Trans Surgeries and Cosmetic Surgeries

The Politics of Analogy

CRESSIDA J. HEYES and J. R. LATHAM

Abstract This article examines the various possibilities for making an analogy or disanalogy between cosmetic and trans surgeries, focusing on the suggestion that trans surgeries are medically necessary while cosmetic surgeries are not—a position that has a great deal of rhetorical force. The authors argue that this disanalogy both fails to understand the complexity of the justifications used by recipients of these diverse surgeries and should be seen as symptomatic of various attempts in medical practice to impose particular understandings of suffering, gender identity, and gender politics on trans patients. The appeal to the intense and intrinsic suffering of the trans patient because they cannot become the normatively gendered person they always believed themselves to be, the authors argue, elides the diversity of trans experience as well as coerces trans patients into a politics of ressentiment.

Keywords analogy, cosmetic surgery, transgender medicine, gender norms

Are surgeries to "change sex" like cosmetic surgery, or even just examples of it? Or are the two sets of elective procedures significantly different ethically and/or politically? More than a question, even, an analogy or disanalogy between the two is often invoked in a throwaway phrase or rhetorical gesture. Some trans advocates, for example, reassure that trans surgeries are nothing like cosmetic surgeries, while some social critics object that both cosmetic surgeries and trans surgeries represent capitulation to social norms and should therefore be resisted for similar reasons. In other work, we have each challenged what one might call "trans exceptionalism"—any view that trans people are uniquely positioned with regard to gender norms (Heyes 2003, 2009) or should receive medical treatment unlike that offered to nontrans patients (Latham 2013, 2017a). We have both pointed out the hypocrisies and elisions that trans exceptionalist positions involve, and the way they often work to marginalize the critical perspectives of trans people.

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In this essay, we continue this work by outlining four strategies through which trans and cosmetic surgeries are compared, in order to explore some of the unarticulated or underarticulated judgments about the reasons individuals have for pursuing certain kinds of surgery, as well as what sort of institutional legitimation such reasons should or can receive. In particular, we are interested in the cases in which trans and cosmetic surgeries are articulated as dissimilar from each other. Specifically, trans surgeries are often described as medically necessary, while cosmetic surgeries are positioned as superficial and fully elective. The "medical necessity" of the former is justified as the best treatment for a mental disorder, which the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) currently calls gender dysphoria (GD). As has been well described in trans studies, the diagnosis of GD paradoxically acts to facilitate trans medical interventions while it simultaneously constrains trans people's narratives about themselves. A central part of this constraint is the appeal, embedded in the diagnosis itself and in the medical practices that surround it, to *suffering* as constitutive of being trans. The disanalogy with cosmetic surgery typically embeds the converse claim—that cosmetic surgeries are undertaken for reasons unconnected to psychosocial distress. This latter claim is clearly false. Beyond simply pointing this out, however, we want to argue that the appeal to specific forms of suffering as constitutive of GD risks a politics of ressentiment, in which the more that suffering comes to define the trans narrative, the greater the purchase of a political psychology that disallows transformative self-descriptions and action. Our purpose here is not to dispute that trans people suffer. Rather, it is to question the effects of defending how trans medical services are made available only following a diagnosis that depends on narrating a particular kind of suffering. This is a theoretically and politically significant project in part because, as media and social attention is focused toward trans lives, we find ourselves needing to justify our presence (and existence) within an ever-more disciplined discourse (e.g., Zwi 2016). How might we make possible a politics of self-transformation (and access to medical services) that allows for being trans in more ways?

Four Comparison Strategies

The very categories "trans surgeries" (or "sex-reassignment surgeries") and "cosmetic surgeries" are internally diverse and solicit different justificatory strategies. As feminist critics of cosmetic surgery have amply demonstrated, the rationales that nontrans women invoke for particular procedures vary historically, interculturally, according to the procedure's perceived relation to normative femininity, according to the health-care system in which it is interpellated, and across individuals (Gimlin 2012; Haiken 1999; Heyes and Jones 2009). Similar caveats apply to trans surgeries: while a particular trans man might see a phalloplasty as his only hope of expressing his masculine sexuality, another might narratively

reconfigure a clitoris into his penis, or welcome the sexual pleasures of penetration (Latham 2016). Genital surgeries are typically represented as the most central procedures in gender transition, with peripheral (and newer) procedures, such as facial feminization, under more vigorous contestation as "optional extras" (for reasons of technological capacity, cost, and conceptual distance from the perceived determinants of sex) (Talley 2014: 78–105). This is often not how trans people themselves perceive medical interventions, especially as genital surgeries are typically the most expensive procedures, which many are yet to be able to access. In the medical imagination, as in the popular one, the diverse procedures that move under the signs "cosmetic surgery" or "trans surgery" have different relationships to medical need or social consequence, and in a lot more cases than may be immediately apparent, patients must be careful to situate themselves appropriately to qualify for medical care, government-funded rebates, insurance coverage, or emotional support. It would be the work of another article to try to capture the actual internal complexity of these two categories, but the fact that they both serve as shorthand provides further evidence that analogizing or disanalogizing them has become largely a set of rhetorical flourishes serving political purposes.

Rhetorical comparisons between trans surgeries and cosmetic surgeries fall into four categories. First, there are those who want to suggest that trans surgeries are *like* cosmetic surgeries, and that both are medically unnecessary and undertaken for ethically suspect reasons. The nature of the ethical disapprobation is different for different commentators: some critiques of both trans and cosmetic surgeries argue that they reinforce oppressive gender stereotypes, in which people pursuing either type of surgery are chastised as troubled victims of false consciousness who engage in self-mutilation (e.g., Jeffreys 2014). For others, trans and cosmetic surgeries are alike in that they are motivated by politically naive dissatisfaction with appearance or are conformist practices undertaken for reasons of fashion, and are thus "nonessential." This view casts trans and cosmetic surgeries as frivolous and superficial, to be permitted (perhaps with concomitant moral disapproval) only as free-market transactions, not in either case as medically necessary procedures (see Vincent 2000, 2001). This analogy is also used in less overt terms to justify *denying* health-care coverage for trans surgeries and other medical interventions (see, e.g., J. Brown 2015; Draper 2015).

Second, for some commentators, cosmetic surgeries and trans surgeries can be fruitfully compared without either being judged negatively. For example, Riki Ann Wilchins imagines a dialogue between an authoritative and condescending doctor and a cowed prospective candidate for a nose job who feels like "a small-nosed woman trapped in a large-nosed body." Diagnosed with "rhinoidentity disorder," the patient is refused surgery on demand and is required to "live as a small-nosed woman for three years" before qualifying (Wilchins 1997: 63;

see also Wilchins quoted in Drescher 2002: 76–81). Here Wilchins parodies the very medical framework that, for other commentators, *legitimates* trans surgeries by distinguishing them from cosmetic surgeries. Her analysis implies that the freedom of choosing a surgical intervention like a nose job ought to be available to those contemplating trans surgeries. Similarly, Dean Spade writes:

> I reject the narrative of a gender troubled childhood. My project would be to promote sex reassignment, gender alteration, temporary gender adventure, and the mutilation of gender categories, via surgery, hormones, clothing, political lobbying, civil disobedience, or any other means available. But that political commitment itself, if revealed to the gatekeepers of my surgery, disqualifies me. One therapist said to me, "You're really intellectualizing this, we need to get to the root of why you feel you should get your breasts removed. How long have you felt this way?" Does realness reside in the length of time a desire exists? Are women who seek breast enhancement required to answer these questions? (2003: 21)

Here Spade objects to the disciplining effects of a therapeutic approach that insists on a particular story about being "troubled" over a long period. He obliquely points out that there is much less disciplining for women seeking cosmetic surgery on their breasts—although the answer to his rhetorical question is not as clear a "no" as he might imagine. Paul B. Preciado extends this analogy to the use of hormones:

> I refuse the medico-political dose, its regime, its regularity, its direction. I demand virtuosity of gender: to each one, its dose; for each context, its exact requirement. Here, there is no norm, merely a diversity of viable monstrosities. I take testosterone like Walter Benjamin took hashish, Freud took cocaine, or Michaux mescaline. And that is not an autobiographical excuse but a radicalization (in the chemical sense of the term) of my theoretical writing. My gender does not belong to my family or to the state or to the pharmaceutical industry. My gender does not belong to feminism or to the lesbian community or to queer theory. Gender must be torn from the macrodiscourse and diluted with a good dose of micropolitical hedonist psychedelics. (2013: 397)

Arguably, these comments imply a normative conclusion: trans surgeries (or hormones) *ought* to be available just as cosmetic surgeries are.

Third, there is the disanalogy according to which trans surgeries are perverse, while cosmetic surgeries are acceptable forms of self-improvement. No one in the literature defends this position in these overt terms, but medicine produces and polices this boundary in precisely this way (see Latham 2017a;

Whitehead and Thomas 2013). As Virginia Goldner summarizes, "while we approve, indeed applaud, any and all efforts at excellence in masculinity or femininity that 'improve' upon the gender that is concordant with one's sex assignment at birth, we fear and despise any gestures toward confounding that gender, or crossing over to the 'other' one" (2011: 160). Take, as one example, the first penis transplant in the United States, performed in 2016 on Thomas Manning, a survivor of penis cancer. "He wants to be whole again," said surgeon Curtis Cetrulo, while the first words attributed to Manning himself by the *New York Times* are "I want to go back to being who I was" (Grady 2016). Discourses of sacrifice, restitution, and merit permeate discussions of penis transplants, with the anxious desire to reassure the public that while the procedure is "cosmetic" (in the sense that one can live a physically healthy life without a penis), it is psychologically critical. Reporting on the use of the procedure for injured veterans, the most prominent constituency with genital-urinary injuries, journalist Denise Grady writes:

> Some doctors have criticized the idea of penis transplants, saying they are not needed to save the patient's life. But Dr. Richard J. Redett, director of pediatric plastic and reconstructive surgery at Johns Hopkins, said, "If you meet these people, you see how important it is."
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> "To be missing the penis and parts of the scrotum is devastating," Dr. Redett said. "That part of the body is so strongly associated with your sense of self and identity as a male. These guys have given everything they have." (2015)

When discussing surgical interventions to that part of the body "so strongly associated with your sense of self and identity as male," lingering in the background, of course, are genital surgeries for trans men. Soon enough the comparison comes to the fore:

> Although surgeons can create a penis from tissue taken from other parts of a patient's own body—an operation being done more and more on transgender men—erections are not possible without an implant, and the implants too often shift position, cause infection or come out, Dr. Redett said. For that reason, he said, the Johns Hopkins team thinks transplants are the best solution when the penis cannot be repaired or reconstructed. If the transplant fails, he said, it will be removed, leaving the recipient no worse off than before the surgery. (Grady 2015)

Trans and nontrans surgeries are directly in contrast here: surgeries offered to trans men are presented as insufficient and inadequate to men who are not trans.[1] The purpose of this surgery, then, is positioned as explicitly *reconstructive*:

> Ultimately, the goal is to restore function, not just form or appearance, Dr. Brandacher [the scientific director of the reconstructive transplantation program at Johns Hopkins] emphasized. That is what the recipients want most. "They say, 'I want to feel whole again,'" Dr. Brandacher said. "It's very hard to imagine what it means if you don't feel whole. There are very subtle things that we take for granted that this transplant is able to give back." (Grady 2015)

Trans men writing about their own experiences have, for some time, described in agonizing detail what it is like to live as a "man without a penis" (e.g., Prosser 1998, 2005), as well as the "psychological uplift" offered through obtaining one (Martino 1977: 255; see also Cotten 2012). While trans people have argued that their experience of obtaining surgeries may also be reconstructive, and in part medical treatment for trans people rests on this assumption, it has its limits: "'Once this becomes public and there's some sense that this is successful and a good therapy, there will be all sorts of questions about whether you will do it for gender reassignment,' Dr. Kahn [a bioethicist at the same hospital] said. 'What do you say to the donor? A 23-year-old wounded in the line of duty has a very different sound than somebody who is seeking gender reassignment'" (Grady 2015). Importantly, a donor is always deceased, so the doctor here is referring to the donor's next of kin. But by obscuring this distinction, the justification for offering this surgery to nontrans men seems more obvious: a man might give up his penis to another man, and certainly, the bioethicist implies, a patriotic American man might be more likely to do so for a serviceman injured in combat. "Somebody seeking gender reassignment," then, becomes less deserving by contrast. The reason seems to be that they never had a penis in the first place and, perhaps, are thus not really men. Would a donor's family be willing to donate their deceased husband's/brother's/son's penis to a *transgender* man? This is different, the doctor implies, and "raises all sorts of questions"; trans surgeries are not reconstructive, they are perverse.

Medical Necessity, Suffering, and the Trans/Cosmetic Disanalogy

It is the fourth analogical strategy, however, that has the longest history and the most powerful rhetorical punch for advocates of trans medical interventions: justifications for trans surgeries often rest on the notion of medical necessity through a contrast with cosmetic surgeries. At its most basic, the argument runs like this: while cosmetic surgeries are optional extras that are motivated by vanity or whim and have a relatively superficial impact on a recipient's life, gender-reassignment surgeries are necessary because of the severity of the mental disorder they effectively treat (see Holden 2016). The governing body of trans medical treatment, the World Professional Association for Transgender Health (WPATH),

puts it this way: "The medical procedures attendant to gender affirming/confirming surgeries are not 'cosmetic' or 'elective' or 'for the mere convenience of the patient.' These reconstructive procedures are not optional in any meaningful sense, but are understood to be medically necessary for the treatment of the diagnosed condition. In some cases, such surgery is the *only* effective treatment for the condition, and for some people genital surgery is essential and life-saving" (Knudson et al. 2016: 3). Trans surgeries are here understood as remedial for GD. As we know, to be a "sufferer" of GD—and hence to qualify for trans surgeries (and other interventions) in contexts in which qualifications are determined in reference to *DSM* and WPATH diagnostics—typically requires that one construe these interventions as a restitutive project, in which the subject is brought home to an originary, hitherto invisible identity (Prosser 1998). In this model, gender is understood as essential, stable, predetermined, and beyond the control or choice of the individual. For example, in speaking about her discrimination case against the insurance company, Aetna, Ashlyn Trider says: "This is a medical condition. I was born with it. It's medically necessary surgery. My doctor has strongly urged this procedure get done. It's pretty straightforward" (quoted in Draper 2015). It also typically requires that trans people express a desire for a conventionally sexed body that aligns with a more-or-less conventional gender—within the medical discourse of restitution, ongoing ambiguity is anathema (e.g., see Latham 2018; Sullivan 2008). Finally, GD is distinguished by the severity of its symptoms: David Valentine reports that, among his informants, trans surgeries are "the only possible solution to life-long suffering and a struggle with the sexed body and its social and personal meanings; it is no more a choice than any other medical procedure that might save a life" (Valentine 2012: 192).

A diagnosis of GD is accompanied by a narrative about gender identity that individual patients must adopt to qualify for medical treatment, to greater or lesser degrees, depending on their physicians and health-care system. For some trans people, the narrative description of GD in the *DSM* is a remarkable fit with their lived experience; for those who do not fully identify with it, however, it leads to constraints on individual self-description that have been criticized within trans studies for a long time (see, e.g., Latham 2017a; Stone 1991; Stryker 1997). To obtain a GD diagnosis, someone seeking trans services must describe themselves as already belonging to an alternative sex-gender category. Thus the surgeries or other services a trans person receives are not positioned in themselves as transgendering (or sex changing) but *gender confirming*. That is, instead of saying, "I want to become a man," a trans man is expected to explain himself by saying (in the GD vernacular articulated by the *DSM*), "I was always a man inside and I need my body to match." This distinction is important, as it acts in disallowing particularly gender-nonconforming interventions such as, most obviously, genital

surgeries without matching hormone use, but a whole host of other combinations of interventions as well. That medicine acts this way purposefully is a point emphasized in the eunuch movement: men who desire castration in order to live as "eunuchs," "a third sex," or "something other than male" are routinely denied treatment on the basis they do not present an appropriate gender identity to receive services (see Vale et al. 2010). The American Psychiatric Association stresses this distinction in the *DSM*: "Some males seek castration and/or penectomy *for aesthetic reasons* or to remove psychological effects of androgens *without changing male identity*; in these cases, the criteria for gender dysphoria are not met [and thus surgical interventions should be withheld]" (APA 2013: 458; our emphasis).

The disanalogy with cosmetic surgery contributes to this reasoning by providing a false counterpoint centered on the nature and degree of the suffering involved. Consider, for example, the following reasoning, contained in part of Commissioner Mary Ross Hendriks's opinion in a case brought through the provincial human rights tribunal against the Canadian province of Ontario when it delisted trans surgeries from health-care coverage: "The Complainants, through their pleadings, in their own testimony, and in the testimony of their witnesses, have recounted to the Tribunal the needless suffering and loss of dignity that the de-listing of sex reassignment surgery has caused to both themselves and to the very small number of others with profound GID [gender identity disorder, the precursor to GD] who require sex reassignment surgery in order to live their lives in equanimity as opposed to tragedy" (2005: §43). In Hendriks's judgment (as in others), the rhetorical contrast with cosmetic surgery stands in for a deeper understanding of trans surgeries as necessitated by psychological suffering that can only be remediated by surgery. This implicates the argument in a number of corollaries: that a key marker of GD is suffering of a specific and identifiable kind; that those who want cosmetic surgery do *not* suffer (or, at least, not as much as trans people, and not enough to cross some threshold for insurance coverage); and that suffering (and the negative mental health sequelae it engenders) is central to making appeals to medical services. These are all controversial claims that would be difficult to investigate empirically and even harder to conclusively justify. Although there is plenty of psychological research on both trans and (to a lesser extent) cosmetic surgery, suffering is notoriously conceptually difficult to quantify or even to describe phenomenologically.

Thus, rather than debating the precise extent or the nature of the suffering that trans people experience, we want to make an argument about the risky political effects of crystallizing in law or public policy a subjectivity premised on psychosocial suffering. To do this, we draw on feminist critiques of ressentiment, which is, in its original Nietzschean formulation, the internalization of a slave

morality. Ressentiment is not simply resentment (although clearly the two words are related). Instead, as Wendy Brown reformulates it, ressentiment describes the paradoxical attachment of the socially marginal to the very wounded identities they claim to want to surpass (1995). For many political movements, characterizing and gaining legitimation for a shared experience of powerlessness and suffering has been a central political project. The danger of ressentiment, however, is that such characterizations will be taken up in the psychic life of individuals, as well as circulated in various ways through the polity, such that transformative, active self-understandings and political projects meet with an often tacit or even unconscious resistance. In Brown's words, ressentiment "fixes the identities of the injured and the injuring as social positions, and codifies as well the meanings of their actions against all possibilities of indeterminacy, ambiguity, and struggle for resignification or repositioning" (1995: 27). This is the first main danger that feminist critics have stressed; the second is that political ressentiment may also rely on and reinforce the very relations of power that it claims to oppose (Stringer 2000). For example, Mariana Valverde comments that "some reflections on the perils of mentoring that can be found circulating (verbally) among younger feminists, suggest that ethical problems can develop when women who have gone through hardship but have then 'risen' persist in seeing themselves exclusively as victims in need of support" (2004: 86).

Glimmers of this critique appear in the texts we have already referenced. Wilchins, for example, remarks: "To get surgery, you have to mount what I call an Insanity Defense. *I can't help myself, it's something deep inside me, I can't control it*. It's degrading. . . . In a civilized society, wanting what you want and getting help should not require you to accept a psychiatric diagnosis, produce a dog-and-pony show of your distress, and provide an identity to justify its realness" (1997: 191–92). The risk of this rhetoric is that this show of distress will come to signify the essence of the trans individual—and ultimately, for those who take a biomedical perspective to its logical conclusion, the meaning of their bodies. As Spade puts it, the presumption that to be trans is to be "desperate," and that only suffering individuals would request trans surgeries, is "a fundamental part of the medical approach to transsexualism." In recounting his own experience, he tells us that "the therapists I've seen have wanted to hear that I hate my breasts, that the desire for surgery comes from desperation." He asks, "What would it mean to suggest that such desire for surgery is a joyful affirmation of gender self-determination—that a[n] SRS candidate would not wish to get comfortable in a stable gender category, but instead be delighted to be transforming—to choose it over residing safely in 'man' or 'woman'?" (Spade 2003: 21).

To describe everyone defending access to trans surgeries by referencing suffering as trapped in a politics of ressentiment would be obviously simplistic, as

well as insulting. There is a risk, however: the more suffering comes to define the trans narrative, the greater the purchase of a political psychology that individualizes gender and disallows critique of the systems that contribute to trans people's suffering in the first place. Sandy Stone anticipated this problem almost thirty years ago when she wrote, "What is lost is the ability to authentically represent the complexities and ambiguities of lived experience" (1991: 295). These complexities include positive experiences of sexuality, comfort with ambiguous anatomy, acceptance of a discontinuously gendered life, or (most pointedly perhaps) critique of the psychiatric systems that discipline trans patients.

There is also a converse critique: the suggestion that cosmetic surgery is undertaken by people (mostly women) who "just" want to look good but who could take or leave a particular intervention glosses over and trivializes the diverse lived experiences of its recipients. Cosmetic surgery *is* often justified on the grounds of extreme psychological suffering—even (perhaps especially) when the bodily "flaws" that recipients hope to correct are within "normal" range (e.g., Blum 2003; Davis 2009; Gimlin 2006; Heyes 2007; Jones 2008). Kathy Davis (1995) famously made this argument in her early work with Dutch women who were, not coincidentally, attempting to secure state funding for cosmetic procedures. This suffering is not only descriptive of a particular subjectivity but also similarly produced by a particular scene of address: some cosmetic surgery recipients are interpellated (and interpellate themselves) into contexts in which their emotional pain or desire for normality acts as a counterpoint to the charges of superficiality and vanity that seeking out cosmetic surgery can provoke. As Eric Plemons argues, "The benefits of enhanced self-esteem or the personal peace that comes from an integrated and socially legible body are used to justify many surgical procedures" (2014: 46; see also Benatar 2006). Arguments from suffering are often, and often successfully, used by nontrans people to enable insurance/public coverage for procedures that are considered borderline cosmetic (e.g., Australian Government 2014; Essig 2010). Although beyond the scope of this article, the scene of address clearly includes specific health-care institutions: privatized medicine delivered through insurance companies places different demands on citizens than public systems, and those that have precedent for covering procedures traditionally thought of as cosmetic differ again from those that have never permitted them (see here Edmonds 2007, 2013 on Brazil; Gimlin 2012 for a cross-cultural analysis of the United Kingdom and United States).

To give a detailed example, Diane Naugler (2009) argues that breast reduction surgery sits uncomfortably on the line between the reconstructive and the cosmetic. The Canadian patients she interviewed used a number of tactics to urge that the intervention be understood as the former, thus justifying their right to a provincially funded surgery. Much like many trans people, they researched the

reasons they would have to provide to physicians to be convincing, and they emphasized (or downright fabricated) the physical pain of very large breasts as well as the psychosocial suffering they experienced. Physical pain is, at least in this context, safer ground: it is an unverifiable yet epistemically significant experience. The psychosocial aspect of their self-descriptions, however, was more problematic: Naugler's interviewees needed to frame their suffering through the lens of a normative femininity. They wanted smaller breasts because they hated the (hetero)sexual attention large breasts brought, but they could not want breasts smaller than a C-cup since that would risk removing *all* such attention, which many (hetero-male) surgeons assume is enjoyable for women (or even a condition of adequate femininity). Butch candidates could not risk honestly characterizing the forms of sexual attention they objected to (or wanted); nor could they invoke their embodied identity as grounds for wanting small (or no) breasts (see Butler 2004: 85–87; Latham 2017b: 188). The appeal to suffering here, then, is intertwined with a normative identity: only a particular *kind* of suffering will do, and the actor's capacity to give it meaning is limited (as well as encouraged) by the medical gatekeeper. This example shows how, just as with trans surgical appeals, suffering is incorporated in ways that risk ressentiment and limit agency: some kinds of pain were irrelevant, others needed to be framed or emphasized in strategic ways, and the absence of pain was a contraindication for surgery.

Thus appeals to suffering do not distinguish trans from cosmetic patients, and in both cases suffering needs to be understood within intersubjective political contexts that are not only enabling but also constraining for individuals. The risk of ressentiment is present in both cases but exaggerated for trans patients because of the scripted personal narratives that the diagnosis of GD typically requires. The disanalogy between trans and cosmetic surgeries likewise glosses over the ways that cosmetic surgeries are incorporated by health-care systems, while coverage for the treatment of GD is disallowed. While advocates for trans surgeries might attempt to differentiate them through recourse to medical necessity (as in the WPATH example above), in practice "medical necessity" is consistently used by nontrans patients to access both public and private health coverage for cosmetic procedures. That is, as we saw in the penis transplant example, psychosocial suffering justifies medical treatment. Similarly, breast removal surgeries for gynecomastia ("male breast development") are available in many Western health-care systems to those designated male (but not female), on the grounds that to be a man with "female-appearing" breasts is traumatic (e.g., see Barros and Sampaio 2012). Trans men may access breast removal surgeries only upon proving themselves to be men (through obtaining a GD diagnosis); female persons who identify as women can never access breast removal surgeries unless they have cancer or some other independent health reason for needing a mastectomy. As Naugler's

work shows, while all women are required to want breasts of some size, breast reduction is permitted only if it fits with a normative gender presentation. Thus access to surgery is managed not through the degree of suffering as a marker of medical necessity but, rather, through conformity to a normative understanding of sex-gender of which GD is a neat part.

Conclusion: Self-Determination and Individualized Care

Medically necessary and *medically indicated* are nebulous terms that are often used for obtaining cosmetic surgeries in which the justification of "improved psychosocial functioning of the patient" is routine and acceptable. The question, then, is why trans people cannot access the same interventions without undergoing considerable psychiatric scrutiny aimed at matching them to a detailed narrative diagnosis. It is an established point in trans studies but, it seems, one that persistently disappears: the GD diagnosis dictates a subjectivity by describing a past, present, and future of required self-understanding that is organized just as much around the gender norms upheld by those who wrote it as by observation of trans patients. This diagnosis is disciplinary, not merely descriptive.

GD is resistant to this critique, and trans treatment protocols more broadly are resistant to antipsychiatric critique, for many historical, conceptual, and political reasons. A central justification of GD from trans critics is that it provides access to health care (or insurance) for trans people. Whether this is true is, in part, a research question that could be answered only by empirical study of the interface between trans patients and diverse health-care systems, and while we reference some of this work, we have not drawn any novel empirical conclusions here. Rather, by unpacking the assumptions buried in a disanalogy between trans and cosmetic surgeries, we hope to have shown that the assumption that GD must be accompanied by defined expressions of suffering originating exclusively in the individual carries political risks, while the characterization of cosmetic surgery as not medically necessary because psychologically trivial is so clearly false that it can only serve as an empty rhetorical counterpoint. Instead, both trans and cosmetic surgeries are justified or withheld within health-care systems using the language of medical necessity. As we have shown, going back behind this language reveals it to be invested in gender conformity in both sorts of cases.

Still, we are clear that access to medical services (including surgery) is important and valuable for many trans people, and it should be provided as we provide care for people with appendicitis or depression. The ultimate question is, what sort of gatekeeping is apt? We do not support completely unfettered on-demand access to any plastic surgery, but we are not psychologists and cannot elaborate what sort of counseling practice is most appropriate here. We are simply noting that whatever gatekeeping is done should not participate in hypocritical

trans exceptionalism, which it currently does. As Timothy Cavanaugh and colleagues argue, "The SOC [Standard of Care]'s continued reliance on mental health professionals to determine eligibility and readiness for treatment perpetuates a message that neither the patient nor the prescribing clinician is capable of a nuanced discussion of gender variance and its management" (2016: 1150). Individual trans patients should be able to describe their past, present, and future; embodied experience and aspirations; felt sense of self; and so on, in diverse terms without being disqualified from surgery. This novel practice would also dispel the risk of ressentiment by uncoupling suffering of prescribed kinds from a singular trans subjectivity. The question "What is medically necessary for whom?," then, is one that should be decided by clinicians with their patients. Indeed, WPATH itself claims, "It is important to understand that every patient will not have a medical need for identical procedures. Clinically appropriate treatments must be determined on an individualized and contextual basis, in consultation with the patient's medical providers" (Knudson et al. 2016: 30). Ensuring just and equitable treatment must not require all trans patients to undergo identical regimes of interventions, and defending the diagnosis is not the only way to ensure access to trans interventions. As Judith Butler argues:

> Examples of the kinds of justifications that ideally would make sense and should have a claim on insurance companies include: this transition will allow someone to realize certain human possibilities that will help this life to flourish, or this will allow someone to emerge from fear and shame and paralysis into a situation of enhanced self-esteem and the ability to form close ties with others, or that this transition will help alleviate a source of enormous suffering, or give reality to a fundamental human desire to assume a bodily form that expresses a fundamental sense of selfhood. (2004: 92)

These more diverse and political aspirations apply across the board to those surgeries we have been calling "trans" and "cosmetic."

Cressida J. Heyes is professor of political science at the University of Alberta. She is the author of *Self-Transformations: Foucault, Ethics, and Normalized Bodies* (2007) and the coeditor with Meredith Jones of *Cosmetic Surgery: A Feminist Primer* (2009). Her work can be found on cressidaheyes.com.

J. R. Latham is honorary fellow in cultural studies at the University of Melbourne. His work has been published in *Aesthetic Plastic Surgery*, *Australasian Journal on Ageing*, *Feminist Theory*, *Sexualities*, and *Studies in Gender and Sexuality*. Visit jrlatham.com.

Note

1. That this distinction is sexual is unsurprising, as trans people are constituted medically through sexual inadequacy (see Latham 2016).

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