused to accept that. I was 20 years old. And out of everybody I saw in all the intervening years, what he said was the truth. It took me 30 more years to accept that.

Rachel's feelings about herself as a transwoman changed somewhat unexpectedly. Her mother had become ill with cancer and as the child who lived closest, Rachel undertook what became a very intimate caretaking role during her mother's treatment. Despite longstanding conflicts in their relationship—many of which were rooted in Rachel's gender issues—the two grew incredibly close through this ordeal.

We were spending a lot of time just together by ourselves. And I just sort of let go of any resentment or anger I had towards her, and I really just wanted to make her get well. Having a positive influence on her life kind of opened something in me that I had closed off. When the whole thing was over, I thought to myself, if I can give her this [beginning to cry softly], then why can't I give this to myself? So, I did.

Tears welled up and streamed down her bruised cheeks as she recalled the epiphany that had not only enabled her to relate differently to herself as a transwoman but had also revived a loving relationship with her mother.

What started to happen for the first time in my life, is that I started letting go of shame. I thought: I got my mother through this, how bad a person could I be? So I did start to just let go of feeling ashamed of myself, and feeling all this guilt. And that was a really new experience.

Her mother's cancer in remission and her divorce from her wife finalized, Rachel began hormone treatments, the beginning of her physical transition from male to female.

I had my first shot and it felt fantastic. I felt like Marilyn Monroe. I remember getting on the train going back downtown and I had to remind myself, 'You still look like a man to everybody.' That's how powerful it was. I recognize that it was psychological, but it was also physical, too.

Though she felt it was likely that she would eventually undergo genital sex reassignment surgery, FFS was her first surgical priority. "The most important thing I could do was change my face," she explained. It was a change that would free her in ways that, on that sunny afternoon, she could only imagine.

For many patients, a new face promised not only a new life but also a radically new—and uncertain—identity. So long as they would no longer be recognized as men, the particular form of their faces did not really matter to them. For example, Patricia looked forward to the *feeling* of her new face more than its look.

I do think it is going to be profound to just get up every morning and look in the mirror and go, 'Oh my god, here's somebody who I've always known was there but I never saw.' You know? Feeling is one thing, but seeing is another. That's kind of the aspect I'm looking for, *without any idea of what she'll look like*. Whatever, it'll be an improvement.

Some patients hoped that the effects of their surgery would be subtle, simply accentuating the features that they already liked about themselves, while others had a

very particular idea of what they thought they would look like following surgery. This was informed by their understanding of what surgical modification could accomplish, as well as their own interpretation of how—and like whom—they looked prior to the operation. Katherine (whose operation was recounted in Chapter Six) both wanted and expected to retain her individuality. “I want to be a feminine version of myself,” she said. “Some people just aren’t realistic. If you’ve got a head like a medicine ball and you want to look like Angelina Jolie, you’re going to have a rough time of it. Rather than emulate someone else, I’d rather be an individual.” Similarly, Brenda—who had consulted with both Howard and Page and ultimately decided to undergo surgery with Page—said, “I guess I want to look like me but more feminine.”

Though word-of-mouth, personal experiences and plenty of online research, patients felt confident that their wildest dreams could come true. They had seen the photographs of scores of former FFS patients whose images and narratives of transformation attested to the possibility of total surgical transformation. It is the actualization of this idealized possibility that has earned Howard a sort of cult following, and a legion of fans and defenders.²

Jill’s Story

Howard had performed Jill’s “full face” FFS nearly ten years before, and she had been an outspoken admirer and supporter of his ever since. “I’ve been a Jim girl for a long time,” she explained with a smile.

When I first met Jill, she reached into her pocket and pulled out her cell phone to show me a picture of what she looked like before surgery. I admit that the difference between the photograph and the face before me was astounding. She clearly took great pride in this fact.

I don’t reject what Joe was. I don’t apologize for what Joe was. I don’t apologize for what Jill has become. I am comfortable with the unique mutt that I am, which is a combination of what Joe was and what Jill is. I like to think it’s the best of both worlds as opposed to the forces of having to be one or the other.

The photograph—and her narration of it—was not only an affirmation of her own reconciliation with her past, but a testament to what FFS could do.

When Jill first learned about FFS in the late 1990’s, she had already come to peace with the idea that she would never transition. She had a reasonably successful life as a husband and father, and felt completely isolated in her knowledge of herself as a woman. If she could not be recognized as a woman, then she would have to learn to accept her life as it was. At that time, before the expansion of the internet, she explained,

There was no validation. There was no hope that we could blend into society and just live our lives. The choices were twofold. One, you accept the fact that you live in some margin—if that was okay. Or you accept the fact that you live something less than a fulfilling life. I was married. I had a son. I had a good

² Dr. Page is slowly growing his reputation and, while he is not nearly so well or widely known, I met former patients of his who spoke of him in very high regard.

career. I had money. I had all of the trappings that society told me that I was being successful, except that I had this secret.

Jill described first learning that FFS was possible, as a moment that was “very empowering but it was also terrifying. When you become comfortable with the impossible, realizing that the impossible is possible gets scary.”

Jill’s initial surgery lasted nearly 13 hours and the recovery, she said, “was hell.” Much like the radical transformation that Rachel envisioned, Jill’s surgery had changed not only her face, but her most basic understandings of herself and her world. Though she had not been politically engaged in her life as a man, since her transition—which began with FFS—Jill found herself confronted with social inequalities that she had never been aware of before.

As a man, I had never experienced discrimination. Really. Not that I knew of. You take it for granted: you’re white, you’re heterosexual—or perceived to be heterosexual—you’re granted a level of privilege that you don’t know that you have that just comes with your birthright. You’re living in a world that’s oblivious to many of the unfortunate realities that others have to face. To have that stripped from you and see that people can be fired over this, people can lose their housing, to see that people in your community are not welcome in women’s shelters but have too much self-respect to go to men’s shelters and so they freeze to death on a park bench because they can’t get a job and they’re homeless. To recognize that in school people get the crap beat out of them because they’re different. Those things are contrary to everything my parents raised me to believe. So I found that I was given opportunities of making choices.

Newly empowered by her changing body and newly outraged by an understanding of life that she had not been aware of before, Jill became a prominent figure in trans-political organizing circles, delivering keynote addresses at national conferences and writing a widely circulated book about her experience of coming to terms with her identity and going through the process of transitioning from male to female. She attributed this radical shift in her life to FFS. “My own involvement never meant to be as significant as it became,” she explained.

Coming here and meeting Sydney and going through this process was the single most profound experience of my entire life. It remains so. And I’ll tell anybody who asks.... The fact of the matter is that coming here, finally looking in the mirror and seeing somebody who more closely reflected on the outside who I knew was on the inside and watching that person develop—because the person that I was six months after I left here was very different than the person who left here. I never would have transitioned without coming to see him. Coming here was day one. It was a physical change, it was a mental change, it was psychological change. It was the impossible becoming possible.

Jill was, quite literally, the poster girl for FFS and for Dr. Howard. Her before-and-after photographs are featured in multiple places throughout Howard’s recently published book on FFS and are staples in his conference presentation slideshows. Not only does Jill epitomize the feminine—both visibly female and normatively beautiful—she also

exemplifies the total life changing potential of Facial Feminization Surgery. Hers is a narrative of redemption that emphasizes her own efforts for self-acceptance as materialized by Howard, the person with the unique skills and vision to see in her—and make her into—the woman she knew herself to be.

Despite both her own and Howard’s characterization of her surgery as an unqualified success, Jill’s time on the operating table was not done. She was in for some revision surgery on her jaw. In some patients, the blood that pools around the bone following jaw contouring surgery can later be reabsorbed and turn into bone. When this happens, patients often return for revision in order to recreate the narrowed jaw that the initial surgery produced. This increasingly square jaw is what brought Jill back to the office. No face—no matter how fantastic—lasts forever.

Zoe’s Story

Not every patient has a surgical result and a story of triumph like Jill’s. Zoe had decided that she wanted FFS early in her transition.

In terms of barriers to entry, the face is really important. One’s ability to be read as female really comes into play when deciding whether to transition. It’s really difficult to be pegged as an MTF from 20 feet away. It was clear to me right away when I started cross dressing that I would not pass as female without some work done on my face.

Zoe had had a Full Face FFS with Dr. Howard nearly a year prior to our interview. She had returned to the office to consult with him about a repair to her nose (the structure of one nostril had collapsed, making it look pinched instead of round and open) and the possibility of re-raising her upper lip. (It was raised 3.5 millimeters in the initial surgery but, like the squareness of Jill’s jaw, the length of the upper lip can return over time). These would have to wait, in any case, because paying for FFS and GSRS in the same year had left her on the verge of bankruptcy.

Zoe had initially been pleased with the results of her FFS. “Right after my surgery I passed really well,” she said, “but lately I’ve had some really upsetting experiences.” Though her FFS had certainly helped her to be read as a woman in casual exchanges, she found that the more time she spent with people, the greater the chance that their perception of her sex would change.³ This was particularly problematic because her work as an overseas flight attendant occasioned extended periods of time and (confined) interaction with new people.

I feel that working as a flight attendant is really empowering. I order people to sit down and fasten their seat belts, and they have to listen to me. There is a lot of power in this. On the other hand, sometimes the passengers torture me.

Their comments and digs wore on her. “I do get read now,” she explained, “but it happens gradually. Like, if I’m in a flight it won’t happen for ten or fifteen minutes.” After that time, passengers had ways of letting her know that they were reading her as a

³ Zoe’s experience is contrary to the assertion of Kessler and McKenna that once a gender attribution is made is it extremely difficult to change (1978).

transwoman. “They’ll call me ‘ma’am’ when they get on the plane, but ‘sir’ when they get off,” she said. “Or someone will start to whistle ‘For He’s a Jolly Good Fellow’ and I turn around and they stop. I can’t tell who’s doing it. In these situations you really feel the hostility of straight people.” Her face and neck grew red as she recounted these cutting and infantile exchanges.

Though Zoe had no way to know whether those who tormented her were straight or queer, she felt singled out by “straight people” whose anxieties about her as a transwoman she found particularly overt. During our conversation, she followed her stories about being harassed by airplane passengers by the story of an experience she had with a straight man with whom she’d had a casual sexual encounter.

There was this guy who drove a shuttle van that I always used to take at work and he was always coming on to me. He told me how great I looked and always asked me out. I thought that he knew I was trans- because everyone at work knew. So one day I finally took him up on his offer. We went out and then ended up having sex, and it was great. He spent a full fifteen minutes with his face in my vagina and really enjoyed himself. Afterward we were lying together cuddling and talking and I mentioned something about the transition. He said, “What transition?” And I said, “The gender transition.” And I could feel his whole body stiffening up. He got really angry. It didn’t turn violent but it felt very violent the way he reacted. I don’t know if he thought that I had tricked him or that somehow his masculinity was at risk, but it was really scary.

For Zoe, these two stories went together as examples of how other people—particularly straight people—saw and responded to her as a transwoman. Though it is clear that the man with whom she’d had sex did not recognize her body as a trans- body, the fact of her trans- status was one to which he’d had an immediate and negative reaction.

Zoe hoped that jaw revision surgery might end these kinds of problems. “I know this surgery doesn’t come with a guarantee that no one will call you a man again, but I feel like that was happening for six months. But for the past six months it isn’t anymore.”

A few weeks prior to our interview, armed guards pulled Zoe out of the security checkpoint line in the Dubai airport. The officers took her into a small room and asked her point blank if she was a man. “I said no,” she explained. “He asked to see my passport, which says *Female*, and he still didn’t believe me. I thought, ‘Oh, fuck. What do I do now?’” Suspecting that she was in fact male, the guard informed her that there is a penalty for lying about your gender in the United Arab Emirates. “Eventually I told him that he could see my vagina if he didn’t believe me. Thank god I had one. That must have pushed him over the line because he just let me go.” Zoe wiped tears from her eyes. “It was terrifying.”

Despite the fact that she is still sometimes read as male, Zoe credits FFS with having saved her life. As long as her social interactions are brief and “casual” she is read as a woman. And this is a very welcome, if fleeting, reprieve.

I felt that FFS was a necessary part of my transition because I had to avoid looking like a cross-dressed male. Therapists have said to me that there is nothing to do but be yourself. But for transpeople I think that is really disingenuous. Surgery enables me to physically and psychically be myself.

Trans- kids aren't allowed to be themselves. I'm the only 45-year-old woman I know who jumps out of bed in the morning to look at my naked body and feel like cheering. That wouldn't be possible without surgery.

[FFS] saved me from suicide. It gave me the ability to have a life, to function. I used to spend hours on my hair and make-up but I always looked like a cross-dressed male. In six months post-op, I wasn't a circus act or the center of attention anymore. But casually my life is better. I just can't deal with the shit every day.

Zoe was undoubtedly disappointed. She, too, hoped to actualize her fantasy of passing unquestionably in all situations, and she offered the story of the airport exchange as proof positive that the promise of her FFS had not been met. Despite extensive facial reconstruction at the cost of many thousands of dollars, she was still being read as a transwoman and experiencing the very real consequences that often come with it.

Zoe is not the first patient who has reported to Howard that she is still being read after surgery. Based on my own experience talking with his former patients and an albeit very limited review of his practice by patients telling their stories online, Zoe is in a small minority. Most patients are pleased by and satisfied with the results of their procedures. Howard has a distinct interpretation of post-surgical reading in general, and Zoe's experience, in particular. Because for him the certainty of the *female* face is total, the suggestion that a person could be read as male following a Full Face FFS operation simply makes no sense. How could anyone see a male face in one that has been made metrically female? The problem must not be in the face itself. Instead, he responds to stories such as Zoe's by locating the problem either in the patient's perception of people's responses to her, or in her failure to adequately support the sex of her face through the marshalling of other appropriately gendered objects and behaviors.

In general, Howard believes that when patients report that they are still being read as transwomen after a Full Face FFS, they are simply misinterpreting the looks of others.⁴

I think what happens with a lot of people is that for so many years people look at you. You're dressed as a female, you haven't had any surgery and you become rather paranoid. Maybe there's a better word. But people look at you and say, 'There's obviously a transsexual.' But then when you become looking good as a female [post-FFS] people will look at you and you have a tendency to read the same thing. You say, "They're reading me." They're not. They're admiring you. They're looking at you like an attractive woman.

⁴ If a patient opted not to have the Full Face surgery, he is more likely to believe that they are being read as male because their face has not been completely transformed. As he explained in a conference presentation, "Less is not more. We've had over the years not more than 4 or 5 patients probably, who came in and said, 'You were going to set my forehead back 8mm, just go 4.' Or 'You want my chin to go up 6, just do 3.' 'You're going to move it forward 8, just go 4.' Fine. I'll do that for you, but you're not going to be happy. They say, 'Oh it'll be perfect because I just want a little female.' Every one of them has come back and said, 'go ahead, fix it' because they still look masculine. You've got to go there. It's crazy, but you've got to do all these things."

While it may very well be the case that we are never quite sure why another person may be looking at us, in this telling the only person who *does* know why a transwoman is the object of another's gaze is the surgeon.

Like all patients, when Zoe first came to consult about the possibility of FFS, her experiences of being “read” as trans- were substantiated by the surgeon's identification of her masculine features. In this process, her experiences of her body's masculinity were externalized, reified, and verified by the rational language of medicine. Before surgery, it was acknowledged that she knew why people were looking at her. The surgeon's assessment of her face ratified her claims. After surgery, however, the knowledge produced by her “experience” of being read does not have the same value. Even after hearing that Zoe had been pulled out of line and interrogated by security officers about the status of her sex, Howard disputed the significance of that event. He interpreted Zoe's experience at the Dubai airport as a result of her post-operative good looks. In Howard's version of the events, the guards were not “reading” Zoe. They were simply “leeches” who wanted to “mess with a pretty girl” because “they're not getting any at home.” Harassment and objectification were simply aspects of being a beautiful woman to which Zoe had yet to adapt. More than that, the attention from these guards proved to Howard that Zoe's surgery had been a success. If she were not beautiful, the guards would never have bothered her. Any other interpretation of that event could only be explained as a kind of held-over paranoia from all of those pre-operative years in which she *really was* being read as a transwoman.

Zoe knew that her dissention made her a “difficult patient” in the office. “Dr. Howard immediately called Sydney in when he saw that I was going to be a complex appointment,” she told me. “Now I have to deal with her in order to get to him. It's frustrating. He doesn't like my complaints.” Zoe was left feeling powerless. Her FFS did not do for her what she hoped it would do. Dr. Howard who was, prior to surgery, among the only people who could “see” her feminine face beneath her masculine one, now utterly dismissed the notion that any masculinity remained—no matter the evidence given to the contrary. What is not seen by the doctor, is not there (Foucault 1973).

Zoe's post-surgical symptoms—her experiences of being read by and reacted to as a transwoman—were determined in Howard's exam, to have no clinical basis; they were signifiers with no sign. According to Howard, there was nothing wrong with her. More than that, the fact of her persistent assertion that her symptoms did matter made her into something else: a problem patient. The problem patient is a concern in all aesthetic and reconstructive surgery as patients and surgeons work to differently balance the promise that surgery can be utterly transformative, but only up to a point. The assessment of surgical outcomes, writes Nancy Fraser, privileges a surgeon's professional expertise above the experience of the patient who lives in the altered body.

Due to the subjective quality of judgments about aesthetic appeal, surgeons are in a somewhat unique position to argue that the results of their surgery are successful even when the participant does not agree. In fact, participants' disagreement on this point is sometimes posed as an indicator of mental disability *in itself*, and the undertaking of litigation is often taken to confirm this (Fraser 2003:127).

Zoe had no interest in suing Dr. Howard. Money would not have given her what she most wanted. Her faith that he could do something more, that facial reconstruction was still the answer, brought her back to ask for revisions. The problem was that whereas before her surgery she and Howard agreed about the masculine properties of her face, now they had reached a point of disagreement about what her face looked like. In such a case, his judgment prevailed. “Where the surgeon deems the operation a success,” Fraser writes, “the patient’s failure to agree is pathologised” (2003:126).

Zoe’s dissatisfaction not only marked her as a “problem patient” with “unrealistic expectations,” but it also marked her as a typically difficult transsexual patient. The figure of the difficult transsexual patient has been a mainstay in clinical literature since the establishment of the diagnosis in the 1950’s. In 1979, clinical psychologist L.M. Lothstein described his transsexual patients as “immature, narcissistic, egocentric and potentially ‘explosive,’ while their attempts to obtain reassignment surgery were demanding, manipulative, controlling, coercive and paranoid” (1979:431). In their article on the aesthetics of feminizing the male face, Habal, et. al., characterize their transwomen patients as “extremely difficult to treat and must be carefully selected” (1990:144). Dutch surgeons Van de Ven, et. al., claim that the “high work pressure” of dealing with transwomen patients is the reason why so few surgeons specialize in FFS.

While most are very grateful and happy with the result of surgery, there is a number of patients that expect their life to change simply with this one operation. When it appears that this expectation is not going to come to fruition, it can result in a torrent of e-mails and telephone calls all the way through to legal procedures. A coherent and well-organised team is required to resist this stress, otherwise the risk is high that the surgeon and his team will suffer burnout (2008:294).

The task of setting expectations is a critical one in this surgical literature, just as it is in Howard’s and Page’s offices. The notion that these surgeons can create a feminine face that will be recognized by everyone who sees it, is one that is, in itself, quite grandiose in scale. The notion that gender can be totally transformed is “realistic,” but any idea on behalf of patients about the precise form that transformation will take—even ones expressly encouraged by surgeons—can, after the surgery, be resignified as unrealistic and characteristic of demanding trans- patients. In these cases, it is the surgeon and his team who are at risk of “burning out” and buckling under the stress of the expectations of transformation that the surgical team helped to cultivate.

Van de Ven, et. al., caution surgeons to be aware of what makes their trans-patients distinct and potentially problematic.

In most aesthetic operations, patients would like to improve their looks but above all continue to look like themselves. When it comes to facial feminisation [sic], patients wish to change dramatically. This means it is easy for patients to develop unrealistic expectations. Some even come with photos of other women that they would like to resemble. As a surgeon, it is very important to make clear to the patient that you will do your best to make her as feminine as possible, but you cannot change her into another woman (2008:294).

I would argue, however, that “changing her into another woman” is precisely what FFS is about. It is what Rachel hoped for in being unrecognizable to her friends, what Jill got

when she left her quotidian life as a husband and became a sought-after political activist, and what Zoe mourned when the scorn that she experienced as a transwoman remained in spite of the expenditures of her best efforts and her life savings. FFS is a project committed to creating “woman” as a socially recognizable category and is, in that sense, a project of ontological invention. As such, changing the patient from an unrecognizable woman into a recognizable one is exactly what Howard and Page promise to do. The pre-operative patient is one whose status as a woman is hers alone to assert, often in direct contrast to the perceptions and attributions of others. The post-operative woman is (ideally) one whose status as a woman is reflected by and thus given iteratively by those around her. It is the desire to change from one to another that motivates patients to seek out and undergo this change. What else is social perceptibility but a change of identity.

In cases like Zoe’s, where FFS fails to live up to its promise of certain and enduring femaleness, the patient and the surgeon inevitably locate the fault of this failure differently. For the surgeon, the problem is located either firmly in the head of the patient, or it spreads out across her entire body—to everywhere except her face. The “floating head phenomenon” that structures so much of the clinical interaction is completely forgotten when patients return to the clinic, unhappy with their results. Now, doctors acknowledge, gendered markers are everywhere: vocal pitch, patterns of speech, dress, hair, make-up, and on and on. Since her face simply cannot be the problem, it must be something else. It is up to the patient to “pile on” the gender signifiers as it were, to support her changed face through learning to dress like, walk like, talk like and otherwise effect *woman*. While the pre-operative fantasy is that the face will change everything, after surgery, the face can only do so much. The doctor can only do what he can do. Zoe had met the limit of what (this) surgery could do for her.

Despite the disappointment and increasing despair that came from her depleted emotional and financial resources, Zoe continued her efforts to be seen as a woman through the deployment of new bodily strategies.

I have found that the way I choose to dress myself has the biggest impact on passing or not. Dressing to expose my breasts just makes my life easier [she pointed at the low-cut sweater and camisole that she was wearing]. It is a choice between being read as a cross-dressed male or a strange looking, slutty woman. Women are much less nice when I have the cleavage from my DD’s showing, but men are infinitely kinder, gentler and more attentive. When I cover my breasts and rely on my face and body geometry to gender me, men are cruel. Someone yelled ‘Hey, amigo!’ at me on the street the other day. I am harassed and not taken seriously when I show my breasts, but I don’t get brought to tears because I look slutty.

Though she made it clear that her preference would have been to dress more conservatively, she had found that she had to work with the gender markers that worked for her. Still, this decision cost her something she had not intended to lose. She was seen as a woman only when she was a *kind* of woman she didn’t want to be. Being seen as a “strange looking, slutty woman” was preferable to being seen as a “cross-dressed male” but, nevertheless, it was a compromise beyond the momentous morning doorbell scene that anchored the promise of FFS. Her new face, as it turned out, was not the key to the radically reconfigured life that she’d hoped for. Instead, she found that she had to keep

working—both with and around this face and body—to get from others the attribution that she longed for.

The Face In Time

Though surgeons describe their goal of producing femininity as though it is a stable and actualizable category, the face itself is always changing. While the reconstruction of the facial bones is more or less permanent (see Jill's story above), the soft tissues of the face are not so easily disciplined. The fact that "the female face" that animates Howard's practice of Facial Feminization Surgery is that of a 16-year-old, white schoolgirl is significant not only for what it tells us about racially specific features and sexual differentiation in the skull, but also about the ideals of youth that adhere to, and have come to constitute, the category of female at work in FFS. We might say, returning to the dichotomous definition of "femininity," that the bone work in FFS produces femaleness, and the soft tissue work produces youth. Either one on their own would not result in the kind of "femininity" that animates FFS for patients or for surgeons, but together the effect is possible.

When discussing Leanne's feminization regime during her initial consultation (described in Chapter Five), Page reminded her that she needed to work with an esthetician to improve the look and quality of her skin. Facelifts, too, are a frequently employed as "follow up" procedures. Sometimes facelifts are necessary to remove excess skin that is left over after the bony scaffolding of the face has been reduced. In other cases, facelifts are simply the technologies of a normative demand that femininity is, in part, constituted by an aesthetic of youthfulness. Sydney, Dr. Howard's assistant, explained to Rosalind that "as we age, we lose our fat and our skull becomes mores visible. That is why at 40 people start using all these injectibles—plump my lips, plump my cheeks." This is true for all women, in Sydney's telling, but it is particularly hazardous for transwomen. She went on: "People who transition very young and never have any problems eventually get older and start to need something." This explanation not only equates aging with masculinity, but also presents transwomen as a special case. They "start to need something" because when their skulls become visible, it is maleness that can be seen.

For transwomen, as for all women, femininity is a receding horizon. The feminine body is one that requires constant maintenance and vigilance against time, its perpetual enemy. Patients often fantasized that the day of the operation would mark the date when the problem of their masculine faces—and thus the attribution of maleness by others—would be gone forever. This fantasy freezes time and is made possible, in part, by a discourse of "the female" that is itself a timeless one. But every fantasy is negated in the act of its production; no face can be as good in real life as was the surgical panacea of the imagination. Aging patients learn that the fantasy of a now and forever femininity cannot hold. They often come back for facelifts and touch-ups years down the road as they learn, like all women, that femininity is always on the wane.

The problem of whether FFS creates femaleness or beauty carries through to assessments of its success or, more precisely, the impossibility of such an assessment. In other words, the question of whether FFS works—a question that I have been asked throughout the course of my work on this project—does not have a simple answer. In the end, the question of its efficacy, of whether it does what it promises to do, is not a question of the technical or of the surgical. This is because, as Howard's denial of Zoe's experience above makes clear, FFS is not about the body itself. It is about but what that body will do; how it will enjoin others to recognize and respond to it. Perceptions give sense to the body; they give its matter meaning. The ways that a face acts to either facilitate or limit the possibility of a recognizable gender is not static. It does not reflect the stability of a dimorphic skeleton, or simply reflect back the qualities of a celebrity headshot. There is no specific thing here; no single female face. It is a general form informed by averages and norms, inflected by a measure of Greek mathematical aesthetics, and the surgeon's own taste for what looks good. It is the physical manifestation of a variety of very specific ways of understanding what a woman is.

In asking the question of whether FFS effects the change in sex that patients want and that surgeons promise, we are walking a new path through territory that is well trodden. Since the first claims that surgical interventions (of the genitals) could enact a change of sex, critics have questioned how changing the physical body relates (or not) to changes in the social status of the post-operative person. In other words, can medico-surgical interventions change men into women, and vice versa? Answers to this question implicate varying understandings of the ontologies of the categories at work here. It depends, in short, on what one thinks it means to be a man or to be a woman. Notions of masculinity and femininity shift across time, place and trends in fashion. The physical limits of the sexed body are neither universal nor totally individual. Like gender, anatomy is a moving target. The great power of FFS discourse, however, comes from the elision of this fact. It is precisely for this reason, I argue, that FFS is a privileged site in which to see the authorities of sex- and gender-making at work.

FFS relies on universal notions of difference but enacts—and literally incorporates—the specific desires and expectations of its audience. The face is made to be seen. In the course of FFS, the surgeon stands in for *the viewer*, writ large. Like a film or art critic, he acts through an admixture of training, experience and taste to proclaim what the audience will see and how they will see it. Whether he bases his claims to authority in the rational legitimacy of science or the affective and aspirational power of celebrity, the surgeon *sees* the patient in two ways at once. He sees her from his unique and expert vantage, seeing through her face to find her feminine face somewhere within. But the woman he sees there cannot be one that is ultimately visible to him alone. He must be able to make a woman that everyone else will see, as well. He must know how to affect this. Whereas beauty may be a matter of taste, femaleness is a matter of fact: either the patient is recognized to be female, or she is not. The surgeon's ability (or at very least, willingness) to stand in as *everyone* and to make definitive claims about what *everyone* will say or think or see, makes FFS an instance in which the otherwise diffuse matrices of authority by which gendered persons emerge becomes personified.

As a set of practices guided by history, by markets, by expertise and by charisma, FFS is about how “what it means to be a woman”—how the definition of a social category—is mapped onto the body by a very few specialized practitioners. What gives the narratives of FFS so much power is that they tell us what we already know. They produce the general knowledge of sex difference as a very specific set of practices, bolstered by overtures to science and aesthetics respectively. Through marshalling these different evidentiary resources, surgeons refocus the power of definition away from themselves as singular, charismatic actors, and diffuse it into the cultural power of consensus in the name of science and of aesthetics. *We all know* that men and women look different, but pressed to say just how they are different and the certainty of that claim gives way to the hemming and hawing of equivocations: some women, most women, white women, young women look some way... some of the time. *We all know* that beauty is exceptional and that those who have it captivate us, though we may not always agree on which persons those are. Through his two modes of sight, the surgeon is able to lay claim both to a unique and powerful way of seeing the woman within the masculine face, and to seeing with the eyes of every person with whom that new woman will come in contact. In the clinic, the surgeon’s cultural capital and authoritative stance turns the ineffability of femininity into something real. Just as the psychotherapist becomes the arbiter of social gender, here the surgeon becomes the arbiter of social sex. Though he may claim to know femininity as a series of properties of the body, what he is actually able to produce is a set of expectations in, as, and through the body. He can make what others will see. As an individual claim, this is weak, but as a claim backed by the power of science and beauty, it becomes plausible. These are things we already believe in.

It is here, in the clinic, where the powers that authorize and enable the emergence of a sexed—and therefore properly gendered—body emerge as recognizable. These are the preexisting forms of authority out of which gendered persons emerge. It does not matter that there is no absolute, ahistorical, universal form of the female or of the feminine face that these doctors actually make. What matters is that they make a face that can be recognized as a woman’s.

The theory of performative sexing offers a way to think about how the taken-for-granted assumptions about the naturalness of the body are produced. Its invocation of the linguistic performative, however, means that the felicity of the sexed body—the fact that it can be recognized as a particular sex—depends upon the recognition and validation of forms of authority that precede it and, thus, bring it into being. Just as Austin’s couple needs a judge to pronounce them “married,” and his employee needs a boss to say, “you’re fired,” so the sexed body needs existing modes of knowledge and power to define it and constitute it as such. These forms of authority vary widely from situation to situation. The limit of the body is not universal; it is particular to time, place and technological capacity. This dissertation is an effort to understand the kinds of knowledge and power that are able to produce the face as a gendered—and mutable—object. What is clear in the case of FFS—as with all trans- medicine—is that the felicity of claiming oneself as a woman is limited by the material body. This dissertation has sought to work through the material conditions of social gender (a category fundamentally constituted between and among members of a social group, as opposed to a category of identity which may be posited solely by an individual) as a thing that is

conditioned by the properties of the body, the dynamics of the market, and the production and marshalling of expertise.

FFS offers a means to think through sex as a practical phenomenon and social identity whose attribution is limited by the material properties of the body in everyday social interaction. In other words, sex not as an abstract cultural byproduct, but as a social reality irreducibly produced between people in the course of everyday life. This is an examination of bodily sex that is not focused inward to the body's concealed properties—concealed either by clothing or by the internalities of the body itself (as measured by chemical or chromosomal presence)—but one that is focused outward to the constitution of “real” sex as a fact of lived reality. To the extent that we understand woman as a social rather than a biological category, this is what *being* a woman means. *Being* as practical action, rather than *is* as an ontological state. FFS is about creating in the body of the patient the expectations of the audience; about making a face that others will respond to and treat as the face of a woman.

Bibliography

- Adams, Annmarie and Thomas Schlich. 2006. Design for Control: Surgery, Science, and Space at the Royal Victoria Hospital, Montreal, 1893-1956. *Medical History* 50: 303-324.
- Adams, Vincanne, Michelle Murphy and Adele Clark. 2009. Anticipation: technoscience, life, affect, temporality. *Subjectivity* 28(1): 246-265.
- Agich, GJ and M Siemionow. 2005. Until they have faces: the ethics of facial allograft transplantation. *Journal of Medical Ethics* 31:707-709.
- Aizura, Aren Z. 2010. Feminine Transformations: Gender Reassignment Surgical Tourism in Thailand. *Medical Anthropology* 29(4): 1-20.
- Alaimo, Stacy and Susan Hekman, eds. 2008. *Material Feminisms*. Bloomington, IN: Indiana University Press.
- Allen, Clifford. 1962. *A Textbook of Psychosexual Disorders*. London: Oxford University Press.
- Andreu, Yasmina and Ramón A. Mollineda. 2008. On the Complementarity of Face Parts for Gender Recognition Progress in Pattern Recognition, Image Analysis and Applications. *Computer Science* 5197: 252-260.
- Atkinson, Spencer. 1963. An Unexplored Field of Communication. *American Journal of Orthodontics* 49(8): 588-592.
- Bakhtin, Mikhail. 1984 [1968]. *Rabelais and His World*. Trans, Helene Iswolsky. Bloomington, IN: Indiana University Press.
- Balsamo, Anne. 1996. *Technologies of the Gendered Body: Reading Cyborg Women*. Durham, NC: Duke University Press.
- Barad, Karen. 2003. Posthumanist Performativity: How Matter Comes to Matter. *Signs* (Spring):801-31.
- Becker, Judith V., Bradley R. Johnson, Richard J. Kavoussi. 1999. Sexual and Gender Identity Disorders. In *Textbook of Psychiatry*. Hales, Youdofsky, Talbott, eds. Washington, DC: American Psychiatric Press, Inc.

- Becking, A.G., D.B. Tuinzing, J.J. Hage, L.J.G. Gooren. 1996. Facial Corrections in Male to Female Transsexuals: a preliminary report on 16 patients. *Journal of Oral and Maxillofacial Surgery* 54:413-418.
- Bednar, Elisabeth A. 1996. Self-Help for the Facially Disfigured: Commentary on 'The Quasimodo Complex.' In *The Tyranny of Normal*. Donley and Buckley, eds. Kent, OH: The Kent State Press.
- Benjamin, Harry. 1954. Transsexualism and Transvestism as Psycho-Somatic and Somato-Psychic Syndromes. *American Journal of Psychotherapy* 8: 219-230.
- . 1966. *The Transsexual Phenomenon*. New York: Julian Press.
- . 1967. Transvestism and Transsexualism in the Male and Female. *The Journal of Sex Research* 3(2): 107-127.
- Bennett, Jane. 2010. *Vibrant Matter: A Political Ecology of Things*. Durham, NC: Duke University Press.
- Benson, Peter. 2008. El Campo: Faciality and Structural Violence in Farm Labor Camps. *Cultural Anthropology* 23(4): 589-629.
- Bergeron, Léonard and Philip Kuo-Ting Chen. 2009. Asian Rhinoplasty Techniques. *Seminars in Plastic Surgery* 23(1):16-21.
- Berlant, Lauren. 2004. Compassion (and Withholding). In *Compassion: The Culture and Politics of an Emotion*. Lauren Berlant, ed. New York: Routledge. pp. 1-13.
- Billings, Dwight and Thomas Urban. 1992. The Socio-Medical Construction of Transsexualism: An Interpretation and Critique. *Social Problems* 29(3): 266-282.
- Blakey, Michael L. 1987. Skull Doctors: Intrinsic Social and Political Bias in the History of American Physical Anthropology With a Special Reference to the Work of Ales Hrdlicka. *Critique of Anthropology* 7(2): 7-35.
- Blinkhorn, Steve. 1982. What Skulduggery? *Nature* 296: 506.
- Blum, Virginia L. 2003. *Flesh Wounds: The Culture of Cosmetic Surgery*. Berkeley, CA: University of California Press.
- . 2005. Becoming the Other Woman: The Psychic Drama of Cosmetic Surgery. *Frontiers: A Journal of Women Studies* (26)2: 104-131.
- Bockting, Walter O., BE Robinson, BR Rosser. 1998 Transgender HIV prevention: a qualitative needs assessment. *AIDS Care* 10: 505-525.

- Bordo, Susan. 1993. *Unbearable Weight: Feminism, Western Culture, and the Body*. Berkeley: University of California Press.
- . 1997. *Twilight Zones: The Hidden Life of Cultural Images from Plato to O.J.* Berkeley: University of California Press.
- Bornstein, Kate. 1994. *Gender Outlaw: On Men, Women, and the Rest of Us*. New York: Vintage.
- Bosk, Charles. 1976. *Forgive and Remember: Managing Medical Failure*. Chicago: University of Chicago Press.
- Bourgeault, I. L., E. Declercq, J. Sandall, S. Wrede, M. Vanstone, E. van Teijlingen, R. DeVries, C. Benoit. 2008. Too posh to push? Comparative perspectives on maternal request caesarean sections in Canada, the US, the UK and Finland. In: *Patients, consumers and civil society*, Chambré and Goldner, eds. London: JAI Press, pp. 99-126.
- Boylan, Jennifer Finney. 2003. *She's Not There: A Life in Two Genders*. New York: Broadway.
- Braun, Virginia. 2005. In search of (better) sexual pleasure: female genital 'cosmetic' surgery. *Sexualities* 8(4): 407-424.
- . 2010. Female Genital Cosmetic Surgery: A Critical Review of Current Knowledge and Contemporary Debates. *Journal of Women's Health* 19(7): 1393-1407.
- Briggs, Charles L. and Daniel C. Hallin. 2007. Biocommunicability: The Neoliberal Subject and Its Contradictions in News Coverage of Health Issues. *Social Text* 25(4): 43-66.
- Brown, Daniel. 1961. Transvestism and Sex-Role Inversion. In *The Encyclopedia of Sexual Behavior, Vol II*. Albert Ellis and Albert Abarbanel, eds. New York: Hawthorn Books. pp. 1012-1022.
- Butler, Judith. 1990. *Gender Trouble*. New York: Routledge.
- . 1993. *Bodies That Matter*. New York: Routledge.
- . 2001. Doing Justice to Someone: sex reassignment and allegories of transsexuality. *GLQ* 7(4): 621-636.
- . 2004. *Undoing Gender*. New York: Routledge.

- Califia, Pat. 1997. *Sex Changes: The Politics of Transgenderism*. San Francisco, CA: Cleis Press.
- Cameron, Loren. 1996. *Body Alchemy: transsexual portraits*. San Francisco, CA: Cleis Press.
- Carey, Jonathan Sinclair. 1996. The Quasimodo Complex: Deformity Reconsidered. In *The Tyranny of Normal*. Donley and Buckley, eds. Kent, OH: The Kent State Press.
- Cassell, Joan. 1986. Dismembering the Image of God: Surgeons, Wimps, Heroes and Miracles. *Anthropology Today* 2(2): 13-16.
- . 1989. "The Fellowship of Surgeons." *International Journal of Moral and Social Studies* 4(3): 195-212.
- . 1991. *Expected Miracles: Surgeons at Work*. Philadelphia: Temple University Press.
- . 1998. *The Woman in the Surgeon's Body*. Cambridge, MA: Harvard University Press.
- Cauldwell, David O. 1949. Psychopathia Transsexualis. *Sexology* 16: 274-280.
- Clements-Nolle, Kristen, Rani Marx, Robert Guzman and Mitchell Katz. 2001. HIV Prevalence, Risk Behaviors, Health Care Use, and Mental Health Status of Transgender Persons: Implications for Public Health Intervention. *American Journal of Public Health* 91(6): 915-921.
- Chase, Cheryl. 1998. Hermaphrodites With Attitude: Mapping the Emergence of Intersex Political Activism. *GLQ: a Journal of Lesbian and Gay Studies* 7(4):621-636.
- Ciotti, Paul. 1999. Why Did He Cut Off That Man's Leg?: The Peculiar Practice of Dr. John Ronald Brown. *LA Weekly*. December 15.
- Cochran, Bryan N., Angela J. Stewart, Joshua A. Ginzler, and Ana Mari Cauce. 2002. Challenges Faced by Homeless Sexual Minorities: Comparison of Gay, Lesbian, Bisexual, and Transgender Homeless Adolescents With Their Heterosexual Counterparts. *American Journal of Public Health* 92(5): 773-777.
- Cohen, Lawrence. 2001. The Other Kidney: biopolitics beyond recognition. *Body & Society* 7(2-3): 9-29.
- . 2005. Operability, Bioavailability, and Exception. In *Global Assemblages*. Ong and Collier, eds. Malden, MA: Blackwell.

- Cohen Jr., M. Michael. 2006. *Perspectives on the Face*. New York: Oxford University Press.
- Cohen-Kettenis, PT and L.J.G. Gooren. 1999. Transsexualism: A Review of Etiology, Diagnosis and Treatment. *Journal of Psychosomatic Research* 46(4): 351-333.
- Colapinto, John. 2000. *As Nature Made Him: The Boy Who Was Raised as a Girl*. New York: Harper Collins.
- Colebrook, Claire. 2008. On Not Becoming Man: The Materialist Politics of Unactualized Potential. In *Material Feminisms*, Alaimo and Susan Hekman, eds. Bloomington, IN: Indiana University Press.
- Coleman, Eli. 1991. *John Money: A Tribute*. Binghamton, NY: The Haworth Press.
- Collins, Harry. 1994. Dissecting Surgery: Forms of Life Depersonalized. *Social Studies of Science* 24(2): 311-333.
- Coogan, Kelly. 2006. Fleshy Specificity: (Re)considering Transsexual Subjects in Lesbian Communities. In *Challenging Lesbian Norms: Intersex, Transgender, Intersectional, and Queer Perspectives*. Angela Pattatuci Aragón, ed. Binghamton, NY: Harrington Park Press. pp. 17-41.
- Conn, Canary. 1974. *Canary: the story of a transsexual*. Nash Publications.
- Crawford, Robert. 1980. Healthism and the Medicalization of Everyday Life. *International Journal of Health Services* 10(3): 365-388.
- Cromwell, Jason. 1999. *Transmen & FTMs: Identities, Bodies, Genders & Sexualities*. Urbana, IL: University of Illinois Press.
- Daly, Mary. 1978. *Gyn/ecology: the metaethics of radical feminism*. New York: Beacon Press.
- Davis, Kathy. 1995. *Reshaping the Female Body*. New York: Routledge.
- . 2003a. *Dubious Equalities and Embodied Differences: Cultural Studies on Cosmetic Surgery*. Lanham, MD: Rowman & Littlefield.
- . 2003b. Surgical Passing: Or Why Michael Jackson's Nose Makes 'Us' Uncomfortable. *Feminist Theory* 4(1): 73-92.
- Dechant, Dorothy. 2000. Our Best Kept Secret: The Spencer R. Atkinson Library of Applied Anatomy. *Contact Point: The Alumni Magazine of the Dugoni School of Dentistry* 80(3): 15-19.

- Delphy, Christine. 1984. *Close to Home*. London: Hutchinson.
- Dempf, Rupert and Alexander W. Eckert. 2009. Contouring the forehead and rhinoplasty in the feminization of the face in male-to-female transsexuals. *Journal of Cranio-Maxillofacial Surgery* pp. 1-7.
- Denny, Dallas. 1992. The Tijuana experience. *Alicia's Girl Talk*, 4(9):18.
- Dewey, J. M. 2008. Knowledge Legitimacy: How Trans-Patient Behavior Supports and Challenges Current Medical Knowledge. *Qualitative Health Research* 18: 1345-1355.
- Diamond, Milton and Keith Sigmundson. 1997. Sex Reassignment at Birth: Long-term Review and Clinical Implications. *Archives of Pediatric and Adolescent Medicine* 151(3): 298-304.
- Draper, Heather and Neil Evans. 2006. Transsexualism and Gender Reassignment Surgery. In *Cutting to the Core: Exploring the Ethics of Contested Surgeries*, David Benatar (ed). Boston: Rowman and Littlefield.
- Dull, Diana and West, Candace. 1991. Accounting for Cosmetic Surgery: The Accomplishment of Gender. *Social Problems* 38(1): 54-70.
- Duggan, Lisa. 1990. From Instincts to Politics: Writing the History of Sexuality in the U.S. *Journal of Sex Research* 27(1): 95-110.
- Ecker, Alexander. 1868. On a Characteristic Peculiarity in the Form of the Female Skull, and its Significance for Comparative Anthropology. *Anthropological Review* 6(23): 350-356.
- Edelman, Lee. 2004. "Compassion's Compulsion" in *Compassion: The Culture and Politics of an Emotion*. Lauren Berlant, ed. New York: Routledge: 159-186.
- Edmonds, Alexander. 2007. The Poor Have a Right to Be Beautiful: Cosmetic Surgery in Neoliberal Brazil. *Journal of the Royal Anthropological Institute* 13(2): 363-381.
- . 2009. "Engineering the Erotic": Aesthetic Medicine and Modernization in Brazil. In *Cosmetic Surgery: A Feminist Primer*. Heyes and Jones (eds.) Burlington, VT: Ashgate Publishing. pp. 152-169.
- . 2010. *Pretty Modern*. Durham, NC: Duke University Press.
- Epstein, Steven. 1996. *Impure Science: AIDS, Activism, and the Politics of Knowledge*. Berkeley: University of California Press.

- . 2007. *Inclusion: The Politics of Difference in Medical Research*. Chicago: The University of Chicago Press.
- Erickson, Julia. 1999. *Kiss and Tell: Surveying Sex in the Twentieth Century*. Cambridge, MA: Harvard University Press.
- Ettner, Randi, Stan Monstrey, Evan Eyler, eds. 2007. *Principles of Transgender Medicine and Surgery*. Binghamton, NY: The Haworth Press.
- Fabian, Ann. 2010. *The Skull Collectors: Race, Science, and America's Unburied Dead*. Chicago: University of Chicago Press.
- Farkas, Leslie. 1987. *Anthropometric Facial Proportions in Medicine*. Springfield, IL: Charles C. Thomas.
- Fausto-Sterling, Anne. 2000. *Sexing the Body: Gender Politics and the Construction of Sexuality*. New York: Basic Books.
- . 2005. The Bare Bones of Sex: Part 1—Sex and Gender. *Signs: Journal of Women in Culture and Society* 30(2): 1491-1527.
- Fee, Elizabeth. 1979. Nineteenth-Century Craniology: The Study of the Female Skull. *Bulletin of the History of Medicine* 53(3): 415-433.
- Flynn, Taylor. 2001. Transforming the Debate: Why We Need to Include Transgender Rights in the Struggles for Sex and Sexual Orientation Equality. *Columbia Law Review* 101(2): 392-420.
- Foucault, Michel. 1973. *The Birth of the Clinic: An Archaeology of Medical Perception*. New York: Vintage.
- . 1977. *Discipline and Punish: The Birth of the Prison*. New York: Vintage.
- Fox, Renée C. and Judith P. Swazey. 1992. *Spare Parts: Organ Replacement in American Society*. London: Oxford University Press.
- Frangos, Maria. 2006. Embodied Subjectivity and the Quest for Self in Televised Narratives of Body Modification. In *Bodies in the Making: Transgressions and Transformations*. Chen and Morgan, eds. Santa Cruz, CA: New Pacific Press. pp. 54-62.
- Frank, Arthur W. 2000. Illness and Autobiographical Work: Dialogue as Narrative Destabilization. *Qualitative Sociology* 23(1):135-156.

- Fraser, Suzanne. 2003. *Cosmetic Surgery: Gender and Culture*. New York: Palgrave Macmillan.
- Gagné, Patricia and Deanna McGaughey. 2002. Designing Women: Cultural Hegemony and the Exercise of Power among Women Who Have Undergone Elective Mammoplasty. *Gender & Society* 16(6): 814-838.
- Garber, Marjorie. 1991. *Vested Interests: Cross-Dressing and Cultural Anxiety*. New York: Routledge.
- , 2004. Compassion. In *Compassion: The Culture and Politics of an Emotion*. Lauren Berlant, ed. New York: Routledge. pp. 15-28.
- Garfinkle, Harold. 1984. Passing and the managed achievement of sex status in an 'intersexed' person (part I). In *Studies in Ethnomethodology*. Cambridge: Polity Press.
- Gere, Cathy. 1999. Bones That Matter: Sex Determination in Paleodemography 1948-1995. *Studies in History and Philosophy of Biological and Biomedical Sciences* 3(4): 455-471.
- Geller, Pamela L. 2005. Skeletal analysis and theoretical complications. *World Archaeology* 37(4): 597-609.
- , 2008. Conceiving Sex: Fomenting a Feminist Bioarchaeology. *Journal of Social Archaeology* (8): 113-139.
- , 2009. Identity and Difference: Complicating Gender in Archaeology. *Annual Review of Anthropology* 38:65-81.
- Gibson, Margaret. 2006. Bodies Without Histories. *Australian Feminist Studies* 21(49): 51-63.
- Giles, Eugene and Orville Elliot. 1963. Sex Determination by Discriminant Function Analysis of Crania. *American Journal of Physical Anthropology*. 53-68.
- Gilman, Sander. 1985. *Difference and Pathology: stereotypes of sexuality, race and madness*. Ithaca, NY: Cornell University Press.
- , 1991. *The Jew's Body*. New York: Routledge.
- , 1998. *Creating Beauty to Cure the Soul: Race and Psychology in the Shaping of Aesthetic Surgery*. Durham, NC: Duke University Press.
- , 1999a. *Making the Body Beautiful: A Cultural History of Aesthetic Surgery*. Princeton University Press.

- L. 1999b. By a Nose: On the Construction of 'Foreign Bodies'. *Social Epistemology* 13(1): 49-58.
- Gimlin, Debra. 2000. Cosmetic Surgery: Beauty as Commodity. *Qualitative Sociology* 23(1): 77-98.
- . 2006. The Absent Body Project: Cosmetic Surgery as a Response to Bodily Dys-Appearance. *Sociology* 40(4): 699-716.
- . 2010. Imagining the Other in Cosmetic Surgery. *Body & Society* 16(4): 57-76.
- Goering, Sara. 2003. Conformity Through Cosmetic Surgery: The Medical Erasure of Race and Disability. In *Science and Other Cultures: Issues in Philosophy of Science and Technology*, Figueroa and Harding, eds. New York: Routledge. pp. 172-188.
- Goffman, Erving. 1959. *The Presentation of Self in Everyday Life*. Garden City, NY: Doubleday Anchor Books.
- . 1961. *Encounters: two studies in the sociology of interaction*. Indianapolis, IN: The Bobbs-Merrill Company, Inc.
- . 1963. *Stigma: Notes on the Management of Spoiled Identity*. Englewood Cliffs, NJ: Prentice-Hall, Inc.
- Goldwyn, Robert M. 1996. Deformity and the Humane Ideal of Medicine. In *The Tyranny of Normal*. Donley and Buckley, eds. Kent, OH: The Kent State Press.
- Gooren, Louis. 2006. The biology of human psychosexual differentiation. *Hormones and Behavior* 50 (2006): 589-601.
- Gould, Stephen Jay. 1981. *The Mismeasure of Man*. New York: Norton.
- Green, Jamison. 1999. Look! No, Don't! The Visibility Dilemma for Transsexual Men. In *Reclaiming Genders: transsexual grammars at the fin de siècle*. Kate More and Stephen Whittle, eds. New York: Cassell. pp. 117-131.
- Green, Richard. 1987. *Sissy Boy Syndrome: The Development of Homosexuality*. New Haven, CT: Yale University Press.
- Green, Richard and John Money, eds. 1969. *Transsexualism and Sex Reassignment*. Baltimore, MD: The Johns Hopkins Press.

- Grossman, Arnold and Anthony D'Augelli. 2007. Transgender Youth and Life-Threatening Behaviors. *Suicide and Life Threatening Behavior* 3(5): 527-537.
- Guttman, Matt. 2005. Scoring Men: Vasectomies and the Totemic Illusion of Male Sexuality in Oaxaca. *Culture, Medicine and Psychiatry* 29(1): 79-101.
- Habal, Mutaz B. 1990. Aesthetics of Feminizing the Male Face by Craniofacial Contouring of the Facial Bones. *Aesthetic and Plastic Surgery* 14:143-150.
- Hage, J.J., M.K. Vossen, A.G. Becking. 1987. Rhinoplasty as Part of Gender Confirming Surgery in Male Transsexuals: Basic Considerations and Clinical Experience. *Annals of Plastic Surgery* 39:266-271.
- Haiken, Elizabeth. 1997. *Venus Envy: A History of Cosmetic Surgery*. Baltimore, MD: The Johns Hopkins University Press.
- Halberstam, Judith. 1992. *Skinflick: Posthuman Gender in Jonathan Demme's The Silence of the Lambs*. *Camera Obscura* Fall:37-54.
- . 2005. *In a Queer Time and Place: Transgender Bodies, Subcultural Lives*. New York University Press.
- Hale, C. Jacob. 1997. Suggested Rules for Non-Transsexuals Writing about Transsexuals, Transsexuality, Transsexualism, or Trans _____. (<http://sandystone.com/hale.rules.html>) accessed 11/11/10
- Haraway, Donna. 1989. *Primate Visions: Gender, Race, and Nature in the World of Modern Science*. New York: Routledge.
- . 1997. *Modest_Witness@SecondMillenium.FemaleMan©_Meets_OncoMouse™: Feminism and Technoscience*. New York: Routledge.
- Hausman, Bernice. 1992. Demanding Subjectivity: Transsexualism, Medicine, and the Technologies of Gender. *Journal of the History of Sexuality* 3(2): 270-302.
- . 1995. *Changing Sex: Transsexualism, Technology, and the Idea of Gender*. Durham, NC: Duke University Press.
- Hekman, Susan. 2008. Constructing the Ballast: On Ontology for Feminism. In *Material Feminisms*. Alaimo and Hekman, eds.
- . 2010. *The Material of Knowledge: Feminist Disclosures*. Bloomington, IN: Indiana University Press.
- Heyes, Cressida. 2007. *Self-Transformations: Foucault, Ethics and Normalized Bodies*. Oxford University Press.

- Heyes, Cressida and Meredith Jones, eds. 2009. *Cosmetic Surgery: A Feminist Primer*. Burlington, VT: Ashgate Publishing.
- Hird, Myra. 2009. Feminist Engagements with Matter. *Feminist Studies* 35(2):329-346.
- . 2000. Gender's Nature: Intersexuality, Transsexualism, and the 'sex'/'gender' binary. *Feminist Theory* 1(3):347-364.
- . 2002. For a Sociology of Transsexualism. *Sociology* 36(3): 577-595.
- . 2004. *Sex, Gender, and Science*. New York: Palgrave MacMillan.
- Hirschauer, Stefan. 1991. The Manufacture of Bodies in Surgery. *Social Studies of Science* 21:279-319.
- Hochschild, Arlie Russell. 1983. *The Managed Heart: Commercialization of Human Feeling*. Berkeley: University of California Press.
- Holliday, Ruth and Jacqueline Sanchez Taylor. 2006. Aesthetic Surgery as False Beauty. *Feminist Theory* 7(2):179-195.
- Holloway, Karla FC. 2011. *Private Bodies, Public Texts: Race, Gender, and a Cultural Bioethics*. Durham, NC: Duke University Press.
- Howells, W.W. 1995. *Who's Who in Skulls: Ethnic Identification of Crania from Measurements*. Papers of the Peabody Museum of Archaeology and Ethnology. Cambridge, MA: Harvard University.
- Hoyer, Niels. 1937. *Man Into Woman: An Authentic Record of a Sex Change*. London: Jarrolds.
- Hoyme, Lucille. 1953. Physical Anthropology and Its Instruments: An Historical Study. *Southwestern Journal of Anthropology* 9(4): 408-430.
- Hrdlička, Alěs. 1919. *Physical Anthropology: Its Scope and Aims; Its History and Present Status in the United States*. Philadelphia: The Wistar Institute of Anatomy and Biology.
- . 1939. *Practical Anthropometry*. Philadelphia: The Wistar Institute of Anatomy and Biology.
- Hull, Carrie. 2006. *The Ontology of Sex: A Critical Inquiry into the Deconstruction and Reconstruction of Categories*. New York: Routledge.

- Humphrey, David C. 1973. Dissection and Discrimination: The Social Origins of Cadavers in America, 1760-1915. *Bulletin of the New York Academy of Medicine* 49(9): 819-827.
- Hunter, Margaret L. 2011. Buying Racial Capital: Skin Bleaching and Cosmetic Surgery in a Globalized World. *The Journal of Pan African Studies* 4(4): 142-164.
- Hunter, W. Stuart and Stanley M. Garn. 1972. Disproportionate Sexual Dimorphism in the Human Face. *American Journal of Physical Anthropology* 36:133-138.
- Huss-Ashmore, Rebecca. 2000. The Real Me: Therapeutic Narrative in Cosmetic Surgery. *Expedition* 42(3): http://penn.museum/sites/body_modification/index.html (accessed 11/15/10)
- Irvine, Janice. 1990a. *Disorders of Desire: Sex and Gender in Modern American Sexology*. Philadelphia: Temple University Press.
- . 1990b. From Difference to Sameness: Gender Ideology in Sexual Science. *Journal of Sex Research* 7(1):7-18.
- Isreal, Gianna E. 2004. Translove: Transgender Persons and Their Families. *Journal of GLBT Family Studies* 1(1):53-67.
- Jones, Meredith. 2009. Pygmalion's Many Faces. In *Cosmetic Surgery: A Feminist Primer*. Heyes and Jones (eds.) Burlington, VT: Ashgate Publishing. pp. 171-190.
- Karkazis, Katrina. 2008. *Fixing Sex: Intersex, Medical Authority, and Lived Experience*. Durham, NC: Duke University Press.
- Katz, Pearl. 1981. Ritual in the Operating Room. *Ethnology* 20(4): 335-350.
- . 1999. *The Scalpel's Edge: The Culture of Surgeons*. Boston: Allyn & Bacon.
- Katz, Pearl and Faris R. Kirland. 1988. Traditional Thought and Modern Western Surgery. *Social Science and Medicine* 26(12): 1175-1181.
- Kaufman, Sharon, Ann Russ and Janet Shim. 2006. Aged Bodies and Kinship Matters: The Ethical Field of Kidney Transplant. *American Ethnologist* 33(1): 81-99.
- Kaw, Eugenia. 1993. Medicalization of Racial Features: Asian American Women and Cosmetic Surgery. *Medical Anthropology Quarterly* 7(1): 74-89.
- Kenagy, Gretchen P. 2005. Transgender Health: Findings from Two Needs Assessments Studies in Philadelphia. *Health and Social Work* 30(1): 19-28.

- Kemp, Martin. 1999. Slanted Evidence. *Nature* 402: 727.
- Kessler, Suzanne J. and Wendy McKenna. 1978. *Gender: an ethnomethodological approach*. Chicago: University of Chicago Press.
- Kirby, Vicky. 1997. *Telling Flesh: The Substance of the Corporeal*. New York: Routledge.
- Kleinman, Arthur. 1989. *The Illness Narratives: Suffering, Healing and the Human Condition*. New York: Basic Books.
- Kleinman, Arthur. 1998. Experience and Its Moral Modes: Culture, Human Conditions, and Disorder. The Tanner Lectures on Human Values. Delivered at Stanford University April 13-16, 1998.
- Komar, Debra A. and Buikstra, Jane E. 2008. *Forensic Anthropology: contemporary theory and practice*. New York: Oxford University Press.
- Kotula, Dean. 2002. *The Phallus Palace: female to male transsexuals*. Los Angeles, CA: Alyson Publications.
- Lam, Samuel M. 2005. Aesthetic Facial Surgery for the Asian Male. *Facial Plastic Surgery* 21(4): 317-323.
- Latour, Bruno. 1987. *Science in Action: How to Follow Scientists and Engineers through Society*. Cambridge: Harvard University Press.
- Leder, Drew. 1990. *The Absent Body*. Chicago, IL: University of Chicago Press.
- Lee, Alvin. 2008. Trans Models in Prison: The Medicalization of Gender Identity and the Eight Amendment Right to Sex Reassignment Therapy. *Harvard Journal of Law and Gender* 31: 447-471.
- Leriche, Albert, Marc-Olivier Timsit, Nicolas Morel-Journel, Andre Bouillot, Diana Dembele, Alain Ruffion. 2008. Long-term outcome of forearm free-flap phalloplasty in the treatment of transsexulism. *Reconstructive Urology* 101: 1297-1300.
- Lippa, Richard A. 2003. Are 2D:4D Finger-Length Ratios Related to Sexual Orientation? Yes for Men, No for Women. *Journal of Personality and Social Psychology* 85(1): 179-188.
- Little, Margaret. 1998. Cosmetic Surgery, Suspect Norms, and the Ethics of Complicity. In *Enhancing Human Traits: ethical and social implications*. Erik Parens, ed. pp. 162-176.

- Lombardi, E. L., Wilchins, R. A., Priesing, D., & Malouf, D. 2001. Gender Violence: Transgender Experiences with Violence and Discrimination. *Journal of Homosexuality* 42: 89-101.
- Lorber, Judith. 1994. *Paradoxes of Gender*. New Haven, CT: Yale University Press.
- Lothstein, L.M. 1979. The Aging Gender Dysphoria (Transsexual) Patient. *Archives of Sexual Behavior* 8:431-444.
- MacGregor, Frances M. Cook. 1974. *Transformation and Identity: the face and plastic surgery*. New York: Quadrangle.
- Mahmood, Saba. 2005. *Politics of Piety: The Islamic Revival and the Feminist Subject*. Princeton, NJ: Princeton University Press.
- Maltz, Maxwell. 1936. *New Faces—New Futures: Rebuilding Character with Plastic Surgery*. New York: Richard R. Smith.
- Mann, Charles C. 2006. *1491: New Revelations of the Americas Before Columbus*. Detroit, MI: Vintage.
- Markowitz, Stephanie. 2008. Change of Sex Designation on Transsexuals' Birth Certificates: Public Policy and Equal Protection. *Cardozo Journal of Law and Gender* 14:705-730.
- Marre, Diana and Joan Bestard. 2009. The Family Body: Persons, Bodies and Resemblance. In *European Kinship in the Age of Biotechnology*, Edwards and Salazar, eds. Oxford: Berghahn Books.
- Martin, Emily. 1991. The Egg and the Sperm: How Science Has Constructed a Romance Based on Stereotypical Male-Female Roles. *Signs* 16(3): 485-501.
- , 2001. *The Woman in the Body: A Cultural Analysis of Reproduction*. Boston: Beacon Press.
- Martino, Mario. 1977. *Emergence*. New York: Crown Publishers.
- Mason-Schrock, Douglas. 1996. Transsexuals' Narrative Construction of the 'True Self'. *Social Psychology Quarterly* 59(3): 176-192.
- Mays, Simon. 1998. *The Archaeology of Human Bones*. New York: Routledge.
- McCown, Elizabeth. 1982. The Female as Baseline for Species Description. In *Sexual Dimorphism in Homo Sapiens*. Roberta Hall, ed. New York: Praeger.

- Meadow, Tey. 2010. "A Rose is a Rose": On Producing Legal Gender Classifications. *Gender & Society* 24(6): 814-837.
- Medin, Douglas L. and William D. Wattenmaker. 1987. Family resemblance, conceptual cohesiveness, and category construction. *Cognitive Psychology* 19(2):242-279.
- Meindl, R.S. Lovejoy, C.O., Mensforth, R.P., Barton, T.J. 1985. Multifactorial Determination of Skeletal Age at Death: A Method and Blind Tests of its Accuracy. *Journal of Physical Anthropology* 68(1):1-14.
- Meyerowitz, Joanne. 2002. *How Sex Changed: a history of transsexuality in the United States*. Cambridge, MA: Harvard University Press.
- Millot, Catherine. 1990. *Horsexe: Essay on Transsexuality*. Brooklyn, NY: Autonomedia.
- Miravel, Julien. 2008. The Physical Examination in Cosmetic Surgery: Communication Strategies to Promote the Desirability of Surgery. *Health Communication* 23: 153-170.
- Mol, Annemarie. 2002. *The Body Multiple: ontology in medical practice*. Durham, NC: Duke University Press.
- . 2002a. Cutting Surgeons, Walking Patients: Some Complexities Involved in Comparing. In *Complexities*. John Law and Annemarie Mol, eds. Durham, NC: Duke University Press.
- Money, John, Hampson, J.G., and Hampson, J.L. 1957. Imprinting and the Establishment of Gender Role. *Archives of Neurology and Psychiatry* 77: 333-36.
- Money, John and Ehrhardt, Anke A. 1972. *Man and Woman, Boy & Girl: the differentiation and dimorphism of gender identity from conception to maturity*. Baltimore, MD: Johns Hopkins University Press.
- Morgan, Kathryn Pauly. 1991. Women and the Knife: Cosmetic Surgery and the Colonization of Women's Bodies. *Hypatia* 6(2): 25-53.
- Morgan, Lynn. 2009. *Icons of Life: A Cultural History of Human Embryos*. Berkeley, CA: The University of California Press.
- Morris, Bonnie. 1999. *Eden Built by Eves: The Culture of Women's Music Festivals*. Los Angeles, CA: Alyson Publications.

- Mülhbauer, Wolfgang and Holm, Charlotte. 2005. Computer Imaging and Surgical Reality in Aesthetic Rhinoplasty. *Plastic and Reconstructive Surgery* 115(4): 2098-2104.
- Namaste, Vivian. 2000. *Invisible Lives: The Erasure of Transgender and Transsexual People*. Chicago: University of Chicago Press.
- Naini, Farhad B. 2010. Commentary: Leslie G. Farkas. *Archives of Facial Plastic Surgery* 12(3): 141-142.
- Nanda, Serena. 1999. *Gender Diversity: Crosscultural Variations*. Long Grove, IL: Waveland Press.
- Naugler, Diane. 2009. Crossing the Cosmetic/Reconstructive Divide: The Instructive Situation of Breast Reduction Surgery. In *Cosmetic Surgery: A Feminist Primer*. Heyes and Jones (eds.) Burlington, VT: Ashgate Publishing. pp. 224-237.
- Neff, Lisa. 1999. Dr. Compassion. *The Advocate*. Los Angeles: May 25, 1999: 69.
- Nouraei, S.A. Reza, Prem Randhawa, Peter J. Andrews, Hesham A. Saleh. 2007. The Role of Nasal Feminization Rhinoplasty in Male-to-Female Gender Reassignment. *Archives of Facial Plastic Surgery* 9(5): 318-320.
- Obedin-Maliver, Juno, Elizabeth S. Goldsmith, Leslie Stewart, William White, Eric Tran, Stephanie Brenman, Maggie Wells, David M. Fetterman, Gabriel Garcia, Mitchell R. Lunn. 2011. Lesbian, Gay, Bisexual, and Transgender-Related Content in Undergraduate Medical Education. *JAMA* 306(9): 971-977.
- Oriel, Kathleen A. 2000. Medical Care of Transsexual Patients *Journal of the Gay and Lesbian Medical Association* 4(4): 185-194.
- Ortner, Sherry. 1972. Is Female to Male As Nature Is to Culture? *Feminist Studies* 1(2): 5-31.
- Pang H., K. Pugh, J. Catalan. 1994. Gender identity disorder and HIV disease. *International Journal of STDs and AIDS* 5: 130-132.
- Perpich, D. 2005. Corpus Meum: Disintegrating Bodies and the Ideal of Integrity. *Hypatia* 20(3):75-91.
- Perry, Elizabeth and Rosemary Joyce. 2001. Providing a Past for “Bodies that Matter”: Judith Butler’s Impact on the Archaeology of Gender. *International Journal of Sexuality and Gender Studies* 6(1/2): 63-76.
- Perry, I. 2006. Buying White Beauty. *Cardozo Journal of Law and Gender* 12: 579-607.

- Pitts, Victoria. 2006. The Body, Beauty, and Psychosocial Power. In *Bodies in the Making: Transgressions and Transformations*, Chen and Moglen, eds. Santa Cruz, CA: New Pacific Press.
- Pitts-Taylor, Victoria. 2007. *Surgery Junkies: Wellness and Pathology in Cosmetic Culture*. New Brunswick, NJ: Rutgers University Press.
- Plemons, Eric. 2010. Envisioning The Body in Relation: finding sex, changing sex. In *The Body Reader: Essential Social and Cultural Readings*, Lisa Jean Moore and Mary Kosut, eds. New York: New York University Press, pp. 317-328.
- . Forthcoming. It Is As It Does: Genital Form and Function in Sex Reassignment Surgery. *Journal of Medical Humanities*.
- Pollock, HC. 1964. Dr. Atkinson Disposes of His Library of Applied Anatomy. *American Journal of Orthodontics* 50(2): 140-141.
- . 1969. The Atkinson Library of Applied Anatomy. *American Journal of Orthodontics* 55(5): 510-515.
- Prentice, Rachel. 2007. Drilling Surgeons: the social lessons of embodied surgical learning. *Science, Technology & Human Values* 32(5): 534-553.
- Prosser, Jay. 1998. *Second Skins: the body narratives of transsexuality*. New York: Columbia University Press.
- . 1999. Transsexual Travelogues. In *Reclaiming Genders: transsexual grammars at the fin de siècle*. Kate More and Stephen Whittle, eds. New York: Cassell. pp. 83-114.
- Rabinow, Paul. 1996. *Essays on the Anthropology of Reason*. Princeton, NJ: Princeton University Press.
- Rahman, Q. and G.D. Wilson. 2003. Sexual orientation and the 2nd to 4th finger length ratio: evidence for organising effects of sex hormones or developmental instability? *Psychoneuroendocrinology* 28(3): 288-303.
- Rapp, Rayna. 1999. *Testing Women, Testing the Fetus: The Social Impact of Amniosentesis in America*. New York: Routledge.
- Raymond, Janice. 1979. *The Transsexual Empire: The Making of the She-Male*. Boston: Beacon Press.
- Reis, Elizabeth. 2009. *Bodies in Doubt: An American History of Intersex*. Baltimore: Johns Hopkins University Press.

- Restack, R.M. 1979. The Sex-change Conspiracy. *Psychology Today* 20:20-25.
- Riolo, Michael, Moyers, Robert E., and McNamara, James A. 1974. *An Atlas of Craniofacial Growth*. Ann Arbor, MI: The University of Michigan Center for Human Growth and Development.
- Roberts, Liz. 2008. Biology, Sociality and Reproductive Modernity in Ecuadorian *in-vitro* Fertilization. In *Biosocialities, Genetics and the Social Sciences*, Gibbons and Novas, eds. New York: Routledge. pp.79-97.
- Robinson, Amy. 1994. It Takes One to Know One: Passing and Communities of Common Interest. *Critical Inquiry* 20(4): 715-736.
- Romm, Sharon. 1992. *The Changing Face of Beauty*. St. Louise, MO: Mosby-Year Book, Inc.
- Romo III, Thomas, Edward S. Kwak, Anthony P. Sclafani. 2006. Revision Rhinoplasty Using Porous High-Density Polyethylene Implants to Reestablish Ethnic Identity. *Aesthetic Plastic Surgery* 30:679-684.
- Rose, Nicolas. 2007. *The Politics of Life Itself: Biomedicine, Power and Subjectivity in the Twenty-first Century*. Princeton, NJ: Princeton University Press.
- Rubin, Henry. 2003. *Self-Made Men: Identity and Embodiment Among Transsexual Men*. Nashville, TN: The Vanderbilt Press.
- Rudacille, Deborah. 2005. *The Riddle of Gender: Science, Activism, and Transgender Rights*. New York: Pantheon Books.
- Sacks, Oliver. 1990. *The Man Who Mistook His Wife for a Hat*. New York: Harper.
- Salamon, Gayle. 2010. *Assuming a Body: Transgender and Rhetorics of Materiality*. New York: Columbia University Press.
- Scheper-Hughes, Nancy. 1990. Theft of Life. *Society* 27(6): 57-62.
- , 2007. The Tyranny of the Gift: Sacrificial Violence in Living Donor Transplants. *American Journal of Transplantation* 7(3): 507-511.
- Schiebinger, Londa. 1987. Skeletons in the Closet: The First Illustrations of the Female Skeleton in Eighteenth-Century Anatomy. In *The Making of the Modern Body: Sexuality and Society in the Nineteenth Century*, Catherine Gallagher and Thomas Laqueur, eds. Berkeley, CA: University of California Press.
- , 1993. *Nature's Body: Gender in the Making of Modern Science*. Boston: Beacon Press.

- Schippert, Claudia. 2007. Can Muscles be Queer? Reconsidering the Transgressive Hyper-built Body. *Journal of Gender Studies* 16(2): 155-171.
- Schlich, Thomas. 2007. Surgery, Science, and Modernity: Operating Rooms and Laboratories as Spaces of Control. *History of Science* 45: 231-256.
- Selvaggi, Gennaro, Stan Monstrey, Piet Hoebeke, Peter Ceulemans, Koen Van Landuyt, Moustapha Hamdi, Bowman Cameron, Phillip Blondeel. 2006. Donor-Site Morbidity of the Radial Forearm Free Flap After 125 Phalloplasties in Gender Identity Disorder. *Plastic and Reconstructive Surgery* 118(5): 1171-1177.
- Serlin, David. 2004. *Replaceable You: Engineering the Body in Postwar America*. Chicago: University of Chicago Press.
- Serano, Julia. 2007. *Whipping Girl: A Transsexual Woman on Sexism and the Scapegoating of Femininity*. Berkeley, CA: Seal Press.
- Shams, Mohammad Ghasem, and Motamedi, Mohammad Hosein Kalantar. 2009. Case Report: Feminizing the Male Face. *Journal of Plastic Surgery* (9): 8-14.
- Sharp, Lesley. 2006. *Strange Harvest: organ transplants, denatured bodies, and the transformed self*. Berkeley, CA: University of California Press.
- Sharpley-Whiting, T. Denean. 1999. *Black Venus: Sexualized Savages, Primal Fears, and Primitive Narratives in French*. Durham, NC: Duke University Press.
- Shilling, Chris. 2003. *The Body and Social Theory*. Second Edition. London: Sage.
- Smith, Nat and Eric A. Stanley, eds. 2011. *Captive Gender: Trans Embodiment and the Prison Industrial Complex*. Oakland, CA: AK Press.
- Sofaer, Joanna R. 2006. *The Body as Material Culture: A Theoretical Osteoarchaeology*. Cambridge: Cambridge University Press.
- Somerville, Siobhan. 1994. Scientific Racism and the Emergence of the Homosexual Body. *Journal of the History of Sexuality* 5(2): 243-266.
- Sørensen, Marie Louise Stig. 2000. *Gender Archaeology*. Malden, MA: Polity Press.
- Spade, Dean. 2003. Resisting Medicine, Re/modeling Gender. *Berkeley Women's Law Journal* 18:15-37.
- Spencer, Frank. 1997. *History of Physical Anthropology*. New York: Garland Publications.

- Speigel, Jeffrey H. 2011. Facial Determinants of Female Gender and Feminizing Forehead Cranioplasty. *The Laryngoscope* 121: 250-261.
- Speigel, Jeffrey H. and Tiffany A. Ainsworth. 2010. Quality of life of individuals with and without facial feminization surgery or gender reassignment surgery. *Quality of Life Research* 19: 1019-1024.
- Spitzack, Carole. 1988. The Confession Mirror: Plastic images for surgery. *Canadian Journal of Political and Social Theory* 12: 38-50.
- Star, Susan Leigh. 1979. Sex Differences and the Dichotomization of the Brain: Methods, Limits and Problems in Research on Consciousness. In *Genes and Gender II*. Hubbard and Lowe, eds. New York: Gordian Press. pp.113-130.
- Stewart, T.D. 1954. Sex Determination of the Skeleton by Guess and by Measurement. *American Journal of Physical Anthropology* 12(3): 385-392.
- . 1979. *Essentials of Forensic Anthropology: especially as developed in the United States*. Springfield, IL: Charles T. Thomas.
- Stewart, Susan. 1984. *On Longing: Narratives of the miniature, the gigantic, the souvenir, the collection*. Baltimore, MD: The Johns Hopkins Press.
- Storrow, Richard F. 2003. Gender Typing in Stereo: The Transgender Dilemma in Employment Discrimination. *Maine Law Review* 55: 117-55.
- Stone, Sandy. 2006 [1991]. The *Empire* Strikes Back: A Posttranssexual Manifesto. In *The Transgender Studies Reader*. Stryker and Whittle, eds. New York: Routledge. pp. 221-235.
- Strathern, Marilyn. 2005. *Partial Connections*. Updated Edition. Altamira Press.
- Strong, C. 2004. Should We Be Putting a Good Face on Facial Transplant? *American Journal of Bioethics* 4(3):1-12.
- Styker, Susan. 1994. My Words to Dr. Frankenstein Above the Village of Chamounix: Performing Transgender Rage. *GLQ: A Journal of Lesbian and Gay Studies* 1(3): 227-254.
- . 1998. Introduction. *GLQ: The Transgender Issue* 4(2):145-158.
- . 2008. Introduction: Trans-, Trans, or Transgender? *WSG* 36(3/4): 11-22.
- Stryker, Susan and Sullivan, Nikki. 2009. King's Member, Queen's Body: Transsexual Surgery, Self-Demand Amputation and the Somatechnics of Sovereign Power. In

- Somatechnics: Queering the Technologicalisation of Bodies*, Sullivan and Murray, eds. Burlington, VT: Ashgate. pp. 49-63.
- Sullivan, Nikki. 2008. The Role of Medicine in the (Trans)Formation of 'Wrong' Bodies. *Body and Society* 14(1):105-116.
- Suzedelis, Ann K. 2006. Adding Burden to Burden: Cosmetic Surgery for Children with Down Syndrome. *Virtual Mentor: American Medical Association Journal of Ethics* 8(8): 538-540.
- Talley, Heather Laine. 2011. Facial Feminization Surgery: The Medical Transformation of Elective Intervention to Necessary Repair. In *Gender and the Science of Difference: Cultural Politics of Contemporary Science and Medicine*. Jill A. Fisher, ed. New Brunswick, NJ: Rutgers University Press. pp189-204.
- Taylor, Janelle S. 2005. Surfacing the Body Interior. *Annual Review of Anthropology* 34: 741-756.
- Thompson, Charis. 2005. *Making Parents: The Ontological Choreography of Reproductive Technologies*. Cambridge, MA: MIT Press.
- Throsby, Karen. Happy re-birthday: Weight loss surgery and the 'new me'. *Body & Society* 14(1):117-133.
- Todd, T. Wingate. 1937. *Atlas of Skeletal Maturation*. St. Louis, MO: Mosby.
- Valerio, Max. 2006. *The Testosterone Files: My Hormonal and Social Transformation from Female to Male*. Emeryville, CA: Seal Press.
- van de Ven. B.F.M.L. 2008. Facial Feminization, Why and How? *Sexologies* 17:291-298.
- van der Tuin, Iris and Rick Dolphijn. 2010. The Transversality of New Materialism. *Women: A Cultural Review* 21(2): 153-171.
- Van Wyhe, John. 2004. *Phrenology and the Origins of Victorian Scientific Naturalism*. Burlington, VT: Ashgate.
- Vegter, Florine and J. Joris Hage. 2000. Clinical Anthropometry and Canons of the Face in Historical Perspective. *Plastic and Reconstructive Surgery* 106(5): 1090-1096.
- Walinder, Jan. 1967. *Transsexualism*. Stockholm: Scandinavian University Press.
- Weaver, Mary and Brevard, Aleshia. 2006. Interview. In *Bodies in the Making: Transgressions and Transformations*. Chen and Morgan, eds. Santa Cruz, CA: New Pacific Press. pp. 63-68.

- Weinzweig, Jeffrey. 1999. *Plastic Surgery Secrets*. Philadelphia, PA: Hanley & Belfus, Inc.
- Weiss, Dennis and Rebecca Kulka. 2009. The “Natural Look”: Extreme Makeovers and the Limits of Self-Fashioning. In *Cosmetic Surgery: A Feminist Primer*. Heyes and Jones, eds. Burlington, VT: Ashgate Publishing. pp. 116-131.
- Whittle, Stephen, Lewis Turner and Maryam Al-Alami. 2007. Engendered Penalties: Transgender and Transsexual People’s Experiences of Inequality and Discrimination. *The Equalities Review*. West Yorkshire, England.
- Williams, Terrance J., Michelle E. Pepitone, Scott E. Christensen, Bradley M. Cooke, Andrew D. Huberman, Nicholas J. Breedlove, Tessa J. Breedlove, Cynthia L. Jordan and S. Marc Breedlove. 2000. Finger-length Ratios and Sexual Orientation. *Nature* 404: 455-456.
- Wiss, Rosemary. 1994. Lipreading: Remembering Saartjie Baartman. *Australian Journal of Anthropology* 5(1/2): 11-40.
- Wolf, Naomi. 1991. *The Beauty Myth: How Images of Beauty Are Used Against Women*. New York: Harper-Collins.
- Wyss, Shannon E. 2004. ‘This was my hell’: the violence experienced by gender non-conforming youth in US high schools. *International Journal of Qualitative Studies in Education* 17(5): 709-730.
- Ying, Zhang, Fang Jianlin, Zou Lijian, Dai Chuanchuang, Zhu Guoxian, Shi Feng, Jin Yuqing, Lu Mujun, Wang Wei, Qi Zuoliang. 2006. Lower Face Remodeling by Mandibular Angle Ostectomy. *European Journal of Plastic Surgery* 29:67-71.
- Young, Katharine. 1997. *Presence in the Flesh: The Body in Medicine*. Cambridge: Harvard University Press.
- Zane, Kathleen. 1998. Reflections on a Yellow Eye: Asian I(\Eye/)Cons and Cosmetic Surgery. In *Talking Visions: Multicultural Feminism in a Transnational Age*, Ella Shohat, ed. Cambridge, MA: The MIT Press. pp. 161-201.
- Zita, Jacquelyn N. 1998. *Body Talk: philosophical reflections on sex and gender*. New York: Columbia University Press.
- Zhao, Lun and Bentin, Shlomo. 2008. Own- and other-race categorization of faces by race, gender, and age. *Psychonomic Bulletin & Review* 15(6):1093-1099.

Zhou, Jiang-Ning, Michel A. Hofman, Louis J. G. Gooren, Dick F. Swaab. 1995. A sex difference in the human brain and its relation to transsexuality. *Nature* 378: 68-70.