



Special Series: Disability and Surgery

Queer crip: Rethinking bioethics of surgery for gender and sexual variance

Tiia Sudenkaarne, DrSocSci^{a,b,*}^a Department of Sociology, University of Helsinki, Helsinki, Finland^b Department of Gender Studies, Tampere University, Tampere, Finland

ARTICLE INFO

Article history:

Accepted 3 June 2022

Available online 19 July 2022

I invite surgeons to contribute to the medical model of gender and sexual variance, bioethically building from queer bioethics and crip views that question compulsory abled-bodiedness paired with compulsory abled-mindedness and cis- and heteronormativity. I discuss how founding bioethics on gender and sexual variance instead of cis- and heteronormativity is better attuned to the factual cornucopia of human gender and sexuality and increases human flourishing. I conclude that although surgical cures must be offered as medically necessary to those who desire them, such cures must be based on individual treatment plans. Bioethics should dismiss curing gender and sexual variance through surgery as a normalizing effort. I encourage further queer crip investigations into surgery.

Introduction

Gender and sexual variance have continued to be medicalized and pathologized in a bioethically questionable way. Surgical interventions are in the core of these ethical debates, ultimately about normativity of normality. In this paper, I wish to offer a critical glimpse of normality as more relational and political than strictly medical. I discuss how compulsory cis-embodiment and heterosexuality intertwines with compulsory abled-bodiedness and abled-mindedness in the service of normativity; how terms such as queer, cripple, defective, deviant, and sick have been used to objectify people whose bodies, minds, desires, and practices differ from the norm.¹

Cis- and heteronormativity refers to the false legitimacy granted to organize medical practices, systems, and policies based on

assuming that the binary understanding of gender and sexuality promotes good life and ethics. Both of these assumptions are false based on the research on LGBTQI+ (including, but not limited to, lesbian, gay, bisexual, transgender, queer, and intersex people) people's lives² and looking at the ethical analyses building on gender and sexual variance as a human right.³ Building an ethics on gender and sexual variance embedded in human rights would reduce the risk to suffer harms based on gender and sexual variance.

I used the rhetoric of curing and caring. Both can be equally potentially harmful from an LGBTQI+ human rights standpoint. I object surgical normalizing cures for gender and sexual variance as they build on the bioethical notion of eradicating gender and sexual variance for cis- and heteronormativity. Instead, I promote consent-based surgery as a part of tailored care plans. The bioethical sustainability of such plans must be crucially informed by queer and crip notions. "Queer" and "crip" elide commonly in the literature, and, because they "share a striking range of political and imaginative affinities,"⁴ provide a substantial prism with which to look at surgery and disability.

Bioethical issues with current medical models

Sexual orientation (defined as an individual's erotic response tendency or sexual attractions) and gender identity (defined as one's sense of one's gender, binarily either male or female) have been regarded as separate categories only relatively recently.⁵ In both the globally influential International Classification of Disease and the Diagnostic and Statistical Manual of Mental Disorders, gender diversity emerged into diagnostics on its own right via the theories of "transsexuality" in the 1920s. The clinical category of "intersex" was introduced via psychosexual "disorders" defined as "physical abnormalities of the sex organs."^{6,7} The categorization of gender variance has shifted from "disorder" to "incongruence" and

* Reprint requests: Tiia Sudenkaarne, DrSocSci, Department of Sociology, University of Helsinki, PL 18, 00014 Helsinki, Finland.

E-mail address: tiia.sudenkaarne@helsinki.fi.

“dysphoria.”⁶ Although homosexuality has been removed from both the International Classification of Disease and the Diagnostic and Statistical Manual of Mental Disorders, homosexuality does not exhaust sexual variance, and sexual orientation change efforts, which are practices that attempt to influence individuals to change from any nonheterosexual orientation to a heterosexual orientation, are a constant, global threat to queer people’s wellbeing.^{8,9}

Gender variance is in the particular interest of surgery as gender is sometimes considered to be “reassigned” or “affirmed” either for an intersex baby with an atypical gender physiology, or later in life based on the incongruence between one’s “experienced gender and the assigned sex,”¹⁰ usually with the rationale that this incongruence causes significant distress (dysphoria).¹¹ These practices entail dualist notions of the body and mind,¹² may grossly infringe on bioethical principles, and further, through psychiatric gatekeeping of the eligibility for transition treatments, intertwine compulsory able-mindedness with able-bodiedness.¹

Intersex activists oppose nonconsensual shaping technologies—including surgery—primarily because they are harmful physically, emotionally, and sexually. The utmost concern, then, is the right to bodily integrity, followed by that to gender identity.⁷ Thus, intersexuality can be seen primarily as a problem of stigma and trauma, not gender. Assuming that intersex individuals in need of health care should be given a diagnosis, post-traumatic stress disorder seems the most appropriate, because it is about trauma, not about gender.⁷ Furthermore, it represents a normal reaction to an abnormal situation, not a pathology in itself. The abnormal situation here is the violence inherent to nonconsensual treatments.¹³

Activists have sustained that queer, transgender, and intersex people actualize their embodied needs rationally, even euphorically, and follow unexpected desires.¹² In gatekeeping the access to transgender health care, the dominant narratives of being “born this way,” having an awareness of one’s trans identity from a young age, being “trapped in the wrong body,” and desiring to surgically and hormonally transform one’s body to the “opposite sex,” considered “transnormativity,” can augment the harm. Crucially, these narratives form the basis of a diagnostic criteria that assesses the authenticity of a patient’s gender dysphoria or incongruence. They reinforce the notion that there would be only 2 genders, affect how medical personnel interact with trans-identified clients, position gender as biologically determined, and often set the desire for surgical shaping as a defining factor.^{12,14,15} A person with a binary-conforming trans narrative is privileged and legitimized by medical discourses over nonconforming ones, as the former’s desires are more uninterruptedly computable to clinicians operating with cis- and heteronormative, ableist bioethics matching right bodies with right minds.¹⁴

Queer and crimp cures

Queer bioethics crucially asks us to consider, in combination with recent disability bioethics and crimp theory, the value and the subjectivity of non-normative, noncisgendered bodies and anatomies, and the clinically normative ways in which non-normative embodiment continues to be inappropriately objectified as urgently in need of curing.¹⁶ It challenges the politics of normativity and reveals the discriminative and unjust practices in health care and also the presumptive legitimacy of the normative.¹⁷

In many countries, due to an abundance of excellent LGBTQI+ activism and theory, gender diverse people can now have, for example, hormone supplementation and surgical procedures covered.^{12,18} In the context of transgender individuals, it must be acknowledged that not all transgender people experience dysphoria or incongruence, and the availability of such diagnostic categories does not exhaust the queer bioethics agenda. In the

context of intersex, it is likely that some intersex people desire shaping surgeries and others do not.¹⁹ Patient and care provider decision making is constrained by a lack of strong outcomes data to support the conclusion that normalizing surgeries improve psychosocial functioning at best, and can do grave psychosocial, emotional, and physical harm at worst.^{19,20} A criteria for surgical shaping and body modification that is less attuned to gender and more attuned to queer and crimp bioethics would build on the appreciation of non-normative bodies as legitimate, appropriate, and neutral. In turn, this criterion would justify the claims of gender-fluid people and nonbinary transgender persons to access shaping technologies (eg, surgery) and further justify leaving intersex embodiment a priori unharmed by them.

Perhaps we ought to consider changing the minds of those who hold the hurtful and mistaken ideas about atypical bodies before we impose change on the bodies of people with atypical bodies.²¹ Surgery for gender variance should be understood as technological shaping that always exceeds medical fact and includes relational, political, and normative elements. It should not be considered a cure for gender and sexual variance either through conflating gender with sex, through imagined shaping of the biological sex to match the social gender, or through the violent shaping nonbinary gender physiology prior consent. Instead, surgery needs to be considered as a part of tailored, consensual care for the individual patient.

Funding/Support

This work has been funded by Academy of Finland project (no. 324322) Social Study of Antimicrobial Resistance; Healthcare, Animals, and Ethics and by Kone Foundation project (no. 321711) Technology, Ethics and Reproduction: Controversy in the Era of Normalisation.

Conflict of interest/Disclosure

The authors have no conflicts of interests or disclosures to report.

References

1. Kafer A. *Feminist, Queer, Crip*. Bloomington, IN: Indiana University Press; 2013.
2. Jones BA, Bouman WP, Haycraft E, Arcelus J. Mental health and quality of life in non-binary transgender adults: a case control study. *Int J Transgend*. 2019;20:251–262.
3. Duffy S. Contested subjects of human rights: trans and gender-variant subjects of international human rights law. *Mod Law Rev*. 2021;84:1041–1065.
4. Fritsch K, McGuire A. Introduction: the biosocial politics of queer/crimp contagions. *Feminist Formations*. 2018;30:vii–xiv.
5. Sudenkaarne T. Queering medicalized gender variance. *Ethics Med Public Health*. 2020;15:1–8.
6. Drescher J. Queer diagnoses: parallels and contrasts in the history of homosexuality, gender variance, and the diagnostic and statistical manual. *Arch Sex Behav*. 2010;39:430–436.
7. Krauss C. Classifying intersex in DSM-5: Critical reflections on gender dysphoria. *Arch Sex Behav*. 2015;44:1147.
8. Gamboni C, Gutierrez D, Morgan-Sowada H. Prohibiting versus discouraging: exploring mental health organizations varied stances on sexual orientation change efforts (SOCE). *Am J Fam Ther*. 2018;46:96–105.
9. Przeworski A, Peterson E, Piedra A. A systematic review of the efficacy, harmful effects, and ethical issues related to sexual orientation change efforts. *Clin Psychol*. 2021;28:81.
10. WHO. International classification of diseases (11th ed.). <https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/90875286>. Accessed January 6, 2021, 2019.
11. APA. *Diagnostic and statistical manual of mental disorders* (5th ed). Washington, DC: 2013. <https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria>. Accessed February 13, 2021.
12. Davy Z. The DSM-5 and the politics of diagnosing transpeople. *Arch Sex Behav*. 2015;44:1173.
13. Fassin D, Rechtman R. *The Empire of Trauma: An Inquiry Into the Condition of Victimhood* (R. Gomme, Trans.). Princeton, NJ: Princeton University Press; 2009.

14. McKinnon RK. Pathologising trans people: exploring the roles of patients and medical personnel. *Theory Action*. 2018;11:74–96.
15. Vipond E. Resisting transnormativity: Challenging the medicalisation and regulation of trans bodies. *Theory Action*. 2015;8:21–44.
16. Tunstall E, Moore SK, Wahlert L. Intersex in the age of queer bioethics: recommendations on the fundamentals of ovotestes interventions for intersex youth. *SQS Suomen Queer-Tutkimuksen Seuran Lehti*. 2018;12:2.
17. Wahlert L, Fiester A. Queer bioethics: why its time has come. *Bioethics*. 2012;6:iv.
18. Bray S. Gender dysphoria, body dysmorphia, and the problematic of body modification. *J Spec Philosoph*. 2015;29:425.
19. Parens E, ed. *Surgically Shaping Children: Technology, Ethics, and the Pursuit of Normality*. Baltimore, MD: Johns Hopkins University Press; 2006.
20. Feder EK. *Making Sense of Intersex: Changing Ethical Perspectives in Biomedicine*. Bloomington: Indiana University Press; 2014.
21. Dreger AD. What to expect when you have the child you weren't expecting. In: Parens E, ed. *Surgically Shaping Children: Technology, Ethics and the Pursuit of Normality*. Baltimore: Johns Hopkins University Press; 2006:253–267.