UNIVERSITY OF CALIFORNIA
SANTA CRUZ

DANGEROUS IF LEFT UNTREATED: THE CONSTRUCTION AND PRODUCTION OF THE TRANSGENDER BODY

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

DOCTOR OF PHILOSOPHY

in

FEMINIST STUDIES
with an emphasis in CRITICAL RACE AND
ETHNIC STUDIES

by

Dana T. Ahern

June 2022

The Dissertation of Dana T. Ahern is approved:

_____
Professor Felicity Amaya Schaeffer, co-chair

_____
Professor Neda Atanasoski, co-chair

_____
Professor Nick Mitchell

_____
Professor Christoph Hanssmann

_____
Peter Biehl
Vice Provost and Dean of Graduate Studies

Table of Contents

List of Tables

List of Figures

Abstract

Dangerous If Left Untreated: The Construction and Production of the Transgender Body

Dana T. Ahern

Transition medicine has developed significantly within the last hundred years, with much of it originating out of Eastern Europe and Asia. With its import into the United States, the state's interest in managing this medicine has also grown. My project argues that as transition medicine has grown, it has increasingly aligned with normalizing processes that closely surveil and control how it is accessed by transgender people. Using transgender memoirs and first-person accounts available through the Digital Transgender Archive (a virtual archive holding a broad collection of materials relating to queer, transgender, and gender-nonconforming life largely from the last one hundred and fifty years), my first chapter begins with a history of transgender medicine alongside developing state investments in medical transition, comparing two state-sanctioned transitions in Great Britain and present-day Latvia. The chapter compares historical legacies of state investment in transgender medicine that conflict with the otherwise homophobic and transphobic policies they enact. In my second chapter, I argue that these histories inform current research methods through an analysis of transgender medical conferences. Based on research I conducted while attending a variety of conferences between 2019-2020, I assess how medicine continues to align itself with the state to construct "healthy" transitions (those that successfully construct normatively gendered citizen subjects) while pathologizing transitions that are unable to become normatively gendered, i.e. trans

people of color and/or non-cis-passing trans people. My final chapter turns to medical and surgical advertisements for transition medicine and connects the histories of medicine with the modern discourse of transition care through an analysis of the sale of transgender medicine. I explore how medicine works in conjunction with capitalism, producing a trans-embodiment that can be bought and sold. I end the dissertation by ultimately arguing that transition medicine's historical alliance with state powers works not to enable medical transition and transgender people more generally, but to manage them.

Acknowledgments

This project would not exist without the mentorship from my committee. I am so grateful to my advisors, Felicity Amaya Schaeffer and Neda Atanasoski, for their patience, generosity, and their belief in both this project and in myself. I am deeply grateful for Nick Mitchell's brilliant teaching, gentleness, and compassion that has kept me going particularly in this last year, and for Chris Hanssmann's generous thinking and source of conversation and intellectual community during the isolating moments of writing this dissertation.

I also would like to thank my professors who also provided insight and support throughout my PhD, including Neel Ahuja, Sylvanna Falcón, and Bettina Aptheker. I also want to thank Christine Hong, who read drafts of articles and chapters and believed in the importance of my work in the moments I could not. Thank you to the staff of Feminist Studies and Critical Race and Ethnic Studies, Taylor Ainslie, Shauntay Larkins, Laura Wilson, and Lisa Supple. I also want to thank the San Francisco State University Science, Technology, and Society Hub for welcoming me and giving me the space to develop my project, as well as the Postsocialist Working Group run by Christina Novakov-Ritchey and Marcos Cisneros, for their brilliant conversations.

Finally, I want to acknowledge my friends who have been intellectual touchstones and emotional supports – Roxanna Villalobos, José Alejandro Mazariegos, Victoria Sanchez, Noya Kansky, Taylor Wondergem, Claire Urbanski, and last but certainly not least, Heather A. Mooney. Heather has been my

collaborator, cheerleader, and most trusted friend. I can't imagine a better person with whom to go through both a master's and PhD. She is a force of nature and I am honored to call her my friend and colleague.

I thank Dr. Eliza Yanik, Doctor of Veterinary Miracles, and the staff of VCA Bascom Animal Hospital, especially Lauren, Tayler, Candace, and Natalie. I am eternally grateful.

Finally I thank my family. Elizabeth Burger – for her patience, support, reassurance, and love, I am endlessly grateful, Patti Ahern, who kept insisting I could do this, Drew, Beau, and Jed Ahern, and Deb, Todd, Jonah, Augustus, and Natasha Burger. Finally, I want to thank Henry and Colleen who came into my life when I needed them most, filling it with joy, love, and comfort. Most of all, I thank Lester and Phineus. They were with me in the beginning and middle and my heart is forever broken that they were not with me at the end.

Introduction

I had just begun my doctoral studies and was trying to build a rapport with my new medical provider, a nurse practitioner who handled the bulk of transgender healthcare at the university, including both transition-related and routine medical care. After telling her about my research interests in transgender studies, even before the project took a medical turn, she suggested that I connect with a committee in the health center that was working to expand coverage for transition medicine for university insurance policies and suggested I get involved. Eager to make connections with other queer and trans people and get involved in my new community, I attended a meeting of the committee. I was, perhaps naively, surprised to find that I was the only transgender person in attendance. I sat back to listen and learn more about the committee and what they were attempting to do for transgender students. They talked about some of the procedures to which they wanted expand insurance coverage and explained to the group why each procedure was medically necessary. My discomfort grew, as the logic of "medically necessary" is a fraught term that begs the question of what procedures or processes are deemed objectively "medical necessity," and which ones are optional. So much of trans health has been positioned as "life-saving," or as alleviating the mental health tolls of gender dysphoria and the dangers that come from ongoing mental anguish, but then which parts of gender transition are deemed frivolous? As I listened to the committee discuss implementing insurance coverage for trans feminine breast augmentation, I was surprised as they described its importance in helping minimize risks of violence

that the potential patient might endure should they be perceived as a trans person. The trans person's need to "pass" as cisgender was prioritized not because of the anguish *they* might feel, but because of the violence their body might provoke. I looked around the room in surprise, wondering if anyone else was having the same reaction as me, but instead, I saw the room quietly nodding along in agreement.

I left the meeting confused and uncomfortable, as I wondered what compromises – what "necessary evils" – were needed as short-term solutions for issues like expanding insurance coverage. What risks did these compromises pose by re-positioning medicine's impact on transgender bodies not as an aid or asset, but as a system exerting power over transness? As trans people, we are familiar with, and indeed have made *progress*, in challenging various narratives of pathology attributed to transness and queerness more broadly. "Homosexuality" was removed from the *DSM* in 1973 and "Gender Identity Disorder" became "Gender Dysphoria" with the DSM's 5th edition, published in 2013.[1,2] At that time, the American Psychiatric Association insisted even that the inclusion of transness as a diagnosis at all was a "necessary evil" for the bureaucracy of medical insurance.[3] In this move away from *pathologizing* transness, however, I argue that transness does not become un-

1. Jack Drescher, "Out of DSM: Depathologizing Homosexuality," *Behavioral Sciences* 5, no. 4 (December 4, 2015): 565–75, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4695779/.

2. Zowie Davy, "The DSM-5 and the Politics of Diagnosing Transpeople," *Archives of Sexual Behavior* 44, no. 5 (June 9, 2015): 1165–76.

3. American Psychiatric Association, "Gender Dysphoria," 2013, https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM-5-Gender-Dysphoria.pdf.

medicalized, but rather commodified through medicine, where the disruptive potential of transness in provoking violence demands management. My project tracks medicalized transgender histories, bringing together memoirs, confessionals, imagery, and communications between and across trans communities to draw out the ways that transness has progressed from a site of pathology to a site of profit. As transness rebukes medicalization, power continues to operate on it via capitalism, such that a depathologized transness, still in need of *management*, is organized by their potential for profit. Memoirs and first-person accounts of early trans lives in the mid-20th century, beyond the romanticized or sensationalized narratives of the firsts of trans history, depict an early and untapped market. This time of medicine pre-privatization (and of transness that existed before its processing as a liberal rights-bearing subject) focuses on the production and management of the trans body as (non)pathological, and it is in this move into the present day that we see the stakes of a fully capitalized transgender subject, increasingly unburdened by pathology, made free at their own cost.

I begin my dissertation by examining the liberal rights bearing trans subject as it emerged out of the retelling of formerly obscured trans histories. I begin to build a transgender archive, looking at what is obscured, not simply as that which falls out of trans histories, but also as that which is forcibly suppressed and also, importantly, as that which does not want to be found or exposed. Focusing on two cases of early medical transitions, one in Latvia and one in Britain, I compare the implications of these two examples of state sanctioned gender transitions as "firsts" in transgender

history and the impact of the suppression and re-emergence of these stories in the last five years. In particular, I look at how the Latvian transition remains a sensationalized story of shameful trans pasts, and the British transition, romanticized in his survival in the archives, becomes mobilized by liberal democratic capitalism to produce the rights-bearing trans subject.

Building on this analysis of how the medicalized trans subject is mobilized by liberal capitalism, I explore what I term the citizen-patient, which collapses the transgender person into a patient as well as a consumer, examining how the citizen-patient is that which is deemed able to transition in a healthy way. Beyond the question of transness as pathological, I use Nikolas Rose's idea of biological citizenship to examine how the pathology of transness is in conversation with and dependent upon the idea of "good citizenship."[4] My project defines transition medicine broadly, as encompassing the transgender surgical industry, transgender pharmaceutical/endocrinological interventions, transition-focused therapeutic/psychiatric care, and the governmental medical institutionalization of transness enforced by global/state health organizations that create transgender standards of care, i.e. the World Professional Association for Transgender Health (WPATH), the World Health Organization (WHO), and the American Psychiatric Association (APA). As medicine as an arm of the state continues to *manage* the

4. Nikolas Rose, *The Politics of Life Itself : Biomedicine, Power, and Subjectivity in the Twenty-First Century.* (Princeton: Princeton University Press, 2009), 140.

disruptive potentials of transness, I explore how it enters and mobilizes trans spaces.[5] At the same time that transgender medicine defines the pathological, it is able to gain access to trans spaces under the premise of offering differential access that is dependent upon one's willingness and ability to be "cured." There are a growing number of providers who challenge or attempt to bypass the institutional standards of care that they believe harm trans people, such as the requirement for therapists to give "permission" to their clients to begin transition, and while I critique trans medicine, I do not want to negate this work.[6] However, the premise of a benevolent provider, perhaps one who is even trans themselves, ignores how the medicolegal systems which continue to manage and *profit* from trans people remain intact. When trans people are under attack by antitrans legislation, they are still "protected" or "defended" under the guise of "good citizenship" – as nonthreatening and "just" wanting access – to medicine, to sports, to bathrooms. The focus on trans people needing access obscures the ways that trans medicine profits from transness in such a way that requires providers have access to patients.

Beyond the question of a medicalized transness, I explore how transgender medicine, particularly transgender surgery, depends on the ability to move through

---

5. Foucault, Michel. "The Politics of Health in the Eighteenth Century." In *Power/Knowledge: Selected Interviews and Other Writings 1972-1977*, edited by Colin Gordon. Vintage Books, 1980.

6. stef m. shuster, *Trans Medicine: The Emergence and Practice of Treating Gender* (New York, New York: New York University Press, 2021), 122–24.

otherwise transgender-specific spaces, and I discuss the commodification of transitioning as an act of unqueering transness. The transgender surgical market processes trans bodies into a site of profit, where these pre-operative transgender bodies, in their visible queerness, cause discomfort to a cis-normative society, and the commodification of trans surgeries encourages what I term a "dis-memberment" from queerness/transness. Medicine, in collaboration with capitalism, encourages a dis-membering from transgender communities and instead offers a space of conditional inclusion. Despite this exploitation of transgender bodies into simply results, or products, I end with an analysis of how transgender people are able to create spaces for knowledge and resource sharing between and amongst each other that refuses their own commodification.

Methods

I examine memoirs and confessionals spanning the major sites of early transgender medical developments in the early to mid-20th century of Britain and Eastern Europe, particularly in the 1940s and 1970s. The technology required for phalloplasty, the surgical procedure used to create a phallus for transmasculine people, originated in Russia in the 1930s, and this technology informed transgender phalloplasties across Europe during this time period.[7] I use these first-person accounts of early transgender phalloplasties to compare how transgender medicine

7. A.I. Gabouev et al., "Nikolaj A. Bogoraz (1877–1952): Pioneer of Phalloplasty and Penile Implant Surgery," *European Urology Supplements* 2, no. 1 (February 2003): 125.

began to be narrated in the mid-20th century and how these stories re-emerge in the present moment, read through and inscribed with the filter of present-day geopolitics.

I connect this analysis with a discussion of formal transgender medical and social conferences in the United States. I focus on three major gatherings: the South Florida Transgender Medical Consortium which is attended exclusively by students and smedical providers seeking (continuing) education, Fantasia Fair which is primarily for transgender attendees seeking community and socializing, and Gender Odyssey which offers both continuing education opportunities for medical providers as well as space for discussions and socializing amongst transgender attendees. I examine these conferences' origins in the late 20th/early 21st century, how their missions have changed over time, and how these spaces produce particular kinds of discourse and dialogue between and across transgender communities and the medical providers with whom they work.

Finally, I look at transgender surgical imagery as it circulates as advertisement or information sharing on social media websites by transgender providers and patients in the United States and Canada in the last five to ten years. I analyze post-operative images, video advertisements, and clips of transition surgeries filmed in operating rooms posted by transition surgeons to their professional websites and social media accounts, such as Instagram and YouTube. I compare these images and videos with those created and shared by transgender people themselves, meant to primarily circulate amongst transgender people seeking more information on surgery and potential surgeons for their own future procedures. I perform close reads of these

pieces of visual media and examine how and where they exist online, and what their intention is in reaching transgender audiences as either advertisement and/or resource.

I sit with and bring to the fore the uncomfortable contradictions of transgender histories – of doctors and surgeons as both advocates and profiteers, of transgender history that is both suppressed and overemphasized. My project assembles a transgender archive of medicine as it is carried in and by the transgender body itself and it attempts to ask what and who make up this archive and these histories of transgender pasts. My project necessitated the conceptualization of transgender archives that bring together otherwise disparate pieces of transgender histories and lives. I use personal memoirs and interviews of people in trans history as both a primary source as well as a point of analysis to examine the consumption of these materials in the present day by transgender communities. My use of transgender medical conferences and gatherings allowed me to explore the infiltration of medicine into transness that promotes not simply a "healthy" transness, but a minimally qeuer one. Finally, I was further able to explore this shift from the framing of medicine as infiltrating transness in my use of social media. I re-articulate the connections across time and space to draw attention to the inception of (particularly medicalized) transness out of and through logics of capitalism, colonialism, and state power that were unconsciously reinscribed upon the transgender body.

Literature Review

My project is in conversation with and framed by medicine, science, and technology studies, transgender studies, and queer studies as I attempt to make sense

of the formulation of transgender identity as it is produced via medicolegal systems and the emerging transgender medical marketplace. In her work on pediatric gender nonconformity, Sahar Sadjadi discusses the increasing legislation across the United States that attempts to ban access to childhood medical transition, noting the nuances that are lost in these debates. Specifically, Sadjadi emphasizes the need to present transgender medicine as unquestionably life-saving in order to argue against these laws. Calling to task the dangers in using the "rhetorically useful figure of the vulnerable child," Sadjadi's analysis focuses on the insufficient research on the health impacts of puberty blockers. Despite the lack of research on the side effects of these drugs, as well as the initial appeal behind the rise in popularity of puberty blockers as a reversible deterrent to later transitioning, Sadjadi notes, "In the U.S. context, however, puberty blockers soon became closely associated with supporting transgender children, within a clinical and cultural field shaped largely by cisgender parents and clinicians." She goes on to discuss the attacks against hormone blockers by conservative and antitrans groups saying, "legitimate disagreement over these medical treatments has become politically implausible in circles that affirm the lives of transgender children." [8] It is this nuance that my project attempts to find in transgender histories. In these alliances with and between states, medical providers, and capitalism, I ask, what *is* life-saving transition medicine? For whom is it life-saving and to what extent? Sadjadi's analysis begins with an examination of both

8. Sahar Sadjadi, "The Vulnerable Child Protection Act and Transgender Children's Health," *TSQ: Transgender Studies Quarterly* 7, no. 3 (August 1, 2020): 512.

antitrans legislation and the response that insists on the importance of transgender life. However, regardless of the outcome, these debates seem to result in the production of an increasingly vulnerable transgender life, where one is positioned as either receiving *no* care, or receiving medical care that is potentially dangerous.

In conversation with works such as Jules Gill-Peterson's *Histories of the Transgender Child* (2018), I explore the interactions between and among the different categories of transgender medicine – surgical, pharmaceutical, therapeutic medicine and the global/state institutions that define standards of care – both historically and moving into the present day, discussing how trans medicine offers differential access to those it deems in need of treatment. Gill-Peterson writes of the problematic inattention to the racialization of (trans)gender in transgender medical archives: "The frequent absence of black trans and trans of color children in the clinic's archive, in particular, is not only a product of medical gatekeeping or the whiteness of transsexuality. It is also the product of a *distance* practiced by black trans and trans of color people from institutionalized medicine, which was well understood to be a dangerous and frequently violent apparatus."[9] Gill-Peterson draws attention to these absences, illustrating the interaction between whiteness, medicine, and the documenting of transgender histories. As she states in her text, Gill-Peterson's archival analysis "[undoes] the stubborn presumption that modern medicine played a causal role in defining the parameters of trans life. It did not. Trans life evidently

9. Jules Gill-Peterson, *Histories of the Transgender Child* (University of Minnesota Press, 2018): 31.

preexisted any early twentieth-century medical discourse that could claim to know it."[10] This critical intervention challenges the inherence of medicine as creating the transgender body and the transgender self, and I seek to build on this intervention in this dissertation. As medicine seeks to re-affirm its importance in defining transgender lives and in creating transgender identity, I further explore how medicine profits from debates within and around transgender identity in connection with state projects of regulating transness. Arguments for transgender civil rights continually center around not just medical access, but the disruptive and violent potentials of the non-medicalized transgender body. These fights for access, rather than challenging the state, encourage instead a *compromise* to transgender identity – one that advocates a making-legible of transness for the purpose of "access." As Gill-Peterson states in her critique of medicine making the trans body, "trans children had no need for medicine to live trans lives," and I build on this question to ask what exactly, if not trans life, has transgender medicine ultimately produced?[11] To answer these questions, I utilize my archival creation and analysis, reading together state investments in transition care, records of medical developments, and transgender pasts. In assembling this archive, I read the formation of transgender subjectivity across and against linear time, troubling the notion of progress that is ascribed to transition.

10. Gill-Peterson, 95.

11. Gill-Peterson, 6.

As transgender medicine becomes framed as life-saving, I consider explore what exactly threatens the transgender life. The standards of care put forth by organizations like the American Psychiatric Association describe "dysphoria" as a primary symptom of transness, a term which originates out of diagnostic tools used to describe a specific state of (often embodied) dissatisfaction, and in the context of "gender dysphoria," refers to the distress of living as the gender assigned at birth. Transgender people themselves also employ the term to describe discomfort surrounding specific body parts or general discomfort around their gendered experience, describing incidents such as "top/chest dysphoria" or "bottom dysphoria" to locate particularly troubling pieces of their anatomies. The Diagnostic and Statistical Manual was largely lauded for its 2013 decision to reclassify transgender identity as "gender dysphoria" as opposed to the former diagnosis of "Gender Identity Disorder," stating, "The current term is more descriptive than the previous DSM-IV term gender identity disorder and focuses on dysphoria as the clinical problem, not identity per se," making clear that the "disease" of transness is not about being trans, but about *feeling* trans.[12] The APA cited the change of this term for the purposes of removing the stigma of "disorder," although they could not do away with a diagnosis altogether stating:

> Persons experiencing gender dysphoria need a diagnostic term that protects their access to care and won't be used against them in social, occupational, or legal areas. […] To get insurance coverage for the medical treatments,

12. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (Arlington, VA: American Psychiatric Association, 2013): 451.

> individuals need a diagnosis. The Sexual and Gender Identity Disorders Work Group was concerned that removing the condition as a psychiatric diagnosis—as some had suggested—would jeopardize access to care.[13]

Despite the intention of keeping the diagnosis for the purposes of insurance access, claims listed under a diagnosis of "gender dysphoria" are still frequently denied by insurance; as such, providers frequently code transgender procedures as "other endocrine disorder." The continued need to work around the diagnosis of "gender dysphoria" calls the usefulness of this change in terminology into question. Most significantly, I argue that "gender dysphoria" as a diagnosis does not actually describe the discomfort a trans person feels about their own body, but instead, describes the discomfort and disruption that a transgender body provokes from cisgender onlookers. A transgender body whose gender will not or cannot be made undisruptive – particularly a racialized transness whose plasticity of gender is always already denied by medicine – becomes labeled noncompliant.

I examine this idea of "noncompliance," particularly as it attaches to racialized transgender patients, in the ways that medicolegal systems attempt to manage transness. In his analysis of visibility, passing, and surveillance, Toby Beauchamp writes of the way transgender bodies, particularly those deemed noncompliant or "unruly" are impacted by these powers, stating:

> Medical science purports to normalize unruly transgender bodies through surgery and hormones. These interventions are intended to eliminate any signs of deviant gendering, creating a non-threatening body that is undetectable as trans in any way. Transgender bodies that conform to a dominant standard of

13. American Psychiatric Association, "Gender Dysphoria."

> dress and behavior may be legible to the state not as transgender at all, but instead as properly gendered and "safe."[14]

He goes on to discuss the ways that these unruly figures are inherently racialized, particularly because of the ways that "proper gender" becomes defined through whiteness, as well as heterosexuality, ability, and class. I examine in more detail the ways that medicine and law align to produce "proper channels" through which to seek transition care. Where once the only way to access these resources before was dangerous, difficult to find, or prohibitively expensive, "proper channels" now exist to "protect" the patient, doctor, and state.[15,16] These proper channels and the protections they offer are distributed unevenly and strategically to reinforce and reify the idea of the law as the only way through which to access and provide transition care. I further examine the outside of these "proper channels" in the ways that they open up queer trans potentialities that refuse the authority of medicolegal transition. Moreover, rather than looking to medicine as having openings for queer potentialities, I explore trans spaces as they are infiltrated by medicine that risk evacuating them of transness. I cautiously explore the ways that attempts to engage trans medicine

14. Toby Beauchamp, "Artful Concealment and Strategic Visibility: Transgender Bodies and U.S. State Surveillance after 9/11," *Surveillance & Society* 6, no. 4 (June 26, 2009): 356–66.

15. Transition providers, as well as patients, have historically been impacted and threatened by the limitations in accessing transition medicine. In 1987, a trans man sued his surgeon for malpractice following a botched top surgery. The surgeon quit his practice following the trial because his malpractice insurance would not cover claims from transition surgeries.

16. Ghosh, Nicholas, and Raj, Rupert. "Metamorphosis Magazine Vol. 6, Nos. 1-2 (January-April 1987)." Periodical. 1987. *Digital Transgender Archive*, https://www.digitaltransgenderarchive.net/files/zp38wc69f.

queerly, or the attempts to explore trans medicine with trans providers, offers a false sense of comfort.

I connect my analysis of the proper channels for medical transition with Eric Plemons exploration of how (trans)gender becomes determined through the medically altered body in his book, *The Look of a Woman: Facial Feminization Surgery and the Aims of Trans-Medicine* (2017). Plemons explores the emergence of facial feminization surgery (FFS) and its impacts on transgender medicine in nuancing the definition of what determines a "successful" gender transition. Plemons's analysis discusses the ways in which a transgender woman's face becomes that which makes her "recognizable" as a woman. Rather than framing "sex" as determined by one's genitals, Plemons describes the shift in transgender medicine that acknowledges a "recognition-based model of sex and of sex change."[17] This argument illustrates how the efficacy and success of medical transition, particularly in the context of FFS, becomes determined by one's recognizability as a woman. This question of recognition becomes increasingly important when considered within the context of legislative protections for transgender people, where one's visible transness becomes that which marks them as at risk. In this framing, the transgender body is one which incites violence. It is not the victim, but the instigator of disruption. If the transgender body is upsetting to the non-trans audience, then what is the relationship

17. Eric Plemons, *The Look of a Woman Facial Feminization Surgery and the Aims of Trans-Medicine* (Duke University Press, 2017), 3.

between trans person and provider? The transgender body receives care not to alleviate its symptoms, but instead to *manage* the disruptive potential.

Plemons further argues that FFS and its growing popularity was made possible in the late 1970s and 1980s as transgender medicine moved into private practice, out of the university clinics out of which it had originated. In this move towards for-profit trans medicine, he states, "trans-medicine was part of a massive wave of privatization of American medicine in the 1980s. In for-profit trans-medicine, as in other medical specialties, patients qua consumers were newly empowered – and expected – to direct their own health decisions."[18] Plemons's analysis illustrates the nuance within the limitations placed upon transgender medicine that both open up access, at least for those who can afford it, at the same time that it positions the transgender body as a site of profit. I explore this shift towards for-profit (trans) medicine in my own analysis of the emergence of transgender surgery as I track the differential routes of accessing transition care as it continues to be held hostage (primarily for poor and of color transgender people) by medicolegal gatekeeping. I examine this connection across medical markets, legislation regulating the access of trans medicine, and the transgender body as a potentially disruptive one.

Contributions

My research examines an as yet unexplored connection between Eastern Europe and the U.S., troubling the United States' position an innovator in medicine and

18. Plemons, 12

transition care (Najmabadi 2014), while I also trouble the positioning of transgender medicine as life-saving and rearticulate an acknowledgement of medicine as violence.[19,20] In April 2021, during his first address to Congress, President Joe Biden stated, "For all transgender Americans watching at home, especially young people who are so brave – I want you to know your president has your back."[21] This gesture came at the same moment that anti-transgender legislation began sweeping the United States, aimed primarily at transgender youth and their ability to both participate on gendered sports teams in accordance with their gender identity as well as their right to access or begin medical transition before the age of 18. As these pieces of legislation continue to attack transgender rights, transgender advocacy groups increase their appeals to the nation, where the appeals themselves increasingly rely on narratives of normalization that reinvest in this system of liberal democracy at the same moment that it seeks to manage transgenderness.

After one such bill targeting transgender youth participation in sports was passed in Alabama, the Alabama director of the Human Rights Campaign, Carmarion D. Anderson-Harvey stated, "Trans kids are just kids. They deserve every

---

19. Alondra Nelson, *Body and Soul: The Black Panther Party and the Fight against Medical Discrimination* (Minneapolis, Minnesota: University of Minnesota Press, 2013).

20 Paul B Preciado, *Testo Junkie Sex, Drugs, and Biopolitics in the Pharmacopornographic Era* (New York, NY Feminist Press, 2017).

21. Joseph Biden, "President Biden's Joint Address to Congress" (April 28, 2021), https://www.youtube.com/watch?v=Bh87V3f0FaA&ab_channel=TheWhiteHouse.

opportunity like every other kid to play the sport they identify in [*sic*]."[22] Veronica Ivy, a trans woman and competitive cyclist who received widespread harassment from people such as Martina Navratilova and Donald Trump following her first-place win at the UCI Track Cycling World Championships, put forth a statement regarding attempts to limit transgender sport participation. She stated, "Now is a terrifying time to be a trans child. There is absolutely an all-out assault on your rights, your dignity. Like the right to play is being taken away from you just because of who you are. And that feels scary." [23,24,25] Anderson-Harvey and Ivy's statements paint the picture of the innocently transgender child – "just a kid" whose "right to *play*" is at risk. Especially considering the relationships between sports and nationalism, the centralization of transgender issues upon the transgender child's ability to participate in sports – to *play* – becomes a metaphor for questions of belonging/nonbelonging via the construction of a transgender citizen. The transgender child, as Anderson-Harvey states, is "just" a child; their inclusion as a citizen holds no threat if it is evacuated of

22. Brian Lyman, "Alabama Gov. Kay Ivey Signs Bill Banning Transgender Youth from Public School Sports," USA TODAY, April 21, 2021, https://www.usatoday.com/story/news/politics/2021/04/23/alabama-kay-ivey-signs-ban-transgender-youth-public-school-sports/7361044002/.

23. Frances Perraudin, "Martina Navratilova Criticised over 'Cheating' Trans Women Comments," *The Guardian*, February 17, 2019, https://www.theguardian.com/sport/2019/feb/17/martina-navratilova-criticised-over-cheating-trans-women-comments.

24. O'Kane Caitlin, "Transgender Cyclist Defends Her World Championship Win after Donald Trump Jr. Calls It 'BS,'" CBSNews.com, October 22, 2019, https://www.cbsnews.com/news/transgender-cyclist-rachel-mckinnon-defends-her-world-championship-win-after-donald-trump-jr-calls-it-bs-twitter/.

25. Lyman, "Alabama Gov. Kay Ivey Signs Bill"

its threatening "trans" qualifier. In addition to the debates surrounding the child, there is increasing discussion and inclusion of nonbinary gender identities. The move to include "X" as a gender category on state IDs suggests that nonbinary transgender people may too now be "just people," such that nonbinary identity does not necessarily preclude the idea of good citizenship that was a requirement long tied to the ability to medically transition.

This dissertation examines how transition medicine, particularly in its engagement with and inclusion of governmental regulatory bodies, create a normativizing framework through which to process transgender bodies. This framework works to create an alliance between medicine and the state, constructing the state as trans-friendly in contrast to so-called transphobic nations, ultimately guiding the development of transition medicine alongside and through logics of capitalism. I explore the transgender body as something that, through medical marketing and state legislation, becomes an object that is conquered, changed, and sold, and subsequently, states are produced as trans-friendly or trans-phobic. This in turn influences and guides transgender discourse itself, as Sahar Sadjadi discusses, where the arguments made that attempt to protect access to trans medicine and legislative protections risk turning conversations that bring to mind nuances around and critiques of these medicolegal processes become "politically implausible."[26]

26. Sadjadi, 512.

Chapters

Using first-person accounts of early transgender historical figures, my first chapter explores early state investments and involvements in transition research as transition surgeries were developed and performed in the mid-20th century, comparing two case studies in Great Britain in the mid-1940s and the Latvian Soviet Socialist Republic in the early 1970s. In examining both the cases themselves as well as their simultaneous re-emergence in the late 2010s, I argue that the British transition of famous early trans man, Michael Dillon, emblematizes a liberal trans subject, romanticized for his survival in trans history. In contrast, the Latvian state-sanctioned transition, because of the ways he remains obscured in transgender history, embodies not a shameful state secret, but a haunting threat of queerness. I historicize the emergence of transgender identity and medicine, following these early state investment in managing transgender medicine and how they influence the formation of a mainstream liberal transgender subject.

My second chapter analyzes transgender conferences that are attended primarily by either transgender people or transition providers and looks at the re-creation and production of transgender identity through medicine. I explore the construction of "healthy" versus "unhealthy" transitions, arguing that medicine both infiltrates transgender identity and becomes an avenue through which transness is attempted to be *managed*. Transgender people are encouraged to make themselves increasingly legible to medicine in such a way that medicine constructs a minimally disruptive citizen-patient. After this critical analysis of transgender history and initial medical

transition developments, I explore how these histories inform current research methods through an analysis of the content and history of transgender conferences that I have attended or that have been made available virtually. I narrow in on modern transition discourse occurring after 2000, located specifically in the United States, looking at three major conferences centered around transgender identity and/or medicine, Fantasia Fair, the South Florida Transgender Medical Consortium, and Gender Odyssey. I analyze Fantasia Fair primarily through secondary source analyses, examining the organizations own archive of programs and promotional materials.[27] I analyze Gender Odyssey's archive of past conferences, and I analyzed SFTMC through virtual conference attendance.

My final chapter discusses the emerging profitability of gender transition surgeries and the increased use of advertisements by surgeons, where transgender bodies become a site or profit. I examine the creation and circulation of surgical advertisements and bodily images and the ways that this processing of the trans body through capitalism operates to foreclose possibilities for a queer, coalitional transness. I perform close reads on advertisements created and circulated by surgeons specializing in transition medicine as they appear on the surgical clinics' websites and

27. Research for this dissertation was largely completed in 2020, at which point COVID-19 required that I make shifts to accommodate the limitations of the pandemic. The 2020 Fantasia Fair conference was cancelled for the first time since its inaugural gathering in 1975, not holding a virtual gathering since its purpose is primarily a social one. Secondary sources became the best alternative source of analysis for this event. Gender Odyssey's 2020 event was also cancelled, but, in large part due to their focus on conversation and education, the organization had archived footage from past events. The 2020 South Florida Transgender Medical Consortium moved to be fully virtual for the first time and has since continued its virtual format allowing otherwise normal attendance for this project.

social media accounts. I contrast this with video footage and photographs created and posted by transgender people on social media websites like Reddit, YouTube, and Instagram to document and share their experiences with other transgender people who might be "shopping" for surgeons.

I argue for the importance in paying greater attention not to individual transgender histories, but to the broader historical contexts that made transgender medicine possible as they continue to affect and construct present-day understandings of transness. I argue for the importance in detangling and nuancing these histories of transgender medicine and transgender identity and my future work aims to unravel and follow the threads of present-day transgender medicine and identity in greater detail to their origins out of Eastern Europe.

Chapter 1

The More Visible We Are, The Closer the End of the World: Embodied Histories of State Sanctioned Violence

Introduction

In an issue of the Transvestite Independence Club's (TVIC) December 1973 newsletter, the same year that the former Yugoslavia hosted the Third International Symposium on Gender Identity, the newsletter featured a small section of blurbs and anecdotes of transgender topics, including a note on a dancer in Yugoslavia:

> On October 1, 1967; "National Enquirer" contained an article by Thomas Porter about a man [*sic*] in Yugoslavia who for 12 years deceived friends and his employer to be a woman. Working as a chorus girl; and one year later become a belly-dancer in a night club.
>
> It was not until his involvement in a [*sic*] auto accident that his real identity was revealed (April 1967). At the time of the article he had asked permission for having his sex change operation. These operations were granted through the Yugoslavain [*sic*] Government. He hoped to return to his job as a belly-dancer at the same club. His name was Zoran Pop-Simonovic, he used the name Zorana.[28]

Despite this story emerging from the sensational and disreputable pages of *The National Enquirer*, this brief mention was determined to be notable, if only briefly, by transgender people looking for both traces of transgender existence beyond their own, as well as a story of hope. Zorana Pop-Simonovic existed without detection as transgender from those around her, known only as herself until she was examined by a doctor, and even after her forced outing, she remained hopeful in her ability to

28. "TVIC Newsletter Vol. 2 No. 23 (December 15, 1973)." Newsletter. 1973. *Digital Transgender Archive*, https://www.digitaltransgenderarchive.net/files/bg257f10b.

medically transition with the permission and help of the Yugoslav government. In being located within the pages of *The National Enquirer*, this story becomes tainted with questions of legitimacy, as Pop-Simonovic disappears amidst the other outlandish stories of questionable veracity. However, this brief and hazy reference hints at a long legacy of state-sanctioned gender transitions, particularly in Eastern Europe. This peripheral note on a past transgender life urges us to reconsider the constructions of transgender technologies, futurities, and, indeed, transgender selves, moving away from present constructions of a liberal trans subject and of the West as a point of origin for queer and transgender cultures. More importantly, while this reference demonstrates the shame, secrecy, and deception that is so frequently attached to transgender histories, it also hints at the significance and potentiality of these more deviant histories in making possible a queer transness that resists the narratives of normative transgender life. Bogdan Popa writes in their work on transness and legacies of socialism as threatening to US racial capitalism, "Queer postsocialist politics, unlike the previous socialist ideology, which was built around a revolutionary end point, rejects conventional temporal linear trajectories. … the new queer politics is a politics without 'revolution' as a necessary end."[29] Popa's argument challenges the very presumption of not just of progress, but, using José Esteban Muñoz's concept of queer utopia, Popa posits a queer postsocialist temporality that positions revolutionary potentialities of histories. While the United

29. Bogdan Popa, "Trans* and Legacies of Socialism: Reading Queer Postsocialism in Tangerine," *The Undecidable Unconscious: A Journal of Deconstruction and Psychoanalysis* 5, no. 1 (2018): 30.

States increasingly offers many ways through which transness can be accepted, I read the lurid stories of Soviet transgender pasts via a queer postsocialist framework that offers an opening through which to unmake and resist liberal futures, offering too an insistence of queer temporality that provides queer possibilities of a transness outside of liberal futures.

With a mind to these sensationalized transgender histories as something that exists in contrast to the properness of present day liberal transness, I move to examine the focus on the body that persists in the archive, where the trans body is framed as deceptive and shameful. Pop-Simonovic's story suggests an embodied otherness that goes unspecified, at least in its retelling by the Transvestite Independence Club that sensationalizes her body in her/her body's ability to deceive, gesturing to a vague and non-specific state-sanctioned medical process that she may or may not undergo. The intrusive curiosity that the transgender body attracts, I argue, produces an archive via the transgender body that is disarticulated from larger histories and, in many cases, from whole transgender selves. While current images of transgender bodies are becoming increasingly widely available via social media, surgeons' websites, and increasing trans representation in popular media (as I will go on to discuss in later chapters), they seem to do so as the transgender bodies of the past fall into present-absence within the archive. While the trans body enters a newly hypervisible moment, it becomes disconnected from its historical contexts, such that the body becomes hypervisible at the very moment it disappears, or rather, becomes undisruptive. With this in mind, I explore the (dis)embodied transgender archive,

looking at who and what survived. In this chapter, I examine the medicolegal systems that work (and have been at work) to manage and organize the transgender body. I explore how these systems maintain their control over the ability for a transgender person to exist and how they cause certain bodies to fall out of the transgender archive. In many moments within the transgender archive, there are vague references to ghostly transgender individuals like Zorana Pop-Simonovic who sought medical treatments and legal recognition of their transitions, begging the question of who remains in the margins of transgender archives as liminal figures about whom we struggle to learn more. This chapter urges us to ask – what does it mean when states have more awareness, more records, more knowledge of the existence and whereabouts of transgender people than their own would-be community?

At the end of the 19th century and beginning of the early 20th century, synthetic hormones began to be isolated and made available for medical purposes, primarily for treatments unrelated to gender transition, such as maintaining virility, until they were ultimately made available for transgender people. Shortly after this increased availability, transition surgeries began to enter the medical archive. While gender variant people, including those who might consider themselves transgender today, existed long before the medicine that allowed them to transition, the advent and increased availability of transition medicine served as a turning point for transgender history and identity, beyond what medicine offered the body, and I argue, emphasized linearity in transness – a before and after of trans history that was

mirrored in the before and after of the transitioning body. With this linearity came a fascination with “firsts” within transgender history, centering not so much on transgender identity, but rather focusing on the medicalization of transgender bodies and identities that reasserts a dichotomy of sensational versus proper medical transitions. Michael Dillon is one of the most widely cited transgender people as having been one of the “firsts” in transgender history, as an early recipient of phalloplasty surgery in the mid-1940s. Other firsts in transgender history receive similar notoriety for their "firsts in medicine (such as Lili Elbe for her early vaginoplasty and fatal uterine transplant), or in their ability to go about undetected as transgender, like Billy Tipton, whose transness was revealed only upon his death. In this way, much of transgender history becomes an archive where the stories of individuals are told through medical records, recorded for the parts of their bodies that were modified (or in Tipton’s case, unmodified) by transition medicine, and disembodied from the geopolitical contexts from which these people and their transness were able to emerge. By entering this project through the site of early phalloplasties, I draw attention to the focus on “firsts” within transgender histories and transgender studies more broadly. This emphasis on firsts re-centers an investment in linearity and progress. It creates a legible starting point which serves as a contrast to the “after” of a transgender future, which asserts a homogenous and singular transgender trajectory. The ways that transgender histories fixate on “firsts” also mirror markers of progress documented by medicine, and I argue that this intertwining of medicine and transness demonstrates a medical undergirding of trans

history, that re-instills liberal notions of progress to trans bodies. This medical framing of transness re-affirms the *body-made-medical* – or a body made *proper* via medicine – as the central discussion point of transgender histories, privileged over (or even erasing) broader conceptualizations of transness. This insistence of making medicine's impacts on the transgender body the impetus that propels trans history ultimately positions the transgender subject as always already medically transitioning/transitioned. In this way, medicine's reach extends beyond the actual (medical) transition and thus its authority begins to be reasserted in determining/constructing (trans)gender as an identity. In this reassertion and recentering of the medical, the potential for transness to challenge normative gender risks being undone.

In discussing "transgender archives," I am referring to the combinations of formal material/digital archives of materials such as the Digital Transgender Archive, the archive of knowledge as constructed via transgender studies, as well as informal archives of trans history that is not necessarily identified as such, such as medical records and techniques, and laws aimed at or impacting transgender people. Finally, I discuss the archive as the transgender body itself, where the transgender body becomes a product of these material histories and thus an embodied archive. Ghostly figures of transgender history come to spectral embodiment in hazy references to a larger transgender population, such as in Pop-Simonovic's case, as transgender histories are constructed with either the romantic stories of individual survival or hidden stories of salacious scandals. In this chapter, I compare two major cases of

"first" transgender people: Michael Dillon, a trans man from Great Britain, and Innokenty, a Russian transmasculine patient who sought treatment in Riga. Dillon and Innokenty were two of the first *documented* transgender phalloplasty patients, with Dillon's surgeries beginning in 1945 and Innokenty's beginning in 1970. They share state involvement in their transitions, where Innokenty's transition was approved by the health minister of the Latvian Soviet Socialist Republic and his Russian gender marker re-registered, and Dillon's transition was officially registered by the British state. These stories, I argue, emerge as either survival or scandal via the geopolitical contexts in which they originated. Where the focus on both stories remain largely on how they serve as foundational moments in transition medicine, in bringing them together, I turn to the question of state involvement and, more specifically, its role in creating transgender medicine and, subsequently, (in)visible transgender histories. I seek to uncover a story woven together with threads of war and empire that make possible the systems of care available today, undergirded by the same logics: conquest, secrecy, and control. I read these embodied histories with an eye for the undiscussed connections between government, medicine, and technology which managed the production of these trans bodies and the subsequent making differentially visible of their stories.

This chapter explores the two cases of the so-called "first" phalloplasties - Michael Dillon's, whose transition took place and was registered in Britain in the mid 1940s, and Innokenty's, whose medical transition took place in present-day Latvia, under the former Latvian Soviet Socialist Republic in 1970. These instances are

significant in their overlaps and departures, exemplifying the formulation of gender transition as it exists in the present moment, as an increasingly (liberal Western) globalized medicolegal process inextricably linked together to produce the modern transgender subject. This medicolegal process includes government provided guidelines for transgender standards of care (e.g. the World Health Organization's diagnostics for transness in the International Statistical Classification of Diseases and Related Health Problems), making record of gender transition (in some cases with confirmation from a medical provider that medical transition has occurred), and determining the in/ability to actually access transition care via insurance or due to one's age.[30] In these ways, medicine and the liberal state are inexorably linked, as they work together to produce a legibly (and governmentally approved) transgender diagnosis and identity.

In this chapter, I focus on the documentation of transgender life and of medical transition, exploring how these historical moments and people enter or are suppressed, making them marginal or absent in material archives, and how they continue to be taken up by transgender studies. To do this, I explore the *construction* of transgender histories and transgender archives, specifically examining the queering versus the unqueering of gender transitions, and with that too, a construction of the

30. Dan Avery, "Lawsuit Challenges Surgery Requirement for N.C. Birth Certificate Change," NBC News, November 16, 2021, https://www.nbcnews.com/nbc-out/out-news/lawsuit-challenges-surgery-requirement-nc-birth-certificate-change-rcna5782.

The Associated Press, "Alabama Legislature Votes to Ban Gender-Affirming Medical Care for Transgender Youth," *NPR*, April 7, 2022, sec. Efforts to restrict rights for LGBTQ youth, https://www.npr.org/2022/04/07/1091510026/alabama-gender-affirming-care-trans-transgender.

unqueered transition as inherently white. I compare the ways both the Latvian and British medical transitions were documented, where both transitions were registered with their respective states. I move into a brief analysis of the stories themselves, focusing on the dual emergence around the same time, where Dillon's long-lost memoir was published in 2017, and Innokenty's story was initially told in 2013 and again to a larger audience in 2018. I compare both initial state reactions to these transitions, where both trans men were able to re-register and live as men, while also comparing reactions to these transitions in their 2010s re-emergence. I then link these state-sanctioned transitions of Britain and the Latvian SSR with U.S. formations of transness for the ways that present day U.S. formations of transness extrapolate upon these stories as forming the basis of/contrast to present-day transgender discourse. In short, I note how Dillon is taken up into the transgender studies archive while Innokenty remains an exceptional figure and shameful state secret. I end the chapter by returning to the radical potentialities of gender transitions, specifically at the site of queer postsocialism via Innokenty and examine how shame, secrecy, and deception are mobilized by queer transition to make possible the radical potentialities of transness that risk being evacuated by state acceptance.

Embodied Archive: Documenting Trans History

I argue that within the transgender archive, liberal whiteness serves as an organizing force, and indeed encourages an engagement with the structuring/re-ordering powers of state documentation. It is these processes of documentation and censure, disclosure and deception, and the re-emergence of "lost" versus hidden

stories that I intend to focus on this chapter, particularly in the comparative between the British and Soviet gender transitions. Through both the suppression of these stories as well as their almost synchronous re-emergence into public awareness, (Dillon's story re-emerged in 2017 and Innokenty's re-emerged to a Latvian audience in 2013 and an American audience in 2018) depict a differential incorporation into/production of transgender histories that mirror their own individual existences as trans people. Dillon's story ultimately became a significant piece of transgender historical/academic canon and Innokenty remains marginal. In particular, I examine how these stories were processed through and received by their respective state powers through either voluntary gender re-registration as with Dillon, or through state pre-approval of the medical procedures as with Innokenty and subsequent state censure. I examine how these processes *manage* the transgender subject and thus, the transgender body-as-archive through these methods of registration and approval. The state investment in managing transness ultimately produces what we understand as mainstream transgender identities – namely, white and incidentally/invisibly transgender – by facilitating and encouraging a willful re-registration with the state that is already foreclosed for those who exist outside state acknowledgement. State approval of transgender identity is thus made visible in a way that erases how transgender identities that exist outside of this limited boundary – those that are queer and racialized – are eliminated by the state because of the ways they risk disrupting

it.[31] With these conceptualizations of management and normalization via state power, I outline the ways various political arrangements have operated historically and specifically in relationship with medicine, relying on medical expertise as an organizing power to manage citizens, where categories of difference are recognized, managed, and made valuable or exploitable.

Transgender medical history is defined by arguments over chronology, as different individuals – as well as different states – are attributed with early achievements in medical advancements. Different individuals and nation-states lay claim to more significant developments and make arguments for why different developments or medicalized markers of progress matter more, such as what trans person accessed specific hormone therapies and surgeries first, and how these treatments make a more "complete" trans person.[32] In these distinctions, we see how the alliance between the state and medicine served to construct the archive of transgender medical history, determining what becomes truth and what falls out. The medical and legal join together in documenting/approving these gender transitions, mirroring future practices in medicolegal transition (e.g. gender marker changes on government documents, name changes, etc.) that determine what makes a person transgender and what makes a person *transitioned*. At this same time, I analyze these

31. Christine Hong, *A Violent Peace: Race, Militarism, and Cultures of Democratization in Cold War Asia* (Stanford: Stanford University Press, 2020).

32. What marks a transition as "completed" comes from binary definitions of sex/gender that create a body as close as possible to one unidentifiable as trans, generally via the presence/absence of secondary sex characteristics, external and internal sexual organs.

early transitions for the ways they lay the groundwork for the relationship between doctor and transgender patient. This doctor-patient relationship within transgender medicine can take different shapes, as alliance, partnership, or simply as a transactional relationship where a doctor both offers a service to the transgender person while also profiting from their bodies, and I argue that the medical history of the embodied transgender archive is as much about the individual transgender figures as it is about these relationships and the ways they continue to exist in the current moment.

In examining the Latvian-Russian transition patient, Innokenty, this move away from Michael Dillon and Western configurations of medical discovery coincides with a shift away from the *individual* transgender person that is so central to liberal interpretations of transgender histories.[33] Whereas Dillon's story highlights his own personal triumphs and success against all odds, the story of Innokenty is devoid of the transgender person himself, instead depicting a ghostly patient, whose story is told by his surgeon. The story involves the histories of transition-related care broadly across Europe and the larger context of the year and a half long process. In these arguments over who and what came first in the history of transition, the fixation on the body remains constant. Michael Dillon, Christine Jorgensen, Lili Elbe – the firsts of trans history – at what point do these romantic myths become medical archives (or perhaps, at what point do these medical archives become romantic myths)? Which bodies

33. Vrushali Patil, "The Heterosexual Matrix as Imperial Effect," *Sociological Theory* 36, no. 1 (March 2018): 1–26, https://doi.org/10.1177/0735275118759382.

count as archives and, if we understand the transgender body as one that is often hidden, where and how does it continue to exist?

Transition History	
1915	Michael Dillon born
1930	Lili Elbe transitions
1935	Testosterone synthesized
November 1, 1936	Nikolaj A. Bogoraz reports on his first phalloplasty
1939	Dillon begins seeking transition care
1938-39	Innokenty Born
1940	Soviet occupation of Estonia, Lithuania, and Latvia
1942-43	Dillon undergoes double mastectomy
1944	Dillon re-registers with male name and gender
1945-49	Dillon undergoes 13 phalloplasty operations
1945-51	Dillon attends medical school at Trinity College, Dublin
1952	Christine Jorgensen comes out via the New York Daily News
1958	Dillon outed via publication in a peerage documenting his family claim to a baronetcy
May 1, 1962	Dillon finishes writing memoir
	Dillon dies
1968	Innokenty reaches out to Kalnbērzs
September 17, 1970	Innokenty completes first transition operation
April 5, 1972	Innokenty finishes last operation - Completes medical transition
1973	USSR Minister of Health, Boris Petrovsky, issues reprimand for Kalnbērzs
1975	Kalnbērzs publishes report in "secret archive"
1991	Latvian Independence
2017	Out of the Ordinary finally published

Table 1. Timeline of transition history[34,35]

34. Dirk Schultheiss, Alexander I. Gabouev, and Udo Jonas, "ORIGINAL RESEARCH—HISTORY: Nikolaj A. Bogoraz (1874–1952): Pioneer of Phalloplasty and Penile Implant Surgery," *The Journal of Sexual Medicine* 2, no. 1 (January 2005): 139–46.

35. Dillon, 233-236.

One of the first and most widely recognized figures of transgender medical history, Michael Dillon transitioned in the mid-twentieth century, pursuing his medical transition while also pursuing a medical degree and ultimately becoming a surgeon. He came from an aristocratic background, being heir to the Dillon Baronetcy of Lismullen in County Meath, Ireland. Michael Dillon has become a hopeful representation within transgender studies, and while he is a hopeful figure, Dillon's aristocratic origins offer an important thread through which to follow to examine the colonial genealogies of transgender identity, medicine, and history. Not unlike those who have mythologized him, Dillon seems fascinated by his own past, searching for answers in an extremely introspective autobiography as he attempts to make sense of his life. Dillon's autobiography, *Out of the Ordinary: A Life of Gender and Spiritual Transitions* (2017), was edited and published posthumously by two transmasculine scholars, Jacob Lau and Cameron Partridge. The scholars' journey towards publishing the book after fifty years says as much about the state of transgender studies as the book itself, namely that transgender people remain in search of proof our past existence, and this search for proof often revolves around medical histories and records, demonstrating how understanding transness continually returns to the object of medical transition.

In her forward to the memoir, Susan Stryker describes the significance of having Dillon's memoir – of knowing in detail his thoughts and feelings about his

experiences as an historical trans person, fully described in his own words.[36] In their editors' note, Jacob Lau and Cameron Partridge describe their process putting the text together for publication:

> *Out of the Ordinary* was typewritten on onionskin paper with sparse hand-written edits. We have transcribed the memoir from digital photographs and photocopies of the original onionskin that were generously provided to us by Pagan Kennedy. In an effort to preserve Dillon /Jivaka's intended phrasing we have largely integrated his edits into the body of the text with-out noting them. Occasionally, when we felt that the raw, layered quality of the handwritten notes was important to preserve, we shared them as footnotes so that the reader can see them on the page in quotations. In one case, a handwritten note appears not in a footnote but at the end of the final chapter. It indicates that the entire final chapter was tentative and could be scrapped depending on whether the author's history of transition had been definitively revealed before the memoir's publication. We felt it important to preserve that note as part of the historical record.
>
> Otherwise, we used sparse notes to point the reader to historical context, to spell out acronyms, or to explain references that may be confusing.[37]

Their forward illustrates a reverence with which they approached Dillon's text, preserving as best they could the true and intended ideas and narrative that would-have-been, if the text had been published as Dillon envisioned. Having his words (minimally) processed by transgender scholars is noteworthy, as these present day trans people's understanding of the story's importance both to Dillon as well as to his community, imbues the text with a particular significance. Further, its publishing by

36. Stryker, "Forward" *Out of the Ordinary*, viii.

37. Lau and Partridge, "Editors' Note" *Out of the Ordinary*, xi.

an academic press shifts the impact of the text from simply holding a romantic allure, to being a scholarly time capsule.

The affective and intellectual appeal of the memoir as an object of scholarly value and of historical significance becomes further apparent in the telling of the tragedy and triumph of a "lost" memoir found and available "at long last."[38] The significance of Dillon's memoir is presupposed, and the attention remains upon the triumphs of its eventual publishing in the face of many years spent lost in a publisher's archive, buried by its author's transphobic family. The story of its publishing becomes about an overcoming, and more specifically, an overcoming that is centered around an individual – Michael Dillon – as opposed to a more coalitional or communal framing. Dillon's position of privilege in Western Europe, with access to a variety of medical resources as well as access to travel and movement is of marginal note, as Dillon is positioned with an air of individual triumph that is a gift for others. Susan Stryker notes in her forward, "it attests … to something greater: the fierce will to make real for others the inner reality that trans* [*sic*] people experience of themselves. That capacity to transform one reality into another is something trans* [*sic*] people often discover within themselves for the sake of their own survival; it is our gift to others to bear witness to the fact that this is a capacity within us all."[39] This is not to deny outright the significance of this text as an object of historical trans

38. Stryker, viii.

39. Stryker, x.

relevance, nor is it to criticize the desire to sit with moments of our own history, but rather I want to trouble the construction of the text, and Dillon by extension, as inspirational. Indeed, this construction reifies Dillon as ruggedly alone and also, primarily and exclusively, as a transgender man, despite his dual identity as transgender man and as a surgeon. His transition was accomplished by and through his relationship with Harold Gillies, with whom he eventually partnered as a fellow surgeon, and his relationships with at least one other trans person, Roberta Cowell. Understanding Dillon simply as a transgender person also operates to erase not just other people's involvement in his transition, but also his own position of power as a doctor himself who worked (albeit in a limited capacity) on transgender people. So much of what remains or becomes central in discussions of transgender history is medicalized, and it is important to consider how even a story like Dillon's – told in his own words – is still a story of transition written and shared by a medical transition provider.

Shortly after the "firsts" of transgender history in Western Europe with Michael Dillon and his surgeon, Harold Gillies, the story of the Soviet-era Latvian surgeon, Dr. Viktors Kalnbērzs, performed an early transgender phalloplasty in 1970.[40] Despite the fact that Michael Dillon's surgeries took place 25 years earlier,

40. Dr. Kalnberzs's father, Constantine, was the Deputy Commissioner of the People's Health of the Lativan SSR.

I note that this was an early *transgender* phalloplasty as the procedure had been invented for cisgender men and performed on them with more regular frequency at this moment in history.

Viktors Kalnbērzs is attributed by some with the first "complete" transmasculine transition, suggesting a "completeness" as defined by binary definitions of male sexual characteristics.[41] Both Kalnbērzs's work, as well as Michael Dillon's surgeon Harold Gillies, was informed in large part by the work of a Russian surgeon, Nikolaj Bogoraz, who pioneered phalloplasty reconstructions of soldiers with genital injuries and loss after World War I.[42] By the time Kalnbērzs began the series of nine surgeries on his patient, who was given the code name "Innokenty" by the hospital, Michael Dillon had received his so-called "incomplete" transition approximately 25 years previous. At least three other such "incomplete" transitions were performed in Belgium and the former Czechoslovakia.[43, 44] I connect these multiple points of transition medicine to indicate the shared origins that made these surgical transitions

41. Daniil Turovsky, "The Trans Man Whose Pioneering Surgery Was a State Secret for Decades," BuzzFeed News, July 11, 2018, https://www.buzzfeednews.com/article/turovsky/soviet-doctor-trans-history.

42. A.I. Gabouev et al., "Nikolaj A. Bogoraz (1877–1952): Pioneer of Phalloplasty and Penile Implant Surgery," *European Urology Supplements* 2, no. 1 (February 2003): 125, https://doi.org/10.1016/s1569-9056(03)80495-5.

43. Dillon is described in one of Kalnbērzs's interviews as having undergone "incomplete" transition, citing letters from Harold Gillies about Dillon, as well as Dillon's own memoir, both of which refer to him as being a "hermaphrodite" or as "intersex." While the details of Dillon's surgical transition are not described explicitly in his memoir, intersex language has long been used by transgender people to describe themselves and Lau and Partridge note in the memoir that this was likely a result of the unavailability of "transgender" language. Dillon also quotes Gillies when he approved the phalloplasty, describing Dillon as having a intersex condition, stating, "I think your case merits surgical interference. I will put you down as an acute hypospadic." The language of "I will put you down" seems to imply a matter of navigating bureaucracy, something Gillies does again when he operates on a transgender woman and uses the claim of an intersex condition as a way to circumvent mayhem laws.

44 Jules Gill-Peterson, Histories of the Transgender Child (University of Minnesota Press, 2018): 16.

Michael Dillon, *Out of the Ordinary: A Life of Gender and Spiritual Transitions* (Fordham University Press, 2016).: 101.

possible, which came, in large part, out of Russia and the Cold War. In contrast to Michael Dillon, who was able to narrate his own story, albeit through a text that was published half a century after he intended it to be, the true identity (or perhaps the post-transition identity) of Innokenty is still unknown. Where Michael Dillon was ruggedly alone, finding survival within himself, in the case of Viktors Kalnbērzs and Innokenty, a number of extra players enter his story, in some ways, to the exclusion of Innokenty himself.

The story of Kalnbērzs and Innokenty comes from at least two interviews in which Kalnbērzs participated in the last ten years, sharing the story behind this early series of transition surgeries that took place in Riga. Although both interviews claim to be the first time the story of Innokenty has been told publicly, Kalnbērzs's first interview took place in 2013 with the Latvian media site, *Jauns News & Media*, and a second interview came out in 2018 through a partnership between *Buzzfeed News* and Riga-based Russian news aggregate, *Meduza*. Buzzfeed's interview was published shortly after Kalnbērzs's ninetieth birthday, almost fifty years after Innokenty's medical transition began. I make note of the origin of the story of Innokenty and Kalnbērzs via these interviews for the ways this story is decidedly not romanticized in the ways Dillon's is. Susan Stryker describes first coming across the story of Michael Dillon "[as] a young transgender historian searching for kindred spirits a quarter-century ago" and in that search, feeling a "romantic allure" of the autobiography that "functioned as a vague receptacle that held half-formed fantasies about connecting with a lost and disremembered past" in contrast to the interview with *Buzzfeed News*

and *Meduza*, who describe "[tracking] down" Kalnbērzs, "to a sleepy suburb of Riga, the Latvian capital, where he spoke for the first time at great length about the world's first full female-to-male gender affirmation surgery."[45, 46] This description of the "sleepy suburbs" gestures towards the trope of the major secrets that a small town quietly houses, known only to the local residents, and with a spectacularizing (and inaccurate) claim of this being the first transmasculine surgery.

Significantly, Innokenty's own voice – indeed even his own true *name* – are absent in both interviews, as the interviewers at Buzzfeed News and Meduza were unable to "track down" Innokenty as they did Kalnbērzs.[47] Where Dillon's story was treated with reverence in the ways that the editors attempted to stay as true as possible both to his story as well as to his vision for the book, we can see through the way the story is told, Innokenty's narrative holds a different allure. The interviews describe Innokenty as impossible to trace and living his life in secret, and in the absence of his post-transition self, his significance lies only with the ways his body becomes the site of medicolegal history – as the "first" trans man and as a shocking state secret as the 2018 article's title and subheading read: "The Trans Man Whose Pioneering Surgery Was A State Secret For Decades: Russia's current record on LGBT rights is

45. Stryker, "Forward" *Out of the Ordinary*, viii.

46. Turovsky, *Buzzfeed*

47. Turovsky, *Buzzfeed*

extremely poor. But 40 years ago, the USSR witnessed a pioneering moment in transgender history."[48]

The story of Innokenty's transition thus begins with these caveats – with the transition allowed, but kept secret, and his story only now emerging of an early transition that happened against all odds, in a state whose poor reputation for queer and trans people has a seemingly long and uninterrupted history. Additionally, where Dillon's story, despite being published in 2017, was simply transcribed with minimal additional notation by its editors, the act of re-telling the story of Innokenty, now fifty years later, imbues the interviews with implications of current transgender political discourse and shifting geopolitical stakes in LGBT rights. [49] This re-telling is filtered through modern political policies in Eastern Europe and Russia, where the geopolitical contexts that made Innokenty's transition possible are ignored or erased. This erasure is easily unquestioned despite there being a history of transgender medical research occurring at least at a similar pace as took place in Western Europe, and arguably emerging more quickly, as phalloplasties were originally developed in Russia. Additionally, Yugoslavia is recorded as having granted at least one transition request for a trans woman in 1967 and hosted the third International Symposium on

48. Turovsky, *Buzzfeed*

49. Jacob Lau and Cameron Partridge, "Editor's Note," *Out of the Ordinary*, xi.

In using the term "LGBT" here because of the ways that political discourse, in the effort to be recognized as inclusive, has shifted to an acronym, flattening the differences across these categories and simplifying the political needs and desires of these groups.

Gender Identity, an international gender conference sponsored by the Erick Educational Foundation, in 1973.[50] Today, Belgrade continues to be a major destination for transition medical tourism, notably featuring the Belgrade Center for Genital Reconstructive Surgery.

Kalnbērzs was described in both interviews as having performed a number of penile reconstructive surgeries on cisgender men and intersex people, and with this reputation, he was introduced to Innokenty by Russian Professor Vladimir Demikhov, who Kalnbērzs referred to as a legend. Demikhov is famous for innovations in transplant surgeries including heart and lung, as well as his work on coronary artery disease, but is most famously known in the United States for ethically dubious experiments, including multiple experimental surgeries of canine head transplants.[51] It is interesting to note that the criticism aimed at Demikhov largely came from the United States, as news of his head transplant surgeries emerged there in 1962. At this same time, the United States was in the midst of its Tuskegee Syphilis Experiment, a study running from 1932-1972 studying the long-term effects of untreated syphilis on non-consenting Black men, demonstrating the objectification of Black men as test subjects and the devaluation and disposability with which the U.S. government

50. Erickson Educational Foundation (EEF). "Erickson Educational Foundation Newsletter, Vol. 5 No. 3 (Fall, 1972)." Newsletter. 1972. *Digital Transgender Archive*, https://www.digitaltransgenderarchive.net/files/zp38wc71g.

The conference was hosted in Dubrovnik while it was still in Yugoslavia.

51. Igor E. Konstantinov, "At the Cutting Edge of the Impossible: A Tribute to Vladimir P. Demikhov," *Texas Heart Institute Journal* 36, no. 5 (2009): 453–58.

treated their lives. In 1963, Dr. Chester Southam, an immunologist at Sloan Kettering, was injecting cancer cells into non-consenting patients at the Jewish Chronic Disease Hospital.[52] While Southam received a one year suspension from the Board of Regents of the University of the State of New York, he was shortly after elected president to the American Association of Cancer Research in 1968.[53] I make note of these experiments and the minimal consequences for their perpetrators on their careers to emphasize the geopolitical implications of Soviet medical experimentation, versus medical research in the United States that developed through the deaths and suffering of Black families. While the legacies of racist medical experimentation that came out of the United States did come under scrutiny in later years, they remain separate from conversations on the development of transgender medicine. Both *Jauns* and *Buzzfeed News* made note of the connection to Demikhov early in the interviews, positioning Innokenty's story amidst a complicated medical genealogy of both significant, life-saving medical innovation alongside the dubious histories of extreme and nefarious medical experimentation. This framing re-positions transgender medical research as experimentation when done improperly, or more accurately, when done in the Soviet Union during the Cold War.

---

52. Susan M Reverby, *Examining Tuskegee: The Infamous Syphilis Study and Its Legacy* (University of North Carolina Press, 2013).

Elinor Langer, "Human Experimentation: New York Verdict Affirms Patient's Rights," *Science* 151, no. 3711 (February 11, 1966): 663–66.

53. Leonard F. Vernon, "Tuskegee Syphilis Study Not America's Only Medical Scandal: Chester M. Southam, MD, Henrietta Lacks, and the Sloan-Kettering Research Scandal," *Online Journal of Health Ethics* 16, no. 2 (2020).

The ways that these stories are told, their similarly timed re-emergence into transgender discourse, and the divergent receptions of these stories exemplify how transgender subjectivity exists – or is constructed – as either heroic and assimilable, or as deviant and threatening. The Soviet transition becomes marred by its proximity to unethical experimentation, further demonstrating how medicine is mobilized by the liberal state, as either ethical or experimental, further confining these stories and the transgender figures they construct into categories of acceptable or threatening.

Medicolegal Genders

As the stories of Dillon and Innokenty's physical transitions begin to take shape, so too do the entanglements between state and medicine. Both men's medical providers were involved in some way with the amending of legal documents. Kalnbērzs aided Innokenty in changing his documents and advocated for him with the Latvian SSR, and Dillon's gender re-registration was suggested to him by his doctor. In both instances, these examples illustrate the ways these early transition providers identified themselves as actors of the state, working to document, organize, and *manage* transitions at the same time as they provide the actual medical treatment. In Dillon's medical transition, he seems to stumble between kindly doctors looking to help him get out of the awkward situation of being "incompletely" male, or anxious, even cruel doctors who thought treating him was a joke or a threat to their own credibility and reputation.

Unlike Innokenty, Dillon's transition was not seen through by one single doctor or even team of doctors, and he saw different doctors and surgeons for hormones, reconstructive chest surgery, and phalloplasty. His transition is in some ways significant because he seemed to frequently stumble upon the appropriate help and advice after each step in the transition. In one instance, he was taken to a hospital after a hypoglycemic fainting spell, and as he had already begun testosterone treatments, doctors were bemused with his masculine presentation that did not match his feminine name and identification documents. After one of these fainting incidents, at some point between 1942-1943, Dillon encountered a doctor who offered to help him pursue surgical transition, beginning with a double mastectomy.

> There was a kindly house surgeon of [a] well-known Quaker family from Bath and when he had heard by story and examined me he brought along a plastic surgeon to see me. […]
>
> The plastic surgeon said he would remove the small but persistent breast tissue and would then put me in touch with a bigger plastic surgeon to whom he had himself been a student. And why not get re-registered, he asked?[54]

The idea of pursuing a change in legal identification documents excited Dillon, who had felt "hemmed in" by these documents which prevented him from living as a man, as the documents would immediately expose him as female assigned at birth.[55] As

54. Michael Dillon-Lobzang Jivaka, *Out of the Ordinary: A Life of Gender and Spiritual Transitions* (Fordham University Press, 2016), 98-99.

55. I describe Dillon as female assigned at birth as opposed to transgender here as Dillon's gender identity and transness were not the issue as much as this remnant of a past life. Dillon's documents did not mark him as transgender, nor did it seem that he was experienced as transgender, a category that was not yet named as such, but rather as someone assigned female at birth who did not visibly fit that category.

such, he pursued "re-registration" in pursuit of a masculine name and to change his birth certificate.

> With the poker-face back on and on the defensive I went to get a new identity card at the Labor Exchange, prepared for grins and curiosity.
>
> "Oh Yes," said the man behind the counter, "we have had quite a lot of these applications," and made me out a new card without batting an eyelid! How common was it? I am none the wiser on that point now.

Dillon further describes his experience being rejected from the British army after getting drafted where upon medical examination, the doctor performing the exam simply stated, "We've turned down a lot like you."[56] This seemingly long history of transmasculine people not simply existing but pursuing medical transition to the point where they would require legal documentation in order to live without risk of being exposed crucially illustrates the long histories of the state's legal recognition and documentation of transgender people. Dillon is one of many early transgender men, and the ability to access legal documents illustrates how the British government was aware of gender transition as a phenomenon and actively engaged in its ongoing catalog and management. After Dillon re-registered his gender as male, he pursued phalloplasty with Harold Gillies, who performed thirteen operations on Dillon between 1945-1949, while Dillon was enrolled in medical school. During this time, while building a relationship with Harold Gillies, Dillon collaborated with him,

56. Dillon, 101.

performing a secret orchiectomy on a trans woman that would allow Gillies to follow the procedure with a vaginoplasty.[57]

It is hard to know how many differences exist between Dillon and Innokenty's transitions and what exactly they were, as Dillon's ability to tell his own story exists in stark contrast to Innokenty's story being told as if a dark secret finally purged by his surgeon after half a century of keeping quiet. In comparing these two stories, we begin to see the significance of the medicolegal entanglements of transition medicine and the state, while also beginning to see the development of early transition providers and the different kinds of alliances and relationships they manage – namely, the relationship with their patients, and an alliance with the government body managing the patients. This question of relationships and alliances is particularly noteworthy in the ways that Kalnbērzs and Innokenty maintained a correspondence (however reluctantly Kalnbērzs claimed to participate) in the face of an ongoing state censure. Innokenty's experiences, despite the sensationalism that surrounds them, opens a radical potentiality of transition medicine – a potentiality in which Dillon's experiences fall short.

---

57. Susan Stryker and Nikki Sullivan, "King's Member, Queen's Body: Transsexual Surgery, Self-Demand Amputation and the Somatechnics of Sovereign Power," in *Somatechnics: Queering the Technologisation of Bodies*, ed. Samantha Murray and Nikki Sullivan (Routledge, 2012), 63–78.

It was illegal to "mutilate" penises under "mayhem laws" in the UK. Dillon performed the orchiectomy in secret, allowing the trans woman to be classified as intersex and thus in need of corrective surgery in the way of a vaginoplasty. Identifying a transgender patient receiving transition care as intersex was sometimes used as a way to bypass laws such as these, as well as a way to more simply or discretely explain transition care not as gender transition, but as treating an intersex condition.

Where Dillon seemed to have, quite literally, fallen into the hands of the right surgeons, Innokenty's efforts (as recounted by Viktors Kalnbērzs) were more deliberate. In some ways, Innokenty was more of a collaborator – or at least an active player – than how Dillon paints himself. As previously discussed, Innokenty sought out Kalnbērzs via Vladimir P. Demikhov's recommendation, a renowned and innovative researcher in Russia. Innokenty worked to convince Kalnbērzs to perform the medical transition, who then consulted with a team of surgeons and psychiatrists to evaluate Innokenty. One male psychiatrist even attempted to seduce Innokenty in an effort to challenge his attraction to women and thus delegitimize his claim to a male gender identity. While these hurdles suggest a less supportive environment that what Dillon experienced, Kalnbērzs paints a picture of a patient less passive than Dillon in the ways Innokenty was made to advocate for himself.[58] Further, due to the fears Kalnbērzs had around performing what was at the time a relatively new (or at least undiscussed) series of treatments, he insisted that Innokenty be fully informed on the procedures he was choosing to undergo.

> Kalnbērzs said he could not guarantee success but would allow [Innokenty] to watch how he operated on intersex patients and decide how to proceed. He gave [Innokenty] a white nurse's coat and told other patients that the person in the nurse's coat was a consultant who would assist with hormonal therapy.

58. This difference in narrative could be in part motivated by the stigma attached to medical transitions, where Dillon sought to minimize his own active pursuit and similarly Kalnbērzs, perhaps due to his own conflicted feelings of performing these transitions, may have emphasized Innokenty's dogged persistence to minimize his own role. Regardless, the investments in how these stories are told demonstrate the ongoing messiness of the transgender archive and the cloud of stigma and shame that obscures the fine details.

> After seeing how Kalnbērzs operated to construct a sexual organ, [Innokenty] was ready to go ahead with the procedures.[59]

While in some ways Innokenty was made to undergo a certain amount of what now might be termed gatekeeping, Kalnbērzs's insistence that Innokenty be particularly informed, receiving knowledge and understanding beyond simply that of a patient, and seeing the medical implications of these procedures, is noteworthy. In lieu of experience and expertise in the question of transition, Kalnbērzs relied on what could be described as "informed consent."

Archiving Transition

What is perhaps most interesting about Kalnbērzs's recount is *how* the story of Innokenty existed in a present-absence within his own story, both in Innokenty's physical absence and his existence only through Kalnbērzs's recount, as well as via the reports that Innokenty's transition was a documented state secret. Kalnbērzs describes a number of consultations he pursued with his fellow doctors, surgeons, and even state officials, getting verbal approval for the procedure from the Latvian health minister. Additionally, the interview with Buzzfeed states, "Kalnbērzs helped Innokenty change his legal documents, something that had to be approved by a Latvian SSR committee that included representatives from the regional offices of the interior and health ministries. The committee asked Innokenty how he felt. He said he was very happy, Kalnbērzs recalled. Innokenty was issued a new passport, a draft ticket, and other documents." Both interviews discuss the investigation that the

59. Turovsky, Buzzfeed

Minister of Health of the USSR, Boris Petrovsky, pursued against Kalnbērzs upon hearing of Innokenty's transition, calling his actions criminal. *Jauns's* interview notes that the committee investigating him was largely interested in the case, with Kalnbērzs stating: "The Commission had professional doctors, and they were fascinated by the case. They evaluated my materials and the patient's narrative in detail. Soon the whole commission was on my side. In the end, the head of the commission summed up that the Latvian surgeon has successfully performed a unique operation and Latvia can be proud of such a specialist." [60] Ultimately, however, the commission's findings were negated by Petrovsky, who issued a reprimand against Kalnbērzs, forbidding him from discussing the surgery. Although Kalnbērzs did receive a reprimand, the various state actors who approved of his actions suggest a more nuanced Soviet opinion of gender transition. Considering especially the other Soviet and socialist states' engagement with transition medicine (notably Yugoslavia and Czechoslovakia, the latter Kalnbērzs noted as the site of another transgender phalloplasty), it is an oversimplification to describe the Soviet Union as inherently transphobic or dangerous for transgender people. I argue that this moment of censure, secrecy, and shame is a critical moment of both queerness and queer potentialities that the USSR opened in transness. The embrace of transness by states like Great Britain, as exemplified by Dillon in the mid-twentieth century, or the U.S.

60. Jauns.lv. "Ķirurgs Kalnbērzs Pirmais PSRS Sievieti Pārveidoja Par Vīrieti," January 1, 2013. https://jauns.lv/raksts/zinas/133798-kirurgs-kalnberzs-pirmais-psrs-sievieti-parveidoja-par-virieti.
Translated: Surgeon Kalnbērzs was the first in the USSR to transform a woman into a man

in the present moment are conditional. The state's embrace relies upon the trans person's willingness and ability to confess one's transness to the state via the utilization of state legal resources to be legible as their gender, while also being invisible as transgender – or rather, invisible as *queer* – in their daily life. In a way, these states engage transness in a kind of risk management approach where they cannot control the possibility that one is trans, and instead attempt to manage its presentation. By refusing to "embrace" transness, the USSR is unable to track and *manage* transness in the ways that the U.S. is able to do, leaving open a queer transness that remains intact.

Dillon and Innokenty's stories re-emerged around the same time (Dillion's memoir published in 2017 and Kalnbērzs's giving his first interview in 2013 and then 2018 when the story reached a U.S. audience), imbuing the stories' contemporary interpretation with modern laws, discourse, and understandings of transgender rights. Buzzfeed's interview with Kalnbērzs for example continually makes note of the general understanding in the USSR of gender and sexuality as firmly linked and heteronormative, such as the requirement that Innokenty's male identification was validated by his unwavering attraction to women. It is important to note that the United States had similar beliefs and policies at this time. Lou Sullivan, a gay trans man living in San Francisco in the 1970s, was initially denied access to medical transition due to his sexuality, and later became an activist and advocate for transition

access in the United States.[61] Buzzfeed frames its interview through current transgender experiences in Russia, making note of the country's rank of "45th out of 49 countries for LGBTI human rights," going on to say later in the article:

> During Soviet times, LGBT people were considered criminals, and any doubts about sexuality regarded as debauchery.
>
> For transgender people, the approach was haphazard. Some patients were able to change their gender on their documents; others were diagnosed with schizophrenia and treated with psychotropic drugs or put into institutions, sometimes for their whole lives.

The interest in transition surgeries that Innokenty's case spurred in medical communities speaks to a more complicated genealogy of transgender lives out of Russia and the former Soviet Union that inform and influence modern transgender experiences. In comparing Dillon and Innokenty, we see the development and changes within medicine, states, and understandings of what it means to be transgender. In turn, these questions of *access* are critical in fully understanding the connection between medical care and the state.

Dillon, in his romanticized, rugged individualism, his fulfillment, demonstrates what is made possible by trusting and engaging in the proper channels and by receiving recognition from the state. He pursued transition medicine not through "back alley" means or by seeking out disreputable surgeons, but in some cases incidentally, as his transition needs were attended to by doctors he met as he was treated for other health crises. He was able to change his legal documents too,

61. Lou Sullivan, Battling Gender Specialists, interview by Ira B. Pauley, *GLBT Historical Society*, 1989.

and while this offered Dillon the chance to move more easily in the world, he was able to do by *recording* his transition – by making himself transparently transgender to the state, and invisibly transgender to the world. This documentation was not done with other trans people – indeed, he noted his continued ignorance and passive curiosity to who they are or where they might be – but instead was done with the state itself. Even, crucially, his formulation as a "first" in transgender medical history illustrates how Dillon enters transgender history with an air of authenticity. In contrast to other figures within transgender history like Billy Tipton or Willmer Broadnax (a Black trans musician who lived at the same time as Tipton also was found to be trans upon his death), Dillon, arguably, never attempted to "hide" his transness even before his public outing; he did not have long term romantic affairs, and his gender change was both affirmed through medicine and fully disclosed to the state via his document changes.

Transness holds an incredible potential in its ability to undo. It disrupts and destabilizes constructions of gender, and in so doing, disrupts that which makes possible these normative categories of identity. In disclosing, documenting, and archiving his body with the state, and in maintaining a distance from other trans people, Dillon exhibits a non-threatening transness – a sterilized transness. While Dillon's story is not untouched by secrecy or scandal, the way this scandal lives in transgender history affects its impact. Dillon was forcibly outed in 1958, when his position as heir to a baronetcy was listed differently between two peerage publications, Burke's Peerage and Debrett's. Debrett's had Dillon listed as the

brother and heir to the baronetcy and Burke's Peerage listed Dillon under his former name as the baronet's spinster sister.[62] Dillon's forced outing via the peerage publications, as well as the many years that his memoir remained unpublished at the insistence of his brother, exemplify the secrecy and shame that risks clinging to the story. However, his ability to tell his own story in his own words, half a century after his death, in addition to the memoir's treatment and reception as a revered relic of transgender history, depict a kind of survival – a heroic re-emergence against all odds that becomes interwoven into Dillon's continued relevance.

Transgender Shame and Queer Openings

In contrast to Dillon's romanticized history made possible through his embrace of a medicolegal processing, Innokenty remains a shadowy, ghostly figure, whose transition is marked by state censure and the implications of secret medical experimentation that came with it. Further Kalnbērzs's "coming forth" further suggests a shamefulness that clings to the story; as opposed to Dillon's ability to tell his own story as a thoughtful reflection on his past and a heroic survival against the odds, Innokenty's story is a long-buried secret. Kalnbērzs only came forth in the twilight of his life to share the details of Innokenty's story and his conflicting feelings on his participation in the gender transition. Kalnbērzs passed away three years after his interview with Buzzfeed News, and his advanced age suggests a confessional-aspect to his decision to come forward, and with this desire to confess, a sense of

62. "GREAT BRITAIN: A Change of Heir," *Time*, May 26, 1958.

shame comes with it as well.[63] This shame is further elaborated in his assertions in his unwillingness to see or keep touch with Innokenty, despite Innokenty's invitations to Kalnbērzs to meet again.[64] I position the shame in contrast to narratives of "pride" associated with otherwise LGBT histories that survive the archive, and I argue that this shame is crucial in maintaining the queerness of Innokenty, and, more urgently, the re-opening the queer potentiality of transness.

By investing in narratives and productions of queer or trans pride with things such as rights and supposed legal protections, states are able to produce a minimally disruptive queer subject, as seen with liberal state projects like gay marriage and military inclusion for gay, and later, trans people. This is not to say that pride movements did not exist in socialist states, but rather, to consider how the liberal state is able to take up narratives of pride, or how pride clings to liberal ideas of transness. I conclude this chapter by exploring shame in more detail, examining it as the route through which transness is able to hold onto its queer potentialities. I argue that shameful queerness is something exemplified especially via these trans origins out of Soviet and socialist states and the production of postsocialist states as homophobic, while simultaneously holding a queerly non-linear history of gay and trans culture.

63. "Mūžībā Devies Akadēmiķis Profesors Viktors Kalnbērzs," Rīgas Stradiņa Universitāte, June 21, 2021, https://www.rsu.lv/aktualitates/muziba-devies-akademikis-profesors-viktors-kalnberzs. Translation: Academician Professor Viktors Kalnbērzs has passed away

64. Turovsky, *Buzzfeed*

In their work on the political potentials of shame to disrupt liberal imaginaries, Bogdan Popa argues that, rather than existing to reify dominant structures, shame interrupts them. With this idea of shame as interrupting, the censure and secrecy surrounding Innokenty offers an entry point to understanding the radical queer potentialities held within transness and in contrast, how these potentialities risk being evacuated from transness. Never actually present, Innokenty's story is told by his surgeon, and although he is made anonymous in his story through a pseudonym, the secrecy surrounding his identity seems to prioritize the protection of the medical and legal actors involved in his transition, as opposed to the protection of Innokenty's entitlement to medical privacy. I examine the ways these histories emerged, how the stories circulated, and how these two figures of a transgender pasts – Innokenty and Kalnbērzs – make possible transgender presents. I explore this through a framing of queer postsocialism, and specifically – especially – in the *looking back* that occurs in the (re)-emergence of both Dillon and Innokenty's stories, I regard this a postsocialist methodological practice. Neda Atanasoski and Kalindi Vora describe postsocialism as "[*marking*] *a queer temporality, one that does not reproduce its social order even as its revolutionary antithesis*. Resisting the revolutionary teleology of what was before, postsocialism creates space to work through ongoing legacies of socialisms in the present." Dillon's story as it emerged in 2017 is one of pathbreaking triumph, "a conquest of the body," as he described his own transition. Indeed, his positioning as an inspirational figure portends a fascist liberalism that does not understand itself as such, instead seeing simply the importance of *progress* as central for transgender

survival. Dillon lays the groundwork for a liberal trans future-present defined by a growing marketing and sale of transgender identity in a medical market that simultaneously, through its investment in capitalist modes of production, is what makes possible the pathologization of transness, that needs to be pathologized in order to be covered by insurance and in order for doctors to understand it as something that needs treatment. Further, this liberal trans future-present is that which accrues political currency through the exploitation and extraction of the violence against/murders of trans people of color, as Gill-Peterson discusses, becoming "objects of necropolitical value."[65]

Because medicine operates as a foundation to transgender discourse and identity, much of the contemporary discourse around transness focuses around the *management* of medicine and, in essence, the management of transness, where questions of access – who has the *right* to access transition medicine, hate crime and anti-discrimination protection, or even transgender identity itself – become primary entry point to discussing transness. This framing decenters the transgender subject, and subsequently assumes the state as a necessary process to transgender life.[66] It positions the transgender subject exclusively through their vulnerability to

65. Gill-Peterson, 1.

66. Maura Priest, "Transgender Children and the Right to Transition: Medical Ethics When Parents Mean Well but Cause Harm," *The American Journal of Bioethics* 19, no. 2 (February 2019): 45–59.

Esinam Agbemenu, "Medical Transgressions in America's Prisons: Defending Transgender Prisoners' Access to Transition-Related Care," *Colombia Journal of Gender & Law* 30, no. 1 (2015): 1–48.

extrajuridical violence and positions the state as the foremost discussant/actor in the conversation of transgender lives – or perhaps more accurately, transgender deaths. Put another way, by entering the conversation of transgender identity through the question of access, I argue positions the state as determining a transgender person's access to *life*. As Lisa Marie Cacho notes in her book, *Social Death: Racialized Rightlessness and the Criminalization of the Unprotected*, "Because the law is presumed to be both ethical and irreproachable, the act of law-breaking reflects poorly on a person's moral character. If following the law (legitimate or not) determines whether a person is moral or immoral, it is all but impossible for people assigned to certain status categories to represent themselves as moral and deserving."[67] This is particularly relevant in the ways that access to medical transition as its availability increased in the United States required that one be of good moral character.[68] The premise of accessing transness as requiring "good moral character" demonstrates how the inability to access state sanctioned medicolegal transition creates a *queer* transness, which is an inherently racialized and criminalized one. While whiteness allows access and entry into certain kinds of compromises with the state, it is a racialized transness that exists always already as nonnormatively gendered and, in that status, as always already immoral. Although states have not

67. Lisa Marie Cacho, *Social Death: Racialized Rightlessness and the Criminalization of the Unprotected* (New York: New York University Press, 2012), 4.

68. stef m shuster, *Trans Medicine: The Emergence and Practice of Treating Gender* (New York: New York University Press, 2021): 30-31.

always been involved in the determination of the validity or reality of transgender existence to the capacity that it has in recent years with increasing records and debates surrounding gender marker changes, military participation, and policies of legislative protections/criminalizations for transgender people, the state's role begins to shift around the mid-twentieth century as transition medicine begins to see major growth.

In contrast to U.S. desire for origins, visibility, and representation evidenced in *Buzzfeed*'s framing of Innokenty's story as a reveal, underground Russian writer and poet, considered a founder of gay Russian literature, Yevgeny Kharitonov, describes a gay Soviet subjectivity, shortly before his death in 1981. In his manifesto, The Leaflet (Листовка), Russian writer Yevgeny Kharitonov writes about the extensive influence of gay people on culture, fashion, and pleasure, during the time of Article 121 of the Soviet criminal code which criminalized sodomy. As Kevin Moss notes in his exploration of Kharitonov's use of camp and the formation of Soviet gay identity, Article 121 was in effect from 1934-1993, bookending Kharitonov's lifespan from 1941-1981.[69] Referring to gay people as "barren fatal flowers," Kharitonov ends his manifesto with a reference to the anti-sodomy laws of the Soviet Union versus queer life in the West:

69. Kevin Moss, "Camp Kharitonov and Russian Gay Identity," in *Na Vzhod! LGBTQ+ Književnost v Vzhodni Evropi/Go East! LGBTQ+ Literature in Eastern Europe*, ed. Andrej Zavrl and Alojzija Zupan Sosič (Ljubljana University Press, Faculty of Arts, 2020), 101–11.

> Western law allows our flowers open meetings, a direct showing of us in art, clubs, gatherings, and declarations of rights - but what rights? and rights to what?
>
> The stagnant morality of our Russian Soviet Fatherland has its purpose! It pretends we don't exist, but its Criminal code sees in our floral existence a violation of the Law; because the more visible we are, the closer the End of the World.[70]

In his reference to Western acceptance relative to Soviet criminalization, Kharitonov's provocative question of "rights to what" challenges the construction of the United States as a state of progress, and sharply gets at the motivation of the U.S. to "allow" for queerness, that ultimately masks its radical and subversive powers.[71] In pointing out how the Soviet prohibition of queer acts works to affirm the existence of queerness, Kharitonov illuminates how the Soviet Union perceives and positions of queerness as something threatening to the state, indeed, as Kharitonov states, "the more visible we are, the closer the End of the World."

If we think about Kharitonov's argument in the context of phalloplasty and transgender medicine, the state censuring of Innokenty's transition (after the Latvian SSR initially affirmed its validity) becomes a moment of a simultaneous burial of Innokenty at the same moment that the censure itself makes the transgender body hypervisible. This contradictory visibility epitomizes the moment of tension of queer

70. Yevgeny Kharitonov, *The Leaflet*. Translated by Kevin Moss, https://community.middlebury.edu/~moss/Listovka.html.

71. It is important to note that the United States did have anti-sodomy laws, which first began to be repealed in the 1960s, until Lawrence v. Texas ruled anti-sodomy laws to be unconstitutional in 2003.

survival even at – or especially at – the moment of death, much in the way that Innokenty's transition speaks to the queer survival because of the *suppression* of his story that occurred rather than his disappearance. Jennifer Biddle discusses the provocation of shame, stating, "As much as shame seeks to avert itself – there is no feeling more painful – shame seeks to confess. To be heard, to be borne by another, to find a witness – shame seeks to be allowed the very conditions denied it in its rupture – recognition by another."[72]

Kharitonov notes the operation of the criminal code by Soviet Russia that works to shame the queer subject, where it is in this shame that it is *witnessed*, and in its witnessing, makes visible the queerness it seeks to erase. This is contrasted with the homogenizing project of Western pride, producing an unqueered assimilable subject. Kharitonov statement, "The more visible we are, the closer the End of the World," lends urgency in understanding the ways that liberal state policies of "inclusion" operate not to include a transgender subjectivity into the nation-state, but to make a minimally disruptive transgender subject.[73] In the case of Innokenty and Kalnbērzs, the censure by the USSR Minister of Health reaffirmed if not the criminality of transition, then the queer discomfort with it. Innokenty was never identified by Kalnbērzs by anything other than his code-name given to him at the hospital, and he has never come forward. Innokenty has, for all intents and purposes,

72. Jennifer Biddle, "Shame," *Australian Feminist Studies* 12, no. 26 (1997), 227.

73. Moss, 108.

vanished into the citizenry, to exist as a secret that may come out at any time without warning, without control, his transness becoming a haunting threat that risks the undoing or remaking Soviet histories. Even Kalnbērzs's decision to come forward shortly before his death suggests Innokenty's presence as a weight on his conscience. In his interview with *Jauns*, Kalnbērzs spoke about meeting Patriarch Alexy II, the 15th Patriarch of Moscow and all Russia in 2006, to whom he was introduced as the first person to complete a gender transition procedure. Kalnbērzs waited with bated breath to see how his sin would be received and described his relief at the patriarch's amiable reception.[74] Innokenty's transition, in its censure and deep secrecy, then becomes not simply a moment of queer shame, but indeed, a viscous moment of queer trans potentiality. It holds the potential to undo and disrupt, as its queerness clings to its participants even as Innokenty dissolved into the shadows of history. The more visible we are, the closer the end of the world.

Conclusion: Transgender Origins and the State

As previously discussed, because of the ways that medicine undergirds so much of transgender history, in addition to the ways that transition medicine is made possible via imperialist powers, the transgender body holds onto an archive of knowledge as it is subjected to fixation, hyperfocus, and fascination. Where there is no singular transgender body, I argue for the importance both in disrupting the idea of a singular transgender history, but also understanding transgender histories and

74. *Jauns*

archives as assemblages of figures, practices, states, and powers. These instances of differentially archived transgender experiences begin to elucidate the nuancing of transgender histories, making space for and insisting upon a more thorough understanding *who* creates, curates, and cares for these catalogs of transgender lives, bodies, and histories. Further, what do these assemblages of archives, histories, and bodies ultimately produce as legible transgender narratives?

In this instance, phalloplasty, particularly these two "firsts," offers an important site through which to understand transgender medical history and its entanglement with state powers and its impacts not simply on transgender people, but how the liberal state *constructs* transgender medicine in such a way that it perpetuates an imperialist agenda. The impact of this emphasis – this *investment* – in "firsts" goes uncritiqued in transgender scholarly debates in a way that ignores and erases how the field is arguably, in many ways, is built on these legacies of imperialism and an investment in linearity. It is this emphasis on "firsts" that is, in fact, an important illustration of how the queerness of transness becomes compromised via an unexamined engagement with what has been constructed as an entry point into transgender history. I argue that the publication and mobilization of these two cases of "first" phalloplasties become emblematic of particular Cold War fantasies. Specifically, I emphasize the ways that this "firstness" exists throughout time as a source of complexity and tension, that exhibited both a moment of nationalist progress via technological breakthroughs as well as through (a retrospective) inclusion of a sterilized trans subject, as well as a moment of censure, as both stories

were hidden at the time of their first telling. It is in the re-emergence of these stories and the legacies of phalloplasty, particularly in the United States, that we see the ways that these early phalloplasties are mobilized, emblematic not just of early research into transition medicine, but emblematic of state investments in transgender *rights*. The notion of progress that attaches itself to transness becomes a valuable asset – indeed the *most* valuable asset as modern transition medicine attempts to reassert itself as progressive and settle into a standardized progressiveness.[75] As discussed, Eastern Europe was a significant origin point for transgender surgeries, and places such as the Belgrade Center for Genital Reconstructive Surgery continues to be a major destination for transition medical tourism and as a surgical training center. Further, its founder, Dr. Miroslav Djordjevic has continued to work in developing new techniques in transition surgery and has both trained American transition surgeons and begun a partnership with Mount Sinai Hospital in New York City. Despite the ongoing influence of Eastern Europe in the field of transition medicine, it is this perceived progressive liberal medical framework that attaches itself to American transgender rights.[76] These early moments in transgender history

75. This standardized "progressiveness" can be seen via WPATH's recent attempt to issue an eighth edition of its transgender standards of care. The writers of this latest edition, currently in progress at the time of writing, have solicited feedback from transgender people in a supposed show of good faith, incorporating trans voices into the construction of these medical guidelines and treatment plans.

76 Even in states within the United States without progressive transgender rights laws, the ways that these anti-trans laws work to network and connect transgender activism across the country solidifies an American reputation of progressiveness that portrays transphobia as simultaneously ever-present and also, consistently defeated by liberal values.

It is interesting further to consider the ways that American medicine, notably for-profit, re-upholds its reputation as progressive for transition medicine. In states with universal healthcare for transition

serve an important backdrop to transgender identity and politics in the present moment. The United States is deeply involved and invested in crafting the archiv*ing* of transness – by pursuing liberal ideals of inclusion, the state encourages a disconnected/ahistorical engagement with one's own individual past gender/transness, and this ahistoricized engagement with trans pasts has become the basis around which transgenderness more broadly continues to be constructed. The U.S. encourages an individual detachment from our previously gendered selves, and subsequently encourages a collective detachment from transgender origins out of war, imperialism, and especially, socialist legacies.

I entered this chapter with the story of Zorana Pop-Simonovic, a dancer who sought transition care from the Yugoslavian government. This story was featured in *National Enquirer* on October 1, 1967 in the same issue that featured on its front page, "YES! FLYING SAUCERS COME FROM OTHER PLANETS 'The Evidence that they Exist is Overwhelming,'" a headline that recalls the science fiction tropes of the time that linked together the threats of communism with alien invasion. Unsurprisingly, Pop-Simonovic's story was not picked up by any more reputable news outlets. Stories of Soviet-sanctioned transitions remained isolated to tabloids and transgender newsletters, even as transgender medical care was continuing to spread throughout Eastern Europe in Czechoslovakia, Yugoslavia, and Latvia.[77] In

---

medicine often results in long waits for full coverage for trans surgical procedures, causing non-U.S. based transgender people to either seek care in the U.S. or via their own private medical networks.

77 "List of Doctors in Foreign Countries Who Treat Transsexuals." Leaflet. 1980. *Digital Transgender Archive*, https://www.digitaltransgenderarchive.net/files/cz30ps84v.

1967, the Johns Hopkins Gender Clinic had only just begun, to shutter its doors just over a decade later. What remains hidden in this archive, prevented from full view from its origins out of Eastern Europe and socialist legacies?

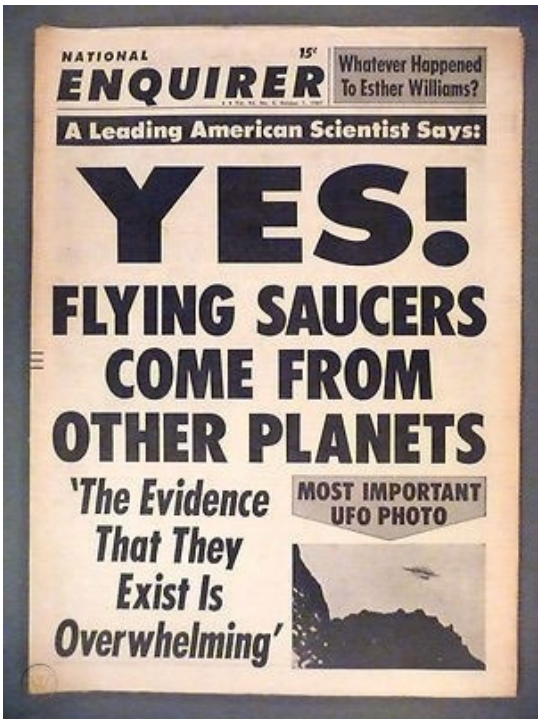

Figure 1. Front page of National Enquirer, October 1, 1967. [78]

78. "YES! Flying Saucers Come from Other Planets," *National Enquirer*, October 1, 1967.


NATIONAL
ENQUIRER
Car Crash Uncovers A 12-Year Secret...
BELLY DANCER IS A MAN!

Figure 2. National Enquirer article written by Thomas Porter about Yugoslavian dancer and trans woman, Zorana Pop-Simonovic.[79]

In building on Neda Atanasoski and Erin McElroy's critique of how "'the democratic ideal' … necessitates the grotesque coupling of socialism with state repression," enacted by Buzzfeed's narration of Innokenty's transition, I further argue this enduring framing of a repressive socialist state infiltrates across this broader framework of transition medicine, transgender rights, and transgender identity overall. I connect this to Bogdan Popa's work that explores queer postsocialism as it helps to "[realize] the revolutionary potential of histories and alliances that are

79. Thomas Porter, "Car Crash Uncovers a 12 Year Secret... BELLY DANCER IS a MAN!," *National Enquirer*, October 1, 1967.

already present in our lives" alongside the histories of state sanctioned – and state censured – transitions.[80] So much of what we understand to be transgender identity and transgender history becomes a question of ownership, as doctors and surgeons take ownership over trans bodies via their medical work, and countries take ownership over transness via their willingness to allow transition to take place. Although transness often is imagined as that which holds radical potential – that which is the supposed inheritor of queer radicality – this question of who *owns* transness risks evacuating it of these queer potentials.

In her 2019 response to her canonical article from 1997, "Punks, Bulldaggers, and Welfare Queens: The Radical Potential of Queer Politics?" Cathy Cohen re-examines the possibilities of queerness that she first described, with the added context of 20 years:

> [T]he space for provocation seems to be quickly closing. What I mean is that queer as a unifying framework for mobilization and action or space available for interrogation and imagining of who could be included in a or the queer political project and what might be the political basis of queer unity is less available as more people adopt queer as a personal politicalized identity, embodying a radical identitarian personal politics, as opposed to a collective position relative to state and capitalist power.[81]

Cohen's seminal piece, coming less than a decade after the fall of the Iron Curtain, speaks to a particular political moment that urges that one identifies their "political

80. Popa, "Trans* and Legacies of Socialism" 30.

81. Cathy Cohen, "The Radical Potential of Queer?: Twenty Years Later," *GLQ: A Journal of Lesbian and Gay Studies* 25, no. 1 (2019): 142.

comrades" by their relation to power as opposed to identity.[82] Putting this in conversation with Bogdan Popa's exploration of the perils of liberalism, I consider the haunting legacies of anticommunism that create a queer subject or a queer moment, describing the opening for unlikely and queer alliances, and articulate a queer postsocialist temporality that could re-open this space for provocation Cohen describes that is/was (perhaps always already) closing.[83] Popa argues that queer postsocialism "[resurrects] political specters" of ongoing violence, going on to say, "A postsocialist imaginary has a queer dimension because it connects anticapitalist projects in the shape of labor resistance through a language of desire and a refusal of power hierarchies and exploitation."[84] These moments of Soviet-era transness offer a queer potentiality to re-open what Cohen describes as a quickly closing space for provocation. As transness continues to be understood and articulated primarily through linear and medically focused transgender histories, transness risks being defined via a revolutionary endpoint, one that has had its queerness effectively managed, successfully evacuated of its queer potentials and absorbed into liberal imaginaries of inclusion.

In bringing together these two case studies of Michael Dillon and Innokenty, I re-focus the transgender archive with a mind not of individual figures nor the

82. Cathy Cohen, "Punks, Bulldaggers, and Welfare Queens: The Radical Potential of Queer Politics?," *GLQ: A Journal of Lesbian and Gay Studies* 3, no. 4 (1997): 437–65.

83. Bogdan Popa, *Shame: A Genealogy of Queer Practices in the 19th Century* (Edinburgh University Press, 2017), 38.

84. Popa, "Trans* and Legacies of Socialism" 29.

homogenized identity of transness, but instead through the multitude of players involved in the creation of transgender medicine and transgender histories. I decenter this romantic fixation on the individual that overwhelms the canon of transgender histories, and instead resituate a transgender archive as an assemblage, demonstrating the intra-action of state power, medicine, and Western imperialism, as well as the surviving histories of queerness, mess, and remains of transgender potentiality. These case studies form the foundation from which the inextricably linked medicolegal construction of transition medicine is formed alongside and through the normalizing and managing of transgender bodies. Moving into the present, I connect these histories to the making of U.S. transgender rights as that which erases transness at the same moment that it purports to recognize it. The United States attempts to promote the nation as a transgender hub, an oasis for trans bodies to enjoy rights as well as highly regarded transition related medical services. In so doing, the U.S. further develops a transgender citizen and transgender non-citizen. It continues to separate and discourage any identification from those deemed undesirable, which in this case becomes a queer trans-ness, a transness of color - an unassimilable body. I argue that the law produces a disidentification with transgender identity, or more specifically with queerness, encouraging identification with a (trans)gendered citizenship that is always already out of reach.

Chapter 2

The Transgender Citizen-Patient: Managing Gender Transition

Introduction

In April 2021, the *Los Angeles Times* published a profile of Erica Anderson, a trans woman and psychologist who works extensively with adolescent and young adult transgender people. Despite her focus, Anderson voiced concern with the seeming increase in transgender youth and subsequent increase in early in life transitions:

> [Anderson] has helped hundreds of teens transition. But she has also come to believe that some children identifying as trans are falling under the influence of their peers and social media and that some clinicians are failing to subject minors to rigorous mental health evaluations before recommending hormones or surgeries.
>
> "I think it's gone too far," said Anderson, who until recently led the U.S. professional society at the forefront of transgender care. "For a while, we were all happy that society was becoming more accepting and more families than ever were embracing children that were gender variant. Now it's got to the point where there are kids presenting at clinics whose parents say, 'This just doesn't make sense.'"[85]

Despite being transgender herself, Anderson's position on early transitioning illustrates how medical providers attempt to *manage* gender transition. This attempt to control gender transition is spurred by the ways that "unmanaged" transitions – those that occur without the supervision or approval of a gender professional – represent a threat, in this case, to a would-be cisgender body and a subsequent

85. Jenny Jarvie, "A Transgender Psychologist Has Helped Hundreds of Teens Transition. But Rising Numbers Have Her Concerned," *Los Angeles Times*, April 12, 2022, https://www.latimes.com/world-nation/story/2022-04-12/a-transgender-psychologist-reckons-with-how-to-support-a-new-generation-of-trans-teens?utm_id=52978&sfmc_id=1828180.

normative family. Anderson also demonstrates the tension between transgender communities and their medical providers, as transgender people resist attempts by providers like Anderson to subject them to unwanted and superfluous requirements that position the provider as someone who determines if their patient is "actually" trans or not. Anderson is profiled by the website "Transgender Map," which was created by Andrea James, a trans writer and activist, and contains information and resources for a diverse range of gender identities on how to pursue gender transition. In addition to information on finding trans-friendly providers, the website also features profiles on people like Erica Anderson describing reasons to avoid her. Through a compilation of interviews and profiles, "Transgender Map" describes Anderson as a "gatekeeping therapist" who refuses to follow informed consent guidelines that are standards of care as defined by the World Professional Association for Transgender Health (WPATH).[86]

86. "Erica E. Anderson and Transgender People," Transgender Map, April 11, 2021, https://www.transgendermap.com/medical/psychotherapy/usa/california/erica-anderson/.

WPATH, formerly known as the Harry Benjamin International Gender Dysphoria Association, is an international organization "[working] to further the understanding and treatment of gender dysphoria by professionals in medicine, psychology, law, social work, counseling, psychotherapy, family studies, sociology, anthropology, sexology, speech and voice therapy, and other related fields." It is made up primarily of both cis and transgender members who work in these fields, and, as part of the organization, work "to promote evidence based care, education, research, public policy, and respect in transgender health." Individuals who do not work in these disciplines are able to join as supporting members who do not have voting rights in the organization.

"Mission and Vision - WPATH World Professional Association for Transgender Health," www.wpath.org, n.d., https://www.wpath.org/about/mission-and-vision.

Transgender identity has been constructed by the media, health professionals, educators, and governmental agencies like WPATH and the World Health Organization in an uncomfortable ambiguity as pathological and non-pathological at the same time, a tension that I examine from the perspectives of transgender people seeking transition medicine in contrast to transition providers. Medicine, primarily via transition "experts" working in mental health, surgery, and endocrinology alongside insurance providers, categorize transgender existence as a pathology, which is posited by medical providers and even some transgender activists as providing validity for treatment. The 2013 decision to keep transgender identity (albeit no longer formally labelled as a "disorder") as a pathology in the DSM (changing from "Gender Identity Disorder" to "Gender Dysphoria") was made in part so as to make transition related care more readily understood as medically necessary and thus, something for which insurance companies would provide coverage.[87] Still others have willingly (or even preferred) to take on medical terms to discuss their transness, describing the incongruent experience of their body and gender identity as a birth defect.[88] Transgender medicine and identity have been, seemingly, inexorably linked and co-constitutive. Medical science, working in conjunction with insurance systems,

87. Despite the presence of gender dysphoria in the DSM, insurance companies in the United States are not required and still frequently do not cover transition related care.

Zowie Davy, "The DSM-5 and the Politics of Diagnosing Transpeople," *Archives of Sexual Behavior* 44, no. 5 (June 9, 2015): 1165–76.

88. Loree Cook-Daniels, "Thinking about the Unthinkable: Transgender in an Immutable Binary World," *New Horizons in Adult Education and Human Resource Development* 24, no. 1 (January 2010): 63–70.

government identification processes, and other constructions of the state work together to process transness into digestibly simple identity categories that become easily registered. Despite narratives of transness as contagion from transition providers like Erica Anderson, access to medicolegal transition has by and large increased across the United States. Standards of care increasingly recognize models of "informed consent," transition medicine is increasingly covered by insurance plans, and moves towards nonbinary "X" gender markers on documentation have becomes more common.[89]

This supposed increased access – to medicine, rights, and care, as well as to increased acknowledgement – comes at a price. From where and from whom are we seeking this access? As part of this dissertation's broader project of assessing transgender rights at the site of the (sometimes literal) construction/production of the transgender body through projects of war, imperialism, and racism, this chapter continues to ask questions about what motivates state projects of trans inclusion, particularly via transgender medical access, and also asks how this affects the category of transness. I address these questions through discussions of transition medicine, which I broadly define as being made up by the transgender surgical industry, medicinal transition (i.e. hormone therapies), gender therapy, as well as

89. Timothy Cavanaugh, Ruben Hopwood, and Cei Lambert, "Informed Consent in the Medical Care of Transgender and Gender-Nonconforming Patients," *AMA Journal of Ethics* 18, no. 11 (November 2016): 1147–55.

Joseph K. Canner et al., "Temporal Trends in Gender-Affirming Surgery among Transgender Patients in the United States," *JAMA Surgery* 153, no. 7 (July 1, 2018): 609–16.

medical institutions such as WPATH, WHO, and the American Psychiatric Association (APA). I then explore how these pillars of medicine, utilized as an arm of the state, become a dangerous and complicated figure in defining and controlling transgender futures.

Openings offered by the United States for transgender inclusion (mirrored in other states like the United Kingdom's Gender Recognition Act (GRA) in 2004 – allowing for a legal change of gender as well as the ongoing efforts to extend the GRA to allow a legal gender change from "M" or "F" to an X gender marker) – reorient transgender activism towards the very systems that seek to prevent our survival.[90] These legal extensions are not so much openings as they are unequal exchanges. These laws and efforts towards legal documentation of transition ask that we trade in the messiness of a queer existence for the sterility, the respectability, and the objectivity of medical sciences, positioning those who remains outside the state constructions of healthy transgender existence at disproportionate risk of violence and death. This "healthy" transness is primarily defined by a transgender person's ability or willingness to access/engage in transition medicine through the approval of medical professionals, a group that is disproportionately poor and of color. This chapter calls into question the sterility of transition medicine and examines the queer

90. Emily Grabham, "Governing Permanence: Trans Subjects, Time, and the Gender Recognition Act," *Social & Legal Studies* 19, no. 1 (March 2010): 107–26.

Hannah J. H. Newman and Elizabeth Peel, "'An Impossible Dream'? Non-Binary People's Perceptions of Legal Gender Status and Reform in the UK," *Psychology & Sexuality*, February 11, 2022, 1–15.

potentialities of an "unhealthy" transition, while also examining the increasingly blurred boundary between medicine and transness.

To explore these calls for sterility and the entanglements between the state and medicine, I examine the discourse of medical transition providers. In this chapter, I narrow in on modern transition discourse, located specifically in the United States primarily after 2000, as attention to transgender rights became more visible with the founding of the Transgender Law Center and Sylvia Rivera Law Project in 2002, and the National Center for Transgender Equality in 2003. I look at three major conferences centered around transgender identity and/or medicine.[91] The first conference I examine is Fantasia Fair, a community-organized conference event for socializing, resource sharing, and community networking/support for transgender people. The next conference I examine is the South Florida Transgender Medical Consortium's Annual Transgender Medical Conference (SFTMC). This conference is aimed primarily at current and student medical providers for continuing education looking to expand their knowledge on transition medicine. Finally, I look at Gender Odyssey, a conference started in 2001 primarily to have conversations within the transgender community, and which was later expanded to include a professional track. This accredited professional track provides continuing education credits, similar to what is available via the South Florida Medical Consortium. In examining

91. Because of the limitations caused by the COVID-19 pandemic, I utilized a combination of virtual conference attendance alongside reviewing archival footage and records of past conferences. While this limited my ability to see in more detail the make-up of the audiences of these conferences, the archival approach allowed me to think in more detail about the histories of the conferences as they changed and evolved since their inception.

these conferences, I explore the expanse of conferences held on the topic of transgender identity, as they range from being simply community gatherings, to spaces in which to pursue medical transition, to specifically medical education spaces where transgender people are, in fact, the minority. Fantasia Fair, which claims to be the longest-running transgender conference in the world, is geared primarily towards transgender people looking for community support versus gatherings that are primarily designed for medical providers such as with the South Florida Transgender Medical Consortium.[92] These conferences exemplify two major kinds of space for transgender discourse, with Fantasia Fair offering a seeming reprieve from the persistent medicalization of transness, and SFTMC offering a purely medical perspective. Gender Odyssey, founded by Aidan Key, a transgender man, began with the intention of being a space for discussions by and for transgender people, but later started to offer a medical/professional track, both for transgender people to learn more about their medical options as well as for transition providers to pursue continuing education. Gender Odyssey offers the ability to look more closely at this increasingly narrow distinction between transgender community and medicine.

In my analysis of these conferences, I examine the ever-presence of medicine within transgender community spaces, infiltrating, expanding, and changing conversations within trans spaces, and ultimately developing the transgender medical

92. SFTMC comes out of South Florida which is a hub for transgender surgery and community; Fort Lauderdale advertises itself as a destination specifically for transgender tourists, and several popular transgender surgeons such as Dr. Charles Garramone and Dr. Sidhbh Gallagher are based in the region.

patient, or, using Nikolas Rose's framework of biological citizenship, what I term the citizen-patient. I analyze the language providers use when talking about transgender communities and discuss the collapse of transgender people *into* patients, critiquing the language of pathology as it gets attached and detached from different trans bodies. In my analysis of transition discourse at transgender conferences, I expose and dissect the alliance of the medical transition industry and the state, where the pathologization of transness is mobilized to create and encourage "proper" channels through which one can access transition medicine and thus, create a normalized transgender subject. The involvement of medicine in physical gender transition evokes questions and definitions of medical treatment, health, and unhealthy transition. I explore the emergence of the depathologized, or "healthy" transgender experience – one that is able to become, if not normatively gendered, then normatively *trans*gendered – and examine what then remains pathologically transgender. These normative constructions of trans-gender, as with normative constructions of gender, become defined through whiteness, where racialized *trans*gender is always already non-normative. As "healthy" transitions are simultaneously *diagnosably* transgender, it is important to consider the ways that medicalized transgender identity comes to be defined by these terms and further, how surgical and pharmaceutical medicine has developed overall. Specifically, I explore how American medicine was built and developed upon histories of experimentation upon people of color, and transition medicine, particularly transition surgeries, has ongoing legacies and proximities to colonial projects of medical mission work.

Medicolegal Collaborations in Transgender Medicine

Transgender medicine, or transition medicine, is a broad field of medicine, generally consisting of some combination of mental health/therapy interventions, hormonal therapies, and/or surgical procedures; in addition to these subcategories of transition medicine are the larger organizations that manage its distribution such as WPATH, APA, and WHO. While many transgender people choose to not engage in any of these medical interventions (and many more only choose to utilize one or two), lingering *questions* about the role of medicine in making legible "transgender" persist. Even in the cases of those who choose not to medically transition, medicine lingers in its ever-present possibility as well as the ways that one's access to it is held hostage by medicolegal gatekeeping. Transness is thus, via this historic and ongoing reliance on these international medicolegal bodies to create standards of care, defined by and through medicine, and in this shift towards an always-already medicalized transness, the effects of medicine's infiltration into transgender communities and identity are as yet underexplored.. In their book, *Trans Medicine: The Emergence and Practice of Treating Gender*, stef m. shuster describes the guidelines put forth by organizations such as WHO and the APA in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), critiquing the lack of evidence they use in defining trans identity describing "[the] medical community's knowledge of trans people" in such a way that suggests a strict distinction between transgender people and transgender medicine, or more specifically, transition providers, that does not, and

arguably has never existed.[93] shuster's work also illustrates how transition providers in the mid-twentieth century limited access to transness for those who had normative presentations of their (trans) gender. For example, beautiful trans women with an interest in building a family, trans men who wanted to marry women, and trans women who wanted to marry men; in short, trans people who were able to live, for all intents and purposes, heteronormative lives, although shuster's argument, importantly neglects to discuss the ways that racialized gender is always already outside the bounds of heteronormativity. Transition medicine, I argue, works to *manage* transitions and, therefore ,transgender people. Even though many transgender people continue to resist and refuse medicalization, its lingering, haunting presence increasingly asks us to make ourselves legible to it, as if it *allows* us to "take part" in our own defining for *medicine's* consumption. In one recent example, while drafting the 8th edition of WPATH's Standards of Care, the organization published beta copies online, inviting transgender people to comment and provide feedback on the document, in a seeming collaboration that suggests a benefit to transgender people as they are made to educate providers on treatment within a system that refuses to allow them to assert their own needs without a doctor's approval.[94] I argue that these moves are not meant to limit transition per se, but to moderate it, working to construct

93. stef m. shuster, *Trans Medicine: The Emergence and Practice of Treating Gender* (New York, New York: New York University Press, 2021), 85.

94. Eli Coleman, "SOC8 Homepage - WPATH World Professional Association for Transgender Health," www.wpath.org, November 16, 2020, https://www.wpath.org/soc8.

a *healthy* transition that removes the risks that transness may otherwise pose, namely, the risk of disrupting the could-be normative lives of cisgender people and families.

In a 1972 issue of the Erickson Educational Foundation Newsletter, Dr. John E. Hoopes is quoted from an article in Ob. Gyn News saying, "Transsexuals are benefited by surgical sex reassignment. Surgical sex reassignment may be of value in a limited group of individuals – those who are diagnosed transexuals [*sic*] and, in addition, are good citizens."[95] Hoopes links between being "diagnosably" transgender with good citizenship. This connection between good, moral, or model citizenship frequently appears in archived correspondences between consulting physicians attempting to make assessments in diagnosing transgender people as legitimately trans. As stef m. shuster examines in their archival exploration of the diagnosis of transness:

> Trans people faced increasing scrutiny from the medical community to become model citizens with no hint of moral imperfection. Having a criminal record, a history of using drugs, or any indication of being socially "undesirable" subjected a trans person to the scorn of medical providers and denial of care. As one doctor pondered, "Should we punish the 'good and

95. The Erickson Education Foundation was a philanthropic organization founded in 1964 by trans man and wealthy businessman, Reed Erickson. The Foundation primarily focused on research and topics on gay and transgender issues as well as new age spirituality.

Aaron Devor and Nicholas Matte, "Building a Better World for Transpeople: Reed Erickson and the Erickson Educational Foundation," *International Journal of Transgenderism* 10, no. 1 (October 12, 2007): 47–68.

Hoopes is a former plastic surgeon at Johns Hopkins who performed transition surgeries in the mid 20th century. Johns Hopkins describes Hoopes as being "regarded as a pioneer for his innovative work in transsexual surgery."

"John Eugene Hoopes," portraitcollection.jhmi.edu, n.d., http://portraitcollection.jhmi.edu/portraits/hoopes-john-eugene.

> deserving' transvestites because some others behave so abominably? After all, that's part of their illness. They're irresponsible misfits."[96]

While transgender people are able to access resources, diagnosis, or inclusion by way of "good citizenship" or "good moral character," it is not unique to transgender experience. However, pathology as a route through which to prove "good" citizenship offers an interesting and contradictory twist to the familiar narrative and begs the question – who embodies "good transgender citizenship" and who exists outside of it?

In his text *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-first Century* (2006), Nikolas Rose analyzes what he terms "biological citizenship" – the next step in the "evolution of citizenship," that began from political and subsequently social citizenship. Rose argues, "biological presuppositions, explicitly or implicitly, have underlain many citizenship projects, shaped conceptions of what it means to be a citizen, and underpinned distinctions between actual, potential, troublesome, and impossible citizens."[97] He further describes biological citizenship as "[encompassing] all those citizenship projects that have linked their conceptions of citizens to beliefs about the biological existence of human beings, as individuals, as men and women, as families and lineages, as communities, as populations and races, and as species."[98] The transgender person occupies (or holds

96. shuster, 43-44

97. Nikolas Rose, *The Politics of Life Itself : Biomedicine, Power, and Subjectivity in the Twenty-First Century.* (Princeton: Princeton University Press, 2009), 140.

98. Rose, 140

the potential to occupy) different statuses of citizenship at various moments – the status of "potential," "troublesome," or "impossible" citizen. But who then is the impossible? How does one's move between troublesome or potential citizen? I argue that the trans person's ability to engage in this citizenship project exists within an illusory future that serves to manage "transgenderness" (or more specifically, the queerness of transness and its radical potentialities) through an incitement to take action. In considering how transgender people are always already outside of the conceptions of normative gender and, subsequently, conceptualizations of families and lineage linked to citizen projects, I argue that transgender people's citizenship be understood in a state of tension. I introduce the concept of "citizen-patient" to describe transgender identity, where a transgender person, by engaging with a medicolegal transition through state-sponsored resources, enters a permanent state of "patient" that seeks both to cure transness as it reifies the pathological. The (in)ability to access transition care positioned by the U.S. is leveraged at transgender people to encourage an understanding of medicine as an advocate for, or even an integral part of transness. Biological citizenship, becomes a project through which the trans citizen-patient is produced, encouraged to enter into alliance with medicolegal transition as Rose writes, "[the] role of biomedical authority here is not to encourage the passive and compliant patienthood of a previous form of medical citizenship. Citizenship is to be active."[99] One's ability to enter into the status of citizen-patient

99. Rose, 150.

is defined/limited by one's ability to be perceived as normatively gendered, and the co-constitutive nature of race and gender, as well as the histories of racial violence that produce medical technologies, thus require that the citizen-patient be understood as white.

In analyzing a medicalized transgender identity via Rose's biological citizenship, I argue that medicolegal systems of transition care – particularly as it is structured by institutional standards of care via WHO, WPATH, ESA, etc. – create a route through which transgender people are encouraged to prove their transness through model citizenship. Rose's framework of biological citizenship comes out of the question of the molecularization of the body and the construction of what he terms the prepatient, where one's status of patienthood is future oriented and determined through the potential for disease.[100] While there are a number of attempts to identify biological and genetic markers for transness, in general, transition medicine is primarily invested in *treating* transness rather than it is concerned about predicting its emergence in individuals. However, understanding transness through Rose's framework brings to light the ways in which the diagnostic criteria for transness engages in the question of "predisposition" for disease differently and subsequently effects how it treats the "disease." Where predisposition for disease brings up questions of prophylaxis and preventative medicine, transition medicine affirms transgender experience via sterilization, thus rendering the question of a transgender

100. Rose, 94

gene as superfluous. Although transgender reproduction is not as uncommon or sensationalized as the media tends to portray it (i.e., Thomas Beatie, the "pregnant man" profiled by Oprah Winfrey in 2008), it is often done on one's own without significant medical support, and further, if a healthy transgender experience is one that does not experience transphobia, we must consider further the implications of sterilization upon the definition of transgender health. In particular, the investment by medicine in ignoring or refusing transgender reproductivity demonstrates the ongoing threat against the normative family that medicine attributes to transness.[101]

There have been a number of calls to depathologize transgender identity, and even the APA has made claims that the continued presence of "gender dysphoria" in the DSM V exists primarily, if not solely, to make medical insurance claims by transgender patients more accessible; however, transition medicine moves to emphasize the ways in which the pathology of transgender identity is tied to constructions of "good citizenship."[102] I explore transgender identity's status as a pathological non-pathology through Rose's framework of biological citizenship, where, I argue, the move towards pathologizing transness works to reify the state's power in deciding the deservingness of transgender people to medical intervention. Further, the state's interventions in accessing transition to make it increasingly, if

101. micha cárdenas, "Pregnancy," *TSQ: Transgender Studies Quarterly* 3, no. 1–2 (May 2016): 48–57.

102. Patricia Gherovici, "Depathologizing Trans," *TSQ: Transgender Studies Quarterly* 4, no. 3–4 (November 1, 2017): 534–55, https://doi.org/10.1215/23289252-4189956.

disparately, available/accessible does not intend to move forward a pro-transgender agenda so much as it attempts to define transgender citizens as sites of potential value, and as productive subjects for the creation of medico-normative value. Medical boundaries continue to be blurred with self-identification, as Rose notes "the language with which citizens are coming to understand and describe themselves is increasingly biological," we begin to engage in a trans self-knowledge production that is governed by the rules of biological citizenship.[103] It gestures towards the tension of transness and its degree of overlap/engagement with understandings of the pathologically transgender. As I move into my analysis of transgender medical discourse, I center this question of who and what defines the "healthy" transgender subject, and who and what falls out of this discussion to become pathologically transgender.

I make apparent the linkages between citizenship, medicine, and the state, and in that linkage, examine the repercussions of this alliance upon transgender people. If "good transgender citizenship" is understood in part as being diagnosably transgender, it is important to consider the ways that medicine comes to these terms and further, how medicine has developed overall. Much of what is now understood as transgender medicine surged into existence in the late 20th and early 21st century with bioidentical hormones becoming more widely available in the 1930s.[104] At this

103. Rose, 148.

104. John M. Hoberman and Charles E. Yesalis, "The History of Synthetic Testosterone," *Scientific American* 272, no. 2 (February 1995): 76–81.

time, early transition surgeries are beginning, with famous transgender historical figures like Lili Elbe and Michael Dillon receiving some of the first documented transition related surgeries in 1930 and 1945, respectively.[105] With Dillon especially, as discussed in the first chapter, transition medicine became something that he did not simply consume, but something with which he collaborated. In the years of phalloplasty surgical procedures by Harold Gillies, Dillon was attending medical school, eventually becoming a surgeon. Dillon collaborated with Gillies to treat a trans woman, Roberta Cowell, performing an orchiectomy that then allowed Gillies to perform a vaginoplasty. Reed Erickson, another trans man and patient of Harry Benjamin, was foundational in constructing transgender medicine as it exists today, since he founded the Erickson Education Foundation (EEF) in 1964, which existed primarily for the study of transgender topics, especially transgender medicine, funding and collaborating with Johns Hopkins, the Harry Benjamin Foundation (not to be confused with the Harry Benjamin International Gender Dysphoria Association which eventually became WPATH), and other gay and trans research groups. This wide-spread philanthropic work by the EEF is credited by Aaron Devor and Nicholas Matte with shaping the landscape of transgender medicine and life in the United States.[106]

105. Bernice L. Hausman, "Demanding Subjectivity: Transsexualism, Medicine, and the Technologies of Gender," *Journal of the History of Sexuality* 3, no. 2 (October 1992): 270–302.

Michael Dillon-Lobzang Jivaka, *Out of the Ordinary: A Life of Gender and Spiritual Transitions.* (Fordham University Press, 2016).

106. Devor & Matte 47.

I emphasize this historical context to demonstrate the long histories of transgender involvement and participation in the creation and distribution of transgender medicine. This legacy continues as seen by the creation and management of large-scale transgender events like Fantasia Fair and Gender Odyssey, as well as the participation of transgender providers on trans medical institutional boards like WPATH. These collaborators of transgender medicine form the foundation of the field as we know it, not through their bodies as products of medical intervention, but in the ways that they contributed to the development of medical transition processes, transgender rights, and transgender discourse more broadly. Although trans people have long been involved in creating and making possible their own medical care, the critiques of trans medicine tend to focus on the ways that medicine sees itself as an authority in determining and treating transness, over the self-determination of transgender people themselves. I argue then, especially in cases like Michael Dillon or the transgender board members of WPATH, it is not transgender voices that are absent from this conversation that make transitioning difficult to access. Rather, I argue that this demonstrates a differential inclusion of privileged transgender voices, and further, I examine transition medicine – surgical, pharmaceutical, and mental health – and its relationship to the liberal state via questions of access, insurance, and power, as well as its legacies out of coloniality and racism, as encouraging logics of control that limit and foreclose possibilities for a more effective and queer way of engaging in gender transition.

In my analysis of transgender conferences, I note a detachment between doctors and patients, creating a firmer boundary that does not discourage collaboration, but rather, actively works to manage it, maintaining an "outside" of medicine for the transgender patient. Transition medicine, and indeed American medicine more broadly, exists in a larger context of racial violence, where American medicine was built and developed upon histories of experimentation upon Black, Indigenous, and of color populations. J. Marion Sims, the father of modern gynecology, famously developed his medical advancements, surgical techniques, and instruments by experimenting and operating on un-anesthetized enslaved Black women beginning in the late 1840s.[107] Continuing this legacy into 1951, biomedical researchers collected cells from Henrietta Lacks, a Black woman seeking treatment for cervical cancer. These cells would later be propagated into a cell line called HeLa and commercialized, without the knowledge or consent of Lacks or her family; it would go on to be used in the production of vaccines, cancer treatments, and other extensive biomedical research projects.[108] While medicine advances upon the bodies of Black women and continues to profit off of the commercialization of Black and Indigenous bodies, these communities continue to be mistreated and underserved by medical providers. The Black Panther Party intervened on some of these abuses and

107. Harriet A Washington, *Medical Apartheid The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present.* (Double Day, 2006).

108. Alondra Nelson, *Body and Soul: The Black Panther Party and the Fight against Medical Discrimination* (Minneapolis, Minnesota: University of Minnesota Press, 2013).

neglects in the 1970s, arguing that systems of racism work to make Black people unwell in their increased exposures to carcinogens, environmental pollution, and their increased bodily vulnerability to other infectious diseases while the U.S. government supported attempts by medical researchers seeking to "biologize" violence, attributing it as an inherent trait of certain biologies, most notably Black men.[109]

These histories point out the disparity of medicine that I seek to explore further, which is not simply who is medicine meant to serve, but what is it truly accomplishing? More urgently, what does it threaten, particularly in the very definition of transness? One might see these histories as a way in which medicine treats indigenous and communities of color as victims of research, or as "collateral damage" in the search for greater truth and knowledge, but in fact, I argue that they demonstrate the ways in which medicine operates as a system of control – a counterinsurgent force. Medicine historically operates as incidentally life-saving, a side-benefit to the larger goal of profiting off of colonialism, anti-Blackness, and state control. I urgently draw connections to these particular examples and moments in time within the medical archive for the ways that medicine works to neglect, pathologize, and experiment upon people of color and to illustrate how these histories do not simply inform modern medicine, but are in fact what make it possible. Transition medicine must be understood through this historical lens as this system operates to produce the transgender citizen-patient. I hold the history of transgender

109. Nelson, 154-155.

medicine in juxtaposition to the macabre legacies of racial medical violence to demonstrate not just the ways that racism and colonialism make medicine possible, but to tease apart and examine the boundaries between "collaborator" and "experimental subject" that begins to emerge in this examination of transgender medical discourse, and further, to critically examine the *management* of the experimental subject.

Transgender Conferences and Trans-Medical Culture

Transgender conferences tend to fall into three major camps: those that cater predominantly to medical providers, those that cater predominantly to transgender individuals seeking community support, and hybrid events that offer both community space as well as space for medical/professional discussion. Analyzing these conferences demonstrates the development of transgender medical discourse alongside transition care more broadly. These conferences, attended by the providers hoping to develop more effective treatment plans for potential patients hoping to understand their options better, provide the backdrop to the construction of transgender health and the transgender citizen-patient. As transgender histories and medical developments began to enter the public sphere increasingly through the early 20th century, the co-constitutive relationships between history/culture with and through medicine, specifically via the medicalization of transgender identities, is as yet unexplored. Moving away from these early collaborations during the infancy of transition medicine, it is important to understand the moments and places in which medicine enters and exits transgender cultures and histories. More specifically, these

moments of collapse, where the medical *becomes* transgender discourse, and threaten to undermine the potentialities of transgender-ness via the unexplored implications of racism, militarism, and the state in transition medicine.

Transgender conferences have existed for many years with the earliest documented transgender conference in the United States, Fantasia Fair, taking place in Provincetown, Massachusetts in 1975.[110] Since 1975, Provincetown has held Fantasia Fair every year excluding 2020, which was canceled due to COVID-19. A 1975 newspaper article described the first FanFair:

> The Fair brought some 50 T.V.s [transvestites] and some of their wives to Provincetown for "'ten glorious days of dressing 'en femme,'" and, according to convention coordinator Ariadne Kane, the Fair was a glorious success.
>
> Featuring classes on dress, makeup, hair-styling, elocution, and a film festival, the Fair allowed many TVs [*sic*] the hitherto unknown luxury of the freedom of being themselves, or their spiritual "sister," in the unique environment of a small town without the ever-present fear of exposure/discovery they live with at home.[111]

Originally created for transfeminine people, early Fantasia Fairs similarly featured workshops on fashion and makeup and personal development, as well as social events like banquets. not unlike more recent Fantasia Fairs which continue to focus on similar topics, include discussions of building community and brief explorations into

110. Fantasia Fair was cancelled in 2020 due to the ongoing COVID-19 pandemic, at which time research for this chapter was being completed and was next held during the Delta-wave of 2021. Because of these limiting factors, this research was done using programming materials from past conferences archived by the FanFair organization.

111. Bil Damonl. "TV Watching in P'town." Clipping. 1975. *Digital Transgender Archive*, https://www.digitaltransgenderarchive.net/files/n009w2543

trans history.[112] As of 2022, Fantasia Fair describes itself as, "Part learning experience, part social gathering, and part reunion, the Fair is a full immersion experience, meaning attendees can and usually do spend an entire week 24/7 presenting their gender as they wish."[113] The Fair is still largely a social/community gathering, with workshops and panels on topics such as exploring gender presentation and understanding transgender histories, as well as social events like meals and fashion shows. Fantasia Fair, unlike many transgender conferences, focuses on creating and discussing queer and trans community and culture, hosting discussions on coming out, family, and introductory courses on gender, as opposed to discussions on the "what and how" of medical transition. As of the 2019 event, presentations included "Demystifying Transgender through proud history, simply biology and a story of resilience," by a military veteran and trans woman, Allyson Hale, which features an informational session on transgender understanding one's own transness, "A Stonewall Witness," by David Velasco Bermudez who described his experience at Stonewall in 1969, and "Tales of the Early Fantasia Fairs!" by transgender activist and Fantasia Fair founder, Ariadne Kane.[114] Beyond these queer and trans specific

112. "Fantasia Fair Program 1977," *Https://Fanfair.info/Wp-Content/Uploads/2018/04/FF-1977-Participants-Guide-Compressed.pdf*, 1977.

"Fantasia Fair Participant's Program Guide," *Https://Fanfair.info/Wp-Content/Uploads/2018/04/FF-1993-Participants-Program-Guide-Oct.-14-24.Compressed.pdf*, 1993.

113. "About Fantasia Fair | Fantasia Fair," fanfair.info, n.d., https://fanfair.info/about-fantasia-fair/.

114. "FanFair 2019: Our 45th Anniversary Celebration! Participant's Guide," 2019, https://fanfair.info/wp-content/uploads/2019/09/2019ParticipantsGuide-Web-version-Final.pdf: 65.

presentations, the conference also features workshops on garment repair and taking one's clothing measurements, demonstrating the ways this non-medical trans-community space caters to the variety of needs of trans people beyond the medical, such as creating a space where one can access help with clothing without discomfort. Fantasia Fair also holds a number of presentations and workshops regarding dating as a transgender person, including cisgender people whose partners have transitioned during the relationship, such as "Reclaiming Emotional and Physical Intimacy: Is it Possible?" held by Dr. Maureen Osborne, a clinical psychologist.[115] Although Osborne gave this presentation in her capacity as a mental health professional, her focus was not on the pathology of transness, but rather in the scope of couples counseling. These nuanced understandings of transness and trans community demonstrates the importance of these non-medical spaces. In addition to these informative presentations, Fantasia Fair features a number of recreational events, including open-mic nights, an award and banquet event, and a dinner dance. The Fair also includes information on a variety of after-hours events for small, intimate gatherings. One such event, called "Roomers," is hosted at the personal apartment of a local trans woman, Sibil Greiner. The conference program describes events like "Roomers" as "the heart and soul of the Fair!" going on to invite attendees, "Feel free to stop by Roomers any night from Tuesday through Saturday and bring a musical

"FanFair 2019," 60.

115. "FanFair 2019," 73.

instrument if you wish. The action starts at 10 pm and goes until 1 am, with attendance growing as the evening progresses. Expect to see Fair organizers and staff, first-timers, seasoned Fairgoers, and the person with whom you just had lunch!"[116] This gathering re-iterates the topics and issues transgender people encounter beyond the ever-present emphasis on accessing medicine.

Although the conference does not center topics of medical transition specifically, the program contains advertisements for medical services and facilities peppered throughout and alongside other ads for local restaurants, events, and shops in Provincetown. The program for the 2019 conference begins with an advertisement for Dr. Marci L. Bowers, M.D. and her services, highlighting vaginoplasty, labiaplasty, orchiectomy, and tracheal shaves for "MtF" clients, and metoidioplasty, hysterectomy, scrotoplasty, and vaginectomy for "FtM" clients.[117] After Dr. Bowers's full-page ad for reconstructive genital surgery is an ad for Dr. Jeffrey Spiegel to "DISCOVER YOUR INNER BEAUTY WITH FFS[facial feminization surgery]?" Dr. Spiegel's ad (see fig. 1) shows a young, white, masculine looking face with short blond hair, fading into an overlaid face – a similar, but distinctly different feminine face with long, silky straight hair blowing in the wind. At the bottom of the

116. "FanFair 2019," 39.

117. Marci Bowers is located in Burlingame, California. It is interesting to note that Dr. Bowers, a white transgender woman, is one of a small but notable number of transition providers who themselves are transgender. She is well-known in transgender medicine, serving on the board of WPATH and famously performing the first of several gender confirmation surgeries for Jazz Jennings, child transitioner of the "I am Jazz" reality television series. After some extended complications after the initial surgery, Bowers was removed from Jennings's surgical team.

ad is an offer for a coupon - providing the doctor's office with your Fantasia Fair ID within a month of the end of the conference entitles the holder to a free consultation.

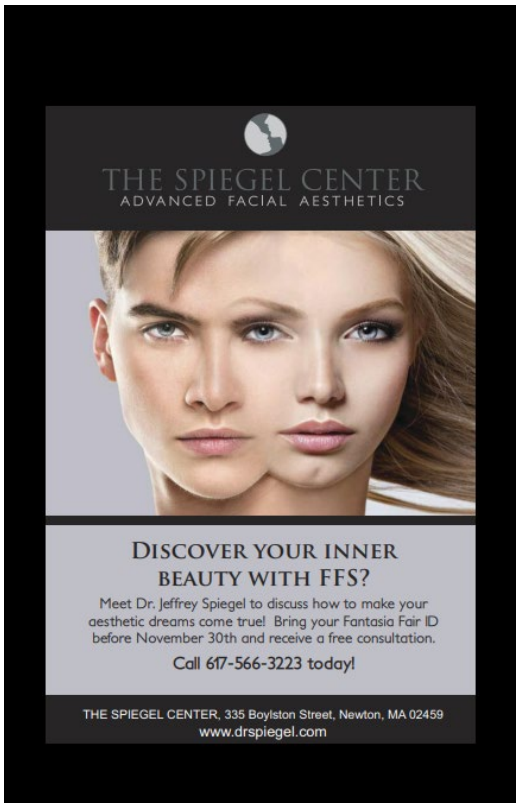

Figure 3. Advertisement in Fantasia Fair program for facial feminization surgery with The Spiegel Center in Newton, Massachusetts.[118]

Although a Fantasia Fair attendee may not be actively transitioning or even pursuing transition information *at* the conference, it is, seemingly, no reason not to be educated about one's options. The expiration date of the coupon encourages future patients to "*act now*," as if while supplies last.

118. "FanFair 2019," 4.

These ads exemplify a number of aspects of transgender life and transition more specifically; they begin to give an idea of the kinds of treatments and surgeries are available, where potential patients might access them, and how to get the process started. They also begin to give an idea of the potential patients for whom the surgeons are catering their advertisements, and subsequently, work to construct the transgender citizen-patient. The advertisement for the Spiegel Center in particular illustrates the transgender citizen-patient most clearly – she moves clearly and distinctly from one end of the gender spectrum to another. She is white, thin, and beautiful, and ultimately, she is moving past her old self, into a fully realized version of her true self. Where the transgender subject of color is the face of hate crimes, the white trans subject is the face of health and medicine.[119] With Dr. Spiegel's help, the white trans subject is able to "discover her inner beauty," and with that discovery too, she can shed her "outer" trans layer and become assimilable, or potentially assimilable. These advertisements demonstrate how transgender medicine, particularly transition surgeons, act as sponsorship for transgender community spaces. Although transition surgery is primarily understood as something to which trans people need access, I instead position transgender surgery in the position of needing access to transgender people and to transgender community spaces. Put another way, I argue that medicine's attempts at "providing resources" to transgender people is

119. C. Riley Snorton and Jin Haritaworn, "Trans Necropolitics: A Transnational Reflection on Violence, Death, and the Trans of Color Afterlife," in *The Transgender Studies Reader 2*, ed. Susan Stryker and Aren Z. Aizura (Routledge, 2013), 65–76.

simultaneously a moment at which medicine enters and accesses transgender spaces, made possible by sponsoring these important events.

These advertisements for surgeons appear amidst ads for local bed-and-breakfasts, restaurants, and tourist attractions (see figs. 2 and 3) for conference-goers to explore on their trip to Provincetown. Provincetown itself is touted as a place of historical significance, "one of the oldest communities in the United States," where the pilgrims stopped on their way to Plymouth Rock and where "descendants of Portuguese whalers" still abound.[120]

120. "FanFair 2019," 4.

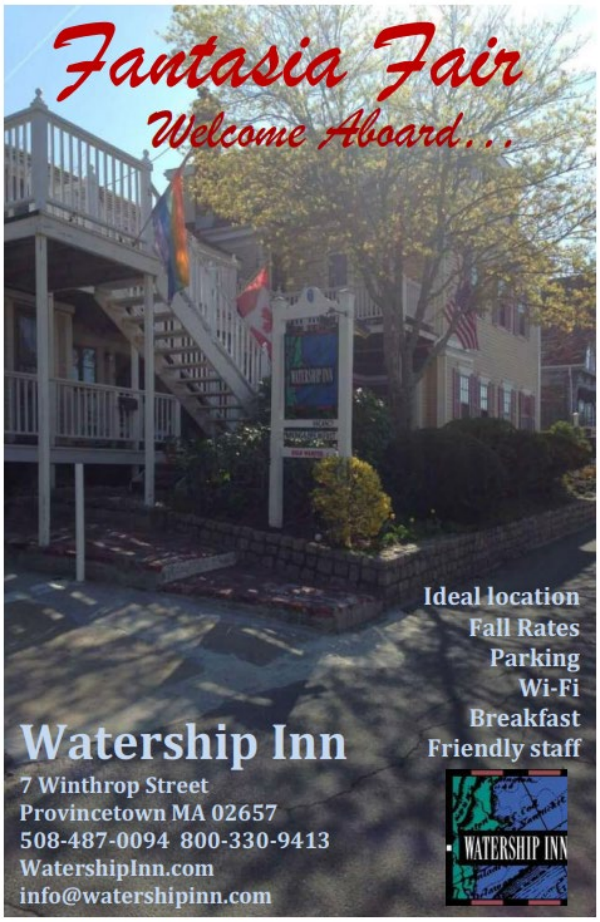

Figure 4. Advertisement in Fantasia Fair program for a bed and breakfast, Watership Inn, in Provincetown, Massachusetts. [121]

121 "FanFair 2019," 86.

Figure 5. Advertisement in Fantasia Fair program for Namaste Spa in Provincetown, Massachusetts.[122]

For the queer and trans visitors, the colonization of the U.S. and its genocide of Native Americans need not cloud the pleasant charm of the area. Although Fantasia Fair is aimed at fostering community and offering support for the more difficult social aspects of transition – such as how to make romantic relationships survive gender transition or how to maintain relationships with family members – these advertisements exemplify the realities of an always-already medicalized transness such that this medicalization is woven into transgender lives, even in spaces like Fantasia Fair that are designed primarily to be spaces for conversation, community building, and leisure. These advertisements serve as a reminder of the constant proximities to medicine, even for trans people who may never choose to

122 "FanFair, 2019," 70.

medically transition. For those who have no immediate plans to access medical transition, the question of whether to pursue medicine or not is often a question that remains open-ended, even if only due to the inescapable nature of medical and surgical advertisements. Additionally, although many transgender people reach a stage at which they consider their medical transition "complete," our relationships to transition medicine rarely concludes. Due to the ways in which hormone treatments are regulated in their status as "controlled substances" and the potential side effects upon organ function, hormone replacement therapies require a regularity of doctor appointments akin to managing a chronic condition in order for prescriptions to be refilled. Further, the promise of new possibilities in transition medicine – new procedures, new techniques, even new surgeons – as well as potential revisions to previous surgical procedures cause one's relationship to transgender medicine to often be an ongoing one, even if only to be aware of the developments. Phalloplasty, for example, is often "put off" by transmasculine individuals in hopes that more significant medical developments will be available in the near future. Transition surgeons note the procedure as having a high complication rate; up to 51% of all phalloplasties will suffer from urethral stricture, often requiring repeated surgical procedures to fix the issue. In addition, there is a rate of partial phallus loss of 7.3% and a total loss of the phallus at 1.69%.[123,124] In contrast, hysterectomies, a common

123. Aaron L. Heston et al., "Phalloplasty: Techniques and Outcomes," *Translational Andrology and Urology* 8, no. 3 (June 1, 2019): 254–65.

124. Richard A. Santucci, "Urethral Complications after Transgender Phalloplasty: Strategies to Treat Them and Minimize Their Occurrence," *Clinical Anatomy* 31, no. 2 (January 22, 2018): 187–

transition procedure for transmasculine people, have a complication rate of approximately 3.1%.[125] Dr. Rachel Bluebond-Langner, a surgeon based in New York who specializes in gender transition procedures, was quoted in an article in the *New York Times* on the process of undergoing phalloplasty, describing the procedure as high risk and saying, "People understand the trade-off [improved quality of life over risk of complication] … But we wouldn't accept this rate of complication necessarily in other procedures." [126] These relatively high complication rates in phalloplasty cause many transmasculine people to put off treatment until medicine progresses, keeping tabs on different advancements such as penile transplant, an option that has been "on the horizon" for several years.[127] This future-oriented perspective of medicine demonstrates the "economy of hope" that the transgender citizen-patient is encouraged to take on, as Nikolas Rose describes, "Contemporary biological citizenship thus both depends on and hopes that the science of the present will bring about cures or treatments in the near future (Novas 2001, 2003)."[128] The tension of

90.

125. C. Emi Bretschneider et al., "Complication Rates and Outcomes after Hysterectomy in Transgender Men," *Obstetrics & Gynecology* 132, no. 5 (November 1, 2018): 1265–73.

126. Jamie Lauren Keiles, "How Ben Got His Penis," *The New York Times*, May 10, 2022, sec. Magazine, https://www.nytimes.com/2022/05/10/magazine/phalloplasty.html?action=click&module=RelatedLinks&pgtype=Article.

127. Patrick Kelleher, "Hospital Debates Penis Transplant in Transgender Patient," www.medpagetoday.com, October 8, 2020, https://www.medpagetoday.com/surgery/transplantation/89033.

128. Rose, 155.

wanting medical procedures that offer both a significant positive impact on one's life while simultaneously being unwilling to risk such significant complications encourages, at minimum, a "keeping tabs" relationship to medicine within trans communities, but even more so, it encourages a political stake as trans bodies become sources of biovalue.[129]

Medico-Colonial Transgender and the Medical Mission

This ever-present relationship to medicine is more obvious in transgender conferences such as Gender Odyssey, which feature both community-centered and medical/professional tracks. Founded by trans man Aidan Key, the Gender Odyssey conference was originally intended primarily as a community space. It first took place in 2001, at which point its main goal was "focused on the needs of those on the trans masculine spectrum." In an interview with Andrea Jenkins with the Transgender Oral History Project, Key described the motivation for putting together the conference to create a space similar to Fantasia Fair and other trans events that either focused on or were primarily attended by trans feminine people. More specifically, he discusses the conference as being a space to bring people together to "have these important conversations" about "gender in relation to our age, our class, our race, just a number of different things like that – or our ability."[130] This intention

129. Rose, 156.

130. Aidan Key, Interview with Aidan Key, interview by Andrea Jenkins, *University of Minnesota Libraries, Jean-Nickolaus Tretter Collection in Gay, Lesbian, Bisexual and Transgender Studies*, January 23, 2016, https://umedia.lib.umn.edu/item/p16022coll97:46.

and this intersectional framework that Key originally intended for the conference illustrates the possibilities of transgender community spaces when medicine becomes decentralized or made absent from the conversation. However, this focus quickly changed as the conference began to expand beyond these original parameters. No longer focusing exclusively on transmasculine experiences or conversations, it added workshops for children and families in 2007, and then in 2012, the organization added a professional component, GO Professional. [131] The Gender Odyssey organization describes GO Professional:

> A one-day conference for professionals and students, GO Professional, was added to Gender Odyssey. Sessions cover best practices for therapists, current medical protocols, and legal and educational considerations, including model school policies for gender diverse students. The following year, GO Pro expanded to two days, with an increase in the number of workshops each consecutive year. [132]

This program is accredited by Rush University Medical Center for continuing education for physicians, registered nurses, and other medical providers, as well as mental health providers such as social workers and psychologist. The framing of GO Professional's programming illustrates both the multilayers of transition medicine – mental health, medical/surgical, and medicolegal. In particular, the linkage between medicine, the law, and school policies illustrates how medicine becomes an organizing framework for transgender bodies, to manage their disruptive potentialities, creating paths through which transgender people – especially

131. "Our History," Gender Odyssey, 2017, https://genderodyssey.org/history/.

132. "Professional Program," Gender Odyssey, 2017, https://genderodyssey.org/pro/.

transgender children – can be directed into opportunities to become citizen-patients. I argue that the inclusion of GO Professional shifts Gender Odyssey away from its purpose as a community space, and instead into a *training* program not simply for medical professionals, but for transgender people themselves in how to make oneself legible as a medicalized subject.

Where the conference originally emphasized this community focus of trans identity and experience, this expanding scope demonstrates the ways that medicine is not just in conversation with transness, but that it becomes a kind of logical progression of conversation within transgender spaces. Gender Odyssey continues to hold events catered to community education and conversation, but the medical aspect of the conferences shifts the conversation significantly because not only has medicine become a major focus of Gender Odyssey via continuing education programs, but in fact, the conference has also become a meeting place for doctors (most typically surgeons) and potential patients to connect, to allow potential patients to see possible options for procedures and even to receive surgical consultations *at* the conference. During its 2016 conference, Gender Odyssey set up a "Meet the Doctor" feature to its program, "A new conference feature this year, Gender Odyssey offers a no-cost opportunity for you to connect privately with several trans surgical care providers, depending on your needs. Each doctor you schedule with will chat with you for 15

minutes and answer your individual questions in a comfortable, private setting."[133] The website linked to "godocs.appointy.com" to schedule up to four consultations out of a choice of six surgeons/clinics including Dr. Tony Mangubat based in Tukwila, Washington, the Meltzer Clinic based in Scottsdale, Arizona, Dr. Scott Mosser based in San Francisco, Dr. Thomas Satterwhite representing the Crane Clinic, Dr. Javad Sajan of Allure Esthetics in Seattle, and the Buncke Clinic in San Francisco.[134] This new feature of the conference provides a significant resource to transgender people who may not otherwise have the chance to meet with this variety of surgeons, but it also suggests a shift in the conference's purpose, and indeed, demonstrates a way in which transgender identity exists in orbit to the question of medicine.

133. "Meet the Doctor - Gender Odyssey," 2016, http://www.genderodyssey.org/events/meetthedoctor/.

134. It is interesting to note that since this feature in 2016, several of these surgeons have started their own practice or moved to another practice that presented at GO. For example, Dr. Satterwhite no longer works at the Crane Clinic and has since opened Align Surgical Associates, and Dr. Zara Ley is now working at Scott Mosser's practice.

Figure 6. Image from Gender Odyssey website in 2016.

Surgeons seem to recognize that many of their transgender patients desire a connection with their doctor, a desire some surgeons seem to encourage. One of these surgeons, Scott Mosser, is a plastic surgeon who founded The Gender Confirmation Center in San Francisco in 2013. At the 2016 Gender Odyssey conference, Mosser gave a presentation entitled "FTM Top Surgery Procedure Options with Dr. Scott Mosser," during which time he advertised limited slots still available to receive top surgery consultations with him before he began his presentation. He encouraged the audience to interrupt and ask questions, welcoming them to divert the presentation wherever they would prefer it go. As he attempted to

move on from the consultation announcement, he was stopped from doing so by several interested audience members asking for alternative ways to sign up for a consultation. Someone responded by offering a physical sign-up sheet, and Mosser reassured that "we'll work it out, because there are plenty of open slots and I'll make time for somebody who's interested in meeting with me, no problem, we'll figure it out," and clarified what exactly the consultation is.

> It's very different from an office consultation. An office consultation is the full-on medical *thing*, you fill out your medical history, we go over all the medical stuff, or even a virtual consultation – we'll talk a little bit about that. We don't do physical exams here, we're just – it's something of a sophisticated meet-and-greet, and for a patient to begin to talk about their goals and for me to begin to educate them on how we could achieve those goals. But it's scratching the surface of what is a real-deal consultation where we could dig into anatomy. […] These consultations here are to help you answer some burning questions and to figure out if you like me, you know to figure out if the vibe is good for us – I mean it will be for me, I really enjoy my patients – but if you feel comfortable enough with me, then you would proceed to one of the other consultation types.[135]

As he moves on, he discusses his work with the medical mission organization he founded, *Destination: Hope International Medical Missions*, where he performed cleft lip and palate surgeries primarily in the Philippines, and he describes the opportunity he has to change the lives of these children and adults who have been living with these "defects."[136] He bridges this seeming tangent with the topic at hand

---

135. Scott Mosser, "Procedure Options with Dr. Scott Mosser of Gender Confirmation by Dr. Mosser" (August 5, 2016), https://www.facebook.com/genderodyssey/videos/ftm-top-surgery-procedure-options-with-dr-scott-mosser/10154418646492718/.

136. Destination: Hope International Medical Missions has since ceased operations, liquidating its assets in 2019 and donating them to the San Francisco chapter of Healing the Children, a similar nonprofit organized around treating facial birth defects. The San Francisco chapter was founded by former Destination: Hope board member, Dr. Evan Ransom.

of top surgery procedure options by talking about the parallels he sees between working with cleft lip patients and transmasculine top surgery patients, saying that these short procedures have larger impacts and that they "address/diminish marginalization and cruelty."

> You really can't for a cleft lip surgery patient, imagine what their life was like up until that point, and just a massive pivot in a completely different direction. A similar thing happens for transgender chest surgery patients, and this is why we love what we do. This is… it's incredibly transformative, incredibly power, powerful. It diminishes marginalization and cruelty for these patients. And, and that's, you know, unfortunately it's the statement on our society that that's one of the reasons that gender dysphoria exists and it's one of the reasons why transgender surgery is so successful. It helps with integration. And the patients are incredibly appreciative. Medical mission patients are of course just, there's just, even if you don't speak their language, there's just this profound moment of connection between yourself, and the patient, and their families that just transcends language and transcends words. … and my trans patients and I, we do speak the same language, we all have that more opportunity to connect and there is a real, real deal connection. We, you know, we sort of both feel like we're not going to forget one another because we've gone through too much.[137]

Mosser's presentation explores this connection that he feels with transgender patients. The language that he won't forget his patients because both he and his patient have "gone through too much." This language of bonding through hardship, both diminishes the power differential between doctor and patient, but also diminishes the barrier between doctor and community. In a way, Mosser is a crucial part of the trans community as he is what makes possible the bodies that we desire. He also describes surgeons, who perform cleft lip and transition surgeries, who leave behind (unsatisfactory) results, something he works to address in his own practice. In

137. Mosser, "Procedure Options."

positioning himself against other surgeons, Mosser makes an interesting rhetorical move where he both affirms the fears of trans people in being operated on by transphobic or unskilled surgeons, while then making possible the good transgender doctor – someone who feels the same connections and emotions as the transgender patient and is doing this work because he sees the pain and injustice that trans people experience and wants to change it. In positioning himself in this way, Mosser's entry into the transgender community becomes about his desire to help others. Indeed, he *wants* to be part of our community, where so many trans people have complicated relationships with belonging or not belonging to the trans community.

In their book, *Trans Medicine*, stef m. shuster describes the development of the relationship between transition providers and transgender patients as transition medicine began to be more available beginning in the mid-twentieth century. The relationships they describe are tense, as providers attempt to either strictly follow the inconsistent and un-researched guidelines put forth by organizations such as WPATH and WHO, or they use the guidelines as a vague reference point. shuster emphasizes how these guidelines are especially concerning with regards to mental health providers, who are made to "sign off" on a patient's decisions regarding transition, where they would not have this permissive relationship to any other part of a patient's life, and the ways that this thus acts to "erode trust in the therapeutic relationship."[138] Where shuster's analysis explores the various ways these doctor-patient relationships

138. shuster, 122-124.

are complicated by transition medicine's nebulous guidelines and by the violence of medicine as a whole in treating marginalized identities, depicting a distinct difference between the trans community and transition providers, I argue that this distinction between transness and medicine is increasingly absent.

Mosser's description of his work as well as his motivation for working in transition surgery is discomforting. He "really enjoys" his patients, seeing an opportunity to change lives to the extent that he does for children with facial difference in the Philippines, suggesting not just an altruistic generosity, but a sense of purpose and "relevance," as he describes some of his relationships with patients as "[transcending] words." The intimacy of this description positions Mosser as *part* of the transgender community, even though he himself is cisgender. This intimacy and the inclusion of providers becomes even more complicated when considering the increasing number of trans people who are actually working *as* trans providers. In one particularly notable example, shuster critiques WPATH's reliance on problematic or entirely absent medical research in constructing its guidelines, but transgender people themselves are actually on its board, with Dr. Marci Bowers being its current president-elect. In another example, the Metzer Clinic, one of the other plastic surgery practices providing consultations at Gender Odyssey in 2016, offered the chance to meet Dr. Toby Meltzer, the practice's founder, and his associate Dr. Ellie Zara Ley, a trans woman on whom Meltzer had operated in 2015, one year prior to

her attendance at this conference.[139] The medicalization of transness surpasses simply the construction of our bodies, becoming about the construction of our communities, our language, and our selves. In the moment where we, as trans people, are also the *providers* who are treating trans people, to what extent are we able to bypass or challenge the limitations of how medicine treats transness, or, do the logics of medicine risk producing a transness that is inseparable from medicine and thus, inseparable from the state?

More than simply infiltrating a community and "taking up space," Mosser's words, particularly the connection he sees between his medical mission work in the Philippines and his surgical transition work in the San Francisco Bay Area, bring together a racial colonial logic to transition medicine. Particularly when framed through Foucault's analysis of medicine as an authoritarian intervention of power, Mosser's description of a connection that "transcends words," for patients for whom he provides the opportunity to live a life otherwise unavailable to them, suggests a cure, or in this case, a fix, that extends beyond the physical.[140] Even though *Destination: Hope* and Dr. Mosser himself do not explicitly perpetuate Christianity alongside the project, I argue that Mosser symbolizes these legacies of Whiteness,

139. "Dr. Ellie Zara Ley - Gender Affirming Surgery in San Francisco," TransHealthCare, November 10, 2021, https://www.transhealthcare.org/ellie-zara-ley/#:~:text=Ley%20transitioned%20in%202015%20and.

140. Michel Foucault, "The Politics of Health in the Eighteenth Century," in *Power/Knowledge: Selected Interviews and Other Writings 1972-1977*, ed. Colin Gordon (Vintage Books, 1980).

colonialism, control, and cure, both for his patients in the Philippines, and the ways that extends to transition surgery.

Mosser is not alone in his medical mission work. Dr. Marci Bowers, in addition to her surgical transition services, works as a lead surgeon for Clitoraid, a nonprofit organization founded by the French based Raëlist movement.[141] Through Clitoraid, Bowers works in Kenya and Burkina Faso to perform reconstructive clitoral surgery as treatment for circumcision, and Bowers describes herself as being "one of the few surgeons worldwide who perform [*sic*] surgical reversal of Female Genital Mutilation (FGM)."[142] She goes on to say, "Our goal in bringing the surgical procedure to Africa is to allow women to control their own destiny, to regain their sense of identity as women and as sexual human beings." Critiques of clitoral circumcision from Europe and the United States continually erase their own long histories of the practice, where critiques of clitoral circumcision only emerged in force amidst the decolonization of Africa in the mid- to late twentieth century. As Esme Trahair writes, "the treatment of FGM/C, from the way it was codified to the terminology in each subsequent WHO report, is an extension of the colonization and attempted regulation of black and brown female bodies."[143]

---

141. Raëlism was founded in the 1970s and is a UFO religion widely regarded to be a cult.

142. "History | Marci L. Bowers, M.D.," marcibowers.com, 2022, https://marcibowers.com/fgm-c/history/.

143. Esme Trahair, "The Social Construction of Female Genital Mutilation," *Inquiries Journal* 12, no. 2 (2020).

Transition medicine, transition *providers*, come out of these legacies of colonial medicine and medicine as a site of authoritarian power and with it, continue to enact these frameworks of cure upon and through their patients, reinscribing Western imperial notions of "health" within and upon transgender communities. The medicalization of trans identity and the bringing of trans *providers* into constructed trans communities is done without attention to these racist, imperial logics that define the problem, the cure, and ultimately "healthy transness." In bringing providers *into* the trans community, transness is medicalized, thus foreclosing possibilities both for a critique of the "cure" from transness and for a critique of the ways trans medicine is distributed such that it reifies constructions of a "racialized other."

(Un)Pathologizing Transition

In September 2020, during the ongoing COVID-19 pandemic, I attended the virtual 19th Annual Transgender Medical Conference organized by the South Florida Transgender Medical Consortium. The mission statement of the South Florida Transgender Medical Conference is "to provide state of the art medical information to mental health and licensed allied professionals, nursing and medical students including support staff that addresses culturally sensitive care and treatment for the transgender and gender non-conforming and gender creative community."[144] In contrast to conferences like Fantasia Fair, the South Florida Transgender Medical Consortium is primarily designed for medical and mental health providers as opposed

144. "South Florida Transgender Medical Consortium," South Florida Transgender Medical Consortium, n.d., https://www.sftransmed.org/.

to transgender clientele. The conference offers a mental health as well as a medical track for continuing education, catered to providers in the field of transgender care and students who are looking to enter the field.

Due to the webinar format of the 2020 conference, the specific identities with regards to race, gender, and sexuality of the presenters and attendees was not as apparent as it may have otherwise been. The majority of the presenters did not disclose any personal identification with transgender identity, but at least one presenter was an openly transgender man. The entry level discussion in presentations seemed to be designed so as to be easily followed by either a lay audience with transgender experience or a cisgender audience with more medical knowledge and training. The providers presenting at the conference covered a variety of topics including pediatric transgender care, links between transgender identity and autism, advanced endocrinology, and supporting transgender people in counseling contexts. A third of the presentations focused on transgender youth specifically. In contrast to Fantasia Fair, SFTMC exists around the desire to share treatment plans and medical research as it develops transition medicine, but this shift away from community into a conversation centering transition begins to inform the dangers of trans pathologization.

The providers entered their discussions with the presupposition of transness as a burden. Their presentations were largely cognizant of arguments against pathologizing transness and were careful not to imply disease in their discussions.

However, the language throughout the presentations still maintained an assumption of transness as having symptoms. In a presentation entitled, "Counseling and Psychotherapy for Transgender Clients: Why? When? How? According to WPATH," Dr. Jim Lopresti, PhD, LMHC, described the move from gender identity disorder to gender dysphoria and the shift away from pathological transness.[145] If transness is to be depathologized, however, this begs the question as to the purpose of medical treatment, of psychiatric or psychological assessments for transgender people looking to pursue transition. While shifting away from the pathology of transness is an important goal, it neglects to address the ways that transgender bodies serve as sites of profit for the medical industry. A depathologized transgender experience cannot exist within a system that engages in the medical marketplace that cannot service a "healthy" body and pathology is re-woven into these medical narratives. Where previously transgender identity was pathologized in all its presentations, Lopresti's pathology posits an (un)healthy transition. Giving the example of the Jazz Jennings, a young trans woman whose transgender childhood was made public on reality television and major media features, Lopresti explained a healthy transition – one with early affirmation of gender identity and early intervention by the family and doctors working to prevent unnecessary pubertal experiences. What gets pathologized in contrast is the transgender identity that lacks this affirmation, early or otherwise – the transgender identity that lacks resources, support, intervention.

145. Jim Lopresti, "Counseling and Psychotherapy for Transgender Clients: Why? When? How? According to WPATH."

Lopresti's presentation suggested that transness was not so much a disease, but rather a collection of symptoms, or burdens, that came both from within the trans person themselves, as well as from outside pressures and stigmas. Specifically, he discussed the importance of alleviating dysphoria by "addressing life-long stigma" by "promoting emergence of an integrated identity." Lopresti's definitions of the symptoms of transness seem to imply that it is transphobia – that which encourages the "life-long stigma" and thus prevents "integrated identity" – as being central to pathological transness. While arguing for the move away from the former standards of gatekeeping transition treatments, Lopresti's presentation described instead "support" and "affirmation," that the transition itself exists not as a treatment, but as another method of affirming the transgender identity. He describes an "alliance" between trans person and transition provider, one that reflects back the trans person's "true" self, which speaks significantly again that where a pathological trans experience is one that experiences transphobia, the first steps to a healthy transition begin not with physical actions, but through the removal of trans stigma from the patient. Although it is the circumstances outside the transgender body that are pathological, it is the trans person who receives the diagnosis of unhealthy transition. As the conference continued, the construction of healthy transition became increasingly clear. These providers were not invested in constructing transness itself as a disease. Instead, a pathological aspect of transness becomes the inability or

unwillingness to access or engage with those who purport to support and assist in transition.[146]

I draw attention again to the concept of the transgender citizen-patient. As previously discussed, the citizen-patient is a status of tension. Transgender bodies, in their queerness, exist always already outside the possibilities of citizenship, but the possibilities of minimizing the appearance of queerness, of sterilizing it, via the permanent status of patient, opens a route through which trans bodies can shift from being *impossible* citizens to potential citizens. Lopresti's framework of the symptoms of transness as they occur from outside the body and happen *to* the body, further exemplify the impossibility of actual trans citizenship. However, it is through one's willingness to mitigate the discomfort of the state specifically through the channels of transitioning in a "healthy" manner that the route towards citizen-patient opens up. I emphasize here that the goals of transition medicine too are never to erase the past gender experiences from medicine or the state – the state retains records of prior names and identities and, as previously discussed, transgender identity particularly once transition begins starts a lifelong proximity to medicine – but to erase it from the trans person themselves such that they are able to, as Lopresti describes, achieve a fully integrated identity.

146. Lopresti, "Counseling."

Pathologically Transgender

This idea of unhealthy transition – one characterized primarily through a lack of family, medical, or social support – further takes shape as providers discussed improving their own treatment plans. Julie Thompson, a physician assistant and medical director of Trans Health at Fenway Health, an LGBT health and research clinic in Boston, Massachusetts expanded upon the development of proper treatment plans and, subsequently, how to navigate trans patients seeking unhealthy or improper treatment. Thompson's presentation, entitled "Advanced Topics in Gender Affirming Hormone Therapy," discussed treatment options as well as the protocols used by Fenway Health to manage transition.[147] The presentation spoke to the developments primarily in transfeminine medicine, around which kinds of hormones and hormone blockers were used and why, and what new brands and methods for drug administration were becoming available. Amidst this, Thompson discussed her treatment protocols and how it was impacted by and through her interactions with her patients. Explaining a case study of a transfeminine client, Thompson described a difficult moment in communicating with and providing medication for the patient. Thompson spoke of the importance in honoring "lived knowledge" with which patients come to her, while managing "belief perseverance" amidst the confirmation bias. In the case study, the patient requested specific drugs that were not FDA approved and additionally requested an atypical administration of the drug that the

147. Julie Thompson, "Advanced Topics in Gender Affirming Hormone Therapy."

patient's trans community told her would increase her likelihood of breast development. Thompson described the difficulty in treating patients with these scientifically unfounded beliefs, as they are often not supported by research and can possibly be harmful to the patients. While this draws attention to the ambiguity in ascertaining at what point a patient's lived knowledge is determined as important to Thompson and other providers, more specifically, it begins to explore the ways in which patients are determined to be compliant or non-compliant. Managing transition becomes less so about monitoring physical development and tracking general health, and more about managing the patient's actions and guiding them down a path of healthy transition.

I do not mean to imply that Thompson and the other providers at this conference are attempting to harm transgender people, nor do I wish to imply that transgender people do not risk harming themselves with inaccurate medical knowledge. Rather, I wish to point out the ways in which providers and patients are unable to acknowledge and manage their positions within the medical industrial complex. The language bounced between a few different verbs around transition medicine – was it treatment? support? management? Transition *treatment* connotes attempts at remedying symptoms of transness, of healing or eliminating them, while management suggests organization or control, and support is defined by the Oxford English Dictionary as "spiritual help ... encouragement, emotional help, mental comfort" and in another definition, "the action or act of helping a person or thing to

hold firm or not give way."[148] Considering these three concepts together points to the ways in which transition medicine is best understood simultaneously as treatment, support, and management, where its attempts to manage transness works in conjunction with the construction of transness – or particular kinds of transness – as something in need of healing.

If we refuse the idea of trans identity as pathology, transition medicine serves as an in-between of "elective" procedures and those that are necessary for treating disease. Transness is "dangerous if left untreated." But how does one provide life-saving treatment for something that isn't a disease? How does one determine the point at which intervention is necessary? Medicine works to maintain an investment in the inherent pathology of transness, while simultaneously working to construct "healthy" and "unhealthy" approaches to transition. Transition providers are attempting to give transgender patients what we ask for – depathologized language, informed consent instead of gatekeeping, honoring our lived experiential knowledge. However, the transition providers at SFTMC entered transgender medicine as if it can be abstracted from the medical industrial complex – as if it can be disconnected and abstracted away from the harmful, violent histories of experimentation and negligence. The belief persists that trans medicine can be – and is – different and separate from these histories, when, in fact, it perpetuates them. Further, understanding medical providers as those who prevent dangerous transition decisions

148. "support, n.," in *Oxford English Dictionary* (Oxford University Press, March 2021).

rather than players within the medical industrial complex denies the reality of predatory medical care of transgender medicine.

Early Intervention

As previously discussed, a healthy transition was positioned within these presentations, and particularly those aimed towards the "mental health" track, via different kinds of affirmation, but especially early support and intervention, such as what was done in the case of Jazz Jennings. The question of transgender children represents a larger conversation which, I argue, is the nexus between the futures of transgender pathology and transition related medicine. In a presentation entitled "Gender Dysphoria in Pediatrics," Dr. Alejandro Diaz, Chief of Pediatric Endocrinology at Nicklaus Children's Hospital in Miami, discussed the determination of appropriate approach for early transition related care. The figure of the transgender child is already fraught, with the fear of intervening too soon – in essence, protecting an imagined cisgender body from the reality of its transness – or intervening too late and making a fatal mistake of timing.

The presentation began with a discussion of controversial topics in transgender medicine and LGBT rights in general as Diaz discussed the search for biological origins to gay and trans identity and John Money's treatment and study of David Reimer, an identical twin who was raised as a girl following a botched circumcision. Contrary to the other presenters at the consortium, Diaz seemed to argue for the acknowledgement of his patients via the proof offered by science as

opposed to prioritizing the "lived knowledge" gestured to by other providers. His language too was controversial, with reference to "disorders" of sex/gender that his fellow presenters avoided. This language was used in a self-aware manner as Diaz noted at one point in his talk, "Whenever I give this lecture to trans community, there are always complaints," referring largely to the debates of different terminologies, and going on to say that it is "impossible to please everyone" before moving on. Diaz notes two exceptionally important things that went unmentioned in the other presentations: the difference in a transgender versus medical audience and the self-awareness not just to his outsider status to the trans community, but to his very specific relationship as a physician to the community. Diaz understood he was largely speaking to his peers and colleagues at the conference, identifying an important position of providers as being both outside the transgender community, but necessarily included – or even reluctantly so. Indeed, it is hardly uncommon for transgender people to acknowledge the poor bedside manner, inappropriate pronouns/language, etc. from providers with which they grudgingly endure because accessing imperfect treatment is more important to them than being unable to access it entirely. Diaz continued to demonstrate the double-edged sword of transgender medicine, acknowledging the current limits of the medicine that his fellow presenters spent little time discussing – the use of gender norms to determine the point at which to begin treatment (preventing girls from becoming "too tall"), pubertal hormone blockers' negative impact on bone density, and potential cardiovascular risks. Even still, Diaz noted at the end of his presentation that these treatments were urgent, that

the "mental health benefits outweigh the health risks," and describing the treatments as "life-saving."[149]

From Diaz's assessment, it would seem that a healthy transgender person is simply alive and fully, effectively, transitioned. Considering his focus on pediatric transition and the presentation of Lopresti of healthy transition as requiring early support and intervention, we can further determine that the earlier a transition begins, the "healthier" the transgender person will be. The child becomes the ever-present transgender figure who dips in and out of existence depending on the context. In a way, the transgender child is only ever visible *as* a child, ultimately becoming a transgender adult who carries with them none of the trauma of an incorrect puberty, such that transness almost morphs into a childhood disease: if treated in childhood, a transgender child can live a healthy, normal life, but if left untreated the risk is "dangerous," or even death. This dichotomy ignores too the ways that transgender experiences differ by race. The equating of transgender adulthood with pathology so severe, that they are always discussed primarily via their specific proximity to death – specifically, death by murder, suicide, or hate crime – is possible primarily via the mobilization of the hypervisibility of trans people of color as always already experiencing violence, where Jules Gill-Peterson describes in *Histories of the Transgender Child* (2018) how trans people of color become "made into objects of

149. Alejandro Diaz, "Gender Dysphoria in Pediatrics."

necropolitical value." [150] In contrast, Gill-Peterson describes the "powerful emblems of futurity" into which the trans child is constructed.

> Sanitized, innocent, and always highly medicalized, they are domesticated figures, either reassuring that the so-called trans tipping point heralds a new generation of liberal progress and acceptance or, to the transphobic agitators involved in political campaigns focusing on bathrooms and schools, acting as proof that trans life deserves to be repressed in its incipient forms for the threat to the social order that its future would represent. […]

The dominant figure of the trans child trafficked in the public sphere today underwrites, as the child has long done in the United States, a potent "racial innocence" that empties trans childhood of its content, including race, rendering it conceptually white while simultaneously libeling the existence of black trans and trans of color childhood.[151]

Two of these causes of death that early intervention transition medicine purports to prevent, suicide and murder, are not about the health and wellbeing of the trans person, but rather, the managing of the transgender body to be invisible, to be acceptably gender presenting so as to not provoke the violence of others. I posit instead that the "danger" that is avoided by early transition is the indelible stain of queerness and, by the ways the trans child is white-washed, I argue that this queerness is always a racialized one. The transgender child, in essence, is the ultimate formulation of the citizen-patient. The transgender child is young enough to have the

150. Jules Gill-Peterson, *Histories of the Transgender Child* (University of Minnesota Press, 2018), 25.

151. Gill-Peterson, 2.

least effects of queerness left upon their body and in that, they are capable of reaching closest (while never quite reaching) actual citizen. The understanding that transition related medicine is in our best interest, that it serves to aid us and offer a hopeful future, neglects to acknowledge the outsideness of these threats to our health – that these are not our own pathologies. Instead, medicine positions itself as the key to our survival, treating the pathology from the most effective angle. Medical institutions work to process transgender bodies and while we are able to use these systems, however flawed, to reach our desired results, we remain at their mercy of their judgment and our bodies remain sites of profit. It ignores the violent histories of its knowledge and ultimately brings us into greater proximity and kinship with ourselves as consumers as opposed to bringing us into greater proximity with our transgender siblings. The medical institution works to fix, cure, and separate us from each other, as it reaches an earlier and earlier space of a cure.

Conclusion: "It is Impossible to Please Everyone"

As Alejandro Diaz said, "it is impossible to please everyone" in the context of transgender medicine. Whose approval, whose *pleasure*, then becomes the priority? What becomes collateral damage? Medicine offers transgender people a significant opportunity – one that, as so many trans people have said, is life-changing – but thinking critically about not just its limits, but its *motivations*, is a crucial question to pursue – to consider the impacts of trans medicine beyond the individual level and to consider how the legacies of racial and colonial violence continue to shape what we know to be transition medicine today. Almost every panel during the SFTMC

conference touched on stories of hope and optimism with past patients, emphasizing the importance of providing transgender people with the care they need in order to transition, but these good intentions to not exist in isolation from the histories of medical racism and sexism that made these treatments possible. Indeed, these legacies inform how medicine's definitions of "good transition," or its definitions of "access," are constructed via and through whiteness, colonialism, and power. As I explore transgender pathology, the citizen-patient, and constructions of healthy/unhealthy transitions, understanding the connections and co-constitutive relationships between medicine, colonialism, and transgender identity becomes increasingly urgent.

A panel at the 2016 meeting of Gender Odyssey entitled, "Straight from the Source: Trans Adult Panel," featured four transgender people as well as a transgender moderator describing the ways they wanted to be treated in medical spaces, both transition-related as well as routine, by their providers. This panel, repeated in subsequent years, is described in the Gender Odyssey program: "This is your opportunity to hear directly from transgender-identified panelists and ask them questions. With a 'what-we-want-you-to-know' approach, our goal is to provide attendees with a window into just a few trans people's lives to highlight the multifaceted, complex paths we often travel." After the panelists briefly introduce themselves, the moderator opens up the questions saying, "So all that said how about we start with a, like, what's your, um… do you want to start with like, the worst story of things you've experienced that just are kind of unbelievable for most people and

yet are kind of regular things that happen to us on a regular basis?" Another panelist quickly interrupts saying, "I just have an issue with how the way that's phrased, sorry! […] We're not here to be a freak show, right? And I feel like our scary stories really support that kind of narrative, so maybe just, I would just offer stories that maybe have some really good medicine for us to offer people here, so they can take that to their clients and their patients? If it is scary, then it's the nature I guess of being trans but…" The panel then continues to give numerous examples of "scary stories" in transition medicine, of providers failing to address the needs of their trans clientele in some ways, by refusing to use chosen names, neglecting to adequately address gaps in care for trans people like mammograms and pap smears, or asking invasive and irrelevant questions regarding gendered body parts out of curiosity. Transition medicine always already looks for the freak show or the horror show, where even though it this practice of confessing ones wounds by the very community that has caused them is acknowledged as undesirable is set up by the ways that it originates out of medical experimentation on people of color, how its practitioners continue to work in colonial capacities to provide medical care to the Global South, and how medicine is, primarily, a site of authoritarian intervention of power. Asking for an inclusive space that refuses to see the transgender body as a freak show is a

futile practice, as we are forced to make ourselves legible through these violent constructions of what it means to be "healthy," or what "care" looks like.[152]

In teasing out these legacies and their continued traces, rather than asking medicine to become more inclusive or more *diverse*, I ask instead, what would transgender medicine look like with attention to these histories? Transgender medicine, with an eye towards accountability practices, holds the potential for being the site of revolutionary transformations within medicine entirely. It would expose the absences, the neglected and under-researched areas of medicine. A radical transgender medicinal practice would disengage from and refuse the limitations imposed upon it by the state, offering the possibility for an overthrow of what we understand as gendered medicine and science more generally. These kinds of practices indeed already are happening. As the state works to make access to medical care more difficult, doctors are working alongside transgender people to find the loopholes and ways around these moments of state control, with acts like overfilling hormone prescriptions to get around "controlled substance laws" becoming an increasingly common practice. The urgent question in transition medicine thus becomes centered around this construction of alliance, where medicine holds the potential to become radical in and through its rejection of the state and reinvesting in the truth of trans experiential knowledge and its revolutionary possibilities.

152. "Straight from the Source: Trans Adult Panel" (2016), https://www.facebook.com/genderodyssey/videos/straight-from-the-source-trans-adult-panel-at-gender-odyssey/10154412074422718/.

Chapter 3

Purchasing Bodies: The Advertisement of Transition Medicine

Introduction

Lou Sullivan was a gay transgender man who first came out as trans and began to seek medical transition in the late 1970s. Sullivan faced many barriers and rejection for transition treatments from providers due to his sexuality. In a 1980 rejection from Stanford University's Gender Dysphoria Program, they described that his history was "not typical for the majority of persons who … have made successful adjustments with gender reorientation and who have been helped, not harmed, by sex reassignment."[153] Sullivan became an advocate for increasing access to transition medicine, particularly by disentangling heterosexuality as a criteria for accessing treatment. When he was diagnosed with HIV in 1986, he wrote in his diaries, "I took a certain pleasure in informing the gender clinic that even though their program told me I could not live as a Gay man, it looks like I'm going to die like one."[154] Well known stories about the historical struggles of transgender people like Lou Sullivan tend to depict a difficult road for trans people in the early and mid-twentieth century, as they often struggled to find doctors willing to prescribe hormonal treatments or perform transition surgeries. As transition medicine became more acceptable within

153. Judy Van Maasdam, "Lou Sullivan's Rejection Letter from Stanford University's Gender Dysphoria Program," Correspondence, Digital Transgender Archive, March 12, 1980, https://www.digitaltransgenderarchive.net/files/6w924b83q.

154. Sam Feder and Alexandra Juhasz, "Setting the Terms of Our Own Visibility: A Conversation between Sam Feder and Alexandra Juhasz on Trans Activist Media in the United States," in *InsUrgent Media from the Front a Media Activism Reader*, ed. Chris Robé and Stephen Charbonneau (Indiana University Press, 2020), 67–86.

medical communities, pathological profiles of "gender identity disorder" depicted a narrow trans experience that excluded many who sought transition care, forcing them to learn how to re-narrate their experiences to be legible as transgender to gender clinics.[155] These stories are prevalent through transgender histories, and the struggles to access transition care continue to be a central topic. News outlets frequently feature stories emphasizing the various barriers to transition medicine, including financial burden, limited/non-existent insurance coverage, unsupportive support systems, or legislation making medical transition illegal. This emphasis on the difficulty of limitations in accessing transition care eclipses the other side of the topic, which is that this field of medicine is not simply difficult to access but is also *highly* sought after and thus, profitable. In one market research report, the market for transition surgeries in the United States was estimated in 2020 to be $304.8 million and is projected to reach $781.8 million by 2027.[156] While trans people do still struggle to easily access care, this struggle is a classed and racialized one; those who are able to afford transition medicine are targeted with advertisements for its sale. The market for transition medicine needs to be understood via the ways it interacts with the state, producing assimilable subjects while simultaneously working to *manage* the racialized and queer unassimilable. Through logics of racial capitalism,

155. Gender clinics focused on the treatment of "gender identity disorder" began to emerge in the United States during the latter half of the twentieth century and, at the time of Sullivan's transition, took patients via application to their programs which insisted that prospective patients meet strict diagnostic requirements.

156. "U.S. Sex Reassignment Surgery Market Report, 2020-2027," Grandviewresearch.com, December 2020, https://www.grandviewresearch.com/industry-analysis/us-sex-reassignment-surgery-market.

transgender bodies become either sites of profit or sites of disruption, and in this, we see the production of an un-queered transgender figure.

To examine more fully the ways that capitalism and medicine work to un-queer the transgender body, I explore what queerness means and how it interacts with transition, where transition can be decidedly queer or un-queered. I argue that this distinction between queer and un-queered transition primarily looks at the ways that medicine prioritizes the "correction" of the body where incongruent gender can be "managed." The central analysis of this chapter explores how transition surgeons market themselves, analyzing the marketing of transgender medicine on their professional websites as well as through their social media platforms. Transition surgeons market themselves, their techniques, and procedures in transgender conference programs, on social media websites, and at transgender conferences. Some have gone so far as to trademark the name of common procedures and techniques, such as Charles Garramone, who controversially trademarked "FTM Top Surgery" in 2009, holding the trademark until 2017. I look at the ways in which medical providers have taken ownership not just over transgender medicine, but over transgender bodies themselves, using them as a source of advertisement and profit. Following, I explore the role of visuality that is central in transition advertisements, highlighting how the best kind of marketing are images of post-operative transgender bodies. This is most commonly depicted via disembodied parts, otherwise described as "outcomes," or sometimes as "fully-realized" whole people, finally reaching a

personal fulfilment that was previously unattainable. I conclude this chapter with a discussion of transgender bodies as sites of profit, analyzing the ways that this marketing shifts the ownership of transgender bodies away from the transgender person, and into the hands of medical markets, and explore the queer possibilities that exist when transgender people narrate their own transitions.

Discomforting Bodies

To examine the racialized and classed contours of this emerging transgender surgical consumer market, I began to question what transition advertisements look like: what forms are they taking? Who produces them? Who are they reaching and why? For the purposes of this study, I use a broad definition of "advertisement," looking at both professionally produced commercials and testimonials, as well as informal videos produced and posted online by former patients, such as surgery reveals on YouTube. Similarly, I examine curated archives of surgical results that are hosted by transition surgeons on their social media and personal websites, as well as surgical results as posted by former patients. While former patients have no financial incentives to produce this content, I argue that these informal referrals/reviews still serve as advertisements; surgeons are well aware of the existence and large followings of transgender influencers and often mutually follow these influencers on social media where these videos and images are hosted. Surgeons are able to utilize proximity to transgender influencers to acquire name recognition.

After months of research perusing various transgender discussion forums, surgical archives, and browsing the professional websites of transition surgeons, I began to receive targeted ads for surgical clinics specializing in transition care. One of the first targeted advertisements I received popped up on the side of the homepage of Reddit, a news aggregate and community discussion website. The "pop-up" nature of the advertisement as well as its appearance on my feed only after browsing trans-specific topics demonstrates the significance of social media as a main route through which to discuss and advertise transition medicine. Social media bypasses potential difficulties in explicitly advertising a politically fraught medical service, allowing a particularly effective form of targeted advertisement.[157] The advertisement on the sidebar of Reddit featured Dr. Thomas Satterwhite, a Black plastic surgeon specializing in transition care. Satterwhite is notable for being one of the top Black transition surgeons, working as a plastic surgery fellow in Miami before moving to the Crane Center for Transgender Surgery (formerly Brownstein & Crane) in the San Francisco Bay Area. In 2018, Satterwhite founded Align Surgical Associates, Inc., a private plastic surgery practice focusing on transition procedures. In addition to Satterwhite, the practice includes two additional plastic surgeons, and the clinic offers

157. Reddit contains numbers "subreddits," which are smaller, more distinct groupings organized around specific and niche topics. There are numerous transgender-specific subreddits devoted to information and resource sharing, support, and conversation.

an extensive range of transition surgical procedures for a wide spectrum of gender identities.[158]

Align Surgical Associates' ad features a former patient, introduced only as "Omega," a Black trans man who had received "top surgery" with Satterwhite, a procedure to remove breast tissue in transgender people who were assigned female at birth.[159] In the video advertisement, we see interspliced images of Omega sitting in an office giving his review of Satterwhite's service with slow motion clips of Omega walking into a generic, well-maintained office building until he (still in slow-motion) takes his shirt off while sitting in an exam chair as Satterwhite looks on, examining the surgical results. Satterwhite, a middle-aged Black man, is depicted without formal introduction in the clip. He simply smiles and chats amiably, his words silent as Omega's voiceover describes his experience. Omega describes what brought him to Satterwhite's office, highlighting the discomfort that his pre-operative chest caused. Importantly, he does not emphasize his *own* discomfort, but rather the discomfort experienced by others, saying, "[My chest was] getting in the way when I uh, of me just trying to live my everyday life. They were causing problems for me and my family. It made other people uncomfortable even when I learned to be comfortable with it, so, it was time for them to go." Omega goes on to say:

158. "About | Align Surgical," www.alignsurgical.com, 2021, https://www.alignsurgical.com/about/.

159. "Top surgery" is a broad term used to describe a variety of surgical procedures that can be used to achieve a flat chest for a trans person. The term "top surgery" is also sometimes used also to describe breast augmentation procedures for transfeminine people or trans people assigned male at birth.

"[Satterwhite is] not just a doctor […] I can call on him and reach out to him so now he's a part of my family. So I tell them if you want somebody who cares for their self as much as they care, then definitely see Satterwhite." It is important to note that Omega's chest is heavily tattooed, with large tattoos covering his surgical scars, suggesting that he is long past the typical healing point where he would still need regular surgical follow ups and doctor supervision. Thus, while Omega feels he can call on Satterwhite to address his needs, the artificiality of the ad suggests that the opposite is also true; Omega was called upon by Satterwhite to give his positive review and star in the clip, both as a satisfied patient and as a desirable product.

As previously mentioned, this was an ad targeted to me after spending months of research analyzing transgender plastic surgery clinics, transition medicine, and critical race and ethnic studies. This presumably led search algorithms to (correctly) identify me as transmasculine, but perhaps assumed that I am non-white, demonstrating that advertising does not accurately or fully reflect the consumers identity, and I argue, it does not necessarily intend to. Instead, these advertisements work to guide specters of identification. Satterwhite's advertisement is emblematic of the genre of transition advertisements and narratives more broadly. More than merely selling the skills of a surgeon, these advertisements promise kinship and connection. Put another way, they sell community. They construct and deconstruct (transgender) identity, molding it into a new shape and determining its proximities, its connections, and its futures. In this advertisement, Omega references the discomfort his chest

brought not himself, but his family, while simultaneously embracing Satterwhite as a family member. This framework reattaches the transgender subject to normativity.

This attempt at reattaching transgender identity to normativity is seen throughout narratives of transgender life. Arguments for transgender acceptance, inclusion, and rights center around the idea that trans people are "just people," which is an argument that is particularly prevalent around discussions of transgender children. An article by the New York Times on the increasing debates for transgender children to access transition medicine argues for the urgency in giving children the ability to transition, stating, "Puberty blockers and hormone therapy, the two gender-affirming treatments given to minors, are most effective if taken when puberty begins, around the ages of 8 to 14, before the age of independent medical consent in most states."[160] For the many transgender people who do not know that they desire medical transition until young adulthood – and indeed, into one's senior years – medical transition is "most effective" when given at the moment that person comes out as transgender and feels ready to begin. The nebulous phrasing of when transition medicine is "most effective" for pre-pubertal children suggests that this is not simply a case of allowing children access to the care they know they need. Rather, transition medicine's "effectiveness" is measured at its ability to create a subject that is minimally disruptive or, discomforting. In short, the sale of transition medicine and the

160. Sabrina Imbler, "For Transgender Youth, Stigma Is Just One Barrier to Health Care," *The New York Times*, September 28, 2021, sec. Health, https://www.nytimes.com/2021/09/28/health/transgender-health-care.html.

narratives around which it is formed encourage an identification with *normalcy*, comforting in the ways that the transgender difference can be rearticulated as undisruptive and profitable. As Nick Mitchell describes in an analysis of diversity, "Diversity, then, is about difference but also its about overcoming – the promise that difference, properly conditioned, either will make *no difference* or, better yet, will transform difference into an asset primed for accumulation."[161]

I consider the evolving advertisement of transition medicine through a lens of *dis-memberment*. I break this term down as it applies to transgender bodies and lives. "Dismemberment" is a violent accusation thrown at transgender people, insisting that pursuing medical transition is an act of "cutting off" body parts. In using and re-imagining the term as "dis-memberment," beyond the body, I confront this violence and re-examine it as it is produced by the profit and sale of transgender medicine. Rather than focusing on the body, I refer to this marketing-induced dis-memberment instead as a way to think through the foreclosed possibilities for transgender community. The market of transition medicine constructs patients as customers, consuming the product of medicine and surgery. In this construction, we as transgender people are *processed* – abstracted from and cured of our transness in a way that (un)intentionally abstracts us from and cures us of the identity that holds us together. Simultaneously, this process seemingly allows us re-entry into a family,

161. Nick Mitchell, "Diversity," in *Keywords for African American Studies*, ed. Erica R. Edwards, Roderick A. Ferguson, and Jeffrey Ogbonna (New York: New York University Press, 2018), 69.

into a society, which was previously uncomfortable due to our pre- or mid-transition bodies.

In his testimonial to Dr. Satterwhite, Omega discusses his motivation for pursuing top surgery, speaking vaguely about his chest causing "problems" for his family; he describes: "[My chest] made other people uncomfortable even when I learned to be comfortable with it." Satterwhite is selling not simply his surgical services, nor just the chance to inhabit a body that is more in line with one's gender identity. In emphasizing the comfort of family in the testimonial, Satterwhite is selling the chance at a kind of reunion, or re-membering of family via medical transition. Omega names Satterwhite "a part of [his] family," and Satterwhite becomes a literal and symbolic stand-in for the family that Omega has seemingly now made comfortable.

I consider more critically what Omega refers to as being "uncomfortable." "Uncomfortable," as defined by the Oxford English Dictionary, is defined as "causing or involving discomfort or uneasiness; disquieting," as well as "incapable of being comforted; inconsolable." I consider this conceptualization in the context of a critical, Black transgender embodiment.[162] In that attempt at "making comfortable" those whom are "inconsolable," we see the reification of family values, of nation, of citizenship advertised by transition medicine and, more specifically, to its sale, while

162. "uncomfortable, adj.". OED Online. June 2021. Oxford University Press. https://www-oed-com.oca.ucsc.edu/view/Entry/210552?redirectedFrom=uncomfortable

gesturing too at the ways that racialized transitions always already exist outside of the possibilities of comforting citizenship. A racialized body that *cannot* comfort the state and its symbolic manifestations then becomes processed through medicine as a source of profit.

Transition surgical advertisements gesture to the ways that medicine and its sale operates as a de-queering project. I consider this through the frame of racial capitalism. Building on the work of Cedric Robinson, Jodi Melamed defines racial capitalism, stating:

> We often associate racial capitalism with the central features of white supremacist capitalist development, including slavery, colonialism, genocide, incarceration regimes, migrant exploitation, and contemporary racial warfare. Yet we also increasingly recognize that contemporary racial capitalism deploys liberal and multicultural terms of inclusion to value and devalue forms of humanity differentially to fit the needs of reigning state-capital orders.[163]

Melamed goes on to cite Ruth Wilson Gilmore's term of antirelationality, which she describes as "a technology for reducing collective life to the relations that sustain neoliberal democratic capitalism." In this way, the medical works in conjunction with capitalism (as seen through the advertisement and sale of/profit from transition medicine) to commodify and thus alienate relations in ways that un-queer the transgender body, and, by extension, to *dis-member* the transgender community from one another. In the testimonial for Dr. Satterwhite, the transgender body – the transgender person – exists at a site of tension. Here, the purpose of one's medical

163. Jodi Melamed, "Racial Capitalism," *Critical Ethnic Studies* 1, no. 1 (2015): 77.

transition diverts away from the urgent need to make a trans person comfortable in their own body, to instead center the "comfort" of those around them and to center their potential as a site of profit. In Omega's reference to his family's discomfort with his body in a state of mid-transition, I argue that "family" can be read as a stand-in for the nation-state, where the trans body, now made *comforting*, is made to serve the purposes of sustaining neoliberal democratic capitalism. In prioritizing the use of the transgender body for the needs (and comfort) of others, the transgender body becomes defined by ownership, as an object to be utilized, as opposed to being defined by the self.

This chapter is not meant to argue against transition medicine. Rather, it is an examination of the ways transition medicine is advertised and the narratives that emerge from and circulate through it. The narratives of transition medicine revolve around those who provide and receive these treatments; in this depiction, the boundaries between medical provider and family are blurred. These advertisements demonstrate how narratives surrounding transition medicine and transgender identity increasingly center questions of *belonging* and queerness, which ultimately works towards the development and deployment of trans liberalism. They advertise the normalization of transition care and transgender bodies above all else, and in turn, move towards an un-queered transgender self, begging the question: who is transition medicine meant to serve and to what ends? And in what ways does this position the individual as responsible for their own liberal access to belonging?

Transitioning Un-Queerly

In order to effectively examine what it means to transition un-queerly, I first consider queerness more broadly. A queer transition is a *pleasurable* act. This pleasure is erotic, a decidedly queer feeling, brought about through the intensity of the desire and subsequent ability to transition, to experience life through a different body. Where the pathological description of transness centers "gender dysphoria," it ignores the queer pleasure that transgender experience in the form of gender euphoria. The pleasure of transition, or the gender euphoria, come from mundane moments of the everyday, of feeling a body change and develop in ways it was not "supposed to," but in the ways you have chosen. The body takes on a new shape and is used in new ways. It is experienced by others as different. There is a queer pleasure in walking past a well-known acquaintance, completely unrecognizable, and free from the tethers of unwanted former connections or an unwanted former life. Where gender dysphoria focuses on the feelings of "distress," transition offers in its place the possibilities of pleasure. However, gender transition begets a moment of tension that simultaneously opens up possibilities of queerness at the same time that some of these bodies – those who do not have further visible marks of queerness or otherness – become increasingly invisible *as* queer, and through that invisibility, become conditionally assimilable.

I consider Deborah R. Vargas's analytic of *lo sucio*, exploring the ways that neoliberal projects attempt to dispose of and sterilize the poor and racialized which it

deems wasteful and excessive, to understand the queerness held within transgender bodies that face the sterilization of assimilation. *Lo sucio* insists on the acknowledgment of the racialized and classed implications of queerness, as well as the surplus of queerness. "[Q]ueer surplus tastes and smells *sucio* and cultivates a presence and lingering perseverance of queer sex and joy within neoliberal hetero- and homonormative violences."[164] This lingering presence of *sucio* speaks to the lingerings of queerness within the transgender body, but I want to further examine the conditions that have made it such that the queerness is left as a residue rather than fully existing, that the trans body becomes something to cleanse of surplus, race, queerness. As the transgender body is made monstrous in its transness, it simultaneously becomes assimilable vis-à-vis medical transition. In welcoming medical institutions into our communities (indeed, becoming our communities), there is a limited understanding of freedom. In many ways, transitioning can be argued as a perfect example of liberal progress, something with a happier, clearer, cleaner after. But what remains? And does the transgender body ever *truly* belong within the nation-state? In considering what it means for medicine to un-queer transition, I examine what queerness is in relation to transition and to transgender identity.

I consider where transgender identity, and by extension, transgender *community*, exists in the logics of capitalist economies and conventional structures of family

164. Deborah R. Vargas, "Ruminations on Lo Sucio as a Latino Queer Analytic," *American Quarterly* 66, no. 3 (2014): 715.

kinship at the site of the transitioned/transitioning body. I argue that transgender consumption and its interaction with conceptualizations of community, identity, and family – or the opportunity to create one's own or re-invest in convention – exists primarily at the site of transgender medicine via the sale of medicine. David Eng describes queer liberalism saying, "Queer liberalism marks a particular confluence of political and economic conditions that form the basis of liberal inclusion, rights, and recognitions for particular gay and lesbian U.S. citizen-subjects willing and able to comply with its normative mandates."[165] He continues, "we need to ask how a constitutive violence of forgetting resides at the heart of queer liberalism's legal victory, its (re)inhabiting of conventional structures of family and kinship."[166] The framing of transgender "community," frequently described in flat, monolithic terms, comes up throughout various discussions of rights and legislation, services and resources, and the general understanding of who might be considered "transgender." While I eschew the flattening of "transgender" as singular, I consider the ways that the idea of a uniform transgender community has emerged in the wake of queer liberalism, and more specifically, the ways it can, does, and aspires to, as Eng describes, (re)inhabit conventional structures of family and kinship. In conversation with John D'Emilio's work on gay identity and capitalism, Eng makes a critical point with regards to the emergence of queer liberalism particularly in the stage of *late*

165. David Eng, *The Feeling of Kinship: Queer Liberalism and the Racialization of Intimacy* (Durham, NC: Duke University Press, 2010): 24.

166. Eng, 25

capitalism, as existing in a "contained" or more fully managed form[167] Eng goes on to quote Gayatri Chakraborty Spivak regarding the victory of *Lawrence v. Texas* in overturning anti-sodomy laws, saying it is something we, as queers, "cannot not want," something that is felt in no place more strongly that the question of transgender medicine.[168] Even still, I look at these opportunities – these moments of purchase – with caution and consider, like Eng, "the social costs and limits of this latest episode in the story of human freedom and progress."[169]

As David Eng, José Muñoz, Jennifer Nash and many others have insisted as urgently necessary, this project thinks queerness, gender, and race as co-constitutive and inseparable, such that any attempted discussion of transgender medicine via colorblind critique is always already an un-queered one. With this in mind, I revisit the language used by Omega in his testimonial for his surgeon, Dr. Satterwhite. Omega's reason for pursuing surgery is comfort, not for himself, but for his family. As Elías Krell describes, "A Black trans-of-color critique shows that we need theories not only for thinking about how trans women of color navigate but also for racialized transmisandry, to explain the ways in which Black trans masculine persons live in a sphere of literal and discursive policing around Black masculinity."[170] While Omega

167. Eng, 30

168. Eng, 25

169. Eng, 25

170. Krell, Elías Cosenza. "Is transmisogyny killing trans women of color? Black trans feminisms and the exigencies of white femininity." *Transgender Studies Quarterly* 4, no. 2 (2017):

refers to making comfortable those who were uncomfortable with his body in a state of in-betweenness of gender, I wish to explore the ways that his body, as a Black trans man, is always already *dis*comforting in the sense of neoliberal democratic capitalism by the basis of his Blackness, and more specifically, Black masculinity.

One of the commonly used arguments for the right to access or expand transition procedures are the ways that, in helping a transgender person inhabit a more normatively gendered body, they will not simply be *healthier*, but safer. As discussed in the first chapter, transgender pathology is deemed acceptable when one *complies* with "proper" medical care as directed by their physician. Further, an effective transition ultimately achieves a "passing" gender presentation, which theoretically allows them to live in absence of transphobia. This premise neglects to acknowledge the intersections of race and gender, where racialized bodies, particularly Black bodies, have historically been subject to the violent reads, exploitation, and experimentation to produce science and scientific knowledge. We see examples of this in historical figures such as Sarah Baartman, whose body was put on display in a French museum after a lifetime of enslavement because her body (and subsequently her dismembered remains), "purportedly evinced medical and scientific proof of black femininity as naturally lewd, primordial, and inferior."[171] The premise of

234.

171. McKittrick, Katherine. "Science Quarrels Sculpture: The Politics of Reading Sarah Baartman." *Mosaic: An Interdisciplinary Critical Journal* 43, no. 2 (2010): 113-30.

"compliance" within the context of bodily control positions medicine, and thus medical transition, as *managing* bodies, ceding bodily integrity at the offer of a bodily freedom, which is always already foreclosed to Blackness.

In 2018, World Athletics (formerly the International Association of Athletics Federations), the governing body for competitive track and field athletics, set new regulations for "female classification" to manage eligibility for female athletes "with differences of sex development" or who are recognized as intersex. It goes on to specify that an athlete must pursue medical intervention to lower natural levels of testosterone if they exceed 5 nmol/L and they must keep them below that threshold for at least 6 months.[172] These regulations came in the wake of the International Olympic Committee's 2015 decision to broaden eligibility to transgender athletes who had completed a minimum of one year of hormone replacement therapy, no longer requiring transition surgeries.[173] During 2021 Tokyo Olympics, some of the first openly transgender people competed, including Quinn (singularly named), a white nonbinary Canadian soccer player competing on the women's team, and Laurel

172. "World Athletics | about World Athletics," worldathletics.org (2019), https://www.worldathletics.org/about-iaaf.

"IAAF: IAAF Introduces New Eligibility Regulations for Female Classification| News," iaaf.org (, April 26, 2018), https://www.worldathletics.org/news/press-release/eligibility-regulations-for-female-classifica.

173. Yannis Pitsiladis et al., "Beyond Fairness: The Biology of Inclusion for Transgender and Intersex Athletes," *Current Sports Medicine Reports* 15, no. 6 (2016): 386–88.

Hubbard, a white trans woman and weightlifter from New Zealand.[174] Quinn and Laurel Hubbard were celebrated as being the first openly transgender athletes to compete at the Tokyo Olympics as a major victory for transgender inclusion. These same Olympics saw four Black athletes who were assigned female at birth barred from competing due to naturally elevated testosterone levels that exceeded the limit set by World Athletics.[175] In addition, CeCe Telfer, a Black trans woman who began competing in women's NCAA Division II track and field events in 2019 one year after beginning hormonal transition as per regulations, was also barred from the Olympics due to high testosterone.[176] This policy change in the Olympics demonstrates the workings of trans liberalism in ways that transgender inclusion operate through logics of colorblindness. The Black body – whether cis or trans – is always already at higher scrutiny for the ways that it exists outside of constructions of normative gender definitions whose standards are defined via whiteness. These examples demonstrate the ways that gender as it is embodied by a white athlete, even if it is outside of normative modes of binary categories as is the case with Quinn, is still more "comforting" than any gender as performed via Blackness. Black transness

174. James Ellingworth and Sally Ho, "Transgender Weightlifter Hubbard Makes History at Olympics," AP News, August 2, 2021, https://apnews.com/article/2020-tokyo-olympics-sports-weightlifting-laurel-hubbard-e721827cdaf7299f47a9115a09c2a162.

175. Kevin Dotson, "Two Namibian Olympic Medal Contenders Ruled Ineligible for Women's 400m due to Naturally High Testosterone Levels," CNN Sports, July 3, 2021, https://www.cnn.com/2021/07/03/sport/christine-mboma-beatrice-masilingi-ruled-ineligible-testosterone-spt-intl/index.html.

176. Jill Martin, "Transgender Runner CeCe Telfer Is Ruled Ineligible to Compete in US Olympic Trials," CNN Sports, June 25, 2021, https://www.cnn.com/2021/06/25/sport/transgender-athlete-cece-telfer-trials-olympics-spt/index.html.

occupies a particular space of precarity that goes unmentioned, where the "comfort" of those who are in proximity to Blackness is prioritized. Blackness exists always already outside of the possibility for normative gender. These examples demonstrate the ways in which it is not so much *trans*gender that operates as discomforting, but rather racialized gender.

A queer transition, I argue, is a transition that resists management, sterilization, and/or containment. It is embodied, (pleasurably) uncomfortable, and excessive. Crucially, I argue, a queer transition is a racialized one. I consider Cathy Cohen's 2019 response to her canonical *Punks, Bulldaggers, and Welfare Queens*. Cohen states:

> What is interesting about the current moment in relation to the use of queer is the space for provocation seems to be quickly closing. What I mean is that queer as a unifying framework for mobilization and action or that space available for interrogation and imagining of who could be included in a or the queer political project and what might be the political basis of queer unity is less available as more people adopt queer as a personal politicized identity, embodying a radical identitarian personal politics, as opposed to a collective position relative to state and capitalist power.[177]

While Cohen discusses her worry with regards to queerness as embodying a "queer politics of identity over a queer politics of positionality," her worries are mitigated in the ways that organizations like the Movement for Black Lives are continuing legacies of Black radicalism. She ends her reflection on twenty years since her

177. Cathy Cohen, "The Radical Potential of Queer? Twenty Years Later," *GLQ: A Journal of Lesbian and Gay Studies* 25, no. 1 (2019): 142

foundational work, saying, "This may not be the radical potential of queer that I envisioned twenty years ago, but this combination of Black feminism and a commitment to queer as a continuation of the Black radical tradition may be our best hope for the radical movements and queer futures we all deserve."[178] What then happens, however, in the case of a queer transgender politics from which Blackness is carefully, effectively cleaved, or dis-membered?

I argue that the whitewashing of transition medicine and transgender identity more generally is that which makes possible an un-queered transition. Further, an un-queer transition is one in which the body can be consumed by the state and made productive. Considering again analytics such as Vargas's *lo sucio* as central to queerness – excess, pleasure, and unproductivity – an un-queer transition centers, if not productivity, then that which can be made into profit.

(Un)Intended Advertising

In his book, *Testo Junkie Sex, Drugs, and Biopolitics in the Pharmacopornographic Era*, Paul B. Preciado describes the history of transition medicine and the development of transgender bodies/body parts as what he terms "pharmacopornographic biocapitalism." Preciado states, "[pharmacopornographic biocapitalism] does not produce *things*. It produces mobile ideas, living organs, symbols, desires, chemical reactions and conditions of the soul. In biotechnology and

178. Cohen, 143

in pornocommunication there is no object to be produced. The pharmacopornographic business is the *invention of a subject* and then its global reproduction."[179] With this in mind, I move into a deeper examination of the process of inventing a subject through the site of medical advertising and the other players involved, notably the transition providers and, more specifically in this case, transition surgeons. As I read advertisements of transgender medicine, exploring what counts as or becomes advertising, this question of profitability remains central, positioning transition medicine in tension with queerness, which complicates and challenges the narratives of what medicine seeks to provide and who it attempts to serve. In framing the (medically transitioning) transgender subject as a product of Preciado's pharmacopornographic biocapitalism, I also consider transgender surgical procedures as the impetus to the production of the mobile idea of trans liberalism.

Surgeons specializing in transition surgery often tend to amass followers amongst transgender communities. These followers amass in part due to the ways that choosing surgeons relies largely on word-of-mouth recommendations between transgender patients, frequently also including visual proof of the results. Transgender forums such as the Reddit page "/r/ftm" contain almost innumerable examples of requests for suggestions or input on a choice between two or three options prospective patients are choosing between, often with some levels of

179. Paul B Preciado, *Testo Junkie Sex, Drugs, and Biopolitics in the Pharmacopornographic Era* (New York, NY Feminist Press, 2017), 35-36.

desperation. One post requested suggestions for "the cheapest surgeon in the US that won't disfigure [him]." Other posts request help finding surgeons with good reputations for specific procedures, specific aesthetic outcomes, or ability/willingness to work with specific demographics who are often refused by surgeons including younger patients, patients with disabilities, larger bodied patients, and patients of color.[180] In addition to requests by patients, there are also collections of shared results on social media, private Facebook groups, and websites dedicated to the hosting of transgender surgical results, such as Transbucket. In addition to these more anonymous methods of recommendations are transgender celebrities and public figures who will share images and videos of their surgical results and experiences as well as the name of their surgeon with their fans and followers. Schuyler Bailar, a Korean American trans man, is one such transgender celebrity, who first gained attention as "the first trans athlete to compete in any sport on NCAA D1 men's team," which he did during his time at Harvard. Bailar, who received top surgery from Dr. Charles Garramone, is now an inspirational speaker, trans activist, and social media influencer, and has acquired a large following on social media with over three hundred thousand followers on Instagram.[181] Emmett Preciado, a Latinx transgender

180. m42069, "What Is the Cheapest Top Surgeon in the US That Won't Disfigure Me," Reddit, August 12, 2021, https://www.reddit.com/r/ftm/comments/p2s8ap/what_is_the_cheapest_top_surgeon_in_the_us_that/.

Pengwin8r, "Experience with Top Surgeons on the East Coast?," Reddit, July 23, 2021, https://www.reddit.com/r/ftm/comments/oq1hxe/experience_with_top_surgeons_on_the_east_coast/.

181. Schuyler Bailar, "Schuylerbailar - Pinkmantaray," schuylerbailar - pinkmantaray, n.d., http://pinkmantaray.com.

actor best known for his role in the television show, *Good Trouble* (2019), has also openly discussed and documented his experience with his surgeon, Dr. Cori Agarwal. Preciado was also the subject of a short, two-part documentary on VICE following his gender transition as a transgender Mormon.

Bailar and Preciado's experiences reach a particularly wide audience because of their positions as a public speaker/activist and as an actor respectively, where their bodies are frequently displayed. The question of who performed their surgeries is more likely to be subject to curiosity for transgender consumers of their content. Both Preciado and Bailar shared this information in a "reveal video" on YouTube, where thousands of videos like them can be found. Transgender surgical "reveals" are a popular genre in transgender social media where trans people who have just received transition-related surgery are filmed in various moments during their surgical transition journeys, focusing on their first post-operative appointment where the surgical results are revealed to the patient for the first time. Reveal videos are posted in large part for consumption by other transgender people. They provide the viewer with a step-by-step look into what this experience might look like, emotionally and physically, with many of these YouTubers including information or posting separate videos detailing advice and information about what they had not known to expect and how to handle it. When surgeons are included in reveal videos, they also provide an idea of a specific doctor's bedside manner and general personality. Beyond these pragmatic reasons, reveal videos can also be an important

act of sharing an intimate and exciting moment with others who truly understand its significance. These "reveal videos" demonstrate another way of creating a queer transgender archive centered around knowledge sharing and coalitional organizing.

While transgender surgical reveal videos exist for a variety of genders and transition surgeries, the genre is dominated by transmasculine top surgery. This is likely due to the inability and/or unwillingness to post images and videos on mainstream platforms of one's genitals for bottom surgeries, and due to facial surgeries not having the same "immediate" impact, as facial surgeries typically require several weeks of healing. In a video search on Google, the search term "ftm top surgery reveal" produces approximately fourteen thousand results, with "mtf top surgery reveal" returning approximately eight thousand videos with all results on the first page of results still depicting transmasculine top surgery. This is likely due to the transmasculine transition from a "sexually explicit" censorable chest to a non-censorable one, where transfeminine top surgery produces a censorable chest. Even beyond this gendered difference, transmasculine top surgery is a procedure that is simultaneously so visible and so specific to a transgender experience. Other transition surgeries that are more typically done for transgender people (i.e. phalloplasty, vaginoplasty, orchiectomy etc.) are made invisible due to censoring, and other transition procedures are either not as isolated to transgender patients (i.e. rhinoplasty, lip augmentation, etc.) or are specifically designed to be dramatically

subtle, as the best plastic surgery is designed to be, as one plastic surgeon describes on his website, "beautiful, natural and undetectable."[182]

Reveal videos, almost always posted by the patient as opposed to the surgeon, are often intensely emotional. Some videos are more long-form vlog-like in format, including footage of moments immediately before or getting ready for surgery. These are often more diary-like, giving day-by-day breakdowns of the post-op healing experience, chronicling each and every moment. Others begin immediately several days post-op in the doctor's office waiting to get their dressings removed. Regardless of the style, reveal videos are extremely informative and provide valuable resources for trans people looking for detailed depictions and explanations of what to expect. Almost all of these videos include the names of the surgeons who performed the surgery, and many of them include footage of the surgeons in the moments before or after surgery. In addition to being an educational resource, the footage becomes a kind of video catalogue of surgical products, as viewers browse images and videos of post-operative chests. In these clips, prospective patients get a glimpse not just into what their potential results might look like, but also into what their experience will *feel* like. Reveal videos depict a moment, crafting a narrative of transition care, and in that narrative too, craft the transgender subject. They also depict an aspirational moment in transition medicine. While they are often watched for the purposes of

182. "90210 Beverly Hills Plastic Surgeon Dr. Gary Motykie MD | Los Angeles | West Hollywood," Board Certified Plastic Surgeon Beverly Hills CA, https://www.drmotykie.com/about-dr-motykie/#philosophy.

finding a surgeon, for many, these videos depict in detail a possible, aspirational transgender future. In these videos, the subjects take shape, with the surgeon-as-savior and the patient as rescued. These "reveal videos" depict *trust* between patient and surgeon that goes beyond medical expertise and blurs the boundary between surgeon and savior, showing the patient crying as they see their bodies in the mirror for the first time, and seeming eternally grateful to their surgeon for changing their lives.

Bailar's reveal video is relatively unembellished and has the feel of a home movie, with his father acting as videographer. It is intimately simple, with a feeling of everyday-ness reserved for family. It includes only the reveal, with minimal discussion of the actual results or experience, although he also posted separate videos documenting his healing one, one and a half, and three and a half days post-op.[183] The reveal video starts with Bailar and Garramone in a medical office as Bailar waits to have his wrapped and bandaged chest revealed for the first time. He looks down at his chest, almost unbelieving in quiet excitement while Garramone matter-of-factly

183. Schuyler Bailar, "FTM Top Surgery: 1 Day Post Op!," www.youtube.com, March 11, 2015, https://www.youtube.com/watch?v=DqupAC9UPqU&list=PLTe5lh9ijug9mC1bAqCgEDyiYe-gPQWdr&index=3&ab_channel=pinkmantaray.

Schuyler Bailar, "FTM Top Surgery: 3.5 Days Post Op!," www.youtube.com, March 15, 2015, https://www.youtube.com/watch?v=DlXB4eWT6xI&list=PLTe5lh9ijug9mC1bAqCgEDyiYe-gPQWdr&index=6&ab_channel=pinkmantaray.

Schuyler Bailar, "FTM Top Surgery: 36 Hours Post Op and Pot Bellies," www.youtube.com, March 11, 2015, https://www.youtube.com/watch?v=yT8PxpqIRTo&list=PLTe5lh9ijug9mC1bAqCgEDyiYe-gPQWdr&index=5&ab_channel=pinkmantaray.

removes the dressing. He makes simple conversation "everything feels so light!" as Garramone unwraps the bandages and does not respond beyond simple instructions for his post-operative care. Bailar looks dazed and happy as he sees his chest for the first time remarking, "They're really gone!" His father responds reassuringly from behind the camera, "They're really gone." Garramone does not acknowledge these quiet moments of emotion, embodying a business-like bedside manner and continues with his work seemingly oblivious to the wide-eyed emotions of his patient. With the video reminiscent of a home movie there is a stark contrast in the feelings of intimacy, as Bailar glances with excitement at his father behind the camera to see his father's reaction to the reveal, while Garramone focuses on removing the dressings and repeating the same post-operative instructions he gives to each patient, repeating almost verbatim the script of instructions heard in the multitude of reveal videos posted by Garramone's patients. This juxtaposition of Bailar's intimate excitement with Garramone's mundanity demonstrates the different stakes of the operation as well as the video itself. Indeed, Garramone's reputation as overly businesslike is one he rejects, but for many, the depiction of a surgeon as coldly competent is reassuring, where the idea of the transition surgeon too begins to formulate.[184] For Bailar, this video is a personal archive as well as a resource for his community. For Garramone, this video represents over one hundred thousand views and the reputation of performing surgery on an increasingly visible transgender figure. It is important to

184. Charles Garramone, Untitled, www.facebook.com, January 13, 2017, https://m.facebook.com/story.php?story_fbid=10154666673335546&id=159677465545.

note too that (as of August 2021) of the first ten results for "ftm top surgery reveal," the top four all depict surgeries performed by Charles Garramone. Although Garramone did not post these videos, his overwhelming presence in these top search results, as well as his frequent work with influencers, suggests that he understands the impacts of these videos upon his business.

In contrast to the simple, intimate depiction in Bailar's reveal, Emmett Preciado's reveal video is more elaborate, with background music and rudimentary stylistic editing, as he crafts a narrative of the experience. The video begins as many do with a short preamble of the patient giving a look into their last moments as "pre-op." The video of Preciado in the surgical center is interspliced with still images of him taking excited selfies and he says, "It's Thursday April 7th, it's 4am and this is the last time I will be wearing a binder. … You watch all these other guys' YouTube videos of it happening and it's like, it's actually happening to me? Like, it's my turn." The nervous excitement is palpable as he and his support person, capture every moment, including the last image of Preciado as pre-op with medical staff wheeling his hospital bed down a hallway and out of sight. We see Preciado immediately after surgery in the next scene, wrapped in surgical dressings in the hospital bed as he bursts into tears at a glimpse of his chest and a medical staff person cups his face gently and tells him, "It's your birthday!" and he responds, deliriously, "It's Christmas." Preciado includes short clips of his recovery in the days following the surgery until the full reveal. The video jumps into a timelapse of a physician's

assistant removing the surgical dressings, the video effect capturing the impatience of Preciado – an impatience contagious to the viewer – evoking an eagerness for the moment of resolution, for Preciado to see his chest fully for the first time. The physician assistant sits him up and guides him to a full-length mirror where, upon seeing his chest, he begins to cry again. The video centers Preciado's reaction, one of palpable joy and profound relief as he announces to his reflection and those in the room with him, "I was supposed to have this chest a long time ago."[185] While Preciado's surgeon, Dr. Cori Agarwal, is not verbally introduced in the video, her role in Preciado's life is clear – it is freeing. It is lifechanging. Agarwal's impact on Preciado's life is made visible and reaches thousands via his YouTube reveal video, as well as via the VICE documentary. Preciado's role as an actor and public figure further expands the reach of what essentially amounts to advertising. In her absence, this idea of a transition surgeon is arguably allowed to be shaped more clearly via Preciado's own experience, as she is clearly *heroic* to Preciado.

I consider the dual purposes that reveal videos serve. These patient-produced videos create a surgical database of sorts, serving as an important resource for other transgender people, but as these videos began, surgeons began to take note, with an opportunity to expand their visual advertising. Thinking back to the example with which we entered this chapter, one could argue that Satterwhite's advertisement

185. Emmett Preciado, "TOP SURGERY - from Check-in to Reveal - FTM (TransMormon)," www.youtube.com, April 18, 2016, https://www.youtube.com/watch?v=tuxhfiYY7p8&ab_channel=EmmettPreciado.

featuring Omega is a kind of "reveal video" due to the common format of the genre that it follows; it introduces the individual's need for the surgery, gives a review of the surgeon, and most importantly, shows the results. Unlike most reveal videos, however, this one was produced by the surgeon himself, which demonstrates the ad-like quality inherent in the genre. It is interesting to note too that Satterwhite's advertisement is excerpted from a longer video that does not function as an ad but is posted on Satterwhite's practice's YouTube channel along with other *informational* videos on the various procedures he and his practice offer. The longer video included a before and after image of Omega's chest, as well as more emphasis on his emotions following the procedure, something more typical of the "reveal video" genre. The "after" moment is particularly important in the genre; it is an intensely visual moment of transition unlike anything else in transition medicine in its immediacy and in the intensity of the emotions present. Omega describes the experience with a large smile saying, "I woke up with a chest – with a chest that I couldn't look at, at the moment! But I woke up happy – with no 'pectorals.'" He goes on to describe his feelings in more detail, "I'm extremely happy, um, because I can be me, be free and not only not worry about me being uncomfortable when I go out and take off my shirt and do things, um, I don't have to worry about other people feeling uncomfortable or looking at me like *what is going on with that dude* … it's an extreme not just happiness, but relief and joy. So, that's what I feel" (emphasis added). Unlike the edited version of his testimonial that appears as a targeted ad, the full-length testimonial focuses on Omega's own self – his emotions, his desires, his comfort as opposed to the making

comfortable of others. In these examples, we see the construction of the *idea* of transition medicine, its subjects and its storylines. Transition medicine becomes imbued with emotion – the desire to get treatment, relief at its eventual attainment, and gratefulness – resituating the transition provider as providing not only medicine, but completion. Positioning this full-length testimonial against the edited version used as advertisement illustrates a different purpose. Where the testimonial sells fulfillment, the advertisement sells a surgeon.

Initially, these videos served as communal resource – an act of knowledge production and knowledge sharing. The videos and their reviews give transgender people a way of navigating medicine safely, as these surgeons come recommended by people who know the vulnerability required to access these procedures. Reveal videos make up an archive of transgender knowledge, bodies, and emotions made by and for a community of people whose bodies have historically been sites of experimentation, fascination, and exploitation. This act of knowledge production simultaneously asks, in exchange for the information, that the viewer bear witness to this physical transformation by sharing in their joy, shock, relief, or disbelief. In the ways that these videos act to connect patients across time and space to access both vital information and moments of joy held still across time, they construct a kind of queer kinship that refuses linear temporality. This archive of visual, textual, and psychic knowledge continues to expand as trans people continue to add to it.

This queer act of community, of sharing knowledge and care, becomes muddied in its appropriation by surgeons, shifting its purposes away from community resource to medical advertising. In capitalizing upon this genre of the reveal video, the purpose of the genre shifts uncomfortably. In the practice of reappropriating the genre, we see the transgender community dis-membered. Rather than creating or adding to a queer transgender archive, these images become produced and curated by those who profit from the community, changing the transgender body into transgender product. More important simply than the ways that medicine capitalizes upon the transgender body, in moving away from the transgender archive, the body risks dis-memberment, cured from its queerness at the hands of the surgeon, and abstracted from its community through the severing of these queer archival practices. The queerness of transition simultaneity is made (im)possible through medicine. Where transition medicine always already is utilizing the transgender body as a site of profit, processing it as a pathologized figure to be cured, this un-queering becomes conditional upon the transgender subject's ability to tell our own stories that holds still possible the potential for queerness. It is this moment, I argue, of both profit and audience that gestures to the ultimate (un)making of the queer transition.

Visual Advertising and Trans Liberalism

As I consider this tension of transition advertisement as serving both the transgender consumer versus the transition provider, I think through the question of visuality and ownership, specifically considering ownership of the body itself. In the

display of racialized transgender bodies, the emphasis on the visual and consumption posits the transition provider in a complicated, arguably violent framework. Plastic surgery in both its practice and its advertising is an intensely visual field of medicine, and where it has its place in the context of transition care, I consider its impacts specifically through the question of gaze and profit. In analyzing these advertisements through the framework of visual cultures, I consider the importance of the gaze in determining and understanding the power relationships present in these videos and through visual advertising. More urgently too, I consider the ways that the medical gaze, particularly in the ways that it exists within profit systems, ultimately work to un-queer the transgender body, or un-queer the transition.

"Reveal videos" in particular exemplify the ways in which transgender people become simultaneous subjects and object. They act as both a kind of advertisement as well as an image-making practice by and for transgender subjects, where they intend to show and offer support, community, and recognition via the resource of these visual moments. What then emerges when medical providers are inserted into this practice, taking it as their own? What happens when providers use these materials for their own purposes, their own advertising, or, in the case of Satterwhite, re-appropriate a trans image-making practice for their own attempts at making profit? Even when a surgeon does not personally or directly engage in this image-making practice, the ways that these videos are used by potential patients to shop for surgeons still implicates these doctors as benefactors. These questions of visuality and sale beg

the question: who owns the transgender body? Who owns its likeness? Where a transition surgeon considers "results" as evidence of their own abilities, they are able to consider these people (via images and videos) not as people, but as objects. Indeed, surgeons are sought on the basis of their reliability and reproducibility of their results, where arguably a surgeon, in a way, *brands* the transgender body. These surgical results are disembodied and fragmented, and transgender identity thus becomes dis-membered, blocking recognition of transness through the re-appropriation of a trans image-making practice into a method through which to derive profit. In contrast to the non-traditional "advertisements" of reveal videos posted by transgender people, or in some cases their surgeons, transition medicine is increasingly marketed through more traditional routes. In contrast to the reveal videos, these conventional advertisements rely moreso on broader ideas of inclusion and diversity. They are not selling products, but rather are selling *trust* – trust that these companies are safe for people who are queer, trans, and of color. They demonstrate how these companies capitalize upon the marginalization and vulnerability of these groups, to create a "safe" marketspace, neglecting to acknowledge that there is no "safe" version of capitalism for queer, trans, people of color.

In a June 2021 ad released at the beginning of Pride month and played across the Hulu streaming platform, pharmaceutical company Eli Lilly described their investment in "diversity" and the queer community specifically, but did so carefully,

without ever explicitly naming it as queer. While Eli Lilly's advertisement is vaguely "inclusive," its release during the month of "Pride" suggests its target demographic to be an LGBTQ+. It is interesting to consider who truly becomes the target of these advertisements, as cisgender LGBQ people would seemingly be no more of a market than a straight, cisgender demographic. This suggests that Eli Lilly engages with a trans liberalism that positions the company as "progressive" via its willingness to profit from transgender medicine. The ninety second advertisement rapidly jumps across different vignettes shown for seconds at a time, moving quickly from a white woman playing tennis, to a group of people playing basketball in front of a sunset that renders their race indeterminate, and another group of Black children dancing in a ballet class. The ad is narrated by a Black woman, her voice disembodied, and plays over the scenes saying, "Medicine will not discriminate against the color of your skin.[186] Medicine pays no attention to the borders we draw to divide ourselves from each other. *Because the body you are randomly assigned to at birth* shouldn't determine how well you are cared for, or how hard we work to find answers, partners, and hope. [emphasis added]"[187]

186. Because the narrator is never seen or physically introduced, their true race and gender cannot be confirmed, but the use of a disembodied voice gestures towards other racialized and gendered implications of attempts at inclusion and/or attempts to reach a target audience, which in this case is a progressive, "queer," and/or non-white consumer.

187. "Lilly - a Medicine Company (:90 Version)," www.youtube.com, June 1, 2021, https://www.youtube.com/watch?v=DZjcLJWg5zo&ab_channel=EliLillyandCompany.

Figure 7. Images from Eli Lilly ad.

As the narrator speaks the words "the body you are randomly assigned to at birth," the camera changes to the image of a white person's torso, wearing a fully unbuttoned collared shirt that partially exposes surgical scars across the chest as the person stands in front of a bathroom sink. The camera begins to move upward to show the person's

head and we finally fully see (presumably) a young trans man. The scars on his chest are subtle, made less noticeable by the partial coverage provided by the shirt as well as the quick camera movement. This person's transness would go unnoticed unless one is already familiar with the appearance common transgender surgical scars. Indeed, as a person with the same scars, I did not notice them upon the first viewing but rather was drawn back to review the scene because of the language used in the narration of a body "randomly assigned at birth."

Figure 8. Image from Eli Lilly ad.

The advertisement focuses on deservingness and overcoming, or survival in the face of obstacles. In turn, the ad positions medicine as an ally to these communities, and not as companies that profit from these communities.

Most interestingly are the ways that race is made present/absent in this ad. The video contains a voiceover by a Black woman who is disembodied from her words and from the ad entirely, making her race is *literally* simultaneously present

and absent, with only the mention that, “Medicine will not discriminate against the color of your skin,” implying a liberal colorblindness. Race goes unmentioned despite being a central focus, with the ad clearly designed to target a diverse demographic. The ad employs a “show but do not tell” approach to race and transness, relying on symbols that will be noticed primarily by those within the communities. Further, the quick juxtaposition in the narration and imagery between the language of “color of your skin” and images of Black people, shifting quickly to the “body randomly assigned at birth” depicting a white trans person, demonstrate the ways that these two categories are held together but separate. These images and voices, complexly (dis)embodied and dis-membered, imply a universality to transness, applied in such a way that it can come to speak on and for a monolithic call for diversity, representation, and safety as offered by corporations like Eli Lilly.

In addition to mainstream advertisements such as that by Eli Lilly, transgender surgeries are more openly discussed and advertised on platforms like Instagram that allow for privacy, or at least, a platform that requires multiple “clicks” to access. The McLean Clinic in Toronto, Canada holds the Instagram handle, @topsurgery, and the account itself is private, only able to be followed once approved by the account administrator. The account profile picture is of Dr. Hugh A. McLean, an older white man in a white physician’s coat and tie, and the only public information on the profile

is a phone number and a link to a YouTube video portraying "The McLean Clinic Top Surgery Team [taking] Toronto Pride 2019."[188]

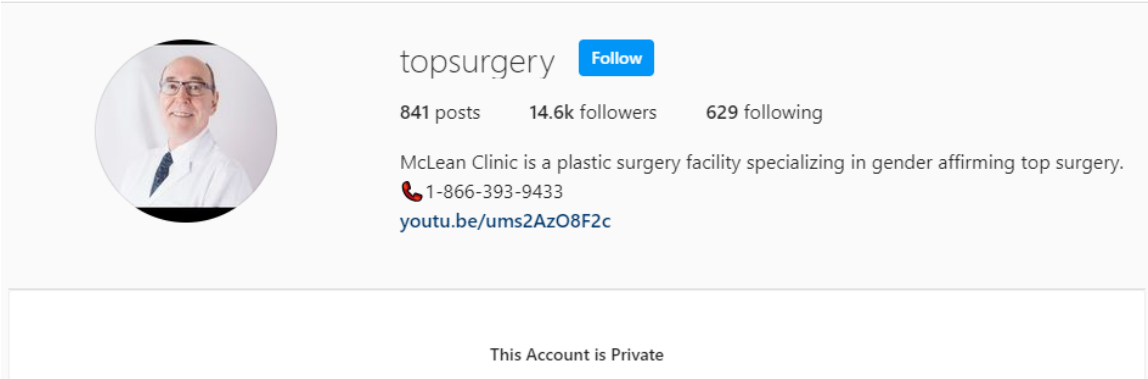

Figure 9. Image from McLean Clinic's Instagram account.

The video was posted by a former employee of the McLean Clinic, Dr. Giancarlo McEvenue, who has since moved to a practice in South Florida and no longer specializes in gender transition surgeries.[189] The video plays heavy, repetitive electronic music, depicting McEvenue as well as nurses and staff of the McLean Clinic walking in the 2019 Toronto Pride Parade. Aside from McEvenue, who is a cisgender man, the clinic nurses and staff are all young and (presumably cisgender) women wearing matching, nonspecific "sports" jerseys that say "top surgery" across

188. Giancarlo McEvenue, "McLean Clinic at the Toronto Pride Parade 2019 #PrideTO," www.youtube.com, July 24, 2019, https://www.youtube.com/watch?v=ums2AzO8F2c&ab_channel=DoctorGiancarlo.

189. Giancarlo McEvenue, "Dr. Giancarlo McEvenue Miami RCPSC Certified Plastic Surgeon," Doctor Giancarlo Plastic Surgery, accessed July 7, 2021, https://drgiancarlo.com/.

the bust and the number "1" underneath.[190] McEvenue's sport jersey says, "Top Surgeon," and he seems to find amusement in the double meaning of wearing a shirt that says, "top surgeon #1." Several employees speak in the video talking about what a good time they are having at the parade, describing "going wild" and their excitement to go back for the 2020 parade. While the specifics of top surgery – the procedure itself, its costs, or the process as handled by the clinic – go undiscussed, it does specifically mention top surgery. McEvenue introduces the video stating, "Dr. Giancarlo here at the Pride Parade. I'm happy to represent the McLean Clinic and top surgery, and what better place to celebrate inclusiveness than the Pride parade, so let's go." The video pauses briefly to capture an image of McEvenue and his all-female staff posing together with a person in drag as a unicorn with a rainbow mane, and then pans to a short clip of the McLean team dancing awkwardly in a circle together as they wave miniature rainbow flags.

Figure 10. Image of McLean Clinic employees at a Pride parade.

190. I do not presume to know the nuanced gender experience of these people and acknowledge that it is entirely possible that some of these people could be trans or non-binary. Rather, I make this statement based upon the performance of a particular kind of cis-gender female experience, where they are all normatively feminine presenting and make no efforts to mark themselves as queer or transgender. This, I argue, posits the clinic staff as a kind of outsider to their client community.

At one point in the video, a staff member vaguely congratulates the patients of the McLean Clinic as well as the clinic themselves because they are celebrating the clinic's 20th anniversary, "We are super excited for all our fabulous patients over the last twenty years with Dr. McLean and now we are going to celebrate the next twenty more to come. Thank you to all our wonderful patients … See you at the McLean Clinic – Number 1!" McEvenue and the other staff members in attendance give short reviews of their experience of the parade with at least one nurse stating that this was her first Pride. The video ends with a single image advertising the McLean Clinic's Instagram account, with the handle "@topsurgery" hovering over the Instagram logo large and centered in the frame, and the McLean Clinic logo much smaller at the bottom of the image.

Figure 11. Image from McLean Clinic promotional video.

While the video does, in a way, attempt sell a product, more central to the advertisement is its attempt to sell the idea of transition medicine. In filming the video amidst a pride parade, the Clinic depicts a transition medicine that is already un-queered, a medicine linked with homonationalist projects of profit and racism and a medicine from which they are all too happy to profit.[191] The various attempts at linking "top surgery" synonymous with "McLean Clinic" are uncomfortably simplistic with the nondescript sports jerseys having no mention of the clinic's name on them. Instead, simply "top surgery" is written (presumably) ironically across the busts of cisgender women, coupled confusingly with a Nike swoosh.

While the other transition surgeons discussed in this chapter focus on the ways they are "*life-changing*," the McLean Clinic demonstrates more directly the attempt to profit from the population they serve. Making "top surgery" synonymous with "McLean Clinic" ultimately depicts the clinic as a primary location for the procedure, also suggesting a kind of scarcity. Considering "top surgery" is such a common procedure and term, it is significant that the McLean Clinic was able to acquire the Instagram handle with that name. Other Instagram handles for surgeons and clinics performing top surgery include more specifics such as, "@topsurgerybymiles" for Miles Berry, a surgeon in the UK, or "@topsurgeryspecialistnyc" for a "boutique

191. Jade Crimson Rose Da Costa, "Pride Parades in Queer Times: Disrupting Time, Norms, and Nationhood in Canada," *Journal of Canadian Studies* 54, no. 2–3 (December 2020): 434–58.

practice" in New York City. Others attempt to use other similarly broad phrases like "@transtopsurgerycenter," which is the handle for a clinic in Atlanta. "Top surgery" as a phrase remains central in each of these handles, demonstrating the wide recognition and far-reaching social media engagement that the McLean Clinic is able to achieve in having ownership over this particular handle.

In obvious contrast to the advertisement from Eli Lilly, the McLean Clinic's video is simultaneously much more overt and less carefully composed in communicating its work with transgender medicine. Instead of playing on network television or subscription streaming services, it is posted for those who might already be looking for it, as it is linked on the clinic's Instagram and only has about 1500 views as of September 2021. It is informal, having been produced by a small video production company specializing in weddings and corporate promotional materials, and it is notably less polished than the national ad campaigns by Eli Lilly.[192]

While the promotional video is clearer in its intent, the clinic's main source of advertisement is through their Instagram account. Where the promotional video has approximately 1500 views, the Instagram account has almost ten times that amount in followers at 14,700. The McLean Clinic's Instagram requires access to be granted by the account's administrator, however full access is granted almost immediately upon request. Instagram accounts for transition surgeons such as the McLean Clinic's are

192. "Videographer in Toronto | Videographers Toronto," videographerstoronto.com, n.d., https://videographerstoronto.com/.

common and have similarly large followings, such as Dr. Charles Garramone with 13,600 followers and Dr. Sidhbh Gallagher with 38,800 followers.[193] These accounts contain hundreds of images of disembodied post-operative chests or people displaying their chests in various stages of healing after top surgery. The majority of these images display just chests, showing the mid-torso to the shoulders, while others included the patient's head, and still others display post-operative selfies taken with the surgeon who performed the procedure. These posts are found using hashtags such as "#manniversary," "#ftm," "lookinggood," and "lgbttoronto." These hashtags are utilized by prospective patients to peruse surgical results in the hopes of finding ideal results and thus decide on a surgeon. Some posts go beyond this simple format. The McLean Clinic account contains images of bodies mid-surgery, as well as several short videos of clinic surgeons demonstrating surgical techniques on a body mid-surgery, in each case with one breast fully removed and the body waiting to be sewn back together.[194] The images are made with a lens of medical sterility, of people made anonymous, anonymous people made bodies, bodies laid bare. They are not simply nude; the viewer sees layers even deeper under clothes, seeing both the bare

193. "Drcharlesgarramone," www.instagram.com, September 17, 2016, https://www.instagram.com/drcharlesgarramone/.

"Drsidhbhgallagher," www.instagram.com, June 14, 2017, https://www.instagram.com/drsidhbhgallagher/.

194. Hugh McLean, "Watch How Surgery Is Performed," www.instagram.com, November 30, 2017, https://www.instagram.com/p/BcI-rZfDD9WsEsHuFiRkyxRJ3w2S0smvunxSLo0/.

Hugh McLean, "For Those That Asked to See the Double Mastectomy, Here It Is," www.instagram.com, December 22, 2017, https://www.instagram.com/p/BdBXAEjFnDnF_QNkMjFgKUEps--aCu6baszcyo0/.

skin the fat, glands, blood, and muscle underneath. It becomes simultaneously more anonymous and yet more intimate. The Clinic exposes the parts of the transgender body that are so carefully concealed until they can be changed, and in posting the body mid-surgery and ripped open, engages in one last visceral exposure. While the images of the reveal videos as shared by transgender patients act as knowledge sharing, one wonders the purpose of these images given the fact that (one hopes) surgeons are not learning surgical techniques via Instagram, and transgender patients seeking out information on techniques tend to focus on the risks, outcomes, and costs as opposed to the literal surgery.

The Queer Transgender Body: What Remains

In an analysis of images of what he describes as "non-standard bodies," T. Benjamin Singer compares medical imagery, primarily of intersex and transgender bodies whose identities are made anonymous by blocking out their eyes, with images, photo essays, and photo studies produced by queer, transgender, and disabled people. In this comparison, Singer contrasts the medical gaze enacted upon "non-standard bodies" that transforms bodies into objects with the ways that these queer images reassert the subjectivity of those made into images. These attempts in medical imagery at making anonymous, as Singer rightly points out, work to change the body into "specimen," or in the case of transition surgeries, as "results." Additionally, these medical images blur identity together – a sea of skin, scars, and "non-standard-ness" – in such a way that the focus becomes that of the pathology, in this case, the

sex/gender. It is crucial to emphasize here again the ways that racialized gender is always already "non-standard." In the case of transition medicine, both in terms of its marketing as well as its practice, we are faced with the question of how medicine seeks to "standardize" a racialized (trans)gender, and how surgical results – how trans-embodiment – become dis-membered through its sale.

Singer discusses how the contexts of these images matter – how they were produced? Who produced them? Do they depict a body in isolation or a person in community? In discussing the nude self-portraits of the transgender artist and activist Loren Cameron, Singer states, "While the medical model asserts that Cameron is a product of medical intervention – or even invention, and thus a proper subject of the medical gaze – this self-image represents him as an active moral and ethical agent assuming responsibility for his own embodiment."[195] He goes further, exploring the use of captions in tandem with imagery using the example of a photo essay on disability that challenges the viewers focus on the body or its parts as opposed the person as a whole. These images directly speak to the viewer, both calling attention to the improper gaze, to the fixation on the body part, while offering a different way of viewing the image. Singer states:

> These images have a textual voice. Contrary to the documentary fallacy, photographs do not "speak a thousand words" unless we have been trained to hear their voices. Ways of seeing are deeply embedded in culture, and images

195. T. Benjamin Singer, "From the Medical Gaze to Sublime Mutations: The Ethics of (Re)Viewing Non-Normative Body Images," in *The Transgender Studies Reader*, ed. Susan Stryker and Stephen Wittle (Taylor & Francis, 2006), 606.

> by themselves are hard-pressed to alter their conditions of visual reception. Visual perceptions of non-normative bodies, in particular, have been shaped through countless structured acts of viewing, in contexts that range from talk show spectacles to case studies of medical pathology. Consequently, supplementary narratives often accompany contemporary images of non-normative bodies. Captioned commentary counters the tyranny of the visual and helps redirect the spectator's pre-conditioned gaze.[196]

I hesitate to simplify Cameron's position as an "active moral and ethical agent," but I am instead interested in a tension of understanding the body and images of the body as both active agent *and* subject to the medical gaze, specifically through Singer's framing of the textual voice. Singer's point is critical in understanding the nuances of gender transition imagery where I would describe the transgender body as being a kind of conversation. In the examples discussed in this chapter, I draw attention to the different textual (or verbal) voices working to both produce the image and to instruct the viewer in how to view them. Indeed, the language within reveal videos, testimonials, and advertisements – the voices themselves become captions of sorts. The conversations between doctors and patients, the unseen narrators, or the trans person discussing their own experiences instruct – sometimes in conflict each other – how to view these videos and images. Medicine instructs a view of pathology made sterile, of a body made into object – into results, while the transgender person enacting their own image-making practice reasserts their active role and instructs the viewer to see them as such. These conflicting messages demonstrate the tension in which transgender people exist through medicine. While transition medicine is crucially necessary for those who desire it, it places the transgender patient in the

196 Singer, 607

position of needing to be "cured" from pathology. Where transgender bodies are viewed through image-making practices that have been created or appropriated by medicine, medicine continues to instruct the viewer in *how* to view transgender bodies, namely, as a body needing treatment or as a disembodied, sterilized set of "results." Where the transgender voice can act to "counter the tyranny of the visual," however, are moments of wholeness that reassert through acts of knowledge sharing via images. In this way, I argue that "wholeness" is not about an individual sense of fulfillment or completeness, but rather a sense of *queer* wholeness – one that refuses *dis-memberment* in creating/maintaining transgender community and coalition.

Conclusion

Depictions of transition medicine in advertising portray a healing – a healed self, a healed family, a healed body. Medicine cannot acknowledge transition as queer because transition medicine is premised upon the very fact that once one utilizes this resource, they can move through life as if they had never had a queerly gendered experience. This is not a new phenomenon, as it was as recent as the 1980s that Lou Sullivan was advocating for his own access to transition care that was denied to him because of his identity as a *gay* trans man, the question behind this lack of access being – why would he transition *into* queerness? While this is no longer the understanding of transition medicine, and medicine allows for gay trans people to access care, I consider still the ways that the idea of queerness remains antithetical to

the medically transitioned body. If queerness remains, has the transition been effective?

The truth of transition medicine is complex because while it is a critical resource, its practice and sale are made possible through the exploitation and fragmentation of people and bodies. The practice of transition medicine cannot be understood as outside of these practices, and we need to grapple with how this violence constructs narratives of transition care and transgender identity. The sale of transition medicine, or more specifically, its position within capitalism, seemingly foreclose the queer possibilities of transgender identity. I sit with the contradictions of transition medicine as simultaneously wounding and healing because while it treats the dysphoria associated with transness, the violence that makes it possible – capitalism, medical exploitation/experimentation, racism – are left in its wake. What, then, is the cost of transition medicine? The logics of profit shape transition medicine through the limitations of access *process* the transgender body through a highly regulated practice defined by scarcity, normalizing, sterilizing, and defining transgender identity. It is not medicine itself that works to unqueer the transgender body, but rather the powers that structure it. If transgender people are used as interchangeable free advertising to demonstrate a particularly skilled surgeon or a body on which to test a new technique, the transgender body becomes an archive of capitalism and progress. The medically transitioned body acts as "results," and as such, becomes an archive of medical knowledge. In considering the medically transitioned body – its

scars, changes, and deviances – exist as a kind of documentation of medical techniques as they have developed over the last century.

I consider again the dis-membering of the transgender body as that which results from the processing and sale of our bodies – the production of a transgender subjectivity defined by the ability for a transgender body to be made *comforting* as opposed to comfortable. I consider what a queer transition looks like and in what ways a queer transition acts as a re-membering. T. Benjamin Singer describes the impacts of images and how these impacts change based not just on who produces the images, but based on the instructions for viewing them and how the audiences then engages or experiences them. These advertisements, social media posts, testimonials, etc. depict a violent landscape where surgeries are unevenly accessible, and where different bodies hold the potential for "effective" treatments based on one's age, race, and sexuality; the goal is not to produce a pleasurable body, but a minimally disruptive one. However, I consider these posts through the eyes of a transgender person who once sought these images out for purposes outside of the goal of a dissertation, and I read these images as a radical queer act of re-membering. These images do not depict body parts nor do they depict results. Rather they share a moment – of hope, vulnerability, and pleasure, and a wish for one's community to fully share in that joy in a future moment. Even in the case of images and videos shared by surgeons, these images were consented to with the hope that our community have access to these images for their own knowledge. Further,

transgender community spaces continue to hold an archive of transition surgery results, with many of them allowing dialogue with the patients themselves. While surgeons can pick and choose what to post, our community shares it in its entirety. In dialogue, we offer resources and words of encouragement for unsatisfactory surgeries or how best to care for scars. While surgeons profit from these images, prioritizing the ability to make comforting, our posts prioritize our own comfort. Rather than seeing these images as ads, I envision these images as knowledge sharing – a coalitional practice, a queer trans world-making act to re-member ourselves, our possibilities, and our power as a community.

In his analysis on the radical re-appropriation of transgender identity as pathology, Christoph Hanssmann describes the long histories of feminist activism to strategically engage technoscientific methods of health care, saying, "While few [feminists] doubted the patriarchal, militaristic, eugenic, and/or capitalist impulses initially shaping [reproductive] technologies and their development, many feminists were (and are) interested in their subversion and repurposing."[197] Thinking alongside Hanssmann's analysis, I consider the ways that transition medicine, engaged through a coalitional praxis, becomes unquestioningly queer. This medicine, with all of the violence from which it originates and with the ways it continually attempts to profit off of our bodies, from which it attempts, in fact, to even trademark them as products for sale, we as transgender people, as transitioning bodies, emerge yet as our own.

197. Christoph Hanssmann, "Passing Torches?: Feminist Inquiries and Trans-Health Politics and Practices," *TSQ: Transgender Studies Quarterly* 3, no. 1–2 (May 1, 2016): 123.

Transgender medicine is that which, to quote Spivak, we cannot not want. However, queerness remains in transition medicine because of the ways in which queer people navigate it in decidedly queer ways. As T. Benjamin Singer discusses in his analysis of transgender visuality, medicine instructs us to view the transgender body through a lens of pathology and cure, of before and after, and as anonymous – specimens and anonymous results made products for the profit of surgeons, but transgender bodies exist in ways outside of the control of medicine. The transgender body does not exist in a state of permanence within the doctor's office. Our results become ours. Surgeons lose control of how these images are shared. We provide resources for each other. A queer transition is that which pulls together and resists fragmentation. It is the act of compiling not our bodies, but our *selves*, made available as a resource for our community. Our bodies are exposed, made vulnerable, not to be consumed, evaluated, or normalized, but seen in all its relevant details. We are whole in how we present ourselves to our communities. Our scars are clear, relevant in the ways that we can be visible with each other in ways that risk exploitation by others. Transition medicine attempts to cure, but leaves behind its residues. As the body heals, the scars become eroticized sites of self-making, of a trans world making practice that creates a future where there may not once have been.

Bibliography

———. “FTM Top Surgery: 3.5 Days Post Op!” www.youtube.com, March 15, 2015. https://www.youtube.com/watch?v=DlXB4eWT6xI&list=PLTe5lh9ijug9mC1bAqCgEDyiYe-gPQWdr&index=6&ab_channel=pinkmantaray.

———. “FTM Top Surgery: 36 Hours Post Op and Pot Bellies.” www.youtube.com, March 11, 2015. https://www.youtube.com/watch?v=yT8PxpqIRTo&list=PLTe5lh9ijug9mC1bAqCgEDyiYe-gPQWdr&index=5&ab_channel=pinkmantaray.

———. “Gender Dysphoria,” 2013. https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM-5-Gender-Dysphoria.pdf.

———. “ORIGINAL RESEARCH—HISTORY: Nikolaj A. Bogoraz (1874–1952): Pioneer of Phalloplasty and Penile Implant Surgery.” *The Journal of Sexual Medicine* 2, no. 1 (January 2005): 139–46. https://doi.org/10.1111/j.1743-6109.2005.20114.x.

———. “Schuylerbailar - Pinkmantaray.” schuylerbailar - pinkmantaray, n.d. http://pinkmantaray.com.

———. “Trans* and Legacies of Socialism: Reading Queer Postsocialism in Tangerine.” *The Undecidable Unconscious: A Journal of Deconstruction and Psychoanalysis* 5, no. 1 (2018): 27–53.

“90210 Beverly Hills Plastic Surgeon Dr. Gary Motykie MD | Los Angeles | West Hollywood.” Board Certified Plastic Surgeon Beverly Hills CA. Accessed August 31, 2021. https://www.drmotykie.com/about-dr-motykie/#philosophy.

“About | Align Surgical.” www.alignsurgical.com, 2021. https://www.alignsurgical.com/about/.

Agbemenu, Esinam. “Medical Transgressions in America’s Prisons: Defending Transgender Prisoners’ Access to Transition-Related Care.” *Colombia Journal of Gender & Law* 30, no. 1 (2015): 1–48.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. Arlington, VA: American Psychiatric Association, 2013.

Avery, Dan. "Lawsuit Challenges Surgery Requirement for N.C. Birth Certificate Change." NBC News, November 16, 2021. https://www.nbcnews.com/nbc-out/out-news/lawsuit-challenges-surgery-requirement-nc-birth-certificate-change-rcna5782.

Bailar, Schuyler. "FTM Top Surgery: 1 Day Post Op!" www.youtube.com, March 11, 2015. https://www.youtube.com/watch?v=DqupAC9UPqU&list=PLTe5lh9ijug9mC1bAqCgEDyiYe-gPQWdr&index=3&ab_channel=pinkmantaray.

Beauchamp, Toby. "Artful Concealment and Strategic Visibility: Transgender Bodies and U.S. State Surveillance after 9/11." *Surveillance & Society* 6, no. 4 (June 26, 2009): 356–66.

Biddle, Jennifer. "Shame." *Australian Feminist Studies* 12, no. 26 (1997): 227–39.

Biden, Joseph. "President Biden's Joint Address to Congress." April 28, 2021. https://www.youtube.com/watch?v=Bh87V3f0FaA&ab_channel=TheWhiteHouse.

Bretschneider, C. Emi, David Sheyn, Robert Pollard, and Cecile A. Ferrando. "Complication Rates and Outcomes after Hysterectomy in Transgender Men." *Obstetrics & Gynecology* 132, no. 5 (November 1, 2018): 1265–73.

Cacho, Lisa Marie. *Social Death: Racialized Rightlessness and the Criminalization of the Unprotected*. New York: New York University Press, 2012.

Canner, Joseph K., Omar Harfouch, Lisa M. Kodadek, Danielle Pelaez, Devin Coon, Anaeze C. Offodile, Adil H. Haider, and Brandyn D. Lau. "Temporal Trends in Gender-Affirming Surgery among Transgender Patients in the United States." *JAMA Surgery* 153, no. 7 (July 1, 2018): 609–16.

cárdenas, Micha. "Pregnancy." *TSQ: Transgender Studies Quarterly* 3, no. 1-2 (May 2016): 48–57.

Cavanaugh, Timothy, Ruben Hopwood, and Cei Lambert. "Informed Consent in the Medical Care of Transgender and Gender-Nonconforming Patients." *AMA Journal of Ethics* 18, no. 11 (November 2016): 1147–55.

Cohen, Cathy J. "Punks, Bulldaggers, and Welfare Queens: The Radical Potential of Queer
Politics?" *GLQ: A Journal of Lesbian and Gay Studies* 3, no. 4 (1997):437-65.

Cohen, Cathy. "The Radical Potential of Queer?: Twenty Years Later." *GLQ: A Journal of Lesbian and Gay Studies* 25, no. 1 (2019): 140–44.

Coleman, Eli. "SOC8 Homepage - WPATH World Professional Association for Transgender Health." www.wpath.org, November 16, 2020. https://www.wpath.org/soc8.

Cook-Daniels, Loree. "Thinking about the Unthinkable: Transgender in an Immutable Binary World." *New Horizons in Adult Education and Human Resource Development* 24, no. 1 (January 2010): 63–70.

Da Costa, Jade Crimson Rose. "Pride Parades in Queer Times: Disrupting Time, Norms, and Nationhood in Canada." *Journal of Canadian Studies* 54, no. 2–3 (December 2020): 434–58.

Damon, Bill. "TV Watching in P'town." Clipping. 1975. *Digital Transgender Archive*, https://www.digitaltransgenderarchive.net/files/n009w2543.

Davy, Zowie. "The DSM-5 and the Politics of Diagnosing Transpeople." *Archives of Sexual Behavior* 44, no. 5 (June 9, 2015): 1165–76. https://doi.org/10.1007/s10508-015-0573-6.

Diaz, Alejandro. "Gender Dysphoria in Pediatrics." Presented at the 10th Annual South Florida Transgender Medical Conference, September 18, 2020.

Dillon, Michael. *Out of the Ordinary: A Life of Gender and Spiritual Transitions*. Fordham University Press, 2016.

Dotson, Kevin. "Two Namibian Olympic Medal Contenders Ruled Ineligible for Women's 400m due to Naturally High Testosterone Levels." CNN Sports, July 3, 2021. https://www.cnn.com/2021/07/03/sport/christine-mboma-beatrice-masilingi-ruled-ineligible-testosterone-spt-intl/index.html.

"Drcharlesgarramone." www.instagram.com, September 17, 2016. https://www.instagram.com/drcharlesgarramone/.

Drescher, Jack. "Out of DSM: Depathologizing Homosexuality." *Behavioral Sciences* 5, no. 4 (December 4, 2015): 565–75. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4695779/.

"Drsidhbhgallagher." www.instagram.com, June 14, 2017. https://www.instagram.com/drsidhbhgallagher/.

Ellingworth, James, and Sally Ho. “Transgender Weightlifter Hubbard Makes History at Olympics.” AP News, August 2, 2021. https://apnews.com/article/2020-tokyo-olympics-sports-weightlifting-laurel-hubbard-e721827cdaf7299f47a9115a09c2a162.

Eng, David. *The Feeling of Kinship: Queer Liberalism and the Racialization of Intimacy*. Durham, NC: Duke University Press, 2010.

Erickson Educational Foundation (EEF). "Erickson Educational Foundation Newsletter, Vol. 5 No. 3 (Fall, 1972)." Newsletter. 1972. *Digital Transgender Archive*, https://www.digitaltransgenderarchive.net/files/zp38wc71g.

“FanFair 2019: Our 45th Anniversary Celebration! Participant’s Guide,” 2019. https://fanfair.info/wp-content/uploads/2019/09/2019ParticipantsGuide-Web-version-Final.pdf.

fanfair.info. “About Fantasia Fair | Fantasia Fair,” n.d. https://fanfair.info/about-fantasia-fair/.

“Fantasia Fair Participant’s Program Guide.” *Https://Fanfair.info/Wp-Content/Uploads/2018/04/FF-1993-Participants-Program-Guide-Oct.-14-24.compressed.pdf*, 1993.

“Fantasia Fair Program 1977.” *Https://Fanfair.info/Wp-Content/Uploads/2018/04/FF-1977-Participants-Guide-Compressed.pdf*, 1977.

Feder, Sam, and Alexandra Juhasz. “Setting the Terms of Our Own Visibility: A Conversation between Sam Feder and Alexandra Juhasz on Trans Activist Media in the United States.” In *InsUrgent Media from the Front a Media Activism Reader*, edited by Chris Robé and Stephen Charbonneau, 67–86. Indiana University Press, 2020.

Foucault, Michel. “The Politics of Health in the Eighteenth Century.” In *Power/Knowledge: Selected Interviews and Other Writings 1972-1977*, edited by Colin Gordon. Vintage Books, 1980.

Gabouev, A.I., D. Schultheiss, C.G. Stief, and U. Jonas. “Nikolaj A. Bogoraz (1877–1952): Pioneer of Phalloplasty and Penile Implant Surgery.” *European Urology Supplements* 2, no. 1 (February 2003): 125. https://doi.org/10.1016/s1569-9056(03)80495-5.

Garramone, Charles. Facebook, January 13, 2017. https://m.facebook.com/drgarramone/posts/10154666673335546 .

Ghosh, Nicholas, and Raj, Rupert. "Metamorphosis Magazine Vol. 6, Nos. 1-2 (January-April 1987)." Periodical. 1987. *Digital Transgender Archive*, https://www.digitaltransgenderarchive.net/files/zp38wc69f

Gender Odyssey. "Our History," 2017. https://genderodyssey.org/history/.

Gender Odyssey. "Professional Program," 2017. https://genderodyssey.org/pro/.

Gherovici, Patricia. "Depathologizing Trans." *TSQ: Transgender Studies Quarterly* 4, no. 3-4 (November 1, 2017): 534–55.

Gill-Peterson, Jules. *Histories of the Transgender Child*. University of Minnesota Press, 2018.

Gill-Peterson, Jules. *Histories of the Transgender Child*. University of Minnesota Press, 2018.

Grabham, Emily. "Governing Permanence: Trans Subjects, Time, and the Gender Recognition Act." *Social & Legal Studies* 19, no. 1 (March 2010): 107–26.

Hanssmann, Christoph. "Passing Torches?: Feminist Inquiries and Trans-Health Politics and Practices." *TSQ: Transgender Studies Quarterly* 3, no. 1–2 (May 1, 2016): 120–36.

Heston, Aaron L., Nick O. Esmonde, Daniel D. Dugi, and Jens Urs Berli. "Phalloplasty: Techniques and Outcomes." *Translational Andrology and Urology* 8, no. 3 (June 1, 2019): 254–65.

Hoberman, John M., and Charles E. Yesalis. "The History of Synthetic Testosterone." *Scientific American* 272, no. 2 (February 1995): 76–81.

Hong, Christine. *A Violent Peace: Race, US Militarism, and Cultures of Democratization in Cold War Asia and the Pacific*. Sanford University Press, 2020.

Hutzler, Alexandra. "White House Open to Third Gender Option on Federal Forms, Not Certain Executive Order Needed." Newsweek, March 8, 2021. https://www.newsweek.com/white-house-open-third-gender-option-federal-forms-not-certain-executive-order-needed-1574588.

"IAAF: IAAF Introduces New Eligibility Regulations for Female Classification| News." iaaf.org, April 26, 2018. https://www.worldathletics.org/news/press-release/eligibility-regulations-for-female-classifica.

Imbler, Sabrina. "For Transgender Youth, Stigma Is Just One Barrier to Health Care." *The New York Times*, September 28, 2021, sec. Health. https://www.nytimes.com/2021/09/28/health/transgender-health-care.html.

Jarvie, Jenny. "A Transgender Psychologist Has Helped Hundreds of Teens Transition. But Rising Numbers Have Her Concerned." *Los Angeles Times*, April 12, 2022. https://www.latimes.com/world-nation/story/2022-04-12/a-transgender-psychologist-reckons-with-how-to-support-a-new-generation-of-trans-teens?utm_id=52978&sfmc_id=1828180.

Jauns.lv. "Ķirurgs Kalnbērzs Pirmais PSRS Sievieti Pārveidoja Par Vīrieti," January 1, 2013. https://jauns.lv/raksts/zinas/133798-kirurgs-kalnberzs-pirmais-psrs-sievieti-parveidoja-par-virieti.

Keiles, Jamie Lauren. "How Ben Got His Penis." *The New York Times*, May 10, 2022, sec. Magazine. https://www.nytimes.com/2022/05/10/magazine/phalloplasty.html?action=click&module=RelatedLinks&pgtype=Article.

Kelleher, Patrick. "Hospital Debates Penis Transplant in Transgender Patient." www.medpagetoday.com, October 8, 2020. https://www.medpagetoday.com/surgery/transplantation/89033.

Key, Aidan. Interview with Aidan Key. Interview by Andrea Jenkins. *University of Minnesota Libraries, Jean-Nickolaus Tretter Collection in Gay, Lesbian, Bisexual and Transgender Studies*, January 23, 2016. https://umedia.lib.umn.edu/item/p16022coll97:46.

Kharitonov, Yevgeny. *The Leaflet*. Translated by Kevin Moss.

Konstantinov, Igor E. "At the Cutting Edge of the Impossible: A Tribute to Vladimir P. Demikhov." *Texas Heart Institute Journal* 36, no. 5 (2009): 453–58.

Krell, Elías Cosenza. "Is Transmisogyny Killing Trans Women of Color?" *TSQ: Transgender Studies Quarterly* 4, no. 2 (May 2017): 226–42. https://doi.org/10.1215/23289252-3815033.

Langer, Elinor. "Human Experimentation: New York Verdict Affirms Patient's Rights." *Science* 151, no. 3711 (February 11, 1966): 663–66.

Lau, Jacob, and Cameron Partridge. “Editors’ Note.” In *Out of the Ordinary: A Life of Gender and Spiritual Transitions*, xi. Fordham University Press, 2017.

Lipsky, Bill. “Michael Dillon: First among Men.” San Francisco Bay Times, January 14, 2021. http://sfbaytimes.com/michael-dillon-first-among-men/.

"List of Doctors in Foreign Countries Who Treat Transsexuals." Leaflet. 1980. *Digital Transgender Archive*, https://www.digitaltransgenderarchive.net/files/cz30ps84v.

Lopresti, Jim. “Counseling and Psychotherapy for Transgender Clients: Why? When? How? According to WPATH.” Presented at the 10th Annual South Florida Transgender Medical Conference, September 17, 2020.

Lyman, Brian. “Alabama Gov. Kay Ivey Signs Bill Banning Transgender Youth from Public School Sports.” USA TODAY, April 21, 2021. https://www.usatoday.com/story/news/politics/2021/04/23/alabama-kay-ivey-signs-ban-transgender-youth-public-school-sports/7361044002/.

m42069. “What Is the Cheapest Top Surgeon in the US That Won’t Disfigure Me.” Reddit, August 12, 2021. https://www.reddit.com/r/ftm/comments/p2s8ap/what_is_the_cheapest_top_surgeon_in_the_us_that/.

Manalansan IV, Martin F. “The ‘Stuff’ of Archives: Mess, Migration, and Queer Lives.” *Radical History Review* 2014, no. 120 (October 1, 2014): 94–107. https://doi.org/10.1215/01636545-2703742.

marcibowers.com. “History | Marci L. Bowers, M.D.,” 2022. https://marcibowers.com/fgm-c/history/.

Martin, Jill. “Transgender Runner CeCe Telfer Is Ruled Ineligible to Compete in US Olympic Trials.” CNN Sports, June 25, 2021. https://www.cnn.com/2021/06/25/sport/transgender-athlete-cece-telfer-trials-olympics-spt/index.html.

McKittrick, Katherine. “Science Quarrels Sculpture: The Politics of Reading Sarah Baartman.” *Mosaic: An Interdisciplinary Critical Journal* 43, no. 2 (2010): 113–30.

“Meet the Doctor - Gender Odyssey,” 2016. http://www.genderodyssey.org/events/meetthedoctor/.

Melamed, Jodi. "Racial Capitalism." *Critical Ethnic Studies* 1, no. 1 (2015): 76–85.

Mitchell, Nick. "Diversity." In *Keywords for African American Studies*, edited by Erica R. Edwards, Roderick A. Ferguson, and Jeffrey Ogbonna, 68–74. New York: New York University Press, 2018.

Moss, Kevin. "Camp Kharitonov and Russian Gay Identity." In *Na Vzhod! LGBTQ+ Književnost v Vzhodni Evropi/Go East! LGBTQ+ Literature in Eastern Europe*, edited by Andrej Zavrl and Alojzija Zupan Sosič, 101–11. Ljubljana University Press, Faculty of Arts, 2020.

Mosser, Scott. "Procedure Options with Dr. Scott Mosser of Gender Confirmation by Dr. Mosser." Presented at the Gender Odyssey, August 5, 2016. https://www.facebook.com/genderodyssey/videos/ftm-top-surgery-procedure-options-with-dr-scott-mosser/10154418646492718/.

Muñoz, José Esteban. *Cruising Utopia: The Then and There of Queer Futurity*. New York: New York University Press, 2019.

National Enquirer. "YES! Flying Saucers Come from Other Planets," October 1, 1967.

Nelson, Alondra. *Body and Soul: The Black Panther Party and the Fight against Medical Discrimination*. Minneapolis, Minnesota: University of Minnesota Press, 2013.

Newman, Hannah J. H., and Elizabeth Peel. "'An Impossible Dream'? Non-Binary People's Perceptions of Legal Gender Status and Reform in the UK." *Psychology & Sexuality*, February 11, 2022, 1–15. https://doi.org/10.1080/19419899.2022.2039753.

O'Kane, Caitlin. "Transgender Cyclist Defends Her World Championship Win after Donald Trump Jr. Calls It 'BS.'" CBSNews.com, October 22, 2019. https://www.cbsnews.com/news/transgender-cyclist-rachel-mckinnon-defends-her-world-championship-win-after-donald-trump-jr-calls-it-bs-twitter/.

Patil, Vrushali. "The Heterosexual Matrix as Imperial Effect." *Sociological Theory* 36, no. 1 (March 2018): 1–26.

Pengwin8r. "Experience with Top Surgeons on the East Coast?" Reddit, July 23, 2021. https://www.reddit.com/r/ftm/comments/oq1hxe/experience_with_top_surgeons_on_the_east_coast/.

Perraudin, Frances. “Martina Navratilova Criticised over ‘Cheating’ Trans Women Comments.” *The Guardian*, February 17, 2019. https://www.theguardian.com/sport/2019/feb/17/martina-navratilova-criticised-over-cheating-trans-women-comments.

Pitsiladis, Yannis, Joanna Harper, Jonathan Ospina Betancurt, Maria-Jose Martinez-Patino, Attilio Parisi, Guan Wang, and Fabio Pigozzi. “Beyond Fairness: The Biology of Inclusion for Transgender and Intersex Athletes.” *Current Sports Medicine Reports* 15, no. 6 (2016): 386–88. https://doi.org/10.1249/jsr.0000000000000314.

Plemons, Eric. *The Look of a Woman Facial Feminization Surgery and the Aims of Trans-Medicine*. Duke University Press, 2017.

Popa, Bogdan. *Shame: A Genealogy of Queer Practices in the 19th Century*. Edinburgh University Press, 2017.

Porter, Thomas. “Car Crash Uncovers a 12 Year Secret... BELLY DANCER IS a MAN!” *National Enquirer*, October 1, 1967.

portraitcollection.jhmi.edu. “John Eugene Hoopes,” n.d. http://portraitcollection.jhmi.edu/portraits/hoopes-john-eugene.

Preciado, Emmett. “TOP SURGERY - from Check-in to Reveal - FTM (TransMormon).” www.youtube.com, April 18, 2016. https://www.youtube.com/watch?v=tuxhfiYY7p8&ab_channel=EmmettPreciado.

Preciado, Paul B. *Testo Junkie Sex, Drugs, and Biopolitics in the Pharmacopornographic Era*. New York, NY Feminist Press, 2017.

Preciado, Paul B. *Testo Junkie: Sex, Drugs, and Biopolitics in the Pharmacopornographic Era*. Translated by Bruce Benderson. New York, NY: The Feminist Press at the City University of New York, 2013.

Priest, Maura. “Transgender Children and the Right to Transition: Medical Ethics When Parents Mean Well but Cause Harm.” *The American Journal of Bioethics* 19, no. 2 (February 2019): 45–59. https://doi.org/10.1080/15265161.2018.1557276.

Reverby, Susan M. *Examining Tuskegee: The Infamous Syphilis Study and Its Legacy*. University of North Carolina Press, 2013.

Rose, Nikolas. *The Politics of Life Itself : Biomedicine, Power, and Subjectivity in the Twenty-First Century.* Princeton: Princeton University Press, 2009.

RSU. "Mūžībā Devies Akadēmiķis Profesors Viktors Kalnbērzs," June 2021. https://www.rsu.lv/aktualitates/muziba-devies-akademikis-profesors-viktors-kalnberzs.

Sadjadi, Sahar. "The Vulnerable Child Protection Act and Transgender Children's Health." *TSQ: Transgender Studies Quarterly* 7, no. 3 (August 1, 2020): 508–16.

Santucci, Richard A. "Urethral Complications after Transgender Phalloplasty: Strategies to Treat Them and Minimize Their Occurrence." *Clinical Anatomy* 31, no. 2 (January 22, 2018): 187–90. https://doi.org/10.1002/ca.23021.

Schaeffer, Felicity Amaya. *Love and Empire : Cybermarriage and Citizenship across the Americas*. New York: New York University Press, 2013.

Schultheiss, Dirk, Alexander I. Gabouev, and Udo Jonas. "ORIGINAL RESEARCH—HISTORY: Nikolaj A. Bogoraz (1874–1952): Pioneer of Phalloplasty and Penile Implant Surgery." *The Journal of Sexual Medicine* 2, no. 1 (January 2005): 139–46. https://doi.org/10.1111/j.1743-6109.2005.20114.x.

shuster, Stef m. *Trans Medicine: The Emergence and Practice of Treating Gender*. New York, New York: New York University Press, 2021.

Singer, T. Benjamin. "From the Medical Gaze to Sublime Mutations: The Ethics of (Re)Viewing Non-Normative Body Images." In *The Transgender Studies Reader*, edited by Susan Stryker and Stephen Wittle, 601–20. Taylor & Francis, 2006.

Snorton, C. Riley, and Jin Haritaworn. "Trans Necropolitics: A Transnational Reflection on Violence, Death, and the Trans of Color Afterlife." In *The Transgender Studies Reader 2*, edited by Susan Stryker and Aren Z. Aizura, 65–76. Routledge, 2013.

South Florida Transgender Medical Consortium. "South Florida Transgender Medical Consortium," n.d. https://www.sftransmed.org/.

"Straight from the Source: Trans Adult Panel." Presented at the Gender Odyssey, 2016. https://www.facebook.com/genderodyssey/videos/straight-from-the-source-trans-adult-panel-at-gender-odyssey/10154412074422718/.

Stryker, Susan, and Nikki Sullivan. “King’s Member, Queen’s Body: Transsexual Surgery, Self-Demand Amputation and the Somatechnics of Sovereign Power.” In *Somatechnics: Queering the Technologisation of Bodies*, edited by Samantha Murray and Nikki Sullivan, 63–78. Routledge, 2012.

Stryker, Susan. “Forward.” In *Out of the Ordinary: A Life of Gender and Spiritual Transitions*. Fordham University Press, 2017.

Sullivan, Lou. Battling Gender Specialists. Interview by Ira B. Pauley. *GLBT Historical Society*, 1989.

“Support, N.” In *Oxford English Dictionary*. Oxford University Press, March 2021.

The Associated Press. “Alabama Legislature Votes to Ban Gender-Affirming Medical Care for Transgender Youth.” *NPR*, April 7, 2022, sec. Efforts to restrict rights for LGBTQ youth. https://www.npr.org/2022/04/07/1091510026/alabama-gender-affirming-care-trans-transgender.

Thompson, Julie. “Advanced Topics in Gender Affirming Hormone Therapy.” Presented at the 10th Annual South Florida Transgender Medical Conference, September 17, 2020.

Time. “GREAT BRITAIN: A Change of Heir,” May 28, 1958.

Timonere, Cole. “Manage ‘the “Letters” for HRT and Surgery: Why Write Them? When How to Write Them?- a Client Centered Approach.’” Presented at the 10th Annual South Florida Transgender Medical Conference, September 18, 2020.

Tornabene, Angelo. "Correspondence from Angelo Tornabene to Lou Sullivan (October 3, 1980)." Correspondence. 1980. *Digital Transgender Archive*, https://www.digitaltransgenderarchive.net/files/1j92g752z.

Trahair, Esme. “The Social Construction of Female Genital Mutilation.” *Inquiries Journal* 12, no. 2 (2020).

Transgender Map. “Erica E. Anderson and Transgender People,” April 11, 2021. https://www.transgendermap.com/medical/psychotherapy/usa/california/erica-anderson/.

TransHealthCare. “Dr. Ellie Zara Ley - Gender Affirming Surgery in San Francisco,” November 10, 2021. https://www.transhealthcare.org/ellie-zara-

ley/#:~:text=Ley%20transitioned%20in%202015%20and.

Turovsky, Daniil. “The Trans Man Whose Pioneering Surgery Was a State Secret for Decades.” BuzzFeed News, July 11, 2018. https://www.buzzfeednews.com/article/turovsky/soviet-doctor-trans-history.

"TVIC Newsletter Vol. 2 No. 23 (December 15, 1973)." Newsletter. 1973. *Digital Transgender Archive*, https://www.digitaltransgenderarchive.net/files/bg257f10b.

“U.S. Sex Reassignment Surgery Market Report, 2020-2027.” Grandviewresearch.com, December 2020. https://www.grandviewresearch.com/industry-analysis/us-sex-reassignment-surgery-market.

“uncomfortable, adj.” OED Online. June 2021. Oxford University Press. https://www-oed-com.oca.ucsc.edu/view/Entry/210552?redirectedFrom=uncomfortable.

Van Maasdam, Judy. “Lou Sullivan’s Rejection Letter from Stanford University’s Gender Dysphoria Program.” Correspondence. Digital Transgender Archive, March 12, 1980. https://www.digitaltransgenderarchive.net/files/6w924b83q.

Vargas, Deborah R. “Ruminations on Lo Sucio as a Latino Queer Analytic.” *American Quarterly* 66, no. 3 (2014): 715–26. https://doi.org/10.1353/aq.2014.0046.

Vernon, Leonard F. “Tuskegee Syphilis Study Not America’s Only Medical Scandal: Chester M. Southam, MD, Henrietta Lacks, and the Sloan-Kettering Research Scandal.” *Online Journal of Health Ethics* 16, no. 2 (2020).

Washington, Harriet A. *Medical Apartheid the Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present.* Paw Prints, 2010.

Wilkinson, Willy. “Intersectionality in the Trans Community.” Presented at the Gender Odyssey, August 7, 2016. https://www.facebook.com/genderodyssey/videos/intersectionality-in-the-trans-community/10154424520977718/.

“World Athletics | about World Athletics.” worldathletics.org, 2019. https://www.worldathletics.org/about-iaaf.n.d.

www.lgbtmap.org. “Movement Advancement Project | Identity Document Laws and Policies,” April 28, 2022. https://www.lgbtmap.org/equality-maps/identity_document_laws.

www.wpath.org. “Mission and Vision - WPATH World Professional Association for Transgender Health,” n.d. https://www.wpath.org/about/mission-and-vision.