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My New Vagina Won't Make Me Happy

And it shouldn't have to.

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By Andrea Long Chu
Ms. Chu is an essayist and critic.

Next Thursday, I will get a vagina. The procedure will last around six hours, and I will be in recovery for at least three months. Until the day I die, my body will regard the vagina as a wound; as a result, it will require regular, painful attention to maintain. This is what I want, but there is no guarantee it will make me happier. In fact, I don't expect it to. That shouldn't disqualify me from getting it.

I like to say that being trans is the second-worst thing that ever happened to me. (The worst was being born a boy.) Dysphoria is notoriously difficult to describe to those who haven't experienced it, like a flavor. Its official definition — the distress some transgender people feel at the incongruence between the gender they express and the gender they've been socially assigned — does little justice to the feeling.

But in my experience, at least: Dysphoria feels like being unable to get warm, no matter how many layers you put on. It feels like hunger without appetite. It feels like getting on an airplane to fly home, only to realize mid-flight that this is it: You're going to spend the rest of your life on an airplane. It feels like grieving. It feels like having nothing to grieve.

Many conservatives call this crazy. A popular right-wing narrative holds that gender dysphoria is a clinical delusion; hence, feeding that delusion with hormones and surgeries constitutes a violation of medical ethics. Just ask the Heritage Foundation

fellow Ryan T. Anderson, whose book "When Harry Became Sally" draws heavily on the work of Dr. Paul McHugh, the psychiatrist who shut down the gender identity clinic at Johns Hopkins in 1979 on the grounds that trans-affirmative care meant "cooperating with a mental illness." Mr. Anderson writes, "We must avoid adding to the pain experienced by people with gender dysphoria, while we present them with alternatives to transitioning."

In this view, it is not only fair to refuse trans people the care they seek; it is also *kind*. A therapist with a suicidal client does not draw the bath and supply the razor. Take it from my father, a pediatrician, who once remarked to me that he would no sooner prescribe puberty blockers to a gender dysphoric child than he would give a distemper shot to someone who believed she was a dog.

Naturally, a liberal counternarrative exists, and it has become increasingly mainstream. Transgender people are not deluded, advocates say, but they *are* suffering; therefore, medical professionals have a duty to ease that suffering. In this view, dysphoria is more akin to a herniated disc — a source of debilitating but treatable pain. "Gender dysphoria can in large part be alleviated through treatment," states the World Professional Association for Transgender Health in its Standards of Care. Dr. John Steever, an adolescent medicine specialist at the Mount Sinai Center for Transgender Medicine and Surgery in New York City, told The Times last month that a gender-affirming approach seeks to "prevent some of the traditional horrible outcomes that transgender or gender-nonconforming youth have ended up with," including increased rates of depression, suicidal ideation and substance abuse.

A gender-affirmative model will almost certainly lead to more and higher-quality care for transgender patients. But by focusing on minimizing patients' pain, it leaves the door open for care to be refused when a doctor, or someone playing doctor, deems the risks too high. This was the thrust of a recent Atlantic cover story in which the journalist Jesse Singal used the statistically small number of people who have come to regret their medical transitions to argue that transitioning is "not the answer for everyone." There was a dog whistle here: Hormones and surgery can and should be withheld from patients who want them when such treatments cannot be reasonably expected to "maximize good outcomes."

Mr. Singal is Mr. Anderson's liberal doppelgänger. Both writers engage in what we could call "compassion-mongering," peddling bigotry in the guise of sympathetic concern. Both posit a medical duty to refrain from increasing trans people's suffering — what's called nonmaleficence. Neither has any issue with gatekeeping per se; they differ, modestly, on how the gate is to be kept.

Buried under all of this, like a sober tuber, lies an assumption so sensible you'll think me silly for digging it up. It's this: People transition because they think it will make them feel better. The thing is, this is wrong.

I feel demonstrably worse since I started on hormones. One reason is that, absent the levees of the closet, years of repressed longing for the girlhood I never had have flooded my consciousness. I am a marshland of regret. Another reason is that I take estrogen — effectively, delayed-release sadness, a little aquamarine pill that more or less guarantees a good weep within six to eight hours.

Like many of my trans friends, I've watched my dysphoria balloon since I began transition. I now feel very strongly about the length of my index fingers — enough that I will sometimes shyly unthread my hand from my girlfriend's as we walk down the street. When she tells me I'm beautiful, I resent it. I've been outside. I know what beautiful looks like. Don't patronize me.

I was not suicidal before hormones. Now I often am.

I won't go through with it, probably. Killing is icky. I tell you this not because I'm cruising for sympathy but to prepare you for what I'm telling you now: I still want this, all of it. I want the tears; I want the pain. Transition doesn't have to make me happy for me to want it. Left to their own devices, people will rarely pursue what makes them feel good in the long term. Desire and happiness are independent agents.

As long as transgender medicine retains the alleviation of pain as its benchmark of success, it will reserve for itself, with a dictator's benevolence, the right to withhold care from those who want it. Transgender people have been forced, for decades, to rely for care on a medical establishment that regards them with both suspicion and condescension. And yet as things stand today, there is still only one way to obtain hormones and surgery: to pretend that these treatments will make the pain go away.

The medical maxim "First, do no harm" assumes that health care providers possess both the means and the authority to decide what counts as harm. When doctors and patients disagree, the exercise of this prerogative can, itself, be harmful. Nonmaleficence is a principle violated in its very observation. Its true purpose is not to shield patients from injury but to install the medical professional as a little king of someone else's body.

Let me be clear: I believe that surgeries of all kinds can and do make an enormous difference in the lives of trans people.

But I also believe that surgery's only prerequisite should be a simple demonstration of want. Beyond this, no amount of pain, anticipated or continuing, justifies its withholding.

Nothing, not even surgery, will grant me the mute simplicity of having always been a woman. I will live with this, or I won't. That's fine. The negative passions — grief, self-loathing, shame, regret — are as much a human right as universal health care, or food. There are no good outcomes in transition. There are only people, begging to be taken seriously.

Andrea Long Chu is an essayist and a critic. Her book "Females: A Concern" is forthcoming.