Episode: *Ethics Talk: Whose Faces Does Facial Feminization Surgery Consider "Feminine"?*

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[mellow but bright theme music]

TIM HOFF: Welcome to *Ethics Talk*, the *American Medical Association Journal of Ethics* podcast on ethics in health and health care. I'm your host, Tim Hoff.

Professional health organizations agree that gender-affirming care is, in the words of an AMA board member, quote, "medically necessary, evidence-based care that improves the physical and mental health of transgender and gender-diverse people." According to the World Health Organization, the American Academy of Pediatrics, the Endocrine Society, the American Psychiatric Society, the American Academy of Child and Adolescent Psychiatry—I think you get the point—according to all of these professional health organizations and many others, the question is not whether to provide gender-affirming health care, but how and when.

Good gender-affirming care, or GAC, including gender-affirming surgery, seeks to serve patients and motivate broader justice and inclusion goals, and we should ask questions that motivate our thinking about those goals. For example, how should health care meet gender-affirming care demands while assuring that specific services like facial feminization surgery, or FFS, are done by clinicians who are well trained and able to grapple with not just the clinical, but with anthropologically situated questions about human face shapes and traits when sharing decisions with patients?

DR ERIC PLEMONS: One of the key problems of this procedure is defining femininity, being able to say this set of characteristics is feminine. Or in a particular patient's case, looking at their face and saying, "Here's the things about you that are troublingly masculine, and so here's where I'm going to intervene."

HOFF: Beyond questions of what counts as "feminine" or "masculine" traits of a face, another tendency to be cautious about in facial feminization surgeries is whether and how such surgeries reinforce facial aesthetics that reify white women's facial features as ideal. How patients' faces take shape at the hands of a surgeon are neither clinically, ethically, nor aesthetically neutral.

Joining me today to discuss facial feminization surgery and how clinicians can best support patient decisions around gender-affirming care is Dr Eric Plemons. Dr Plemons is a medical anthropologist and associate professor of anthropology at the University of Arizona, where he is also the director of the medical anthropology concentration and certificate programs and the co-chair of the University of Arizona Transgender Studies Research Cluster. Dr Plemons, thank you so much for being on the podcast.

DR ERIC PLEMONS: I'm thrilled to be here. Thanks for having me. [music fades]

HOFF: So, as some of our listeners might not actually know, facial feminization surgery is a set of procedures, rather than a specific operation, that is directed toward helping a gender

transitioning person pursue their facial aesthetic goals. To begin with, can you tell our audience members a little bit about which interventions are often included in FFS?

PLEMONS: Yeah, it's actually kind of a complicated question because different surgeons take different approaches to what they mean by facial feminization surgery or FFS. So, there's one clinician, for example, who told me all aesthetic surgery is feminizing insofar as femininity and youth are often conflated. But those people who specialize in FFS often divide the procedures into two types. So, one is soft tissue interventions, and one is bone interventions. And one of the things that makes FFS distinct from, say, just getting a rhinoplasty or getting a brow lift is that the aim is to change the entire facial complex, not just one component at a time. And so, the way it's often described is that if you change soft tissue, so doing a brow lift or a lip lift, without changing the bony architecture underneath, you end up, as one patient described it to me, looking like a man with a face lift. So, these bone interventions are really a key piece to what makes FFS distinct from other facial surgeries. So, we'll start with those bone interventions starting at the top of the face and going down.

So, the first, and as many people argue, one of the most important interventions that you can make is by changing what's often called a heavy brow, or some people say a Neanderthal brow, which can be changed by either burring down the thickness of the bones under the eyebrows and the forehead. But in burring, you're going to have a really limited amount of intervention you can make because those bones aren't terribly thick. So, the more radical is to take off the frontal, part of the frontal bone and set it back into that frontal sinus. When you do that, just above the eyes, you also then have to change the way that the nose articulates with the forehead. So, a rhinoplasty is almost always involved. Then moving down, some clinicians add cheek implants in order to make the cheeks look fuller or rounder. You can then shorten the chin, so from underneath your bottom teeth to the point of your chin can be made shorter. And the jawbone at the very back, so that flare at the back of the mandible under your ears, can be reduced to make a softer and less square or blocky head. So, those are the bone interventions that can be undertaken.

And then the soft tissue interventions work in concert with those. So, one of the most dramatic, again, can be done in the top of the head, so the forehead, scalp, and eye region. So, with one incision from ear to ear, you can pull the scalp forward, which can alter the hairline and can help people with temporal baldness if they have any baldness, by making the hairline rounder and come further down on the head. At the same time, you can raise the eyebrows on the forehead, and that forehead, you remember, has been made a little bit smoother and less blocky by the bone work underneath it. And you have the benefit of reducing crow's feet when you raise the forehead. So, you can see there another way in which youth and femininity get conflated to be the same thing. Then you have soft tissue parts of the rhinoplasty. You can also raise the upper lip. The idea here is that females should have a few millimeters of what they call tooth show, which is that when you kind of have your mouth at a neutral position, you can see the teeth. That's thought to be a feminine quality. You can then add lip filler to make the lips fuller if you want to do that. And then the final soft tissue intervention is removing the cartilage at the Adam's apple.

So, some people choose to do all of these, which is a really intense and invasive intervention, and some people choose to do some of them. That has to do a little bit with what the patient looks like and what the patient would like from surgery, and it also has to do with the surgeon and their particular skill set. Not everybody is trained or capable of doing all of these interventions, and some surgeons don't believe that you should do all of them. So, it, as you say, is a big collection of procedures that are used not consistently across patient populations.

HOFF: Hmm. I'm wondering if the procedures and goals involved in FFS over the past couple of decades or so have changed to accommodate shifting beauty standards. For example, FFS is not a terribly old intervention.

PLEMONS: Yeah.

HOFF: But you mentioned tooth show, which seems like the kind of thing that would be subject to pretty rapid shifts in cultural conceptions of beauty. And just as an aside, our January 2022 episode briefly explored the history of teeth and mouth-based beauty standards alongside our issue on the medical/dental divide in health care. But have we seen changes in the "standard" that FFS aims for, or is the intervention a little bit too young to sort of have experienced the shifts in beauty standards over time?

PLEMONS: No, it has changed quite a lot, and that mostly has to do with the number of clinicians who are now practicing FFS. Because one of the key problems of this procedure is defining femininity, being able to say this set of characteristics is feminine. Or in a particular patient's case, looking at their face and saying, "Here's the things about you that are troublingly masculine, and so here's where I'm going to intervene." So, the perception of the surgeon is really key in all of this. And you can see, or I've tracked in my own research, different clinicians' responses to the problem of what is femininity. Some of whom take a very metric kind of approach: They use anthropometrics to define and understand the difference between the feminine and the masculine as a problem of form. And other clinicians are much more subjective in their sense of what femininity looks like and are more likely to use words like "beautiful" than use words like "female."

And so, really, when prospective patients are interested in looking for a clinician, in part, what they're doing is testing out the narratives of these different clinicians and how these clinicians are explaining to them what their face looks like. So, it's a really interesting process. I mean, when I was doing fieldwork in these surgeons' offices, I learned to look at my face differently because I'd never thought about it as a discrete set of parts, each of which can be altered in various ways. I've only ever thought of it as one thing. And so, you do learn a kind of a distinct way of looking at these parts and understanding them as gendered individually and then as a group.

HOFF: So, it sounds like there's a lot of subjectivity for patients in determining what kind of clinician they want to work with. And that subjectivity raises a difficult question, which is, is there a point where FFS should probably stop for most patients? To expand, is there a sort of healthy facial feminization on one hand that is helpful for a patient's self-esteem, and which brings people's outward visual identity more into alignment with their gender identity, and on the other hand, a kind of body dysmorphic tendency—and I realize the focus on dysmorphia itself is somewhat contested in the community—but on the other hand, that needs attention and resistance from both patients and clinicians?

PLEMONS: Yeah, and I think this is an area in which FFS really has a lot in common with the other kinds of evaluative processes that people who do facial surgery deal with all the time. There is certainly, for facial plastic surgeons, the kind of legend of the rhinoplasty patient who would never be satisfied, who comes back for revision over and over and over again. And at some point, the clinician has to decide, "I'm no longer going to intervene because I do not share this patient's understanding of what they look like," right? We've come to an impasse where the patient's sense of their appearance is out of out of touch or out of scale with the clinician's assessment of their appearance, and so, nothing more can be done.

And I think one of the things that's interesting about facial feminization, and certainly when I wrote about it in my book, one of the things that I think makes...one of the things that FFS makes clear is that gender is a thing that we get from other people. It's not a thing that is a discrete quality of your body that you have all alone in space. It's that your status as a woman or your status as a man is given to you iteratively by other people throughout your lifetime. You know, I'm a man when I'm seen as a man by others, when I'm allowed to use the bathroom without being harassed, when I'm put in the men's group, when I do all of these social things that recognize me in that way. So, FFS, the success or failure of it isn't a thing that happens in the operating room. It's a thing that happens everywhere after when people are either recognized as women or not. And their sense of being recognized as women comes from their daily interactions, their exchanges with people, how people address them, how they talk to them, include them, or exclude them from sex- and gender-specific spaces, activities, and social roles.

Surgeons don't ever see that. They can't possibly. And so, when these two parties disagree about whether FSS quote-unquote "worked" or not, they're coming at the question with really different sets of knowledge and really different ways of intervening. So, there certainly were cases in the research that I did when surgeons said, "Your outcome is terrific," and the patient said, "People are still calling me 'sir'." And at that moment, they have two really different relationships to understanding what the problem of the face might be and really different ways of intervening. So, we can say then that that would be a moment in which the procedures should stop. They will stop because the surgeon no longer knows where to intervene. But that, as I said, is kind of where it overlaps with the typical evaluative processes that people who do facial plastic surgery deal with all the time in terms of setting expectations and articulating outcomes and helping patients to narrate their outcomes positively long before they've healed, which is a really powerful tool in a surgeon's toolkit.

HOFF: Similar to gender being a thing that is given to you by the people that you interact with, race functions, at least in part, in the same way. In your 2019 article *Gender, Ethnicity, and Transgender Embodiment: Interrogating Classification in Facial Feminization Surgery*, you suggest that FFS not only feminizes but also whitens faces and that this happens regardless of whether or not ethnicity is explicitly considered during pre-surgical consultations. So, why is FSS seen as "whitening?" And what needs to evolve about the intervention to make it racially, culturally, and ethnically inclusive?

PLEMONS: Yeah. So, one of the insights from whiteness studies is understanding whiteness as a thing that's defined negatively. So, it's a thing that's defined more by what it's not than by what it is. And so, I argued that facial feminization ends up being whitening when it's aimed or oriented toward what's presented as a very neutral idea about what femininity is, that femininity is a thing that has a form, and FFS moves toward that form. And that somehow femininity can exist separate from race and ethnicity, which are characteristics of our faces that are used all the time in real life, right? So, separate from this kind of dividing up into categories, you have race over here and then you have age over here and then you have masculinity and femininity over here. In fact, in the world, they're all in one face. So, anytime FFS argues that what it aims to do is feminize, but it doesn't qualify what it means by feminize, the result is whitening because it is neutralizing. It's trying to make this neutral claim.

And it's really striking when you read FFS clinical literature how seldom race is actually mentioned. So, you'll see explanations, you know, "Femininity looks like this. It has a narrow nose, it has plump lips, it has a heart-shaped face," these kinds of things that are actually quite distinct in terms of racial and ethnic specificity. And then like a lot of facial plastic surgery,

there'll be a separate category for race and ethnicity. And what ends up happening in this discourse, and a lot of facial plastic surgery discourse, is that there is this assumed neutral body on top of which categories like race and ethnicity get layered so that the neutral body underneath is a white body, an unmarked body, and then it can have ethnicity added, right? So, anytime this sort of neutrality exists where race is not mentioned, whitening is the effect in terms of its being neutralizing, not in terms of saying, "I want to make this person look Caucasian."

And we've seen over the last 20 or so years the emergence of ethnically sensitive cosmetic surgery in which people argue, "I'm going to intervene. I'm going to give you a nose job, but I'm going to keep your blackness. Or I'm going to give you a nose job, but I'm going to keep your Asianness." And the need even for that discourse to emerge signals that for decades and decades and decades, whiteness, this sort of neutralizing whiteness, was the articulated goal such that we need this special category of ethnically sensitive cosmetic surgery.

And really, getting back to the origins of FFS as a set of procedures, they were based initially on anthropometric standards from the early part of the 20th century that were all done on white people. And it is the case, still, in the contemporary, that facial anthropometrics that exist out there are overwhelmingly on Caucasian populations, but they're often not named as that. So, in order to begin to think differently about femininity, we have to remember that femininity never exists outside of ethnic and racial specificity and that there is no such thing as a universal neutral femininity. That it's always marked somehow. And I think the process of becoming more aware of that is the first step of saying, "When you say feminine, when you say a feminine face is heart shaped, except for Asians, what kind of femininity did you have in mind?" And really forcing an articulation of that question in order to signal that it's not just femaleness that you're intervening in when you shorten someone's chin. It also has to do with these very specific ideas about what facial shapes mean and who they belong to.

HOFF: Hmm. Yeah, it sounds like surgeons need to have a very wide set of skills. You talked about earlier needing just the technical skills to provide all of these different types of interventions that are included under the FFS umbrella, but they also need this historical, anthropological perspective to help inform and guide patient decisions.

PLEMONS: In my perspective that's true. [laughs]

HOFF: Right. Yeah, I guess in an ideal world, they might have these.

PLEMONS: Yeah, that's exactly right. Because otherwise you end up, like I said before, if you have a big, blocky nose and somebody says, "I'm going to make your nose more narrow" or something, we can say that's feminizing insofar as we're collapsing of femininity and beauty and linking beauty to particular kinds of standards. But is that rhinoplasty that you get from the plastic surgeon who does dozens of rhinoplasties, does that fit within an overall goal of creating a feminine female face, or is that about providing a rhinoplasty? And so, it makes sense, of course, that surgeons work with the tools they have and that many people, I'm quite sure, have excellent intentions of wanting to help an underserved population. But part of why I call my book on FFS, the subtitle is *The Aims of Trans- Medicine*, is to try to put these interventions into a broader question about what it is that clinicians are trying to do when they intervene in sex and gender for trans people? How do you know if you did it right? What do you know is a good outcome? In order to answer that question, you have to think about what is the role of medicine here? What is the outcome that you're hoping to achieve? And to really have a reflection on that.

HOFF: Well, and that in turn, raises the question of what the role of health professions education is in preparing clinicians to ask these questions and to engage with their patients in a productive way when they're pursuing really, any kind of care, but especially gender-affirming care. So, what should be that role, and how have you seen, or perhaps not seen, health professions curricula designed to accomplish it?

PLEMONS: Yeah, I mean, I think anybody who studies LGBT representation in med school curricula knows that it's terrible. Most, many clinicians report having had one to two hours total in their entire medical education focused on LGBT populations. So, whenever I give talks at med school, in med schools, the first thing that I recommend doing is just demystifying trans folks for clinicians. Oftentimes people think, "Well, I can't provide trans care because I don't know anything about trans people." Most of the care that a clinician ever provides to a trans person will have nothing to do with their transition. It will have to do with the fact that they have pneumonia or a broken ankle or an earache or high cholesterol. And so, just getting that kind of sense out of the way that agreeing to help a trans person is participating in transition, that those two things are not the same.

And I think we're starting to see a greater demand in electronic medical records, for example, to have different ways of asking about names and pronouns and preferred gender reference. There are in some EMRs body organ indexes, right, that ask, "What gonads do you have, what genitals do you have," or all of these different things. So, when working in clinic, doctors are going to need to be able to have facility with these kinds of questions, to be able to ask and to be able to treat their patients with respect. So, I think in some ways it's really that demystification that's the most important key. And for learning, certainly for people who are doing hormone prescriptions or things like that that do not require special skill beyond what they have for most of the patients that they're treating, to just understand that this is not a whole life career commitment to say, "I am a doctor who treats trans people, and that's what I do." It's absolutely folded into a regular part of a curriculum.

I was asked by a medical school to help consult in making clinical training curricula or some case studies. And so, I had suggested what I thought to be a very simple intervention, which was, you know, in these clinical skills tests that you do in which you are giving students a case to look at on paper and try to make a diagnosis, make a person trans but have COPD, right? And the response that I got from the medical school was, "That's going to be really confusing to our students. Our students will be confused and led down, like a red herring, [chuckles] led down the wrong path if our person with COPD also has genitals that they don't expect." And my response was, "That's exactly the point." There are ways that you can introduce the fact that trans people exist as bodies all throughout the curriculum that doesn't have to be about gender transition in the same way that your person who has cancer could also be gay in no relationship to the cancer that they have, and you still have to treat them respectfully. And wouldn't it be something if your students were introduced to that from the very first year, rather than waiting for two hours to get that one bit of curriculum about HIV prevention?

HOFF: So, our conversation so far has assumed that clinicians, although they might not know how, they generally want to and should help trans patients, whether that's specifically with gender-affirming care or just with general health care needs. But you've also written about the expansion of Catholic health organizations' traditional refusal to engage in safe reproductive care and the full range of end-of-life care expanding to include gender-affirming care. You suggest that while "religious liberty" and "right to life" arguments are deployed by some Catholic clinicians in order to avoid standard of care in both reproductive care and with trans health care,

the arguments work a little bit differently in these instances. What should our listeners know about conscience-based refusals of gender-affirming care, including FFS?

PLEMONS: Yeah. So, I became interested in this question when, after 2014, the Affordable Care Act started to really ramp up public dollars in support of trans folks' medical care. At the same time, corporations were really growing their coverage for trans medical care, and at the exact same time, the market share of Catholic hospital ownership was going up exponentially. And so, the question was, what happens when these two things happen at the same time? All of a sudden, people are supposedly giving more access through insurance coverage to procedures, but increasingly the hospitals around them won't provide that care based on a principle of religious liberty. And so, I became interested in understanding how Catholic bioethicists explain why they won't provide this care.

And it's interesting because there's this document called the *Ethical and Religious Directives* that Catholic health care systems use to decide which kinds of care they'll provide and which they won't. And those directives have, for decades, included very specific information on beginnings-of-life and end-of-life issues. So, they include guidance on what to do with ectopic pregnancy, for example, or assisted reproductive technologies on one hand, and then they'll talk about euthanasia or end-of-life interventions, withholding care, etc. And those have been in there explicitly for decades and decades. So, there's nothing in there about transgender health care, despite the fact that the *ERD* has been around and used really in force since after the Roe decision in 1973. There's never been anything in there about the nature of sex and gender, but Catholic bioethicists claim that there is something very old that's just never been in there that is the reason why they won't provide care for trans folks.

So, what I became interested in was how it is that this religious liberty claim that has shielded Catholic health institutions from providing various types of beginning and end-of-life care could all of a sudden be expanded to trans people? And the only way that's really worked is by, number one, analogizing trans health care to things that they don't do. So, by making it seem like trans health care equals sterilization, for example, which is manifestly not true. Or by making it seem like the Catholic Church has always believed that there is a sex and gender assigned to the soul. In that sense, the soul and body are coincident in Catholic anthropology, that there's no way they can intervene in a kind of transgender that's often analogized to having a break between body and mind or body and spirit. So, as I said, there is no actual statement about either trans health care or sex and gender in the *ERD*. And so, it's these false analogies and a claim to historic precedent that allows them to expand the *Ethical and Religious Directives* beyond life and death to now include a Catholic definition of sex. So, what's really interesting to me is by trying to read these Catholic bioethicists and see what kinds of rhetorical ways they're trying to do this, even though there's nothing in the actual wording of the directives that deny health care.

And so, most of what you see in terms of the denial of trans health care in Catholic institutions is centered on hysterectomies, on performing voluntary hysterectomies. And so, in the papers, certainly in the right-wing papers, they'll say something like, "The courts have forced, will force Catholic hospitals to perform transgender surgery." To the general reading public, what they think is that surgeons are being forced to perform general reconstruction operations, which is absolutely not true. And any surgeon will tell you, you can't be forced to do something you don't know how to do. So, that's manifestly not true. But insofar as voluntary hysterectomy gets linked into the process of transition, it's characterized as a transgender surgery, and on that basis, marked as out of bounds.

I'm not familiar with any claims to FFS that have been denied in Catholic institutions based on those grounds. That is likely because of any, because most FFS is not covered by insurances anyways. So, if you want to go in and get a nose job, for example, you can ask for a nose job. You can ask for a brow lift. You can ask for lip fillers without saying, "To aid my transition, I would like to do this and this thing." So, that's one of the kind of mechanisms that people can use is by simply not calling it FFS; you call it something else. But most of the issue has been around voluntary hysterectomy or a few cases I've seen of people, trans women's request for breast augmentation being denied.

HOFF: So, we're nearing the end of our time here. But before we go, I'd like to end, as we often do, by asking if you could provide three points of consideration for health professions students and trainees, perhaps especially those looking to go into surgery with the intention of providing transition care or gender-affirming care of any kind, what three things should those students and trainees think about as they continue their education and begin their careers?

PLEMONS: Yeah, I think one of the things that's really exciting for people who are students at this stage of their career is that in 2015, the very first ever, in the history of the United States, fellowship in trans surgery was created. And since that time, there are now several different programs that have such fellowships. So, there are ways for students to get this kind of education in a formal setting rather than doing as the previous generation had to do, which is self-fund travel around the world to do short-term apprenticeships or fellowships with people who have established practices. So, there are those institutionally sponsored opportunities now in a way that didn't exist before, and that's really exciting.

There are a new generation of trans health programs opening up at universities across the country where folks can, as new clinicians, new surgeons go and get actual real hands-on experience. And those places have really done a good job, I think, in most cases of integrating not only clinical care, but the kinds of best practice gender-affirming care that many trans people want and have come to expect. So, it's not simply, "Here's a note. Go to the surgeon's office. They'll do the procedure that you want." But from intake and literature and insurance management and all of that stuff, that these folks are really committed to trans people's health as a holistic kind of concept. So, there are those clinical opportunities.

I think the other thing that I always encourage students to do is to ask and demand for the representation of trans and other queer people in your medical curricula. If students aren't asking for it and programs are not providing it, they're not going to start providing it if they think that everything is going just fine as it is. So, I think that those are really great opportunities.

And the other piece of advice that I like to give is if you are a physician of any type, you should have in your mind somebody to refer your patient to if they ask about trans health care and you don't know the answer. There's nothing more disempowering to a patient than to work up the courage to ask a hard question in a clinical space that's already vulnerable, no matter what you're there for, and have your trusted physician say, "I don't know." So, even if it's not in your town, even if it's a neighboring town, or even if it's a great website that has information that you trust, to know that in advance, rather than waiting for some patient to work up the nerve to come out to you or to ask you for a question, and then you go, "Oh, right! I should find out the answer of where decent trans health care is in my region." [theme music returns] Just take five minutes and find that out in advance.

HOFF: Dr Plemons, thank you so much for your time on the podcast today.

PLEMONS: It was my pleasure. Thank you for having me.

HOFF: That's all for this episode of *Ethics Talk*. Thanks to Dr Eric Plemons for joining us. To read our full issue on *Patient-centered Transgender Surgery* for free, visit our site, JournalofEthics.org. For all of our latest news and updates, find us on Twitter and now on Instagram @journal.of.ethics. We'll be back next month with an episode on BMI-based denials of care and how to fight them. Talk to you then.