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"You Know a Girl When You See One": Experiences of Surgeons Who Perform Gender Affirmation/Reassignment Surgery (GAS)

Christian, Robert

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Boston University
**YOU KNOW A GIRL WHEN YOU SEE ONE**: EXPERIENCES OF SURGEONS WHO PERFORM GENDER AFFIRMATION/REASSIGNMENT SURGERY (GAS)

Robert Christian – Boston University School of Medicine, Boston, MA ©2014

Most recent research regarding GAS focuses on discrimination and health disparities faced by the transgender community, and on perspectives and identity constructions of patients transitioning from one gender presentation to another. However, few studies address perspectives and experiences of the surgeons performing these operations. This poster serves to gain insight into some of the experiences of these surgeons, in the context of contemporary American society.

### 1. Introduction

Gender is a cultural construction, which relies on societal ideals and norms. For example, the picture to the right appears to show a girl playing with dolls. However, it depicts Renoir’s youngest son. Long hair and pink ribbons were associated with boys in Europe in 1905.

In the United States, the dominant view is a gender binary – males and females. Those who step outside this cultural norm, which includes the Transgender community, are subject to societal discrimination and marginalization. A subset of the Transgender community seeks out surgical procedures, in the form of GAS, in order to align their physical body with their gender identity.

This poster examines GAS surgeons’ narratives in order to answer questions of how they

1. Classify these surgeries
2. Normalize the procedures
3. Act in order to maintain what is at stake for them when assuming the identity of gender affirmation surgeons

### 2. Methods

**Recruitment**
- Convenience Sampling
- Surgeon Participants Recruited From Two Transgender Health Conferences in the Northeast
- 5 Surgeons
  - 2 practice in the Northeast, 2 in the Midwest, and 1 on the West Coast
- 1 Local Informant

**Data Collection**
- Individual, Unstructured Interviews
  - In-Person
  - Over the Telephone
  - 26 – 93 Minutes
- Surgeon’s Websites
- Data Analysis
  - Grounded Theory
  - Interpretative Phenomenological Analysis

### 3. Results

**1. Entering the Field**

The surgeons were able to classify these operations as acceptable forms of surgery in two ways. First, some of the surgeons had direct experience performing GAS procedures and working with transgender patients during the enculturation process.

“When I was a plastic surgery fellow... the chairman of the department did transgender surgery... when I was on service with the chairman, I helped do the surgeries. And so I met a number of transgender patients, and participated in their surgery, so I became fairly comfortable with the surgery at that time.”

[Dr. B]

Several surgeons, however, lacked prior experience during the enculturation process.

“I didn’t start out with the idea of working on transgenders... When I was asked to come to Green University one day [to do plastic surgery]... I called the chairman of the department... he was chairman of plastic surgery... He was very much, very early involved in transgender surgery... I called him... and I said I’ll come to your program, but I don’t want anything to do with your transgender patients [laughs]. It was just something that I totally wasn’t interested in. I was totally interested in reconstructive surgery.”

[Dr. D]

A second, reconstructive classification was also used, especially by those surgeons without prior experience. By using the same techniques used in other reconstructive procedures, the surgeons are able to classify GAS as an acceptable operation.

“But that’s what… facial feminization, comes from… because basically all the operations… that I do in facial feminization, all involves taking care of kids with their craniofacial problems.”

[Dr. D]

**2. Reconstructing Normal**

To be able to operate, the surgeons must view GAS as “normal” so it make sense clinically, medically, and socially.

**Normal Surgery**

Surgery is the body, and is clinically separate from the mind. Surgeons must be sure to operate on the former, not the latter. GAS fixes a patient’s body, and therefore it is a normal surgery.

“Ever since I took care of the very first patient, I’ve been convinced that they are truly born in the wrong skin.”

[Dr. D]

**Normal Outcomes – Surgeons**

Normal bodies must be produced. Surgeons rely on clinical biomarkers to create these normal bodily outcomes.

“Well, I read… five books, on physical anthropology of the face, skull, and I was determining what was the difference between the male and female skulls… measurement differences, and the other thing is contour differences… between a normal male and a normal female.”

[Dr. D]

**Normal Outcomes – Patients**

Patients’ goals must align with those of the surgeon’s normal.

“I said, ‘What do you expect from this surgery?’... He says, ‘Well, I expect to be beautiful.’... Why is it important for you to be beautiful?”... He says, ‘So I have friends. I don’t have lots of friends.’ And I cancelled the surgery... in my mind this person was not a transsexual at all.”

[Dr. D]

When a patient’s goals are not normal, such as being of the wrong mind, by wanting a surgical procedure to gain friends, the surgeon will not operate.

**3. Daily Professional Lives**

The surgeons act out their daily professional lives to maintain what is most at stake for them.

**Economics**

These operations are very expensive. Surgeons act to maintain this aspect of their practice.

“When I left the university I stopped all insurance. I don’t take any insurance at all. That was part of the problem. I wasn’t getting paid enough. So I didn’t want to be part of insurance anymore.”

[Dr. D]

**Competent Physician Identity**

Surgeons legitimate GAS, and thus act to maintain their identities as competent physicians.

“There’s nothing illegal about it. There are code numbers for all the procedures that we do... Diagnostic code numbers and procedure code numbers... it’s recommended by the AMA, it’s recommended by all the professional organizations. It’s pretty discriminatory not to do it.”

[Dr. A]

**Caring Doctor Identity**

There is a lay perception that doctors should be compassionate. A surgeon’s staff is an extension of their identity, and as such the surgeons must act to maintain their identities as caring doctors.

“We had a lot of problems on the floor with nurses... a lot of nurses weren’t understanding. And we had to cut a couple of nurses away from working with my patients.”

[Dr. D]

**Great Surgeon Identity**

The surgeons discuss GAS in ways that highlight them as creative, innovative, and at the technological forefront of their field – all qualities of great surgeons.

“[These surgeries are] very, very challenging...very, very advanced type surgeries... You sort of get to push the envelope a little bit.”

[Dr. C]

**4. Conclusion**

Surgeons learn through direct experience during medical school and residency, clinical experience, and through the communities they serve. They use this knowledge and experience to classify and normalize procedures. These surgeons act within this knowledge to maintain what can be lost.

There is a constant interplay between the surgeons, their patients, and the transgender community. This allows these actors to influence and be influenced by each other.

**Applications**

This research could be used to help those individuals seeking GAS in choosing a surgeon. By understanding the ways in which these surgeons understand GAS, the patients will be better informed in searching for a caring, understanding, competent healthcare provider.

By continuing to focus research on the experiences of those who are performing these operations, we can begin to understand these phenomena from different perspectives.

These surgeons are not only acting to operate on bodies, they are acting to transform them. Through future research, they may even be able to help transform society and medicine.

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**6. References**

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