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(Re)making sex: A praxiography of the gender clinic

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Abstract
This article traces the multiple enactments of sex in clinical practices of transgender medicine to argue against the presumed singularity of 'transexuality'. Using autoethnography to analyse my own experience as a trans patient, I describe my clinical encounters with doctors, psychiatrists and surgeons in order to theorise sex as multiple. Following recent developments in science and technology studies (STS) that advance the work of Judith Butler on sex as performatively reproduced, I use a praxiographic approach to argue that treatment practices produce particular iterations of what sex (and transexuality) 'is' and how these processes limit and foreclose other trans possibilities. I consider the ethical, political and material-discursive implications of treatment practices and offer a series of reflections about the effects and effectiveness of current clinical practices and the possibilities for intervening in such processes in order that, following Annemarie Mol, we might (re)make sex (and transexuality) differently.

Keywords
Autoethnography, female to male, gender dysphoria, medicine, multiplicity, posthumanist performativity, praxiography, psychiatry, surgery, transgender

What is transexuality?[1] An innate feeling? A medical condition (or disorder)? A clinical diagnosis? An identity? A surgery? All of these at once? Or, perhaps, it is one thing here and another thing over there, or a little further along (to paraphrase Mol, 2002: 96). Following recent scholarship in *Feminist Theory* that examined 'Sex and Surgery' (Edmonds, 2013; Guntram, 2013; Kraus, 2013, Zeiler, 2013), here I analyse my experience of being treated as a trans patient in order

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to study how sex is made (and remade) in clinical management of transexuality, and beyond. Without formally citing her work, *Feminist Theory*'s special section elaborates on what science and technology studies (STS) scholar Annemarie Mol describes as 'the way medicine *enacts* the objects of its concern and treatment' (2002: vii; emphasis in original). Mol's work, the special section and this article all question how medical practices – understood to treat patients, problems and diagnoses – *produce* those very phenomena regarded as pre-existing treatment.[2] Using the methodological tools of STS and autoethnography, I analyse the events of my own medical 'treatment': beginning in a doctor's office, receiving a referral to a psychiatrist, navigating consultations with various medical professionals and, finally, undergoing surgery.[3] In so doing, I ask: How is 'transexuality' *being done*? How is sex *produced* and *maintained*? How is medicine implicated in enacting sex (and 'sex differences')? And, what does this mean for feminist theorising? As I argue in this article, tracing multiple enactments (makings) of sex demonstrates that sex is not one thing: a static, discrete (and biological) entity that pre-exists relations and practices. Rather, sex is *emergent*; constantly being made and remade in and through particular situations, contexts, practices and encounters. Thus, by studying the *practices* through which sex emerges, we can see *how* sex is *enacted multiply* across a range of situations. Theorising the multiplicity of sex in this way lets us see how particular possibilities for 'changing sex' become viable, while other ways of being trans are foreclosed.

Constructing sex

For some time, feminist theorists have argued that 'sex' is not a natural state but culturally and socially produced. Biologist Anne Fausto-Sterling's (1985, 2000) work details intersex variations to show how the biological complexities of sex are not reducible to two discrete categories. Fausto-Sterling emphasises how medicine *acts* to control bodies, especially through cultural stereotypes. Philosopher Judith Butler argues that sex is *reiterative* – and Mol emphasises this performative influence in her own work (Mol, 2002: 36–42). For Butler, 'gender is not a performance that a prior subject elects to do, but gender is *performative* in the sense that it constitutes as an effect the very subject it appears to express' (1991: 24; emphasis in original). Yet, as Mol describes, '[Butler] says that it is important to study the pervasive and mundane acts by which gender identity is performed. But she doesn't actually engage in such a study' (Mol, 2002: 39). Although Mol does not analyse 'sex difference' in her study of atherosclerosis, she does acknowledge 'sex difference' as a multiple object (2002: 144, 151, 178). While both Butler and Fausto-Sterling suggest sex is unstable, my work here traces *how* sex emerges in clinical practices of my own transgender medical encounters. For trans studies scholar Susan Stryker, sex is better understood as 'a mash-up, a story we mix about *how* the body means, which parts matter most, and how they register in our consciousness or field of vision' (2006: 9; emphasis in original). By analysing the details of my medical encounters, I show how, in complex and subtle ways, medicine produces

sex 'anew' in each specific context and encounter (see: Seear, 2014). Further, it is not only practices and encounters that produce sex, but material resources (time, money, access, as well as surgical reconfigurations of flesh), narratives, the interpretation and (re)articulation of diagnostic features and treatment guidelines, logic, assertiveness, attention to detail and, perhaps, a certain attitude to the rigidity of the aforementioned. By using the tools of autoethnography and praxiography I extend the work of Butler, Fausto-Sterling, Mol and Stryker by examining exactly *how*: 1) sex is ontologically multiple; and 2) the clinical narrative of transexuality is both founded on and perpetuates the notion of sex as singular.

Praxiography

In her ethnographic study of the disease atherosclerosis, Mol (2002) considers the ways atherosclerosis is enacted in different departments of a hospital (outpatient clinic, operating room, pathology, haematology), through various investigative and measuring tools (such as microscopes, X rays) and across different treatments (from invasive vascular surgery to walking therapy). Through this attention to practices, Mol argues that atherosclerosis is not a singular discernible physicality ('hardening of the leg arteries') of which there are various 'aspects' (such as pain on walking or weak pulsations in the foot). Rather, in each context atherosclerosis *becomes a different object as it is enacted in practice*. Atherosclerosis is *felt by a patient* as pain when walking and *felt by a doctor* as weak pulsations in the foot. It is *measured as pressure loss* from the arms to the feet. To a vascular surgeon, atherosclerosis is *plaque* removed from a leg artery. To a radiologist, it is *shadows* on an X-ray. To a pathologist it is *thickened intima visible under a microscope*. For Mol, these are not different perspectives pertaining to a (prior) singular object. Rather, they are different *versions*; phenomena (objects, ontologies, knowledges) cannot be predetermined but are enacted in practice: 'reality does not precede the mundane practices in which we interact with it, but is rather shaped within these practices' (Mol, 1999: 75). This way of thinking extends constructivist logic that draws attention to the 'made-ness' of phenomena. Reading Mol, STS scholar Suzanne Fraser explains that constructionism implies that phenomena are constituted in a way that is 'singular and terminal'. That is:

> these processes happen once, come to an end and, as a result, we are left with a disease or other object constituted in a certain way: a product of its social and temporal context to be sure, but complete and now immutable in its constructedness. [...] Against this view, Mol argues that, on the contrary, phenomena are always being made and remade. (Fraser, 2010: 233)

Butler, too, argues that 'Construction not only takes place *in* time, but is itself a temporal process which operates through the reiteration of norms; sex is both produced and destabilised in the course of this reiteration' (1993: 10). But the question remains, *how*? What can pursuing sex as a multiple object through

some of the 'mundane acts' and clinical practices involved in (my own) medical encounters as a trans patient tell us about what sex *is*? The usefulness of studying the specific contexts of individual encounters is emphasised by Mol, who argues:

> If practices are foregrounded there is no longer a single passive object in the middle, waiting to be seen from the point of view of seemingly endless series of perspectives. Instead, objects come into being—and disappear—with the practices in which they are manipulated. And since the object of manipulation tends to differ from one practice to another, reality multiplies. The body, the patient, the disease, the doctor, the technician, the technology: all of these are more than one. More than singular. This begs the question of how they are related. For even if objects differ from one practice to another, there are relations between these practices. Thus, far from necessarily falling into fragments, multiple objects tend to hang together somehow. Attending to the multiplicity of reality opens up the possibility of studying this remarkable achievement. (2002: 5)

A Molian praxiographer, then, examines how phenomena materialise (multiply) in practice and how these enactments are related. While 'object' implies definiteness and independence, it is necessary to bear in mind that each enactment of sex ('sex-object') is intra-actively produced (following Barad, 2007). Consequently, what is important is how phenomena 'hang together'; as Mol suggests, the 'ontology of medical practice is not the ontology of a single practice: there are as many frictions between objects enacted as there are between the practices in which their enactment takes place' (2002: 150). Conflict in practice cannot be static: tensions must be *managed*. For trans people, tensions, frictions and clashes abound across a range of sex-enactments, and this gives us the opportunity to study how these tensions are managed. For this reason, rethinking sex in this way is particularly useful to trans research as it does not rely on a pre-existing, definite notion of sex, which limits (and forecloses) certain trans possibilities. Rather, multiplicity, as I have argued elsewhere, 'better allows us to take seriously the necessarily complex ways of being trans' (Latham, 2016: 349) – and, indeed, being sexed.

Writing selves

Trans studies as a critical field insists on the author taking account of oneself, in part from feminist critiques of objectivity and science (especially Haraway, 1991) and as a response to having been written *about* by others (Stone, [1991] 2006: 232). In *The Transgender Studies Reader*, Stryker and Stephen Whittle explain that an 'explicit articulation of [one's] own embodied stake in the matter at hand, and the knowledge gained from [one's] own embodied situation [. . .] exemplify important methodological hallmarks of transgender studies' (2006: 315). In this way, the very emergence of trans studies hinges on explicitly prioritising the work of trans

people and taking our experiences seriously, yet often this 'use of the self' remains under-theorised in this field. Against this tendency, I turn to how using one's own experiences is helpfully articulated in autoethnography.

Autoethnography attempts to use productively the rupture outlined by Elspeth Probyn: 'On the one hand, ethnography tends to erase the mediating researcher in the name of epistemology, and on the other, autobiography erases any notion of mediation between the self and experience' (1989: 21). Autoethnography seeks to address both these criticisms together, and 'tries to disrupt traditional and dominant ideas about research, particularly what research is and how research should be done' (Adams and Holman Jones, 2011: 110).

In their introduction to *The Handbook of Autoethnography*, editors Stacy Holman Jones, Tony Adams and Carolyn Ellis define autoethnography as:

> (1) *purposefully commenting on/critiquing culture and cultural practices,* (2) making *contributions to existing research,* (3) *embracing vulnerability with purpose,* and (4) *creating a reciprocal relationship with audiences in order to compel a response*. (2013: 22; emphasis in original)

These are all features in common with 'auto trans studies', as is the aim to 'illuminate more general cultural phenomena and/or to show how the experience works to diminish, silence, or deny certain people and stories' (Holman Jones et al., 2013: 23).[4] Yet there is a political difference here. For Holman Jones et al., autoethnography is one form of knowledge among many: 'autoethnography does not claim to produce better or more reliable, generalisable and/or valid research than other methods, but instead provides another approach for studying cultural experience' (2013: 33). Trans studies, however, is unequivocal that the experience of the writer *is essential* to producing research:

> Transgender studies considers the embodied experience of the speaking subject, who claims constantive knowledge of the referent topic, to be a proper – indeed essential – component of the analysis of transgender phenomena; experiential knowledge is as legitimate as other, supposedly more 'objective' forms of knowledge, *and is in fact necessary for understanding the political dynamics of the situation being analyzed.* (Stryker, 2006: 12; emphasis mine)

This is in part a challenge to the way trans research is overwhelmingly produced by nontrans people, especially doctors (see: Cromwell, 1999: 19–30). Yet, as Mol makes clear, 'The praxiographic is not universal, it is local', it must be (2002: 54). However, it is also more than this: '[T]he stories I tell here are not only about what happens [here]. With some changes, shifts, and specific alterations, they might be told, to some extent, by someone else, some other time, about a lot of other [places]' (Mol, 2002: 50). Surely my story too, to some extent, may be told by someone else, somewhere else; anywhere there are 'gender clinics' and 'trans patients'. As a patient I had to play down my critical, scholarly insight. I cannot

articulate how I was given this impression by the medical professionals I saw, except to say I had the very distinct feeling that my qualifications in gender studies would work against me; that if they thought my pursuit was 'intellectual' more than 'psychological', I would not succeed (see: Butler, 2004: 76–77). Perhaps I am wrong. But I was aware, too, of legal scholar Dean Spade's (2006) difficulties in attempting to secure chest surgery whilst maintaining his scholarly outlook. My aim here is less about offering a trans case study (yet it is this also) and more about using my own particular experience to mount an argument about how sex is ontologically multiple – always already in process and enacted in practice – and how trans medicine specifically produces particular iterations of what sex is. My work in this article may be better understood as an *auto-praxiography*: a study of practices in which I enact and am enacted as *male*, *female*, *transexual* and suffering a mental disorder. In this way, I bring autoethnography, STS and trans studies into coalition in this article as a useful, and urgently needed, way to rethink sex and how trans medicine is currently practiced.

What I did

The events described herein took place over six months some seven years ago. At the time, I kept notes of my experiences, including a timeline and diary of all my appointments. I planned on using these notes to write a publication for a trans men's organisation to assist other people seeking these services in Australia. About three months after my final appointment I did write up those notes as a report, which was ultimately rejected by that organisation as not adequately reflecting their user-base of 'ftms'. In the rejection email from that organisation/individual, I was told 'it really sits better within a genderqueer framework'. In this way, what transexuality (and maleness) *is* was reproduced *within trans organising* in line with narrow (and clinical) notions that exclude me and my story. I quote from this manuscript occasionally as there were certainly things I had forgotten, and would have been lost to me without this document. `I use this font to indicate text from that manuscript`. As I wrote this journal article, I checked my narrative against my diary and, when I later received it, my medical file. This file includes all the reports by, and correspondence between, the various doctors. I quote from these reports also. These are important verifying and validating strategies: I have not relied on my memory alone (see: Chang, 2008: 49). It is also useful to note that the encounters reported here are private and legally protected, and therefore difficult if not impossible to study from the outside.[5] No fictional details (including composite characters) have been used, to guard against misrepresenting the events of this story. Some identifying characteristics have been removed. These are details that matter: the doctors' reputation, age, ethnicity, demeanour. Yet, as it is accepted practice to conceal these details to protect the privacy of informants, especially those who have not been consulted on their representation, as those appearing within this article have not, I follow that convention.

Clinical sex(es)

'Events are made to happen by several people and lots of things. Words participate, too. Paperwork. Rooms, buildings. The insurance system' (Mol, 2002: 25–26). There are many actors in this story: Doctors. Pathologists. Psychiatrists. Surgeons. A hospital. Nurses. Clinics. Private consulting rooms. Desks. Windows. Receptionists. Forms. Clothes. Drugs (or 'medications'). Telephone calls. Letters.

Not all trans people seek surgical or hormonal interventions, and not all who do, do so through a medical practitioner. Hence a person may be trans without being a patient, but through the *practice* of presenting at a clinic with what might be termed 'trans desires' (or concerns), a trans person becomes a trans patient. I became a trans patient when I attended a general practice clinic specialising in transgender health. I had not been there previously and as such I had to fill in a registration form: 'sex?'. I wrote FtM.

- Sex is self-determined: FtM

Entering the clinic, I am nervous. I already feel as though I am performing and must perform well in order to get what I want (the surgical removal of my breasts – though I can't remember how I phrased this to him). The doctor measures my weight and blood pressure, and then prints out a pathology request and a referral letter to see a psychiatrist. A psychiatric assessment is standard clinical practice only for trans patients. For surgeries involving nontrans patients, the *plastic surgeon* is expected to assess the psychiatric state of patients and referrals for psychiatric assessment are not a matter of course (see: Hodgkinson, 2005; Latham, 2013). For example, nontrans men who develop breasts receive the diagnosis 'gynecomastia' and are not required to undergo psychiatric assessment if they request mastectomies (see: de Barros and Sampaio, 2012). In this way, clinical practices (and the referral in particular) are making sex differently: even when the procedure involved is identical. The trans status of the patient produces divergent trajectories of treatment (see: Latham, 2017).

To the doctor, sex is not static, or singular. It is complex, multifaceted, malleable and diverse. To him, I am seeking to change sex from female to male – a *process* possible through various medical interventions, many at his disposal. I sought out this doctor in particular because other trans people regard him as 'sympathetic'– that is, experienced with trans patients and compassionate to trans desires.

- Sex is not permanent

I have my blood drawn by a pathology nurse and sent to a laboratory for testing. One week later I return to the doctor for the results. My total testosterone level is reported at 1.4 nmol/L. The reference range listed on the report is 0.5–2.6 nmol/L, 'the healthy range for adult (pre-menopausal) females'. The male range is 8.0–30.0 nmol/L (Sikaris et al., 2005). Sex is being enacted in the testosterone levels in the blood *and* the doctor's knowledge of my natal sex. That is, they are

coordinated (following Mol, 2002). My testosterone level is framed as evidence towards sex as an apparently stable, prior and singular object.

- Sex is assigned at birth: F
- Sex is testosterone levels in the blood: F

What if my reference range was listed as 8.0–30.0? My reported level would not be within the healthy range, but quite far below it. Would the doctor then write me a prescription for testosterone? Maybe he would request a testicle examination? Would this count as androgen deficiency requiring auxiliary testosterone? No. Not *for me*. Not *yet*.

Remember that this sex-object (hormone levels) is not why I am here. Sex is *enacted* multiply *in these encounters*. But not all sex-objects are equal: there is a hierarchy. For the medical doctor, these are the objects that are valorised:

- Sex is hormones
- Sex is genitals

The doctor says it is normal practice to undertake a genital examination and chromosomal testing to check for intersex variations. He follows this by saying he finds this unnecessary. What a relief. The doctor makes me feel as though he is on my side. He does this by framing certain measures as inessential. But there is something else happening here too. The doctor is revealing how transexuality happens in the clinic: in ways divergent to treatment guidelines (in this case, Meyer et al., 2002). This is also my initiation into the *cost* of transexuality. The doctor excuses me from these tests because chromosomal testing is expensive and a genital examination invasive, and for him these are unwarranted costs. He tells me later that he doesn't like the way transexuality is treated as a specialist issue; he says it should be a general practice issue. I learn that this is how he treats his patients, and I appreciate it. But there will be other costs that I will not be excused from.

Female levels of testosterone in the blood, female assigned sex at birth, adolescent development within the normal female range: these sex-objects are all coordinated to singularise sex (as female). Where is my maleness (or transexuality)? It is a *feeling*. And it is this feeling that is to be examined next: by the psychiatrist.

- Sex is feeling
- Women want to have breasts

Psychiatric sex(es)

The doctor cannot provide me with a referral letter for surgery (or prescribe testosterone) because he is not deemed qualified (transexuality is not a general

practice issue). This requires a 'gender specialist', someone with clinical training 'within any formally credentialing discipline—for example, psychology, psychiatry, social work, counseling, or nursing' (Meyer et al., 2002: 8). There is a 'free' service 'available' but when I enquire, the waiting time is over six months. I can see the same specialist in his private consulting rooms, for a fee (> AUD200 per appointment) within six weeks. This is important because transexuality is being constituted by practices that *require resources*: money and time, stress, pressure, clinic visits, tests ... I book the earliest available appointment. This is possible for me because I am working in two casual, flexible positions and I have savings; others would have to wait the six months for a 'free' consultation. This can be a very long and arduous process.

I have read a lot about trans experiences of psychiatric assessment, dating back to the 1960s when trans patients based the retelling of their life histories on Harry Benjamin's ([1966] 1999) reported patients' narratives. This began a cycle of enacting transexuality as something very specific: being born in the wrong body, always having a feeling of belonging to 'the other sex' and hating the genitals, roles and possible futures of one's assigned-at-birth sex (see especially: Stone, [1991] 2006; Latham, forthcoming). I know there are more recent accounts of trans people who continue to find it difficult to be approved for surgery if they do not recount this prescribed story (see especially: Cromwell, 1999: 8; Spade, 2006; Laird, 2008: 78–79).

Consultations

The psychiatrist is located in an office building. The reception desk is high and I have to stand on tip toes to peer over it. There are no windows. I give the receptionist my referral letter and wait in a corner.

His office is almost as big as the reception area. It has a large window opposite the door. I look out and wonder if anyone can see in, can see me in here. There is one armchair that faces the door, with its back to the window. This is where I must sit. There is a table with a glass and a jug of water. His desk is along one wall that puts us in the somewhat awkward position of him sitting at his desk partially turned towards me. Along the other wall opposite his desk is a large bookshelf. I look at his books. I am nervous. I pour a glass of water.

I tell him I am there to obtain a referral letter for surgery and ask how many sessions that will require. He says probably four to six.

'To prove I'm a competent adult and that my request for surgery is not a manifestation of psychosis?'.

'Yes, so you can give informed consent'.

I don't want to lie to the psychiatrist. I have read the World Professional Association for Transgender Health (WPATH) 'Standards of Care' (SOC) (Meyer et al., 2002) and the diagnostic criteria in the *DSM-IV-TR* (American Psychiatric Association [APA], 2000).[6] I feel as though I have a sense of what

to expect. But I am wrong.

> He asks me a lot about what I think my life will be like 7 years in the future. I just don't think like that, I say, I'll have graduated, hopefully [...] He keeps repeating the question and I get the distinct feelings [sic] I am supposed to say that I'll be all hairy and muscley [sic] and have a 'man's job'. [...] my politically astute answers warrant repetitive questioning; he just asks me the same question again.

In the psychiatrist's consulting room, sex is a *believable narrative*. Transexuality is articulating the feeling of belonging to 'the other sex' *convincingly* (see: Prosser, 1998). The psychiatrist is telling me that sex is the coordination of *feeling in the present* with descriptions of the past *and* ideas about the future. Sex is being constituted thrice:

- Past-sex
- Present-sex
- Future-sex

In their own accounts of their lives, not all trans men describe a legibly 'male past' (see for example: Cromwell, 1999: 127; Kotula, 2002; Green, 2004; Anderson-Minshall, 2008; Beatie, 2008; Krieger, 2011). These accounts, however, do not make sense to the psychiatrist in this clinical context. I didn't expect this line of questioning. I don't think I do very well. When I return for the second appointment, the psychiatrist confirms as much:

> He says something about how I didn't have a very good time last time. [...] He says that under the current DSM's diagnosis 'gender identity disorder' that I wouldn't pass, but that it's currently being re-written and that I would fall under the new one, and that's ok. Right, I think, so I didn't say the right thing.

I don't fully understand what he means by this – but I do understand that I did not succeed in presenting an appropriately convincing narrative. He says the process is about informed consent, but it is clearly more than this. I don't (want to) lie because part of me (and my project) wants to show him that trans people can be different from what he assumes. This is risky.

- Sex is a convincing narrative

Managing contradictions

In the *DSM-IV-TR*, the 'diagnostic features' of GID are described in this way:

> There are two components of Gender Identity Disorder, *both of which must be present to make the diagnosis*. There must be evidence of a strong and *persistent cross-gender*

> *identification*, which is the desire to be, or the insistence that one is, of the other sex (Criterion A). This cross-gender identification must not merely be a desire for any perceived cultural advantages of being the other sex. There must also be evidence of *persistent discomfort about one's assigned sex* or a sense of inappropriateness in the gender role of that sex (Criterion B). (APA, 2000: 532–533; emphasis mine)

The *DSM* is making sex as two objects *that must coincide*:

- (cross) gender identification
- persistent discomfort (about one's assigned sex)

It is precisely this sex/gender rupture from which 'transgender' gets its name. Yet my refusal to articulate bodily hate and disarticulate 'sex' from 'gender' is putting me in a precarious position. How to manage this contradiction? *What to do?*

> He asks me how I feel about my genitals. Fine, I say, that's what I've got. He replies: 'Right well, you can't just be into men, you need to reject your femaleness'. Well, that doesn't sit too well with me. I say if I could just wake up with a male body, I'd want that. But that's not the reality.

The psychiatrist is telling me that, to him, sex is genital. Men, the logic goes, would be very unhappy having a vagina. That is, hating my genitals would be understood as evidence of my being male. This is how he interprets and applies the *DSM* criteria (and this makes sense, as historically the genital-specificity of one's self-loathing was more explicit; see: APA, 1987). In this way, he is also *making* sex (and transexuality) genital. Yet many trans men articulate their (positive) experiences living as 'men with vaginas' (probably most famously porn star Buck Angel; see: Angel, 2013). Trans men also (re-)enact their genitals as male in a variety of ways (see: Edelman and Zimman, 2014; Latham, 2016). I do not comply. I am not so bold as to reiterate these arguments here, in part because I do not think they will work and I am trying to expedite this process as quickly (and therefore as cheaply) as possible. My response is a strategic move: I use my knowledge that there are no surgeons performing female-to-male genital reconstructive surgeries in Australia.[7] 'One cannot be both', he says. Sex must be becoming singular: I must feel myself to be male *and* hate being female.

For Mol, objects in medicine rarely *clash*. Instead one takes precedence in a hierarchical order: 'In cases where two facts contradict each other, one may be accorded more weight than the other' (Mol, 2002: 63). In this arena, I need the articulation of my 'gender identification' to carry more weight than my 'feelings about my genitals'. In order to bestow upon me the diagnosis, the psychiatrist is looking for this hierarchy in my narrative. Sex is becoming singular *and* becoming

multiple. In the psychiatrist's report, he writes:

> [J.] does not express intense dislike of his natal female genitals. As he quite reasonably says 'I'm reluctant to hate parts of my body that I cannot change'.

This description makes sense due to the assumption that male genitals cannot be adequately imitated surgically (for a rebuttal to this myth, see: Cotten, 2012). *As he quite reasonably says* … What if the psychiatrist believed there was an adequate surgery to change female genitals into male genitals? How am I managed as a patient as I refuse to account for Criterion B? Will I be dismissed without the surgeon's referral? How can one hang together as a trans patient who doesn't hate their genitals? I am failing at presenting *enough* male sex-objects – of proving myself – I'm on the verge of my sex being made female (and thus being denied access to the surgery I have requested; women cannot obtain this surgery, see: Latham, 2013).

Persistent discomforts

The *location* of this persistent discomfort now comes into play. I do not have persistent discomfort with female gender role(s) – because I understand women to be capable of any 'gender role'. I do not experience persistent discomfort about my 'female genitals'. The psychiatrist manages this by asserting the inimitability of male genitals; the unavailability of a surgical solution. Again, neither of these sex-objects are why I am there and yet I am made to account for them. And, as you can see, these objects are not being enacted 'willingly' in alignment with his expectations/requirements. Rather, I am being compelled to articulate and enact sex (and transexuality) in a specific way, a way that is limiting my ability to articulate my actual experiences and desires.

He takes another tack: He asks me what I think the difference is between being a butch lesbian and a trans man. I say something like 'I don't know, I'm not going to tell anyone else what is right for them, but this is what I want [meaning surgery]'.

He then asks the question again. The effect of this repeated questioning leaves me with no doubt that my first answer was, if not wrong, at least *insufficient*. I'm reminded of Sandy Stone's observation that achieving the diagnosis is a matter of there being 'several possible answers, but only one is clinically correct' ([1991] 2006: 231). In my first answer, I am trying to enact sex as a *material desire* ('I want to look this way'). But that is not enough. I need to make a case for myself as something other than a butch lesbian, preferably (perhaps only?) 'as a man'. Implicit in his repetition is that butch lesbians do not – cannot – desire to change their bodies in the way I am trying to, and that butches do not – cannot – think of themselves as men. I know that they can, and do (see: Hale, [1996] 2006; Halberstam and Volcano, 1999; Bergman, [2006] 2010). I am astutely aware of critiques of this logic, and yet they have no currency *here* (see especially: Halberstam 1998: 287–310; Hale, 1998: especially 322; Salamon, 2010: 165). What to do?

Diagnosing maleness

In his report, the psychiatrist writes 'He presents dressed in what would generally be accepted as a quite masculine fashion' and 'He presented to all consultations dressed in neat casual masculine attire and his gait and mannerisms were quite masculine'. The amount of work I put into *looking* male is considered evidence towards the extent of my *feeling* male . . . *to the psychiatrist*. Like the pathologist measuring the testosterone in my blood, the psychiatrist is *measuring my maleness*, and in this way constituting what sex *is*. For him, I enact a 'masculine' presentation and he sees this as evidence for my *feeling* male:

- Sex is dress: M
- Sex is gait: M
- Sex is mannerisms: M

But, of course, not all people who look masculine 'feel male', or use masculine dress as a way of expressing maleness. Indeed, many people use fashion, gait and mannerisms to express sexuality, specifically *queerness*. Here *my queerness* is being reconstituted as maleness, because 'maleness' facilitates the surgery I am seeking. Queerness and, as he has already told me, specifically butchness, does not.

The psychiatrist makes some other assessments too: 'He is – in height, weighing – kgs, of – body build giving him a body mass index of –. Gender neutral facial features facilitates his passing in the male role'. Hormonal intervention alters a person's physical appearance, but there are some features that cannot be changed, such as height and bone structure. Testosterone may induce a squaring of the jawline (through re-distribution of fat on the face) and receding of the hairline, as well as facial hair growth. Yet some people may blend invisibly into their non-birth-assigned sex without hormone supplementation (Billy Tipton, for example, or Gemma Barker; see: *The Girl Who Became Three Boys*, 2012). But 'facial features' do not exist in isolation.[8] Mol reminds us to 'keep the specificities of the imaging technique in mind' (2002: 162). The psychiatrist is assuming sex is both stable (that my facial features and his other physical assessments are fixed) and malleable (that I may 'pass in the male role'). But it is *in this process* that he is *making sex* all of these (mutliple) phenomena.

- Sex is facial features
- Sex is height
- Sex is body build

Something else is happening here too: the role of the psychiatrist is shifting. He is not (only) assessing my psychological competency and ability to give informed consent. He is scrutinising more than my 'feeling of being male', more than its

'evidence' in my self-presentation: He is judging (and enacting) my aesthetic and bodily maleness. What is sex so far?

- Reported at birth (according to visible genitals): F
- Hormone levels in the blood: F
- Breast prominence: F
- Body/facial hair patterns: F
- Body build: ?
- Dress: M
- Hair style: M
- Mannerisms: M
- Gait: M
- Height: ?
- Facial features: ?
- Feeling: ?

Transexuality makes visible the multiplicity of sex because these objects are scrutinised in a clinical context *and* because they *do not coordinate*. Transexuality is the clash of certain sex-objects. 'The difference between [objects] may not attract attention as long as the objects they enact coincide' (Mol, 2002: 51). The crucial question, then, is: *How are these contradictions managed?*

- Sex is diagnosable: ?

And then he tells me I need to see another psychiatrist:

> Given that his transgender treatments are likely to fall outside *the usual trajectory* for most trans-men i.e. testosterone therapy preceding chest reconstruction, I have asked [J.] to see my consultant colleague [...] for a second opinion. (Emphasis mine)

The SOC state that there are *a variety of treatment options*:

> After the diagnosis of GID is made the therapeutic approach usually includes three elements (sometimes labelled triadic therapy): a real-life experience in the desired role, hormones of the desired gender and surgery to change the genitalia and other sex characteristics [... Some] make more comfortable accommodation to their gender identities without medical interventions [... *T]he diagnosis of GID invites the consideration of a variety of therapeutic options*. (Meyer et al., 2002: 3–4; emphasis mine)

But does it, really, in practice? His requirement that I see a second psychiatrist shows how guidelines are enacted, and how different desires are marginalised, in practice. It is deflating and stressful.

A second psychiatrist

If the reason for psychiatric assessment prior to surgery was – as the first psychiatrist asserted – to check I was competent to provide informed consent, then I would need to see a second psychiatrist if the first psychiatrist was unsure *this* was the case. But the first psychiatrist states in his report that I *am* a competent adult 'of above average intelligence'. However this is not sufficient because my request for chest surgery (only) 'falls outside *the usual trajectory*'. What, then, is happening here? The diagnosis and its treatment trajectory are complicating matters. The second psychiatrist agrees to approve my request for surgery. He concludes:

> Although he has been binding his breasts on a regular basis, which he finds quite painful, he does not feel this is 100% effective and it still restricts what clothing he can wear. [... J.] does not wish to commence masculinizing hormones because of the risk of complications and side effects. [...] His rationale for undergoing surgery is entirely plausible and reasonable.

There it is, 'plausible and reasonable' – but what did I say to achieve that description, to impress that upon him? I lied. I said I didn't want to take testosterone 'for health reasons', not political reasons, or simply that it was not my preference. These are not legitimate reasons. Also, if binding was effective (effective at what? Looking a certain way or feeling a certain way?), would my request still be 'reasonable'? Transexuality is being made not just as the articulation of multiple sex-objects in alignment, but also as an *order of treatment*. Mol argues that in medicine two 'diverging signs cannot have a single object as their common source' (2002: 62). My desire for chest surgery and not testosterone is being read (and enacted) as two diverging signs: 1) wanting to change sex from female to male through chest surgery; and 2) not wanting to change sex from female to male through refusal to commence 'masculinizing' hormones. Yet, this divergence is being smoothed away by the *psychiatrists' rationalisations* – and they in turn are being enacted as mine ('*His* rationale'). STS scholar John Law notes that this is one way multiple objects are made to hang together: rationalisations serve to 'explain apparent inconsistencies away' (2004: 60). In this way, the 'apparent discrepancies' (to quote Law again, 2004: 74) of my narrative, 'case' and treatment trajectory are re-making transexuality differently. But to what effects?

Surgical sex(es)

I arrive at the surgeon's office on a Wednesday. When I attempt to register at reception, I am asked for a referral letter, which I do not have.

'It should have been forwarded to you,' I say.

The receptionist looks at me suspiciously and begins to make phone calls. Here, my transexuality is *administrative*. It is a letter from a psychiatrist (or two) stating

that I satisfy the diagnostic criteria required for treatment. Sex is bureaucratised: it is enacted across a range of documents and records.[9] When I ask the receptionist for any information on surgery (I think I say a double mastectomy), I am given a sheet on male to female genital surgery. Maybe it was an accident. But I think it's more likely that trans maleness continues to be invisible, even within this 'trans specialising' clinic.

I am not nearly so nervous as I was seeing the psychiatrists. The 'disease diagnosed and the disease treated are different objects' (Mol, 2002: 94). The surgeon's role is to treat, not to diagnose. Or so I think.

I enter the surgeon's office and he asks me why I am there. He sits behind a large, dark wooden desk. There is a human anatomy poster on the wall behind him. I sit in one of the two chairs in front of the desk. Chest reconstruction, I answer.

'Well what are you? You seem to be something in between, I mean, you look like a girl'. As Judith Lorber astutely notes, this kind of language consciously and deliberately devalues (1994: 100). *What to do?* There is a clash that must be managed – I say I am not planning to take testosterone, I am seeking chest surgery – will he do it? He asks to 'take a look' and I stand and undress from the waist up. I stare at the anatomy poster and try to think of my body as just that: *anatomy*. He grips both my breasts in his forefingers, assessing the tautness or elasticity of the skin, I assume. Constituting phenomena 'is also a matter of touch' (Mol, 2002: 88). I am being made an inverse-Galatea, his grip transforming me from subject to object.[10] He says results are usually good for people with my body shape (What is 'good' to him?). He says I should be taking testosterone.

'Have you ever done this surgery on someone not taking testosterone before?'.

'No'.

'Is it a problem?'.

He says again that I should take testosterone, otherwise 'what is the point?'.

He laughed when I said I wanted the surgery first, and fobbed me off.

Plastic surgeons (re)construct bodies *towards* cultural norms (Blum, 2003; Heyes, 2007; Jones, 2008) and, in so doing, these practices reiteratively constitute such norms (returning to Butler, 1993). Men who develop breasts may access plastic surgery to have their breasts removed. Women may obtain breast implants or reductions. These are the operations the surgeon performs. To the surgeon, I am 'something in between', and so which surgery is 'appropriate' for me? He says the waiting time for surgery is six months and that I should come back when I am taking testosterone. I pay for the appointment (> AUD200) and leave.

I think again about the SOC which state that 'gender variance among female-bodied individuals tends to be relatively invisible to the culture, particularly to mental health professionals and scientists' (Meyer et al., 2002: 3). How many people think I'm male when I'm in public, how I feel about myself, even how the psychiatrists have assessed my maleness – these sex-objects *are not here, they*

are somewhere else. I thought the place for me to prove my maleness was with the psychiatrists, and that that was over. But, again, I am wrong.

The psychiatrist told me that there is only one surgeon who performs the operation I am seeking, and that he only sees patients referred by this 'gender specialist team'. The gender team consists of the 'trans specialists' in the fields of psychiatry, clinical psychology, social work, endocrinology, speech pathology and plastic surgery. They collaboratively 'approve transition cases'. In my medical file, I see that the surgeon is listed as present at the meeting at which my 'case' is discussed and surgery approved. The date listed for the meeting is the night before my surgery consultation. On the meeting minutes, it says: 'Not taking hormones. Doesn't want them'. I assumed this clash would be discussed (and resolved) at that meeting; that is, that the rationalisations would be made and agreed to – isn't that the purpose of the team and the meeting? I assumed my approval and referral letter for surgery was the result of this agreement. But again, agreements at meetings or on paper are each only one enactment. What happens in the consultation is another. The surgeon writes to the psychiatrists the day I first meet with him:

> She has been dressing as a male for quite some time but still looks quite feminine. She has not commenced hormones and is somewhat reluctant to have Testosterone prior to her mastectomy. [. . .] I have not made any definite arrangements but await to hear from you again.

I hope that the female pronouns used here are, by now, as abrasive to you as they are to me. Pronouns are powerful enactments (see: Spade, 2011b; also, Halberstam, 2012). Another member of the gender team writes to the surgeon in response:

> This is to advise that the above patient was discussed by the team at the meeting of [. . .]. The patient was approved for Gender Reassignment Surgery, having fulfilled the required WPATH International Standards of Care. The patient has been referred to you for assessment and ongoing surgical treatment *as you think appropriate*. (Emphasis mine)

The multiplicity of these enactments becomes clear in this divergence between the surgeon's understanding of what makes a good candidate (someone using testosterone) and the gender team's view (someone 'having fulfilled the required WPATH International Standards of Care'). It appears the surgeon cannot abide a patient with this *clash*: discordance between hormone balance (female) and chest shape (male). The surgeon reveals that he too enacts transexuality, *and not only surgically*. His opinion of my (in)appropriateness for surgery is also *making transexuality*. The surgeon assumes (and enacts) transexuality as singular, stable and following a specific (and fixed) trajectory: a complete (or as complete as possible in his estimation) shift *from* female *to* male. That is, *my* remaking of transexuality is being challenged. In this way, the surgeon is limiting (*making limited*) trans possibilities: other trans desires are *being made impossible*. In particular, the possibility

of seeking explicitly *trans* (rather than male or female) interventions is foreclosed. Once again, I am on the brink of being refused. But I persist.

Later, at home, I phone the surgeon's office and make another appointment for a week later. When I return, the surgeon asks me if I am taking testosterone yet.

Every time I saw him he asked me if I was on T[estosterone] yet and when I would be.

I ask if he can do the surgery regardless. I argue that I want the surgery *first* and that I will take testosterone *later*. By suggesting my request is one distinct only *in chronological order*, I am trying to persuade the surgeon that the coordination he finds necessary will be realised eventually. (Importantly, I learned this narrative rationalisation from the psychiatrists.) He sighs and says yes. How is this agreement achieved? I am persistent. Persistence is a medically quantifiable object: remember *persistent discomfort*. Perhaps I enact my persistent discomfort in my persistence in obtaining this surgery? How much must one suffer to achieve *satisfactory persistence*? And *what is being lost* in my acquiescence to this narrative?

In the SOC, there is a 'clinical threshold' that specifies exactly *how much discomfort* is required: 'when concerns, uncertainties, and questions about gender identity persist during a person's development, become so intense as to seem to be *the most important aspect of a person's life*' (Meyer et al., 2002: 2; emphasis mine). So that is exactly how much. I certainly do not meet that requirement.

- The most important aspect of a person's life

The surgeon tells me the risks of surgery: I care about this (what is going to happen to my body, what *could* happen) but it is hard to listen. This is important because wasn't the very purpose of all these requirements 'informed consent'? Yet 'informed consent' is disappearing (it has been for some time) – how? By the time I am finally here, in the surgeon's office, I am worn down: the barrage of intrusive questions, the judgements of my looks, the pressure to acquiesce to a particular narrative I find politically suspect … I do not feel like he is trying to help me, or that I am assessing his suitability to work for me (*on* me). I feel instead as though I am begging him to agree to accept me as a patient and, thus, whatever he says, I shall go along with. *Perhaps I should seek a different surgeon? I could go somewhere else*. Could I? Would other surgeons be any different? And how much more work would that be (and cost)?

I return to the reception desk and make a booking for surgery. I request the earliest possible appointment. It is in five weeks' time (not six months – did he lie to me? Maybe his schedule opened up … but I doubt it).

Preparing for surgery

Breasts are considered a fundamental signifier of sex. And that is why in order to have my breasts removed I must convince a number of doctors that I am

actually male. This is the only way to obtain this operation. As you have seen, I cannot say, 'I am a woman and I would like not to have breasts'. But, and here's a secret, I don't *feel male*. I don't know what that means, and I have no idea how one would articulate such a feeling without reproducing sexist stereotypes and, in so doing, enact maleness as misogyny.

Three weeks later I must pay the surgeon (>AUD4000) and anaesthesiologist (>AUD2000) upfront and register at the hospital. My nervousness does not subside; in fact it develops into a red, itchy rash on my arms. I return to the doctor's clinic for pre-surgery blood tests and a chest X-ray and I show him my arms. He asks if I am allergic to anything or have started using any new soap.

'No, there's nothing like that. I think I'm nervous about the surgery'.

He says I am probably mildly allergic to something and suggests I take an antihistamine. It does not work.

The antihistamine keeps the itchiness at bay but the rash is spreading. I return to the clinic and see a different doctor. I explain to him that I am having surgery and am nervous about it. He also says that I am probably allergic to something and prescribes me a mild cortisone cream, which offers little palliation. My rash, too, is being distributed. I understand it as a physical expression of mental anxiety. To the general practitioners, it is entirely separate: it is a physical reaction to a physical stimulus. The treatment I am offered is physical: it suppresses the physical symptoms, but not very well. I am not offered anti-anxiety medication. This seems the perfect microcosm of my transexuality: the body is the object treated. Sometimes this makes sense and sometimes it does not.

Two weeks before my surgery date I am sent a 'Sex reassignment consent form' from the gender clinic. It must be signed by me, co-signed by a medical doctor and a solicitor and returned to the clinic before my surgery date. One of the stipulations I must sign off on is:

> I have had the International Standards of Care for transgender persons explained to me, and I acknowledge that these Standards of care have been adhered to by the doctors treating my gender identity disorder.

I sign the form and send it to a friend from high school who is now a solicitor.[11] My friend signs the form for me and sends it via Express Post to the clinic.

- Sex is having the right paperwork

In the hospital

I must pay upfront for my stay (theatre fees > AUD2000; hospital stay > AUD800 per night). I am shown to a semi-private room where there is another patient behind a curtain. I am given a cotton gown, told to put it on and to

'try to relax'. A nurse comes by and asks me some questions: am I allergic to any medications, what surgery am I here for –

'Double mastectomy'.

'Both breasts?'.

'That's right'. She takes my blood pressure and notices the red, blotchy rash on my arm.

'You're quite nervous aren't you?'.

'Yes'. *I'm having major surgery. A part of my body is about to be amputated!* And here's another secret: I think as well – *For what? To look different? Is this all worth it?*

The surgeon comes by and says he will mark me before they give me something to calm me down. I take off the gown and he draws on me with a thick, blue permanent marker. His hands are rough and so are his sketches. I look down and see that the rash covers my breasts and chest. I wish I could ask how I will be cut. I wish I could take photos, but I am alone, and I am not that brave. It is all I can manage to just be here, enduring.

I am taken into the operating theatre in the evening and the surgery lasts about three hours. I am the third of the surgeon's three patients for the day. I wonder how my sex was enacted in the operating theatre. To the anesthesiologist, who monitors my heart rate and rhythm, breathing, blood pressure and body temperature, I suppose the norms I must be compared to are 'female'. But to the surgeons, even if the breast removal may be coordinated female (through disease for example), my chest is *reconstructed as male*. This happens a number of ways, by: leaving some remnant upper pole breast tissue (this is not done in female mastectomies); removing, trimming and reattaching the nipple-areola complex 'in a male position'; and by making the incisions along the ridges of the underside of my pectoral muscles (the inframammary fold), resulting in scars that follow the shape of the muscle (see for example: Berry et al., 2012).

- Sex is (not) having breasts: M
- Sex is nipple size: M
- Sex is nipple position: M

When I wake up outside the theatre, I hear a male nurse exclaiming: 'What is that!?'. A female nurse replies, 'Breast tissue'.

I want to see it. I want to know how big it looks outside my body. I want to take it home. I cannot speak however. When they notice I am stirring I am wheeled back to the room. I wish I could have seen the surgery. Seen the cuts, the removal of tissue. I have seen photographs of the procedure (especially Kotula, 2002) and I try to imagine it. I look down and see my bandaged chest: Flat.

- Sex is chest shape: M

The following day, my wardmate is receiving visitors behind the curtain. I learn that he has undergone the same operation as me. He is talking to someone about

taking testosterone: He says he has taken only a low dose and will probably stop now that he has had this surgery. I wonder if he would have taken testosterone if he thought he could obtain this operation without doing so.

A male chest

Ten days after the surgery, I see a second surgeon to have the stitches removed. This surgeon was the assisting surgeon for the operation. When I enter his office, he says 'Now what can I do for you, young lady?'.

It is a patronising way to speak to an adult. He might flatter teenage girls this way, but I am twenty-five. This surgeon makes it clear to me that, to him too, I look like a girl.

'I just need to get my stitches out'.

I take off my shirt and compression vest and lie on a table. The rash is completely gone. I have questions, 'How many stitches did I have?'.

'A lot'.

I want the details. My chest is very numb. I will come to learn that this is the dulled sensation of scar tissue. As I am leaving he calls me 'boss'. It is also patronising. But its iteration is *an enactment of maleness*. Has the surgery made me male? Or his observation that I have undergone the surgery, an operation available only to (trans) men? Perhaps he looks at my file on his desk and sees I have the psychiatric referral letters, but I don't think so. There is a clash between how he perceives me and the surgery I have received. A clash cannot be static. The performative iterations of sex must be managed: the surgeon greets a female patient, he sees the patient has undergone a male procedure, he corrects himself. My legibility as male is *increased* by the surgery. But it is not unambiguous. Sex, to borrow from Mol, is 'more than one – but less than many' (2002: 55).

(Re)making sex and transexuality

In this article, I have destabilised assumptions about what sex (and transexuality) *is*, arguing that both are not stable, 'natural', singular or pre-determined. Following the works of Butler and Mol, sex and transexuality can be more usefully understood as phenomena being made and remade multiply in (clinical) practices (and beyond).

In `the manuscript`, I emphasise how assertive I needed to be in order to avoid rejection – rejection I felt constantly on the precipice of receiving from all the medical professionals I encountered. The way this pressure shaped my clinical encounters, and how I adjusted my story accordingly, reveals how difficult it is to obtain trans medical interventions if you do not want *them all* or if the dominant, conventional narrative does not describe your experience. This shows how sex is shaped, enacted and *made* in these clinical processes and continues to be enacted as singular (stable, coherent, binary, stereotypical and sexist) even by 'gender specialists' who, in so doing, reiterate it. In my experience, these clinical professionals wanted as many sex-objects as (they deemed) possible to change in

order to *align*: Testosterone therapy must accompany (and preferably predate) chest surgery. They also demanded sex be articulated in a specific way; hardly different from how Benjamin first articulated transexuality in 1966 in his treatment guidebook *The Transsexual Phenomenon* (see: Stone, [1991] 2006; Latham, forthcoming). But something else happened too. I *did succeed*. Even though both the surgeon and the psychiatrists *at first* did not support my application for surgery without hormones, *eventually* they did. How did I achieve this? I persisted. I outlined to them details of the SOC (that they purport to comply with):

> the [SOC] guidelines recognise there isn't a specific trajectory or order in which certain medical interventions need to take place. I had to mention this repeatedly, and it tended to be reacted to with astonishment.

I argued my case. In his final post-surgical letter, the surgeon reports:

> I have again raised the possibility of her commencing Testosterone in the not too distant future. She seems rather reluctant to consider this and I really wonder what her final aims are. She certainly seems to be very fixed in her ideas.

How different a sentence sounds if phrased: 'He certainly seems to be very fixed in his ideas'. Yet in the articulation of his suspicions ('I really wonder what her final aims are'), we can see something more. The surgeon expects that his work changes/corrects one sex-object (breasts), *while the others are altered elsewhere* (presumably by hormone use, and preferably first). It appears he cannot make sense of someone who has undergone *only* this surgery – and certainly not by using the pronoun 'he'. The surgeon makes almost explicit his frustration and resentment of having undertaken a 'sex-changing' procedure that appears not to have altered his patient's sex. In this frustration, we can see how (trans) medicine aims at (re)producing stereotypical sex categories, but also how patients *exceed* these expectations and can produce new trans ontologies.

As sex is multiply enacted, it also hangs together. A praxiography lets us see *how* by examining the terms of specific contexts and mundane, everyday practices. This takes work: you (I, we) must make sex and transexuality fit within the realm of comprehensibility. In medical treatment (and in life) the question is always: What to do? How to move forward? When there is a clash – and there are many – something happens: sex-objects are moved, re-read, re-aligned; *something changes*. I shifted my narrative by articulating my desire for chest surgery as an *alternative order of treatment*, rather than as an end in itself. And it worked. Practices don't change radically, they change slightly, marginally; one encounter at a time.

Transexuality is a productive site for understanding how sex is made in medicine and how this shapes what is possible, not only for trans people who seek medical interventions, but more widely. Transexuality has a specific clinical trajectory, but I have used this medical narrative as a way to show how sex is enacted multiply and hangs together across a range of processes, practices and encounters not

limited to (trans) medicine. By theorising sex as ontologically multiple, as I have done, we might better understand how medicine *acts* to produce sex in specific (and often oppressive) ways. This will better equip us to open up not only trans possibilities in seeking medical interventions, but how we understand (and enact) sex categories elsewhere. If sex is constituted as stable, singular and binary (as it is in medicine), then, of necessity, any process of 'changing sex' must conform to a very narrow bridge from 'one sex' to 'the other'. This is how trans medicine continues to be practiced. Trans medicine, and the surgeon is metonymic of this, *aims* to make sex according to material-discursive, socio-biological stereotypes, but 'practice is never so certain that it might not be different' (Mol, 2002: 164). A praxiography shows *how* these practices make some trans ontologies possible and foreclose others, as well as *how alternatives might be made viable*.

What did I make possible? The psychiatrists, the surgeon, all told me I was 'the first'; the first person to receive this surgery without taking testosterone (at this clinic). Others have told me since that they, too, have achieved this goal. Like Fausto-Sterling, I want to suggest that 'certain entrenched medical practices be reconsidered, both for the benefit of the patient and for the welfare of our culture as a whole' (1993: 4). What might it mean to take seriously trans multiplicity in medical practice and beyond? Current clinical practices restrict our ability to know what trans people want, and how trans people understand (and make sense of) our bodies in many, alternative ways. This makes changing these treatment practices urgent. How might medicine (and its practitioners) rethink (and re-produce) managing transexuality and trans patients accordingly? How can we, as feminist theorists, challenge and hold to account medical treatment practices that further oppress those at the margins? How might we shape and remake sex in more ways?

My intention in publishing `the manuscript` was to help those whose desires, like mine, do not follow 'the usual trajectory'. Yet my difficulties in having it published, even on a trans website, limits its *impact*: the potential of shifting the boundaries of what sex (and transexuality) is (and can be) is restricted by the limit of one's reach. I hope in publishing this article that the reach (and 'effects') of these remakings will be expanded.

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Notes

1. My intention in using 'transexuality', rather than the more popular 'transgender', is to emphasise how sex is enacted multiply in various treatment processes. While 'transsexual' has been used to differentiate those trans people who pursue medical interventions (especially genital surgeries) from those who do not, this is not how I am using this term. On the contrary, there are many nonsurgical ways to change sex, some of which I have outlined elsewhere (see: Latham, 2016).
2. I use 'phenomena' here to signal objects, subjects, discourses, events and so on, following Karen Barad as articulated through her theory of 'agential realism' (2007). My work here is informed by Barad's, yet a more explicit engagement is beyond the scope of this article.
3. The very term 'treatment' implies a pre-existing condition, and constructs that condition as a deficit. I challenge the appropriateness of this way of thinking about disease in general, and transexuality in particular, throughout this article.
4. I use 'auto trans studies' to specify trans work done by trans people that makes explicit their own experiences.
5. On using autoethnography as a way into protected relationships, such as that of doctor-patient, see Chang (2008: 50–51). On the ethical politics of autoethnography, and in particular representing others, see Chang (2008: 54, 68–69) and Tullis (2013).
6. The time I was experiencing these clinical encounters was prior to the release of the *DSM-5* (APA, 2013) and the SOC-7 (Coleman et al., 2012). However, its relevance persists, as trans scholars Zowie Davy and Eliza Steinbock assert, 'this redrawing of the boundaries of sexual pathologies also keeps the universality of transgender pathology current' (2012: 274).
7. Both this psychiatrist and, later, the surgeon tell me that there is no one performing female-to-male genital surgeries in Australia. The surgeon says this is because 'there's no point'.
8. My own reading of my 'facial features' materialises through the similarities I have with my sister (and the ways they have always been described to me). Skull X-rays would reveal similar bone structures indicative of our shared genetic heritage: we appear to have almost identical noses, lips, eyes and chins, though she has slightly more prominent cheekbones and straighter teeth. Yet we are very different in many ways: Amanda has long, bleached-blonde, flat-ironed hair and she guffaws often. I have shortish, scruffy hair and I scowl. She shapes her eyebrows so that they are very narrow and round. I do not. When the psychiatrist suggests I have gender-neutral facial features, he is seeing my face through the encounter in which we meet and the context of many other ways I present myself, but he reports these observations as though they are predetermined and biological 'facts'. I doubt he would describe my sister's facial features as 'gender-neutral'.
9. For a comprehensive examination of the effects of 'administrative violence', see Spade (2011a). See also Salamon (2010: 179–182).
10. For a discussion of how roles in this mythological story play out in contemporary cosmetic surgery material-discursive practices, see Jones (2008: 'Morphing Industries', 59–81).
11. I have this *privilege*: I went to a high school where the likelihood of graduates becoming lawyers was substantially higher than elsewhere. But what if I hadn't? What if I had had to explain my transexuality all over again to another complete stranger: to produce a

story that makes sense *to a lawyer*? Transexuality would be something else again. It is a relief to avoid this. And there are a lot of difficulties I do avoid. My story is a speedy one and an easier one than that experienced by the vast majority of trans people. Yet, for this very reason, the difficulties I articulate here reveal the urgent need to rethink clinical practices, and it is a place to start.

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