Messing With Medicine:
Disruptions of Medical Systems in Online Communities of Trans People

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TABLE OF CONTENTS

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Introduction

Is medicine working? This could be a question of whether a pharmaceutical is effective, a surgery is safe, or if an inoculation has stopped an epidemic in its tracks. But on a more fundamental level, there is a question of whether medicine—its technologies, its laborers, its diagnoses, and its hierarchies of power—is truly improving health and lives. Of course, if it's not, we have a problem—unlike some problems, we can't simply do away with medicine entirely. The more specific question is thus: is medicine working as well as it needs to for the people who need it?

This thesis examines trans and genderqueer online communities, and people whose lives are frequently entangled with medicine and medical systems to better understand their answer to this question. For these trans people, medical systems have serious failings—and one response to such failings is a radical, sexual, performative disruption of medicine and medical hierarchies that I call, tongue-firmly-in-cheek, "medicinefuck." My theory of medicinefuck shares many features with another movement in trans communities called "genderfuck," which is another radical disruption, but aimed at gender instead. Genderfuck goes by other names—including genderbending or gender hacking, but I have chosen the vulgar form for two reasons. Firstly, genderfuck is more frequently used in the communities I look at; and second, I view the use of a violent sexual expletive to describe this disruption of gender as deeply meaningful wordplay. Equally, for medicinefuck, I could use "medicine hacking," or "open-source medicine," both of which have pleasing allusions to the technological dependencies of this medical disruption and acknowledge the anti-profit and not-always-legal aspects of this disruption. But medicinefuck (and genderfuck) is a provocative performance with uncertain results—to elide the sexual aspects and connections by refusing the expletive is a critical and analytical failure.

I draw medicinefuck from examinations of trans communities talking about health care, on Reddit, a forum ecosystem; and YouTube, a video-sharing platform. In these communities, medicinefuck modifies how individuals learn medical information, guides them in interacting with medical actors and institutions, and disrupts, if not destroys, the power dynamic between doctors and patients. While for trans communities and trans people, medicinefuck seems to have mostly positive impacts, its effects can be uncertain, which is especially true in non-trans/gender-affirming care contexts.

This thesis has 3 chapters. Chapter I is an introductory context of some trans theory and gender-affirming care, and then the concept of genderfuck from which medicinefuck is drawn. Chapter II is a deep dive into medicinefuck, starting with it's links to genderfuck and an in-depth description. Then, Chapter II discusses YouTube and Reddit and their trans communities, looking at how they are designed to foster certain types of communities, which modifies the medicinefuck (and general activity) on them. Then, with a brief digression to discuss non-medicinefuck disruptions of medicine, Chapter II ends with medicinefuck grappling with its mattering and importance by interacting with existing strands of trans and feminist theory. Chapter III features four close readings: a YouTube video blog from a popular transfeminine influencer; a Reddit user seeking advice on her transition; a YouTube vlog about self-medication by a trans man; and an online seminar (or webinar) from a hospital system on hormone therapy for trans people. These close readings are opportunities for in-depth understanding of medicinefuck and the ambiguous impacts of medicinefuck.

0.1 *A Note on Terminology and Theoretical Approach*

Transgender, transsexual, trans*, trans, genderqueer, gender variant, and gender nonconforming are all terms used variously—but not interchangeably—to refer to parts or the entirety of a diverse community of people who for many reasons do not align with a strict, binary, and unchangeable conception of gender. Nearly all writing about transgender lives begins with a definition of transgender, which seems ever elusive and constantly contingent.

This search for definition makes sense—it is often assumed to be vital to have a stable foundation on which to build theories. For my purposes, the transgender community includes everyone who, for any reason, may have sought, be seeking, or may seek in the future "care" (medical, social, mental—*techne*) that affirms that person's gender identity.

In general, I refer to transgender people as trans people in acknowledgement that the trans community contains people who are moving across many different substrates, including gender. Trans is an identity, an action, and sometimes an object or institution, and leaving it incomplete (as opposed to transgender, transexual) reminds us that trans is incomplete. At times, I include the label genderqueer, which aims to acknowledge that many journeys don't have destination, and are simply "movement[s] across a socially imposed boundary away from an unchosen starting place"[1]. In other words, this is a conscious effort to include nonbinary and genderqueer people, who have their own valuable experiences and who are at times excluded from the larger trans community.

Another important consideration is my own identity as a cisgender man. Cisgender is a term with its own host of problems, as outlined by A. Finn Enke: it implies a binary of cis-/trans-ness; it implies cis- is—as the Latin translates—constant and static in meaning and context; and through its use reproduces traditional and regressive politics of gender and sex[2]. I am fortunate that I can mostly avoid this term, but despite its problems (or perhaps its problems are its design), I should acknowledge that in many respects I am a cisgender voyeur. In this, I look towards Sandy Stone and Jacob Hale's *Suggested Rules for Non-Transsexuals Writing about Transsexuals, Transsexuality, Transsexualism, or Trans* _____. for several important guidelines for my writing:

> Don't erase our voices by ignoring what we say and write… by insisting that we must have academic credentials if we are to be taken seriously… Beware of replicating the following discursive movement: Initial fascination with the exotic; denial of subjectivity, lack of access to dominant discourse; followed by a species of rehabilitation… Don't totalize us, don't represent us or our discourses as monolithic or univocal; look carefully at each use of 'the', and at plurals… Don't uncritically quote non-transsexual "experts"…

> Start with the following as, minimally, a working hypothesis that you would be loathe to abandon: "Transsexual lives are lived, hence livable".[3]

This thesis contains a multitude of quotes from complete strangers—strangers both to me, and on the pseudo-anonymous environments that I look at, strangers to everyone else. I have tried to grasp their meaning and respect their intentions. Because of my language limitations, I examine only English-speaking communities, and in general, I assume that members are from Anglophone countries. This is not to deny the vibrant trans communities across the world who do not use English, nor the possibility that community members on a global internet have equally global nationalities. This project, while intimately tied to trans communities, is also a project following Stone and Hale's rule that research looking at trans communities should seek what those communities tell about the other, not what it tells about trans[3]. This "tell about the other" concept underlies an important aspect of my theorizing: while medicinefuck is deeply linked to genderfuck, and present—and more importantly, easily visible—across trans communities, it is not exclusive to trans communities.

Finally, while genderfuck, medicinefuck, and this thesis are at times humorous and playful, and utilize humor as crucial tools in their disruption, the matter at hand is serious. Trans people have much higher rates of anxiety, depression, self-harm and suicide compared to the general population[4–6]. Trans people face serious societal discrimination and transphobia for expressing their gender identity. Across the world, trans people are frequently more legally precarious than any other queer minority. Transmisogyny—bigotry rooted in both misogyny and transphobia—harms trans women everywhere. In America and elsewhere, race is an undeniable additional stressor for trans people, leading to significantly higher violent death rates among trans people of color[7]. Financial barriers to gender-affirming care exclude many trans people from care that improves their lives. It is against these oppressive regimes that genderfuck and medicinefuck are deployed and must be deployed. Medicinefuck and genderfuck can be a matter of survival—both literally and metaphorically.

Chapter I Defining Genderfuck

> The only reason we even feel like we need a theory about trans people is that society is so unaccepting of us that it's constantly demanding we justify our own reality … And the attempt to prove [our gender logically] is as degrading as it is futile.
> – *Contrapoints, "Transtrenders"*[8]

In Stone and Hale's *Rules for Non-Transexuals*, they remind everyone that trans experiences and communities cannot be totalized by any writer, that there are a multiplicity of discourses and individuals. This is an important reminder for any writing which professes to describe "Trans Theories of Gender"—certainly, a near infinite fractal. This chapter focuses especially on some of the trans theories of gender that are most relevant to the deployment of medicinefuck. In the first section, this includes performativity and passing, and the relation of these theories to gender-affirming care. The second section is a deeper dive into genderfuck, a destabilizing theoretical project present across online and offline communities, which draws from performativity theory. Both are important for understanding medicinefuck, which has commonalities across both.

1.1 Trans-ing Gender

This chapter starts with a quote from a video essay by trans theorist Natalie Wyn, who runs the YouTube channel Contrapoints. The 2019 video essay, titled *"Transtrenders"* engages with two long-running strands of thought in trans communities. On the one hand are "transmedicalists" (also mockingly called truscum) who believe that experiencing gender dysphoria is an essential component of identifying as under the trans umbrella[8]. On the other are more fluid gender variant and trans communities who argue that gender identity is multifaceted and incompatible with strict, binary understandings of gender that a dysphoria diagnosis implies (equally mockingly called "transtrenders," as in trend-followers)[8]. Ultimately, this quote reminds the viewer that these debates are only necessary because trans people are a target for oppression. This section briefly interacts with this debate as a starting point for larger questions of trans theorizing, including performativity and passing. It is also useful as a starting

point because it so strongly divides online trans communities, and so in a sense provides a starting point for understanding the social webs between these online communities.

Transmedicalists charge that essentializing gender dysphoria is the most effective way for trans people to access health care and fight for recognition in a hostile, cisgender society[9,10]. Many online creators and subreddits discussed in this thesis[1] charge that requiring dysphoria to be trans excludes many people who identify as trans or genderqueer and further excludes those unable or unwilling to participate in medical discourses. This has led to the development of "gender euphoria"—the happiness arising from presenting in gendered way congruent with a persons chosen gender identity. Discussions about psychiatric diagnostic criteria and the medicalization of trans experiences are deeply embroiled in this debate, as I will cover in more detail in Chapter 2.3. Versions of this debate have existed in trans spaces for decades and continue to matter in online communities, with YouTube video essays[8] and subreddit moderation rules that at times entirely divide communities as (not) accepting transmedicalists[11,12]. This is notable—it is one of the many overtly political stances that community moderators take, and it is a political stance that deeply implicates medicine and medical gatekeeping. For some communities, medicine is rendered inaccessible by transmedicalist gatekeepers who rely on a medicalized dysphoria; while for other, access problems come from trans people who refuse to operate within the structure of medical power and refuse a dysphoria diagnosis or binary transness more generally. But "dysphoria/no-dysphoria" is not the end-all-be-all trans theory.

Judith Butler' theory of performativity revolutionized gender studies when first published in *Gender Trouble* in 1990. Butler uses an understanding of (compulsory) performance to argue against formulation of concrete identity categories of lesbian and homosexual. Butler argued that "identity categories tend to be instruments of regulatory regimes," whether working for or against those regimes[13]. While Butler writes under the shingle

[1] Including Contrapoints, Kat Blaque, r/egg_irl, r/traa, r/transtimelines

of lesbian and worries about "being recolonized by the sign," they argue that categories must always be sources of trouble[13]. In taking their work and applying it more strictly to trans theories, there must be an acknowledgement that the "trans" category can similarly be dangerous (or liberatory).

Jack Halberstam is one trans theorist concerned about the category of trans. "Having a name for oneself," Halberstam writes, "can be as damaging as lacking one"[14]. For this reason, Halberstam chooses to use "trans*" with an asterisk because it refuses certainty and settling, and makes trans* people the "authors of their own categorizations"[14]. This is especially important as Halberstam considers the way trans* theorists have incorporated or drawn the impetus of language and classification surrounding trans* people from colonial and racial projects of subjugation. I have chosen not to use trans* with the asterisk—while an important interruption, I think it can go too far in implying a progressive, broad categorization where none exists. For example, transmedicalists will strongly object to inclusive trans* which easily accepts genderqueer people who do not conform to their medical framing. But outside transmedicalist communities, a movement away from "transsexual" has been part of a wider effort to move away from the medical system[14]. Like many systems, medicine tries to stabilize the meaning of words, to the detriment of trans* activists. Arguably, the development of medicinefuck in trans communities is an attempt not only to wrest control of medicine from health systems, but also control of *trans* from health systems. Halberstam does not settle the question of naming, for it is fundamentally one that should remain unsettled.

Butler builds the understanding of the instable category from their observation that the category (of lesbian, of "I," of any identity) requires performance. "It is through the repeated play of sexuality that the "I" is insistently reconstituted as a lesbian "I"; paradoxically it is precisely the *repetition* of that play that establishes as well the *instability* of the very category…" [emphasis original][13] . For trans theory, substitute gender for sexuality (or alternatively, don't) and "trans" for lesbian. Such instability of the category applies equally to heterosexuality as it

does to homosexuality, and this births the realization that each exclusive identity category within a system is "radically unstable … confound[ing] the possibility of any stable way to locate the temporal or logical priority of either term"[13]. Trans is not a derivation of cis, but something without which cis cannot exist—borne out by the fact that "trans" as a prefix for gender variance had been used for nearly a century before the development of "cis"[2]. It is this instability that Enke reminds us of when discussing the pitfalls of the use of "cis" as a theoretical term.

So, if the categories are unstable by their dependence on performance, what does this performance look like, and why does it matter for genderfuck or medicinefuck? Butler writes that "in imitating gender, drag implicitly reveals the imitative structure of gender itself—*as well as its contingency*"[15] [emphasis mine]. Drag puts on gender—by showing it as something that people can put on, it reveals that people *always* put it on. Butler is careful to acknowledge that gender is not necessarily "a performance that a prior subject elects to do," but instead "compulsory," mandated by social norms and structures. Trans people can perform gender in compulsory and self-directed ways, and both are (re)inscriptions of gender categories and trans categories. These performances can become destabilizing: some research shows cis people have greater social discomfort with trans individuals who "successfully" "imitate" traditional gender binaires[16]. Genderfuck is a sort of drag, except unique in that it is always a choice—one still subject to the compulsions of a cis-hetero regime, but one made by the individual to destabilize gender itself.

Butler has been criticized by some in the trans community for seemingly denying the importance of biology to lived/experienced gender[17], and gender performativity has been criticized as ultimately ineffective at explaining and validating the breadth of identification in the transgender community. For example, performativity theory seems to exclude trans people who are not attempting to transition socially or medically—lacking a performance, can they truly be considered trans[18]? Perhaps, it is for this reason that transmedicalists exist: transmedicalism is an attempt to use the medical system to legitimize a category—or categories, of trans and of

the given gender simultaneously—in the face of great categorical instability. But Butler does not exclude trans people who have not begun a transition: performativity—that is, the continual "imitation" of some supposed origin—creates gender "as an illusion of an inner sex," but does not constitute the inner psyche itself[13]. What does this mean for genderfuck and medicinefuck? Primarily, that they are *actions*, and performances, not identities or inner selves. Genderfuck is like drag in that it can be put on and taken off—it is also like drag in that its presence necessitates a destabilization of gender. Similarly, and perhaps more obviously, medicinefuck is not an identity but a performance that destabilizes through ironic and perverse reworking of medical discourses.

Performativity theory has one more important aspect for understanding genderfuck. Butler writes that publicly claiming a homosexual (or trans) identity is not an escape from oppression: "being 'out' must produce the closet again and again in order to maintain itself as 'out'"[13]. There are many reasons beyond theoretical critique that being "out" can be oppressive—trans people face high levels of transphobia and transphobic violence in the U.S. and across the world, and such oppression only worsens when considering the effects of misogyny, homophobia, and racism[7,19]. Passing and "being stealth"—two terms for talking about the ways that trans people navigate "outness" and closets—are important because they are, to differing degrees, a dominant mode of trans activity in medicine. Genderfuck, from which I draw the theory of medicinefuck, is not only an interruption of gender (as a binary), but also passing as a tool of trans individuals.

Passing refers to the individual appearing as one type of body when society has previously claimed that individual as a different type. Originally, passing was deployed in the context of racial passing where a non-white person could claim a white identity to avoid social discrimination if they matched the phenotypical standards of "whiteness"[20], but understandings of gender have long accompanied the word. C. Riley Snorton argues that cross-gendered slavery escape stories "explicitly articulated themselves as 'passing narratives'"—which included passing

across racial, gender, and social lines[21]. Snorton writes that "as "passing" became a term to describe performing something one is not, it trafficked a way of thinking about identity not only in terms of real versus artificial but also … proximal and performative."[21] Passing is performative in the sense that it implies falsity—but Butler tells use that its implications are less false and more unstable.

Another important aspect of performativity is in the 'compulsory' performance. Passing is not compulsory—it is a self-directed action—but this is complicated by the normative violence that encourages people to pass, and the way that society moderates successful passing. In other words: there is no right way to be trans, but there is definitely a right way to pass[18]. Snorton continues to theorize passing as a "way to suppress the violence" that constructed slaves as slaves, and slave women as enslaved women, particularly[21]. In this way, passing could be figured as revolutionary action even as it submits to binary structures. Passing claims for the individual privileges that society would otherwise close to them: in escape narratives, it allows ex-slaves to adopt social fictions that hide them from slave catchers. For trans individuals, successfully passing not only can deflect the violence of gender norms, but additionally affirm their gender identities to themselves[20]. In online trans communities, users frequently ask the larger community if they pass as their gender—seeking affirmation and also advice—more generally acknowledge that they have "a long to go"[22–25]; the implied destination being successful passing. Passing is very important; and Wyn claims that "most binary trans people" want to at least "seem like our genders to the people around us", even if that doesn't involve perfect passing[26]. It is from this centrality of passing that trans people have developed the concept of "being stealth."

"Being stealth" refers to the practice an individual passing successfully in daily life while not telling most people that the individual is trans[27]. It is distinct in that while passing implies not telling people your gender identity, "going stealth" is explicitly an effort to publicly refuse any trans identity in day-to-day interactions. Being stealth is sometimes viewed as a form of protection: "authenticity seemed less important than ensuring I could get home safely to hug my

grandmother at the end of the day…It made me feel safe."[27] Like the original ex-slaves passing to freedom in escape narratives, passing is a means of survival. Trans people face heightened levels of violence and hate crimes, motivated by transphobia and homophobia[7,19]. Violence affects all trans people, and trans women of color in particular; and there is evidence that trans women who have a more difficult time passing are less likely to report violence to law enforcement[28]. This is an example of how "being stealth" also affords privileges not linked to just conventional gender presentation and successful passing—"being out and passing entailed constant betrayals large and small, reminders that so many people's for you is conditioned on you looking and acting cis."[29] When a stealth trans woman reports an incident of gender-based violence, her (assumed) claimed cis identity participates in existing discourses of violence which orient women as especially deserving of protection from violence. If instead the trans woman is open with her transness, the discourse changes from one of violence-against-women to one of violence-against-trans, which is a power orientation which society—and the police—views differently. Being stealth claims a cisness that passing (which "merely" claims traditional gender) does not.

Being stealth, and passing more generally, is not critically uncontested. Some trans theorists have criticized the theoretical conception of passing as reinforcing essentialist regimes of sex and gender, in which some people—namely, cis people—have "authentic proprietary claims over particular social identity…" and others don't[30]. This is a danger in engaging in passing discourse, but I look again to Butler's reminder that these identity categories are inherently unstable; in a sense, they require passing to exist to reproduce themselves. Passing (and being stealth) is also criticized from a sense of betrayal of the larger community, because the trans person passing as cis now has access to cis privelege[27]. Most importantly for genderfuck and medicinefuck, however, is the way that passing, and being stealth, has been called a larger instrument of trans oppression. Further than just supporting essentialist gender schemes, it interrupts organization and activism of trans people and trans bodies. Passing

becomes “a means through which the violence of assimilation takes place” and disconnects trans (as an identity category) from political use[31]. Or on a even more basic level, it disconnects trans people from their identity—in this, passing reveals it contingent nature as at times a comfort and at times a prison[27]. By passing, the trans community loses its power to disrupt. Genderfuck, which refuses passing, at least temporarily, becomes an action that works against the regimes that passing supports; Section 1.2 covers this in more detail.

Passing is a nexus for disrupting gender and an oft-debated aspect of trans life, both in critical theory and informally online. Performativity theory reminds us that what people can perform, people can interrupt—and nearly everything can be performed. The transmedicalist focus on dysphoria offers an alternative understanding of a trans experience entangled with the medical establishment. Most importantly, these theories are neither complete in themselves, nor a complete accounting of trans theory in general—rather, they are inroads to the theoretical development of medicinefuck. The next subsection is a deep dive on the landscape of gender-affirming care (GAC). My purpose in talking about gender-affirming care directly after discussing transmedicalism, performativity theory, and passing is not to inextricably link them together but point out the ways that GAC can extend theories of passing and performativity. Additionally, an understanding of the history and current options available for gender-affirmation in medicine is important for fully developing genderfuck, and more to the point, medicinefuck.

1.1.1 Deployment in Gender-affirming care.

This subsection has two goals. Firstly, to make clear the multifarious technologies and techniques which comprise gender-affirming care, and in doing so, underline the ways in which trans communities have depended on mutual information sharing about care. Secondly, to give the reader the understanding of what, exactly, medicinefuck is disrupting. Broadly speaking, gender-affirming care has two purposes. First, to aid in passing, and second and simultaneously, to reduce gender dysphoria and/or induce gender euphoria[32].

Gender-affirming care has a long history, from the first endocrinology treatments in the 1910s to increasingly sophisticated and personalized surgical procedures in the present day. Gender-affirming care was first practiced at Berlin's Institute for Sexual Science (*Institut für Sexualwissenschaft*) founded in 1919 by Magnus Hirschfield[33]. From the very beginning, this incorporated gender and gender variance into first into medical understandings, not social understandings. Early scientific understandings of transgender care focused on Male-to-Female (or transfeminine) subjects, in both endocrinology and vaginoplasty—the first successful MtF genital reconstructive surgery occurred in 1931 at the *Institut*, while the first phalloplasty occurred in 1946[33,34]. Christine Jorgensen was one of the most well known transfeminine stories, with the headline of "Ex-GI Becomes Blonde Beauty" frontpage on the New York Daily News in 1952[35]. "The focus on transfeminine patients in surgery largely continued into the latter half of the 20th century, but transmasculine (Female-to-Male, FtM) techniques continued to be developed[33]. This continues to affect modern care: transfeminine and transmasculine individuals face different challenges in social and medical transition.

It is important to note two things: firstly, in nearly all cases, patients also made use of hormone treatments—originally, simple oral doses of estrogen or testosterone were used in concert with surgical procedures; and secondly, surgical care often took multiple surgeries over several years of varying complexity[34,36]. Surgeons designed initial vaginoplasties and phalloplasties for cisgender individuals; ciswomen or cismen who were seeking care to correct congenital or traumatic injuries to the genital area.

In the scientific community, 1966 saw the publication of *The Transsexual Phenomenon*, one of the first scientific texts to argue for physical modifications in care: writing "Psychotherapy with the aim of curing transsexualism is a useless undertaking with present available methods. The mind of the transsexual cannot be changed in its false gender orientation."[37] Obviously, this language is loaded with transphobia, and great strides in acceptance and understanding have been made in the medical community. But language

surrounding diagnosing (and thus medically treating) transgender patients continued to be loaded with stigma. In 1968, the second edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) included gender dysphoria under the parent category of "Sexual Deviations", which changed to "Psychosexual Disorders" in the DSM-III of 1980, "Sexual and gender identity disorders" in the DSM-IV of 1994, and finally "Gender Dysphoria" in the DSM-5 of 2013[33]. This evolution of the DSM also reflects a lengthy battle with its publisher, the American Psychiatric Association, and scientific thought more broadly, by trans activists.

Hormone treatments are nearly always the first physiological interventions in gender-affirming care, and thus represent an important frontier of research and point of gender-affirming care. I will be careful to note that not all trans and genderqueer people are on hormone therapy—or indeed, any medical therapy. Rather, physiological medical interventions (hormone therapy or surgery) are a medical option for *some* trans people[32]. Hormone therapy takes two main forms: Hormone Replacement Therapy (HRT) and puberty blockers. Like most gender-affirming care, hormone therapy can have differing effects on transfeminine and transmasculine individuals.

Endocrinologists originally developed HRT as medicine for cisgender people. For cisgender women after menopause changes in the endocrine system can result in symptoms of hot flashes, night sweats, and sleep disturbance, among others[38]. For cisgender men, fluctuating testosterone levels can lead to health risks, or, more commonly, loss of sexual function. HRT replaces naturally produced hormones that are dropping in level[38]. As trans individuals have sought more standardized care, HRT has come to refer to hormone therapies for both MtF and FtM patients that "replace" hormones produced by the sexed body with hormones that change physical characteristics to better align with desired gender identity[39]. This is a radical, and originally "off-label" use of hormones, and only relatively recently has HRT been widely prescribed (by the medical establishment) for gender-affirming care[40].

Generally, feminizing HRT involves the use of estrogens and anti-androgens, designed to enhance breast growth, reduce facial and body hair, reduce muscle mass/growth, and redistribute fat patterns to a female pattern[39]. Feminizing hormones in adults can lead to weight gain, mental mood swings, libido changes, male sexual dysfunction, gallstones, and slightly increased risks of hypertension and cardiovascular disease[32]. Masculinizing HRT involves the use of testosterone, designed to stop menses, deepen voice, increase muscle mass, change muscle/fat distribution, and increase facial and body hair growth[39]. Masculinizing hormones can also increase clitoral sensitivity and change libido patterns, and mood patterns more generally[39]. Masculinizing HRT can cause weight gain, acne/oily skin, balding, sleep apnea, and liver problems[32]. Because endocrinologists did not create HRT for gender transition, a rich history of "bio-hacking" and self-administration of hormones and understanding of their effects has developed within trans communities. I explore this more in the next section, but this begins the first steps of what I will call medicinefuck.

Both forms of HRT have varying time-scales, with the first effects beginning within weeks), and others taking up to 5 or 6 years to fully mature[32]. HRT can also negatively affect fertility of both those assigned male and those assigned female at birth[41]. Research shows that HRT significantly improves mental health of trans individuals among adolescents[32,42] and adults[32,39]. HRT becomes more effective the earlier in puberty it starts—several irreversible changes accompany typical puberty, most significantly breast growth and voice dropping[39], and puberty itself can be a source of growing gender dysphoria for trans adolescents who slowly watch their bodies develop "wrong" to their inner sense of self[42].

Puberty blockers were originally designed for cisgender children, echoing other forms of gender-affirming care, and have only recently been adapted for suppressing 'normal' puberty of gender dysphoric children[43,44]. They provide time for adolescents to explore their gender nonconformity while preventing development of secondary sex characteristics that can worsen dysphoric thoughts and make later transition more difficult[32,43]. However, they are associated

with risks, most notably stunted growth and low bone mineral density, and additionally have high costs related to production and monitoring that make them inaccessible to many people[44]. They are also very effective at improving mental health and general functioning, in concert with other support mechanisms[42,44,45]. Generally, puberty blockers are regarded as reversible interventions that prevent irreversible secondary sex characteristics from developing and work well as interventions for adolescents and children who are considered too young to consent to irreversible medical procedures, and whose parents feel uncomfortable with consenting on behalf of their child. Hormone therapies thus constitute an important part of gender-affirming care for many trans people and are a topic of intense study in the field of endocrinology.

Surgical procedures can be an important part of gender-affirming care for many people, and these procedures have long been part of the history of gender-affirming care. While historically, most forms of gender affirming surgery where initially created for cisgender people—whether as part of disease prevention, trauma healing, or cosmetic improvement—many new techniques are now pioneered explicitly for gender-affirming care. Again, it is important to note not all genderqueer or trans people want surgical interventions. It is also notable that "bottom surgery"—i.e., surgery of the genitals like phalloplasty or vaginoplasty—is less important to many individuals compared to "top surgery"—surgery of the face or chest, due to helpfulness of top surgery to passing as cisgender. This subsection will serve as a brief survey of surgery options for FtM and MtF individuals.

For MtF individuals, feminizing surgery can be divided into three parts: neovagina construction, and breast augmentation, and various "cosmetic" surgeries across the body[46]. Neovagina construction is premised around desires for lessening of gender dysphoria stemming from the penis[47], and a desire for genitalia that functions as a typical female vagina in aesthetics and erotic usage[48,49].. Vaginoplasties typically require intensive aftercare, including daily forced dilation, and patients frequently return for reoperations (but mostly for cosmetic issues)[50]. Vaginoplasties also carry significant financial costs, especially if they require reoperations, and

like all gender-affirming care, are inconsistently covered by private and public insurance policies[51].

Breast surgery can also be an important part of surgical care for MtF individuals. Breast augmentations were created for cisgender women, and the techniques, risks, and complications for MtF breast augmentation are very similar[32]. MtF individuals are recommended to be on feminizing hormones for at least a year prior to breast augmentation to maximize natural breast growth and improve aesthetic results of breast augmentation[32].

MtF individuals can also include further non-breast and non-genital surgeries as part of their gender-affirming care. These include facial feminization surgeries, and fat redistribution surgeries like liposuction and lipofilling, among others. Facial feminization—usually a mix of rhinoplasty and shaving of the bone of the jaw and brow[52]—is another important medical intervention[46]. Surgeons have long used these surgeries in various forms for cisgender patients, and thus I will not closely examine the details. Suffice to say, these surgery techniques and procedures are incredibly diverse, with varying needs and outcomes on a case-by-case and surgeon-by-surgeon basis.

FtM masculinizing surgeries have similar variety and divisions: masculinizing genital surgeries, breast reduction/chest contouring, and non-chest/genital miscellaneous surgeries. Masculinizing genital surgeries often focus on the construction or highlighting of a neophallus, and frequently include hysterectomies. The “ideal neophallus”, chased as a holy grail by surgeons, is one that takes a single-stage procedure, is aesthetically pleasing, has erogenous sensitivity, permits standing urination, and has minimal complications[53,54]. Phalloplasties generally fall into two types: the metoidioplasty and the free flap phalloplasty[53,55].

Both techniques have several advantages and disadvantages—frequently, the choice between the two techniques is further constrained by surgical considerations or financial limits, but always requires an exceptionally thorough conversation between patient, surgeons, and urologists, especially because of the significant risks[32,56]. In addition, genital surgery is not one of

the priorities for transmasculines, who seek more hormone therapy and chest reconstruction[46]. Accordingly, many transmasculines choose instead to only receive "top surgeries" and hysterectomies[32].

FtM chest reconstruction surgeries are another surgery chosen by transgender men. Like breast augmentation, there is a long history of mastectomies in cisgender women. However, chest reconstruction is unique in that it aims not only to remove any sign of the surgery, but also remove all the "feminine" characteristics of the chest wall, including feminine contour and nipple placement and size, and has many different techniques[57,58]. Additional gender affirming surgical care includes fat redistribution and pectoral implants[32]. In general, across transmasculine and transfeminine people, hormone therapy is the most common physiological intervention, followed distantly by top surgery, and even more distantly by bottom surgery[59].

There is gender-affirming care that is not so explicitly medical in nature. The World Professional Association for Transgender Health's (WPATH) *Standard of Care* notes that "while some people need surgery and hormone therapy… others need only one of these treatment options and some need neither"[32]. Other forms of care can be speech therapy, psychotherapy, gender presentation changes, breast binding or padding, legal gender changes, and hair removal. In fact, one survey asked trans people to rank the importance of various pieces of gender-affirming care. For trans men, change of dress/clothing, name and legal gender change, speech therapy, hormone therapy, chest reconstruction and breast binding were ranked as the most important forms of care; trans women said that legal gender change, hormone therapy, breast augmentation, frontal bone setback, and removal of body hair were the most important[46]. These varying rankings of care indicate both the dual purposes of care (dysphoria and passing) and how transmasculine and transfeminine people have different needs.

Mental health care and psychotherapy can be important for trans people. Rates of mental health problems are elevated in trans individuals, including higher rates of depression, general anxiety, suicide, and self-harm[4–6]. In a very large survey of trans adults, 41% report having

attempted suicide—25 times the rate of the general population[60]. Psychotherapy can ease dysphoria and support coping mechanisms, greatly improving quality of life even in the absence of other medical care[5,32,61,62]. Access problems exist with psychotherapy, especially with youth who may not be "out" to their guardians[4], but also to any person with financial constraints.

Chest binding involves the use of a "binder" to compress chest tissue and create a more masculine profile. It is a frequently used tool for gender presentation—one study found that 87% of transmasculine respondents had used binding in the past[63]. As a technique that is very easy to do, it is rife with amateur techniques with varying effectiveness and risks[64–66]. However, breasts are frequently one of the most dysphoric body features, and binders almost universally report happiness and lessening of dysphoric feelings when they bind[66–68]. The transmasculine community has worked to share information and develop research on chest binding, with a focus on best practices and outcome, and online communities of transmasculine people are full of advice and misinformation on chest binding[66,69]. Chest binding is great example of gender-affirming care that has been promulgated mostly by chest binders themselves, rather than by the medical establishment.

All gender-affirming care is personal, and beyond even the varying realities of surgical considerations, different people have different wants and needs for their care. For example, some trans people never receive surgery or hormones; some by choice, and some by social or financial constraints. Some only seek hormone therapy, some try hormone therapy but find unsatisfying, some stay on hormone therapy their entire life. Intervention needs vary wildly by individual, and require treatment plans to be tailored on a case-by-case basis[70]. Additionally, as understanding has grown in the broader medical community about transgender issues, trans advocates have worked to depathologize gender variance and dysphoria[32]: the DSM-5, published in 2013, was the first to remove stigmatizing "disorder" language around gender dysphoria[33]. Gender-affirming care continues to be depathologized and individualized to personal needs.

Gender-affirming care is also personal in that barriers to care vary wildly across trans populations, based on geography, income, race, and social and family acceptance. Insurance is the leading payee of medical costs in the US and is crucial to understanding barriers to care. Insurance eligibility and access are consistently identified as barriers to gender-affirming care[6,59,71], and navigating insurance further complicates seeking care[4,60,72]. As mentioned, all insurance programs as currently making decisions drawing the line between "cosmetic" and "medically necessary" gender affirming surgeries. The Affordable Care Act prevents federally funded programs from categorically excluding gender-affirming care[73], but decisions on funding are made on a case-by-case basis by states and adminstrators[74]. Eleven states explicitly exclude transgender health coverage and care for state Medicaid, and twelve states exclude care from public employee insurance policies, and twenty-seven states have no rules mandating gender-affirming care in their private insurance markets[75]. Several states have explicitly banned gender-affirming care for any person under the age of 18, including the use of puberty blockers, or have such bans in the works[76].

The story of the Arkansas ban is instructive, showing how the public misunderstanding about gender-affirming care, as well as transphobia more generally, can negatively impact trans people. Titled the "Save Adolescents from Experimentation Act", it refers to the "experimental" nature of puberty blockers (which were originally designed to block precocious puberty), but simultaneously raises the spectre of surgical experiments on hapless children[77]. However, GnRH agonists are well understood, reversible, and are the best practice care for gender dysphoric youth[32,43]. Now, transgender youth will need to either go out-of-state or just move entirely to access care[78]. Like other barriers, the harm falls most heavily on youth of color and low-income youth.

In sum, gender-affirming care seeks to reduce dysphoria, aid in passing, and/or induce gender euphoria, and is both hard to navigate as a patient and has serious problems with access. Gender-affirming care is not without controversy and criticism within trans theory. The next

section outlines one aspect of this criticism, called genderfuck, along with its attendant theoretical underpinnings.

1.2 Genderfuck

A genderfuck, or genderfuckery, is a performance of gender meant to "fuck with" concept of gender itself. The first critical descriptions of a genderfuck were in the late 1960s, and its legacies have continued to the modern day: Christopher Lonc writes in *Genderfuck and Its Delights*, "I want to try and show how not-normal I can be. I want to ridicule and destroy the whole cosmology of restrictive sex roles and sexual identification"[79]. In essence, genderfuck is a performance or expression of gender that is meant to confuse and bewilder the audience, perplex typical binary rules surrounding gender, and explicitly invite sexual desire into gender expression[80]. It is distinct from nonbinary gender identities, which more generally rejects the gender binary in self-identification. Genderfuck is less of an identity as it is a performance: forcing the 'other' (or the audience) to engage in a disruption of gender. It is also, in some ways, a model for medicinefuck—an idea explored in Chapter 2.

In disruption, genderfuck refuses passing, and refuses stealth. This is an active, purposeful performative choice—a performance deeply engaged with "the transgressive pleasures produced" by working against normative forces of gender[13]. Drag culture is probably the aspect of genderfuck that has received the most mainstream attention, especially over the last decade through programs like *RuPaul's Drag Race*, though musical artists like David Bowie and Harry Styles have also enacted genderfuck in very public forums with varying success. I return to Butler's explicit acknowledgement of drag, saying that "in imitating gender, drag implicitly reveals the imitative structure of gender itself—*as well as its contingency*"[15] [Emphasis mine]. Butler uses drag to show how gender is created by imitation and performances, and only briefly touches on the capacity of drag to destabilize gender entirely, but others go further. Sandy Chang, a drag king and psychologist, writes, "I consciously try to fuck with gender. I might do a drag king performance and then come out of the dressing room

afterward, totally dressed up as a femme; I want to mix things up. I want to challenge people[81]." Genderfuck destabilizes contingent mechanisms not just within the inner gender identity but in all who watch. In this way, it is even more explicitly performative—as in, done for other people, for voyeurs—than many of the repetitions and imitations discussed by Butler.

Genderfuck arises from some of the currents of thought surrounding successful, turn of the century queer rights movements. These movements, which put white gays and lesbians first, and supported a certain project of assimilation into what many queer and trans theorists saw as existing and unchanged oppressive system of gender and heterosexuality, as well as supporting nationalist and colonial projects[82]. Snorton and Jin Haritaworn describe this poignantly while outlining what they call "trans necropolitics", the process through which trans of color deaths—most frequently gender variant people and transfeminines of color—are used to fuel white gay and lesbian agendas[19]. Central to this idea is the contradiction of the ever-present "devaluation of trans of color lives and the nominal circulation in death of trans people of color"[19]. In other words, the trans of color lives only matter when they end and can be deployed in theory or in activism; for example, in advocating for the importance of providing medical care, or in the creation of hate crime legislation. By using trans lives and deaths to galvanize state action, "trans women of color act as resources … for the articulation of a more privileged transgender subject" and simultaneously become a tool of state power (on behalf of the privileged trans subject, or other privileged subjects)[19]. At some level, this thesis is complicit in this necropolitics: medicinefuck is construed as a liberatory project against a background of violent transphobia—medical and otherwise. But genderfuck (and medicinefuck) is not for the benefit of a certain type of trans body.

Conventional narratives of passing and gender-affirming care are some of the discourses that privilege some trans bodies over others—passing bodies, young bodies, white bodies. Priya Kandaswamy writes about the feminist anti-domestic violence movement in the context of privileged bodies; necropolitics comes to the forefront here (though Kandaswamy doesn't use

the word): women of color, sex workers, trans women, and the "criminal" women are those most impacted by domestic violence and those most in need of radical change—but their suffering and their death is used to fuel therapeutic policies for a certain idealized, noncriminal, white, victimized women[83]. For this reason, Kandaswamy asks "what kind identities are we forced to adopt and police when we engage in state-centered politics? What acts of passing are required to gain state protection? What are the problems and pitfalls of passing (strategic or not) as a kind of politics?"[83]. In this context, Kandaswamy is speaking of passing as cis and as a victim for the political power than funds women's shelters. This passing condemns those unable or unwilling to pass to the margins state actions meant to help the marginalized. Genderfuck refuses passing-in state politics or in individual interactions—and can thus be a tool of resisting necropolitics.

A foundational book for an understanding of genderfuck is Paul Preciado's *Testo Junkie,* a multifaceted account of gender, technology, pharmaceuticals, pornography, sex, and capitalism. Three threads of inquiry are woven throughout Preciado's book: firstly, a performative epistolary to a close friend and writer who died of a drug overdose (or an "overdose of biopolitics") early in the writing process; secondly, an account of Preciado's deepening "addiction" to both testosterone and to VD, his lesbian lover; and thirdly, "conventional" critical theory that seeks to define the pharmacopornographic era—a integration of the pharmaceutical and pornographic industries that make the body and sex the fundamental unit of capitalism from which value is extracted[84]. Preciado's book is in some ways a self-professed manual of gender bioterrorism—or what I would call genderfuck—and in others a close reading of a sexually driven disruption of medicine (i.e., medicinefuck) which, arguably, began with the use of synthetic hormones.

Preciado introduces the pharmacopornographic era by "using as an axis the political and technical management of the body, sex, and identity" to understand the development of industry and capitalism in the 20th century[84]. This axis reveals that industry implements a

"ensemble of new microprosthetic mechanisms of control of subjectivity by means of biomolecular and multimedia technical protocols" in the forms of synthetic fluids and transformed organs, explicitly pornographic images and actions, and knots of sex-capital driving the growth of cities[84]. This is the "biomolecular (pharmaco) and semiotic-technical (pornographic) government of sexual subjectivity" that comprises pharmacopornographic structures[84]. Pharmaco is expressed in industrial control and creation of molecules regulating the body, while pornographic is expressed in the ability of images (or creations) "activat[ing] in the body of the spectator."[84] Preciado goes further by arguing these structures have become the model of all forms of capitalist production in the new century, and the techno-body (as a subject) is the source of new (orgasmic) production. I posit medicinefuck as an immune response against the capitalist, medical control of the techno-body.

Necessary for a pharmacopornographic regime is the development of "technogender"—the idea that gender is a biotech artifact existing (or reproducing) because of, or from technology[84]. Preciado identifies new preoccupations and technologies surrounding sex assignment as the beginning of modern technogender. In this case, "technologies" refers not just to material arrangements which create new categorizations of knowledge, but arrangements of knowledge itself as a technology. Dissemination of a "normal" expression of the penis and vagina, and later chromosomes and hormones, creates gender. Post-WWII, Preciado says that that the pharmacopornographic regime is the result of the mixing of nineteenth-century naturalist ideas about sexual dimorphism and a new biotech industry in which individuals and society design sex and gender as social roles[84].

Nowhere is this more obvious than in the birth control Pill. The FDA required pharmaceutical companies to develop a way of technologically reproducing a "natural cycle" of bleedings while on the Pill. Conceptions of sexual dimorphism—to be a woman is to bleed—mixed with the possibility of designing new rhythms of hormonal actively: the technogender that resulted reinforced the dimorphism, at least temporarily[84]. Preciado also

connects this to Butler's theory of gender performativity: extending beyond theatrical performance, the Pill is a living, technological mimicry of the body—what Preciado calls biodrag, the "pharmacopornographic production of somatic fictions of femininity and masculinity."[84] The Pill had two functions: as a contraceptive, and as a production of technogender that imagines itself as the perpetual natural state of being[84]. This idea is also evident in gender-affirming care. Hormone therapies were first developed for cis bodies: the molecular revolution was first utilized to create our technogender. Preciado argues that FDA—and the political force of government—expects cis men to have high testosterone, and for the past several decades, synthetic testosterone has frequently been prescribed for cis men with "low-T syndrome", to say nothing of the use of steroids like testosterone creating a technobody that more closely conforms to "male" phenotypes. On the other hand, society expects cis women to have low testosterone (though how low is not agreed on). Ergo, the FDA won't license testosterone for women because to do so would be disrupt the biodrag performance of gender—dimensions both of pharmacology and of (pornographic) performance[84].

Genderfuck disrupts passing, disrupts gender, and disrupts the technological and economic apparatuses that create and enforce gender. In this, it aims to be liberatory both for the people performing it and everyone who watches it. Already, in this liberatory aim and mechanism, the beginnings of a liberation from medical hierarchies of power is visible—medicinefuck. The next section is a brief overview of the genderfuck happening in online communities.

1.2.2 In Online Communities

Considerable amounts of time have been spent on trying to develop a theory of trans: and this chapter begins with a Wyn quote that attempts to problematize that theorizing. Wyn has another insight to offer, in a very genderfuck manner: she wryly remarks that only way for her to prove her womanhood is to "go out and fuck the most brutally heterosexual man [she] can find, and be validated in cum"[8]. This is the essence of genderfuck, (even as expressed by a trans

woman who admits being most comfortable expressing a very binary version of femininity). Genderfuck is not simply an attack on traditional conceptions of sex, gender, and sexual activity, but one that invites these concepts to be instruments of their own destruction. It is a radical and disruptive performance of politics.

Genderfuck is intrinsically connected with the online spaces that have fostered it. Even early in the development of YouTube's trans community, trans creators were exploring these concepts in new spaces in new ways. One creator, Diamond, long structured her channel as a satirical news broadcast—performing as a newscaster with purposefully varying levels of "feminine polish"[85] to raise awareness of trans issues. Explicitly, Diamond relied on sexual disruption, saying:

> "That's how I started doing videos—what I said is that I'm going to put my body out there and be sexy and that will pull people in but the next video you see is me talking about trans issues, so there was, like, a give and take where I would rattle people in but be an educator at the same time" (quoted in Raun 2016)[85]

Diamond's performance of news-anchor sex appeal serves flip the script on trans issues, disrupts conventional narratives (especially prevalent during the creation of her earlier videos in 2010) and is uniquely possible on YouTube, which provides an outlet for creative, short-form video content that couldn't be effectively distributed in prior environments.

Online communities also use genderfuck as tool to disrupt passing. This has real consequences: Passing and stealth is also part of a discourse of deception and "trans panic." Trans panic refers to the criminal defense tactic where a defendant claims that the shock of discovering their romantic or sexual partner is trans prompted them to commit violence or murder against trans individuals[86]. This plays into a common trope: that trans people—especially those who pass successfully—are deceivers and duplicitous[87]. The duplicity is also closely related to the finding that trans people who successfully pass are more destabilizing to gender binaries than cisgender people[16]—to borrow Butler, the successful "imitation" becomes a destabilizing insubordination. Contrapoints' video essay on the "duplicitous trans" trope has

2.8 million views, and rather than playing into assimilation, Wyn films herself in full, genderfuck drag[88]. Most of Wyn's videos are done in a mix of "natural" Wyn—usually when she is speaking as herself—and many different characters (also performed by Wyn) who play with gender presentation. Wyn's genderfuck performances, which she sometimes refers to as drag, are both rhetorical tools in her theory analysis and destabilizers of a trans or cis identity.

Kat Blaque, a black trans women and vlogger, has talked about her frustration around passing and stealth; something that she does in day-to-day life but which complicates her friendships with queer people and her dating life, which moves across queer borders and BDSM communities[89]. Blaque doesn't offer answers, or even guidance, for trans viewers, but her genderfuck is in the explicit description of her sexual relations and how they are shaped by her passing and her trans identity. And her experiences problematize the concept of passing and of stealth—highlighting the contingent nature of both. A lot of her online hate mail centers on how "[she is] obviously, you know, a big old tranny" but in offline interactions, "most people in most spaces" who interact with her believe her to be cis[89]. Her passing is context dependent and changing. These creators, and others, genderfuck through passing and stealth discourses, highlighting their instability.

The example of self-administered hormone therapy can be illustrative and connect to my next idea of "medicinefuck." Hormone therapies have been self-administered by trans people for nearly as long as the hormones have been understood—again to look towards Jorgensen's experiences, as she began hormone therapy on her own prior to traveling abroad for genital surgeries[35]. But self-prescription of hormones can be a contentious topic within the trans community—many trans YouTube creators showed their viewers how they gained access to and self-injected their hormones in detail, while others refrain because they consider self-administration to be dangerous[85,90,91]. This sort of information sharing has long existed on YouTube—primarily because hormone therapy has for such a long time been inaccessible to trans people. Trans activists and organizers in many countries work to increase accessibility,

price, and wait times continue to result in trans people seeking information about self-medication. This is especially true in the U.K., where the National Health Service has extremely long waiting times for endocrinologists. The NHS uses wait times instead of price as a rationing measure; as a result, trans people with extra money look towards self-medication as an viable option, especially since HRT can result in such an improvement in quality of life[90,91]. But self-medicating HRT can be dangerous, and remains a contentious topic in the trans community[92]. Discussions of this topic can frequently be a part of or altnatively response to currents of medicinefuck which could destabilize concepts of "(self)medicating".

HRT is also disputed when included as part of a genderfuck performance (or an identity perceived by others as genderfuck. This relates more closely to the aforementioned debate between transmedicalists and genderqueer inclusive trans advocates: because the two sides view access and price of gender-affirming alternatively as under threat or gatekept. Paul Preciado describes pushback from other woman when he began taking testosterone as a woman[2], because he "took testosterone outside the aegis of a medical protocol, without wanting to become a man, because [he] used testosterone like a hard drug, like any other…"[84]. Again, this description and others in Preciado's work strongly express genderfuck: hormones (as a tool of technogender) become hard drugs, drugs that change sex drives and impart altered states of consciousness. Simultaneously, these online discussions about access to gender-affirming care involve patients and individuals in the medical process in new ways. Self-administered hormone therapy can be tool for transition or for genderfuck, and equally disrupts the traditional doctor-patient boundary through multiple mechanisms.

[2] Paul Preciado transitioned from a woman to a man in 2014 but begun his first experiences with testosterone in 2006 while still identifying as a woman, as detailed in his 2008 book *Testo Junkie*.

Chapter II Fucking Medicine

2.1 From Genderfuck to Medicinefuck

In the same way that genderfuck is less an identity and more a performance of gender disruption, medicinefuck is a performed disruption of medicine. With such a broad initial description, it seems obvious that medicinefuck is not the pure domain of trans people or trans communities. Rather, because of the linkage that I see between traditions of genderfuck and traditions of medicinefuck, I am choosing to examine medicinefuck in online trans communities. Where is this linkage? Primarily in purpose, location, and mechanism.

Purpose is most easily grasped: in the same way that genderfuck seeks to destabilize gender, medicinefuck seeks to destabilize medicine for the benefit of people. Medicine, and our health care systems in general, are massive, rigid hierarchies of power. The patient going into the exam room—often situated in the mind's eye in flimsy, backless gown—is shuttled between nurse, doctor, specialist, and back again. Meanwhile, especially in the U.S. health system, insurance actuaries, adjusters, approval boards, and shareholders negotiate with health systems over who pays for what—a negotiation that happens entirely outside of the patient's control. The health system itself, which organizes staffing, purchases medical technology, arranges for trainings and seminars and professional development, is run by administrators far removed from the doctor/patient interaction. Even the use of the word "patient": it obliterates the individual and their particulars from the large health system. A patient is not a mother, or a brother, or a worker or a child, or even someone who seeks better health; they are someone who the larger apparatus acts upon.

Medicinefuck says "fuck that." Beyond the negative implications of these power structures for equity and diversity, beyond the alienation and disassociation that this can cause in its victims—these hierarchies are bad for health of many people. Medicinefuck shakes up the normal power dynamic between patient and doctor, and the power dynamic that draws the lines

between medicine and non-medicine, between *health* and everything else. However, in contrast to genderfuck or other radical liberatory projects, medicinefuck does not seek to abolish medicine entirely. Medicine is important, and the pharmaceutical, surgical, and medical technologies that medicine supports are important for the well-being of populations—including trans people. Instead, it could be included in the project articulated in *The XenoFeminist Manifesto* of a "long-range strategy" for creating a freer, open-source medicine[93]. Of course, stated purpose does not always equal actual effect, but medicinefuck is an effort to destabilize these hierarchies and boundaries.

Medicinefuck shares a common location with genderfuck, which are both active and present in online trans communities. Conversations around hormone therapies in particular can incorporate both in the same breath, simultaneously. There are several reasons for this. Firstly, because the primary purpose of these communities is not usually medical advice or discussion, but rather a more general community building, disruptive performances of gender/medicinefuck are not excluded in the mandate in the same way that a narrowly tailored online health community can restrict user activity[3]. Secondly, the mechanism of genderfuck and medicinefuck is quite similar.

Both medicinefuck and genderfuck are, at their core, *performances*. They are not identities, but something that people perform in view of others to disrupt norms. Genderfuck presents the audience with a confusion of gender discourse (or language) that frustrates the audience's instinctive urge to gender others and invites new understandings of gender. Medicinefuck presents the audience with purposeful confusion of medical discourse, which invites new understandings of medicine, health, and health systems, and the individuals place therein. This idea of performance is most clearly seen in the following idea: medicinefuck

[3] www.transbucket.com is an example of a trans online health community with a very narrow mandate of sharing pictures and reports on gender affirming surgical procedures and surgeons, and a place where medicinefuck is not active.

impacts the doctor's office but isn't primarily originating within doctor's office—it originates wherever people *share stories* of the doctor's office.

Another crucial component of medicinefuck is the sex. What separates medicinefuck from any of the many other processes disrupting health systems is that, like genderfuck, it invites sex and sexuality into the performance. In the case of trans online communities, the sexual aspect of gender-affirming care—since so much of gender affirming can be about looking sexually attractive or feeling sexually functional and non-dysphoric—can become an explicit mechanism of disruption. It makes more sense to seek sexual advice about gender-affirming care from *people who have sex*, not the doctors who prescribe care. And seeking gender-affirming care is about sex! I look to Preciado's (very-medicinefucky) *Testo Junkie* as an example of sexual performance which disrupts the conventional view of medicine and pharmacology in favor of pharmacopornographic understanding of sex and capitalism. It is the required presence of sex in medicinefuck (and genderfuck) which requires use of the expletive—both a disruptive swear and an implied activity.

Moreso than genderfuck, medicinefuck interacts with trans necropolitics. Necropolitics marks some for death in a transnational system of homophobia, transphobia, and racism through "institutional processes of deliberate neglect and disposability," [94]. A major dimension of those processes is medical systems, though Haritaworn and Snorton are more focused on geopolitical positioning. And even as the medical system has become more hospitable for trans people, transphobia remains a serious problem for trans people interacting with medicine. This effect is worse for trans of color, as outlined by Snorton in discussing the death of black trans woman Tyra Hunter[19]. Medicinefuck aims at these medical institutions and asks how those marked for death can create their own discourses of power. How can trans people look after their own health, or take back their health from the medical systems which thrive on their absence?

The remainder of this chapter outlines the structures of YouTube and Reddit and begins to draw out some of the interesting medicinefuck activity occurring in trans communities on those websites. It ends with a further critical exploration of medicinefuck drawn from specific examples, and finally connecting to other existing strands of critical thought, including Preciado's pharmacopornography and Haraway's cyborg.

2.2 Fucking on the Internet

Medicinefuck is, at many levels, a question of "medical" information flow and performance, and the internet is rapidly becoming a buzzing marketplace of information exchange. Scholarship over the past several decades has examined how online information seeking and communities can change medical decisions and doctor-patient interactions. Rönkä & Katainena (2017) used Actor-Network Theory to examine how communities of recreational drug users incorporated medical and pharmacologic perspectives into "non-medical" drug use[95]. Importantly from their analysis, the community and the design of the internet technology of the community become important actors in the network of power. Another study of hematology patients explored how access to online health information shapes doctor-patient interactions by allowing patients to enter interactions with more background information and confidence in asking specific questions[96].

Seeking health information online serves several functions. Firstly, it can fill information gaps in health systems, especially in rural communities and among people with rare medical needs[97]. Secondly, it can help people who feel like their concerns are being dismissed by doctors or who are overwhelmed by the volume of information discussed during an in-person visit[98]. Finally—and perhaps most crucially when discussing information-seeking about gender-affirming care—seeking health information online can be more private and convenient, as well as providing intrinsically more varied perspectives on care[99]. A large proportion of patients access online health information—among internet users, some surveys have found

excess of 70% of all patients use the internet for health information[100], and among sexual minorities the rates are estimated to be much higher[101].

Undoubtedly, the presence of online communities has changed how people understand their health, just as the internet itself has changed how doctors and patients interact, with the rise of telehealth that over the past decade that exploded with the onset of COVID-19. But I have chosen to focus on the expression of medicinefuck found in trans communities, and trans communities have several important differences compared to other communities that share health information online. Firstly, and most importantly, sharing of explicitly medical information is not the primary or even secondary function of online communities of transgender people. Instead, these online communities discuss and enact gender theory, and thus are places that create gender and gender-transition by virtue of the inscription of new patterns of living and being upon a new (electronic) substrate that at times can be entirely divorced from material reality.

The transformative power of the internet has long been remarked upon for its contribution to the social and political organization of marginalized and minority groups. This effect has been magnified for minority groups that are dispersed—both spatially and in social standing—across a population, like transgender people[102]. With the advent of the internet, people questioning their gender could form communities for support and understanding that were previously much harder to develop (largely through 'zines or community advocacy groups, inherently spatially limited).

For example, YouTube's founding in 2006 created a new transgender video blogging community that has grown explosively since[85], with new creators with different purposes entering the scene. Informal communities on Tumblr, a microblogging website, use specialized tagging tools to connect with other transgender users and build communities of support[103]. On Reddit, which site owners have more formally organized into interest- or topic-specific communities called "subreddits," transgender subreddits run the gamut from serious outreach

to jokes to political advocacy and boast hundreds of thousands of subscribers. Even in the case of a more mainstream social media site like Facebook, transgender people use features like nicknames and curated post privacy settings to try out new presentations without announcing changes to their entire social circle[104].

Some of the information shared through these networks is explicitly medical—doctor recommendations, side effect PSAs for hormone therapy and breast-binding, tips for navigating insurance or health systems. Other interactions are based purely on seeking support; for example, researchers have examined how communities on Tumblr are therapeutic mechanisms for improving mental health, finding that users utilize Tumblr's online interaction tools to reassure and empower themselves[103]. These interactions are worth looking at in detail because they quickly reveal conflicts in power between doctors and (assumed) patients. Some Tumblr users describe how "Tumblr created opportunities for do-it-yourself health and self-care during the transitioning process" but researchers are quick to caution that "information quality may be variable given it was not vetted by medical professionals"[103]. Such comments about medical misinformation are not unusual in research on online communities, transgender[101,103,105] or otherwise[98,99], and for good reason. Medical misinformation runs rampant nearly everywhere on the internet; and it was only after COVID-19 that technology platforms began designing and implementing mechanisms for dealing with misinformation in earnest. But by noting the conflict, these researchers inscribe into a scientific record a particular dynamic of power; where the internet misinforms the non-medical public, a public that depends on the doctor as an intermediary for medical information.

I don't fault researchers for highlighting this problem, especially since in the case of sexual minorities medical misinformation can go from rejection of medical science to outright transphobia or homophobia, like search results that tout the effectiveness of conversion therapy, or outright deny the possibility of transitioning genders. Rather, I am noting that even in *the*

research about these online communities, tension exists between users/patients/people and doctors/medicine/health systems.

In examining medicinefuck, I have chosen to look at online trans communities on YouTube and on Reddit. These communities are largely understudied but are important locations of both genderfuck and medicinefuck, and the following sections aim to describe these two quite different social media websites at a high level, with a bird-eye look at some of the medicinefuckery happening across them. However, it is important to understand that these websites are just two websites out of many, and that trans community-building happens across the internet in hundreds of different forms. I have chosen to look at YouTube and Reddit because the distinct design choices between the two have resulting in very different communities, and those differences are worth examining in the context of medicinefuck.

By focusing on YouTube and Reddit, I exclude major social media websites like Tumblr, Facebook, and TikTok. Facebook has large numbers of private communities, like doctor-specific trans groups that are invite only, and sometimes only by word-of-mouth. Tumblr and TikTok face different inaccessibility problems: trans content is frequently censored or rendered impossible to search for, making it difficult to research. In my exclusion of these important locations for community building, I do not mean that they don't matter, or that they themselves are not important platforms for medicinefuck.

2.2.1 YouTube as a Community Pantheon

YouTube is a place of community for transgender creators and users, but with several major differences between it and other social media platforms. Firstly, it is rooted in video, not text. Secondly, the structure of YouTube means that communities grow first around a particular creator, within the comments of that creators' individual videos, as opposed to other sites where a community grows around a particular tag or within a dedicated but multi-source subreddit. Thirdly, as YouTube grew its userbase, Google focused more on creating a "viewer experience" as opposed to a "user experience"[85]. Compared to Reddit, which mimics a forum style,

YouTube's comments are more impenetrable: there is no CSS style which can improve readability; replies can't nest and are hard to track; comments are presented as an infinite scroll with no set order, making it difficult to return to the same comments at a future date. All these features mean that interaction and community building on YouTube is between the video creator and the "community"—not between individual viewers. And of course, for creators with a large following, the number of comments on videos mean that the creator can only interacts with a generalized "community." This environment makes YouTube well suited to the development of parasocial relationships—a relationship where the viewer considers the creator a friend despite having no real interaction with them[106].

It is for this reason I refer to YouTube as having a Community Pantheon; unlike other platforms, there is a strict and persistent hierarchy between creators/viewers which is difficult to disrupt, and this hierarchy seems to have gotten stronger over the past decade as the most popular YouTubers get even more subscribers. It is also a pantheon in the sense that YouTube is the second most visited site in the world[107]. This is evident in the (admittedly sparse) research on transgender YouTube creators.

The 2016 *Out Online: Trans Self-Representation and Community Building on YouTube* by Tobias Raun is an online ethnography of 8 transgender YouTubers—four masculine-identified and four feminine-identified and their videos produced from roughly 2006-2011. Of the 8 creators, only one has over 100 thousand subscribers today, and most had less than 15 thousand subscribers, and many are no longer active. These creators often (though not exclusively) focused on the journey of the transition, and their blogging was in some way a "step toward comfort, negotiating how one is or can be seen"[85]. As much as they were efforts towards building a community (and in all cases, were successful, at least for a time) they were also a personal archive. It is in this early YouTube blogging that that the nascent trans YouTubers created some of the first transition timelines or commemorations. Typically, this would be a video of still images set to music that documented the visual effects of changing

gender presentation and bodies and describes the steps undertaken to achieve the changes: hormones, surgeries, weight training etc[85]. Other videos are a more detailed documentation of preparation for and recovery from gender-confirming surgeries; and some creators teach viewers how to self-inject hormones[85]. But much of the content doesn't discuss medical intervention at all, but rather daily life, relationships, and the creators complicated relationships with their own bodies.

There are of course many smaller transgender creators like these 8 in the ten thousand to 100 thousand range actives on YouTube now, but they are far eclipsed by the most popular transgender YouTubers, many with over a million subscribers. In fact, the most popular transgender YouTuber NikkieTutorials, a makeup artist with 13.9 million subscribers, was not out as *trans* woman until nearly 12 years after starting her channel[108]. This new wave of transgender creators is in some ways notable because the most popular have much wider audiences; they aren't vlogging about transgender experiences as much as they may be creating video essays, doing make-up tutorials, and being lifestyle influencers. Compared to earlier or less popular youtubers, support and advice given around gender-affirming care and mental health is a much smaller proportion of their total content output, but still exists like in one trans entertainer Gigi Gorgeous' account of her sperm bank experience[109]. However, these creators also are more aware of each other. Natalie Wyn and Abigail Thorne, the two most popular transgender creators in "BreadTube"—a loose affiliation of leftist video essayists—frequently collaborate on videos, and Wyn has made her own video performing a close reading on Gigi's sperm bank experience[110].

As Google the corporate owner of YouTube, continues to refine it as a platform, the most viewed transgender YouTubers have expanded their target audience beyond transgender and trans-allied viewers. But again, this doesn't mean that there are no channels aimed at those audiences. These channels have videos like "Being with A Trans Girl: Boyfriend's Perspective"[111], "Being Trans at Work"[112], or "How to Get Rid of Dysphoria"[113]. Many of these channels are

varying mixes of skits, lifestyle vlogs, and trans-specific experience and tips sharing, question & answers, and health advice relating to surgeries, hormone treatments, or binding. A separate brand of channels focuses on voice training, providing exercises and practice tips for people seeing to adjust their speaking voice. This is interesting in and of itself—while speech therapy (by professionals) is included in WPATH's Standard of Care[32], the number and penetration of videos freely available on YouTube for voice training suggests that many trans people do all of their voice training by following online guides—a major disruption in providing care. And of course, transition timelines are still exceedingly popular, by both regular YouTube creators and more infrequent users.

Other information includes general tips on how to pass successfully—how to style clothes and hair, how to stand and walk, how to speak and act—what would normally not be considered health or medicine information. However, as I raised earlier regarding how the same chest augmentation is "cosmetic" for the cisgender body and "medically necessary" for the transitioning body, transgender experiences can interrupt conventional boundaries between medicine/drugs.

YouTube videos about transgender people include four more basic types. Firstly, are news clips, documentaries, and other online content created by media companies about transgender people. Secondly, there are vast numbers of TikTok compilations—anywhere from a couple minutes to over an hour of different shorter videos by many different creators stitched together—that are hosted on YouTube. Thirdly, there are many independent political commentators who produce transphobic content directed at both transgender and cisgender audiences. All these venture too far afield from my main focus, which is on online communities made up of transgender people, or are not easily parsed, in the case of TikTok compilations (TikTok is a large hotspot of transgender community building but is difficult to search because of transgender-term search suppression by the TikTok algorithm).

The final type of content notable on YouTube is medical content produced by non-governmental organizations—frequently by Gender Clinics attached to hospital systems or universities—that reviews the medical processes of HRT and surgeries. Searching for "transgender HRT" or "transgender surgeries" has top search results from UCLA Health and the Cleveland Clinic, among others, designed for transgender patients and doctors that have been published within the last couple years. Certainly, these videos are likely important sources of online health information for many individuals and are evidence of new forms of health outreach by health systems that have been made uniquely available by YouTube.

As a final note on the construction of YouTube is the algorithm. While YouTube allows you to subscribe to creators—sending notifications and a listing of all the new videos released by certain creators—much of video discovery happens through the Watch Next algorithm, which determines what videos you most likely to be interested in based on your history, demographics, and what you are currently watching[114]. There is some evidence that the YouTube algorithm functions to radicalize viewers, and in an effort to drive engagement (i.e. ensure the user continues to watch videos and consequently advertisements), YouTube will progressively suggest more and more extreme videos, either on the left or right[115–117]. Because acceptance of transgender people is frequently strictly aligned with other political views (and is a political hot-button issue itself), and even if it weren't, a large portion of the "community" is organized and mediated by the algorithm.

And this relationship does not act in just one direction, but both. The algorithm is purposefully kept opaque, but both creators and viewers have suspicions on what actions can boost standings and what can hurt standings, and change their behaviors to better boost or bury their own videos or the videos of their favorite creators[118]. For transgender creators, this can mean being very circumspect about sex, graphic details around surgery, and other content deemed "age-restricted" by either the YouTube team or viewers to prevent being buried by the algorithm. I will further note that transgender narratives of sex and sexuality being deemed

"age-restricted" is itself a deeply political choice that assumes that children shouldn't be exposed to transgender bodies or politics, even as many individuals first start reckoning with their gender as young teenagers. Additionally, when viewers "report-bomb" a creator's videos, as often happens with transgender creators, creators are both punished by the algorithm and restricted from advertisement revenue. So savvy creators constantly adjust their content, so the algorithm views it more favorably, even as YouTube's engineers are constantly tweaking the algorithm to prevent exploitation and improve its viewer/ad retention. As YouTube has matured as a platform, its algorithms have gone through increasingly sophisticated refinement to account for massively increased datasets, demographic knowledge, and constant work against exploitation, which has only increased the power and specificity of the algorithm.

Thus, for trans communities—and all online communities—the algorithm(s) that disseminate creators and their content are a major actor of power. All communities on YouTube are subjects of its exercise, and the engineers working behind the curtain have zero accountability to users. As mentioned before, the purpose of algorithm is not distribute information, spread power, or, as the YouTube's mission statement says, "to give everyone a voice [because] the world is a better place when we listen, share and build community through our stories"[119]. Rather, the algorithm is meant to increase the number of ads watched by viewers. And achieves this goal not by using a "human" conception of what matters to viewers, but by feeding an incredibly large amount of data lacking any social context into predictions, guided by rules—about video length, about comments, about watch times--implemented by engineers. This has important implications for medicinefuck and genderfuck. Creators' continued viewership and their communities are dependent on the algorithm for continued success. Even if algorithm rankings were not important for effects on creator revenue and sponsorships—and it seems reasonable to assume that many of the smaller creators who make pittances from YouTube are not in it for money—you can't have a community without viewers. And because medicinefuck and genderfuck go beyond typical social norms—either in talking about "age-restricted" topics or

being subject to report bombing because of trans topics—YouTube is inherently less friendly towards medicinefuck movements.

This is not meant to imply that social norms wouldn't matter in the absence of an algorithm—as Reddit's community moderation will show, these norms can have incredible power. Instead, I mean to highlight that the invisible and largely unknowable algorithm makes social norms harder to navigate and discourages disruptive work around those norms because it can so effectively hide that work from potential viewers. This is also not to say that YouTube does not have creators engaging in medicinefuck and genderfuck; just that the engineered design is hostile to it.

YouTube is undoubtedly one of the earlier centers of online community for transgender people as the internet developed. Its changing design leads to changing styles and target audiences for transgender creators on the platform and has meant that the most successful trans youtubers have largely stopped specifically targeting trans audiences. Despite this, many trans youtubers continue to distribute information on gender-affirming care—both in the narrow definition of as it pertains to hormone therapies and surgical procedures, but much more in terms of dealing with dysphoria, answering general lifestyle questions, and providing tips and other advice for successfully passing as one's identified gender.

2.2.2 Reddit: Forums All the Way Down

Reddit.com is a social media site started in 2005, providing a space for users to submit images, videos, GIFs, and links to individual topic- or interest- specific "subreddits[4]", where submissions are voted on and commented on by other users, or "redditors[5]". Top voted submissions rise to the top of each subreddits listing, or if voted enough, to the site's general front page. Subreddits generally have (volunteer) moderation teams that enforce general site and subreddit-specific rules and generally help manage the community. In this way, it mimics

[4] Subreddits are stylized after their url address; so the subreddit at www.reddit.com/r/BreadStapledToTrees with 300,000 subscribers is written as r/BreadStapledToTrees and contains pictures of bread stapled to trees.
[5] Similarly, users are referred to as u/[username]

some aspects of standalone forums; with pinned posts, search functions within subreddits, a robust commenting system designed for discussions and replies. The user drives most engagement by choosing subreddits to join, rather than an algorithm that suggests posts or subreddits (though algorithms are still important to Reddit's operation). Reddit is the seventh most popular website in the U.S[120], and has a relatively large and very active transgender community.

Because subreddits can become very topic specific, there are many for trans people and queer people in general. Trans focused subreddits include humor subreddits like r/traaaaaaannnnnnnnnns and r/egg_irl; lighthearted chat subreddits like r/TransyTalk and r/TransVent; political action subreddits like r/LateStageGenderBinary and r/tranarchism; and general subreddits like r/asktransgender, r/MtF, r/ftm, and r/transtimelines. These subreddits range in popularity—the most popular have 300,000 members with thousands of comments each day, and the smallest just several thousand subscribers. Compared to large subreddits, even the most popular trans subreddit is on the smaller side—over 500 subreddits have over one million subscribers[121]. But because the Reddit administration designed Reddit to encourage cross-posting submissions to several subreddits at once, which frequently overlap in the nature of topics; most users are members of many of these subreddits at the same time. Additionally, moderators of one subreddit are frequently also moderators of other subreddits, so there is "official" interchange from one subreddit to another encouraged by moderators (i.e., "check out our sister subreddits in the pinned post") and by users.

Like the forums that Reddit was originally modeled after, subreddits and the general Reddit community have a highly specific language of communication relying on in-jokes and references that can be impenetrable to new users. For example, r/egg_irl, a trans humor subreddit, focuses on jokes and memes about trans people who have not yet come out to themselves (uncracked "eggs") spotted in the wild ("irl," in real life). Reddit is also notable in that many of the largest trans subreddits only really started their explosive growth in the past

several years, and simultaneously overtook some longer-established trans focused subreddits[122]. This is indicative of both Reddit's growing userbase and the impact that moderation can have on a community.

Other than the subreddit's title, moderation is the only distinction between any given subreddits, and done entirely by volunteer teams. With few exceptions, most trans-specific subreddits are strictly moderated: the wider Reddit community can be virulently transphobic, as well as bigoted in other ways, and since all subs can be accessed by any user absent a user-specific ban, moderators frequently need to remove transphobic comments and posts. Another option employed by some subreddits is to automatically ban any user who frequently posts in certain subreddits. In the past, those auto-ban worthy subreddits have included r/The_Donald and r/NoNewNormal, a Donald Trump fan subreddit and COVID-denial subreddit respectively that were both later permanently deleted by Reddit corporate for harassment and rule breaking. Moderation is a frequent place of contention among Reddit users for a multitude of reasons[6], illustrating the importance of a community's self-regulation to its development. Again, since moderators are volunteer users, this complicates the division between community leadership and community members and between moderation and participation.

Community moderation can be both more and less opaque compared to YouTube's algorithms. Communities almost universally have explicit community guidelines, ranging from the specific, like formatting rules, to the general, like rules against hate speech or calls for violence. However, community moderators have ultimate discretion over when to ban or delete user submissions. This means that many subreddits have gone through periods where users have revolted against community moderators (or vice versa) for abandoning or revising guidelines, leading to the creation of splinter subreddits, subreddit swaps (where two subreddits

[6] On many leftist subs like trans subs, the discovery that a moderator is a "tankie" (slang for a supporter of the authoritarian tactics of the USSR and Chinese government) can cause entire communities to shift url addresses.

switch topic but not names), or resignation of moderators, either by themselves or when forced to by other members of the moderation team.

But unlike YouTube, moderation is a frequently talked about in communities. This, coupled with the ability to make your own community with different moderation rules, means that there is great diversity in subreddits: for nearly any category, you can find a subreddit that excludes or prohibits the other side. Trans subreddits can reflect ideological splits in the trans community like that around the (un)importance of dysphoria, or more basic splits of whether the topic is primarily trans men or women, or nonbinary people. The administration-built community moderation around community-specific norms instead of sitewide norms. Ultimately, this means that discussions around medicinefuck can be more fruitful—subreddits, especially trans subreddits, can be very open to discussing medical information and explicit content that might be "age-restricted" in other contexts. Following is a brief, birds-eye view of some the conversations and community guidelines in some trans subreddits.

Advice, memes, and encouragement are the largest areas of engagement across most of these subreddits. r/transtimelines, a subreddit with 150,000 members, is devoted to users posting timelines of their transition, whether assisted with hormones, surgeries, or just changes in gender presentation. The typical format of a r/transtimelines post is two or three pictures, one labeled as some months or years prior to transitioning or the beginning of hormone treatment, and one labeled with the time since beginning HRT, or a transition more generally. One r/transtimelines example from u/ProjectZach is especially interesting: u/ProjectZach posts about the "project" of his transition into Zach across bodybuilding and trans subreddits, and on his (now-deleted) tumblr[123]; an acknowledgement of the way that his identity has consciously molded and designed. Comments are nearly universally positive affirmations, as it is a heavily moderated subreddit, sometimes with questions about specific details about the HRT or the surgeries/doctors, or other details. Comments on timelines act to reinforce gender presentations, and frequently contain affirming gender signifiers. Rather than

comments saying “you’re beautiful!”, it’s “you’re beautiful, girl!”[124]. In this way, participants on r/transtimelines are not just sharing their transition but enacting it through visual media; by posting their timelines, they reinforce and create their transition through gendered bodies and in a gendered space. In discussing transition timelines on YouTube, Raun suggests that these timelines are “steps towards comfort, negotiating how one is or can be seen”[85]. In this reading, while r/transtimelines can be inspiring and helpful to those who have not yet started their transition, its main purpose is for the redditors seeking reinforcement. r/transtimelines follows in the long tradition of trans people sharing before/after pictures; from Christine Jorgensen, the “Ex-GI [Becoming a] Blonde Beauty” with illustrations in the New York Daily News[35], to the aforementioned timelines posted on YouTube starting in 2006.

But there are subreddits like r/MtF and r/ftm can get even more detailed than r/transtimelines, and are more frequently places of information sharing, not just community support. In r/ftm, u/sourdoughpizzacrust details his mastectomy by describing his age, surgeon’s name, surgery type, and pre-op preparation[125]. He talks about his complication (a suture that wouldn’t dissolve and had to be manually removed) and his scar care and discusses his experience with another user who also had a mastectomy with the same doctor. In r/MtF, u/dearMontserrat reaches out for support after a consultation for facial feminization surgery went poorly and increased her insecurities, and other community members offer their own opinions based on her pictures on what would be most important to get done in a facial feminization procedure[126]. This is especially interesting for how it displays a disruption of the normal process for surgeries; instead of seeking second opinions from other surgeons, u/dearMontserrat first reaches out for community support.

But like YouTube, subreddits can support users in other ways. On r/MtF, u/Crazy_Explosion_Girl asks if “straight trans women…exist” because she “genuinely feel[s] sorta isolated”[127]. Other redditors reassure her, share their own experiences with their changing sexuality, and commiserate with her perception that many spaces for trans woman assume a

lesbian or bisexual orientation by default. Another subreddit which focuses on community support (if through a humorous lens) is r/egg_irl. On r/egg_irl, users have user-inputted "flair" (short descriptions appended to their username) describing their status as an "egg" (trans still believing they are cisgender), "cracked," or just trans, along with other egg-related puns. But for a user to even label themselves as an 'egg' is to acknowledge that they are not comfortable with their gender; as u/ExpendableToMe (flair: *on crack*) points out: "cis people don't have eggs"[128]. Meme subreddits like r/egg_irl and r/traaaaaaannnnnnnnns provide anonymous opportunities to seek affirmation and shared experiences, and help individuals better understand their own feelings on their gender.

The Reddit system of hyper-specific subreddits and strong, user-led moderation tools creates fertile ground for trans online communities to develop. These communities are important places to share both medical information (in the classic sense) and information on all aspects of life as a trans person, as well as better develop user's own understanding of their gender identity.

2.3 Medicinefuck Online

Both YouTube and Reddit have medicinefuck shared across them, though their differing designs and moderation strategies necessitates differing content. Medicinefuck has existed prior to these specific online systems, and online systems in general, but new online communities have provided fertile ground for the further development of medicinefuck in much the same way that they act as new ground for genderfuck. This is most evident when examining sex and performance.

Sex is a frequent undercurrent of discussions in trans online communities. Transition timelines show how "friggin hot" and "yummy" the poster has become[123], medical advice posts discuss the suitability of various genital surgeries for sex, and navigating shifting sex drives and sexuality is a frequent topic across online communities[127,129]. These sexual undertones necessarily complicate narratives of medicine which frequently position sex and sexual activity

outside the medical sphere—or, when they do intersect, deny the intersection outside of the doctor's office. The (nearly) permanent archiving of online communities and the permissive attitudes of many provide fertile ground for disrupting conventional doctor-patient hierarchies that position the doctor and health system far above the patient.

Many trans YouTubers have Q&A videos with their romantic partners, where sex is a subtle but persistent undercurrent of discussions of romantic life—or outright talked about[130]. Jamie Raines, a trans YouTuber, had "strict boundaries" in his sex life before "particularly top surgery—bottom surgery, less so"[131]. This indicates the shifting sexual and intimate desires and comfort levels that can accompany gender affirming care, and how, at least for Raines, not all gender affirming care is created equal. Raines and his partner are an interesting case for another reason: Raines has a PhD in psychology and is a researcher of gender and sexuality health—but both Raines and his partner are prolific lifestyle vloggers on YouTube who tend to avoid explicitly scientific or medical theorizing videos. Raines' dual position as medical researcher and very non-medical vlogger confound the line between doctor and patient, and in ways that many of his viewers don't even consider. But certainly, Raines' discussion of his sex life implicates gender affirming care and reminds viewers how important sexual dimensions to medical care can be.

Outside of these partner videos, discussions of gender-affirming care nearly always include sex either explicitly—in the case of discussing how hormones impact sex drive[132] or sexual function after genital surgeries[133]—or implicitly. Video transition timelines of transmasculines feature flexing chests and pecs as objects of sexual desire: for Raun, a "fetishized marker of masculinity[85]", and one that engages as much with the medical interventions which shaped those chests as it engages with the language of gender. In the case of trans online communities, the sexual aspect of this medicine—since so much of gender affirming can be about looking sexually attractive or feeling sexually functional and non-dysphoric—becomes an explicit mechanism of disruption. It makes more sense to seek

sexual advice about gender-affirming care from *people who have sex*, not the doctors who prescribe care.

A quick note on "sexual aspects" in medicinefuck. I am not arguing that the trans experience is one that automatically implies sex, or sexual activity. Linking sex (usually as a moral ill) with trans people belongs to the rhetoric of transphobia, often expressed in talking about "sexual deviation." That very phrase creates a normative sexual politics and consigns queer sexuality and gender to historically criminal and medicalized margins[134]. Rather, medicinefuck invites sexual readings because it more openly engages with sex and acknowledges sex as an important aspect of human lives and human communities. Medicinefuck says that sex matters and brings that focus on sexual mattering into the health system through interactions across communities.

Tongue-in-cheek disruptions are common online and comprise a part of medicinefuck. For example, most gender-affirming care has very specific medical language: gender-affirming care is itself medical language for a broad range of technologies. Online, communities frequently refer to gender-affirming care in much cruder language. Wyn says that she refers to her bottom her surgery not as "gender confirmation surgery" but instead as her "sex-change operation", despite that calling it a sex change not accurate, because calling it a sex-change "makes her laugh"[110]. Hormone therapies also have cruder slang terms. Feminizing hormones are most frequently called E or Spiro (as in estrogen and spironolactone, an antiandrogen), but also Titty Skittles, Titty Pills, Tit Tacs, Anticistamines, Breast Mints, and Antiboyotics[135]. These names take back the molecule from medical science and highlight the effects and purposes of the biotechnology—promoting breast growth and creating a new trans gender presentation—instead of the scientific name. Medicinefuck allows trans communities to rhetorically control the titty skittles, rather get controlled by doctors who prescribe estrogen.

Performance is the bread and butter of these interactions. As mentioned, the internet's archival powers are immense: any information a user submits publicly becomes a part of that

user's personal performance of digital life. While true on Reddit, it is especially true on YouTube. Taking a video of yourself for public consumption—not just validation, like on r/transtimelines—is a performance that is used by bloggers to create their masculinity and transness[85]. In the same way, when bloggers disrupt the typical medical information hierarchy by offering their own perspectives, outcomes, and advice, they perform this disruption. While oriented towards helping the viewer, it isn't enough to say that these videos are altruistic—there is an element of performing medicinefuck for the blogger's sake. Video's detailing self-administration of hormone regimens[91,136] may caution or reassure viewers, but the simultaneously are exultations of pride—pride in controlling their own body, their own medicine, and their own health.

Subreddit communities similarly engage taking back control from medical systems. In many jurisdictions, trans people are required to speak with a psychologist prior to gaining access to gender-affirming care through the medical systems, such as in Britain[137]. WPATH's Standards of Care recommend that there be a referral process for trans people to access medical interventions[32]. These requirements, some more onerous than others, frustrates trans people as an additional barrier to accessing care.

> "How many trans people does it take to change a lightbulb? The answer is… only one! But they will have to get three professionals' approvals that the room is, in fact, dark."
> *-Transcription of post by u/atinaaaaa on r/traaaaaaannnnnnnnns*[138]

The fact that the room is dark—or in a similar joke, that you are hungry[139]—is practically self-evident, just as a trans identity, gender dysphoria, or gender euphoria can be self-evident and the requirement that you receive an referral both a major barrier and at some level insulting. In the comments on these post, users don't provide solutions to these problems, but continue to commiserate about the frustrations of dealing with medical systems and cis people who doesn't understand trans experiences[138,139]. This is a slight, and firmly tongue-in-cheek, disruption, but a disruption none-the-less.

Disruption of information hierarchies is especially evident when looking a particular brand of video: one that explains the decision to not seek genital surgery[140,141]. Ignoring, for the moment, the large financial, social, and medical barriers to intensive surgeries like genital construction, these videos are a conscious rejection of a dominant mode of medical consumption. The United States loves to consume medical care, whenever it can. If insurance will cover it—whether it be a drug, a surgery, or other procedure—then insurance incentivizes the patient's consumption, or the doctor's prescription. The argument—literally performed on a public platform for advertising revenue—that such consumption is not right for everyone's health or happiness is one that strikes right at the heart of health systems. Trans YouTuber Blaire White's video thumbnail features her gleefully biting into a hot-dog[140]; playing with phallic representations in a medicinefuck performance.

But focusing too much on the literal performance on YouTube blinds the eye towards subtler (and yet more literal) forms of performative medicinefuck. The output of gender clinics and, to a lesser degree, plastic surgery practices on YouTube is a prime example of this second-order performance. Many clinics and practices have Q&As with surgeons and support staff. In these cases, the clinic participates in medicinefuck by performing a sort of mock consultation that brings medical information outside of the 1:1 doctor-patient relationship and into a public forum. To be sure, the clinics would couch this activity in the language of medical care—as patient outreach that serves to connect practitioners with potential patients and empower patients on their health journeys, for example—but there remains a thread of medicinefuck. Perhaps this only exists in the extent that such patient outreach is a response to criticisms (originating within and without medicinefuck) of existing information and power hierarchies. It may be more useful to separate this sort of performative content into an understanding of the *impacts* of medicinefuck on health systems, rather medicinefuck itself. Regardless, growing interest in using social media as a tool for patient outreach acknowledges

the transformative power of social media in general, the importance of reaching patients where they are, and the active health-interest communities online[142].

Medicinefuck also fosters more explicit interactions between online communities and health systems. In 1948, the World Health Organization (WHO) radically redefined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity[143]." Despite this longstanding definition, health is frequently understood in the much more limited capacity as a disease, despite public health's best efforts. As a prime example, look no further than the medicalization of transgender people. I will point again to the Diagnostic and Statistical Manual of Mental Disorders (DSM), which from 1968 to 2013 defined being transgender as a *disease*[33] (needing to be cured, presumably). Only after concerted effort by trans activists was the DSM 5th revision updated such that while acknowledging the health impacts of gender dysphoria, it understood transgenderism as not as a disease but a factor that influenced "physical, mental and social well-being" aspects of health. This change was spurred by dissatisfaction among online trans communities as well as the more formally organized World Professional Association for Transgender Health (WPATH).

But trans communities did not stop there. DSM-4 defined the diagnostic criteria for trans people as a mental illness called "Gender-Identity Disorder", or GID[7]. WPATH and other trans advocates argued that such a criteria pathologized trans experiences and stigmatized trans communities. In the DSM-5 revision, the working group (comprised mostly clinicians) of struggled with balancing the goal of reducing stigma while maintaining a comprehensive diagnosis that allowed access to care[144]. DSM diagnostic criteria are important aspects of getting insurance to pay for psychiatric and other forms of care. Eventually, the working group settled on "Gender Dysphoria," the "marked incongruence between the gender they have been assigned

[7] In a quite frankly hilarious example of the role of technology in mediating language, the Microsoft Word automatic spellcheck recommends that I replace "GID" with "gender dysphoria" because it is "best to avoid language that could imply a gender bias." Such a recommendation is surely driven by the DSM-5's switch to calling the diagnosis gender dysphoria, itself prompted by trans activists, leading to this bizarre ouroboros of shifting language.

to … and their experienced/expressed gender. This discrepancy is the core component of the diagnosis. There must also be evidence of distress about the incongruence"[145]. This emphasis on distress as necessary for diagnosis has frustrated some in the trans community. WPATH's most recent Standards of Care 7 (SOC7) stress that gender dysphoria, while possibly an important concern, does not need to be present for identification as trans[32]. More generally, the WPATH—which includes clinicians, physicians, and activists and community members in its advisory board—is highly cognizant that the trans community has members who reject any amount of pathologizing and diagnostic frameworks[146]. This is in some ways a form of medicinefuck itself—forget WHO's expansive definition of health which necessarily implies that there is a diagnosis for a poor "state of being," this is an absolute of the medicalization of trans identities. As discussed in Chapter I, from the earliest usage of transsexual and transgender, medical workers have incorporated trans identities into medical literature (and medical hierarchies). To actively fight, online or not, against this absorption of sexual and gender identity is profoundly an expression of medicinefuck, and one that has been active for as long as trans identities have been medicalized. WPATH is currently seeking feedback on the 8th revision of its SOC, and there is some discussion on the revisions from community members on YouTube[147] and Reddit[148–150]. All of discussion is meant to highlight how medicinefuck has broad effects across the health ecosystem.

2.4 What Isn't Medicinefuck?

My construction of medicinefuck as theoretical framework is necessarily broad, reflecting the way that medicinefuck seeks to broaden or disrupt rigid, normative frameworks. And medicinefuck exists beyond trans communities (and online communities). However, this is not to say that everything is medicinefuck. My outline of medicinefuck at the beginning of this chapter still holds: medicinefuck is a performed "fucking" of medicine. This means that many of the disruptions of medicine don't belong under this umbrella, or only occasionally belong A prime example of this is in current discussions about vaccine safety and COVID-19 denialism.

Vaccine hesitancy—or the desire to delay, perhaps indefinitely, uptake of a given vaccine—has long existed, but online networks and social media particularly has led to rapid growth in vaccine hesitancy[151]. COVID-19 denialism specifically is a more recent development, but naturally overlaps with vaccine hesitancy or refusal[152]. Fundamentally, medical misinformation on the internet is a disruption of medicine—both in impact (lowered vaccine uptake) and in form (who is trusted to dispense health information?). YouTube and Reddit are hotspots of vaccine and COVID-19 skepticism, and have both implemented measures to control this misinformation[153,154]. While the larger pathology of medical mistrust, conspiracy theories, and COVID-19 denialism is beyond this work, it is clear that at times, these anti-vaxers perform medicinefuck. Fears about the effects of the COVID vaccine and fertility abound on online communities[155,156]; skeptical individuals use the language of sexual virility and prowess to distinguish themselves from those who taken the vaccine[157]. Sex and sexual function are a sensitive issue for many people, and so centering "medical information" discussions around sex makes the message more attention-grabbing. Mask-wearing is also subject this is idea, where "capitulating" to mask mandates indicates a weak or defective masculinity[158]. Conversely, vaccine "supporters" highlight evidence that COVID can cause erectile dysfunction[159]. In trans reddit communities, joking that the COVID vaccine or infection has caused gender transition is a well established meme[160,161] In a way, this is an anti-medicinefuck: using sex to appeal to medical authority and the health system status quo.

Not all vaccine skepticism or COVID denialism is medicinefuck, though it is all certainly a disruption of medical hierarchies. In the same way, many of the interactions between members of trans online communities are not medicinefuck, even if they are a disruption of medicine. In Chapter III, the close readings, it is important to understand that the selected readings are a small percentage of total community output, and not even all health information sharing in these communities are medicinefuck, instead just being a general disruption. These disruptions may be beneficial, or may not—as in the case of vaccine misinformation—or may be entirely

unclear in effect. Crucially, medicinefuck is a medically disruptive performance that implicates sex.

2.5 Cyborgs Fucking in Pharmacopornography

At some point in outlining a new theoretical tool, it becomes important to ask—why does it (f***ing) matter? Medicinefuck may be an apt description of a particular form of medical disruption, a disruption that may be quite common across the internet, but it might not be a useful description. To answer this question, I look to Preciado's *Testo Junkie* once again, as well as Donna Haraway's *Cyborg Manifesto*. In Preciado's pharmacopornographic regime and in the construction of his book, I find the tissue linking medicinefuck to larger social structures. In Haraway's cyborg biopolitics, I find the importance of understanding medicinefuck as tool and weapon. Medicinefuck matters because it creates and reproduces medicine, or the control of the body.

A quick recap of the important understandings drawn from Preciado's *Testo Junkie*. First, the use of hormones in medicine is indicative of a new era of pharmacopornographic capitalism and the control of the body. This regime creates a biodrag performance of gender—equally, a technodrag creation of technogender—while various forms of medicinefuck and genderfuck work against technogender and the capitalist control of technogender.

This brings us to the construction of *Testo Junkie* itself. The book is about his "refusal of the medico-political dose" in testosterone addiction. This disruption is where I see genderfuck and medicinefuck. Genderfuck, (or gender hacking, bioterrorism, or copyleft politics, as Preciado uses) in Preciado's construction of a pharmacopornographic regime uses the molecules of pharmacology as a weapon against technogender. This is evident in Preciado's own self-administered testosterone and his disavowal of the neoliberal (i.e. pharmacopornographic-industry-driven) project of transness which incorporates HRT under the aegis of the state, tightly regulated by industry and medicine. But I define Preciado's gender bioterrorism as simultaneously medicinefuck—in Preciado's construction, it is already

"anti-pharmacopornographic activism" which seeks to disrupt medical and pharmacologic industries to end up with "viable forms of incorporated gender". Medicinefuck is performing disruptive sex: *Testo Junkie* is about being a junkie of sex, testosterone, technology, and gender.

To express this addiction, Preciado graphically describes his sex, his dildos, his dosages, his highs, and his lows in a sexual economy. He describes visits to his doctors and gynecologists, documenting their confusions and befuddlement. Thus, an integral part of his pharmacopornographic theorizing lies in his usages of his biology and his pornographic expressions as the capital from which he extracts the value (of the book). Preciado performs (for the reader) the very technobody capital extraction that he describes. Preciado's work goes beyond just describing what I call medicinefuck: it is medicinefuck itself.

In the same way that technology and gender-affirming care creates Preciado's technogender, technologies of interaction and pharmacology create medicine. Or, at least to the extent that technomedicine can be distinct from the technobody[8]. Medicinefuck, like genderfuck, uses technology as tool of its construction of what "medicine" means, or should or shouldn't mean. It is not a disruption that leaves the subject mixed-up but fundamentally unchanged: rather, medicinefuck is an attempt to entirely reconstitute medicine. That matters, quite a bit.

Of course, "technomedicine" is not nearly as radical of construction as technogender. The concept that medicine is determined by technology is practically self-evident. My purpose when talking about technomedicine is in linking between disruptions of technogender and medicinefuck as a disruption of technomedicine. Haraway's *Cyborg Manifesto* becomes useful this linking project. The *Cyborg Manifesto* calls for the development of a cyborg politics—a politics that allows an escape from the "maze of dualisms" that embroil political and theoretical thought[162]. Preciado also draws on the cyborg as for his technobody/gender development of pharmacopornography, but the cyborg has a productive use in understanding medicinefuck in

[8] This is a further reason that I am drawing my theory of medicinefuck largely from trans communities: technogender and medicine are already so linked, that genderfuck and medicinefuck (as disruptions of each) are deeply intertwined.

its own right. Medicinefuck is a destabilization—between doctor and patient, between medicine and health, between health and life.

Haraway's Manifesto is meant to "build an ironic political myth faithful to feminism, socialism, materialism"[162]. The cyborg is a fiction to match the fiction of the concept of "'women's experience'" [quotes original], and as fiction and lived experience it is a tool to map reality and understand social relations[162]. Medicinefuck is not so ambitious as a theoretical tool but is certainly an offspring of the cyborg realities of online communities and medicine. Like the cyborg, it looks "for *pleasure* in the confusion of boundaries"[162]—and uses pleasure to confuse boundaries—in search of a better mode of life and medicine.

Like medicinefuck, Haraway's cyborg is ""resolutely committed to partiality, irony, intimacy, and perversity."[162] Medicinefuck's commitment to these values is obvious across trans YouTube TikTok compilations and the many meme subreddits. For example, one Redditor posted a combination transition timeline/meme making fun of COVID-19 denialists who believe that vaccines have side effects (and as discussed previously, are widely lampooned as masculinity-obsessed). The before picture labeled: 'before the "covid" "pandemic"'; the after picture: 'after three "vaccine" shots' [quotes original]; the bottom text: "WAKE UP SHEEPLE!!!!!"[161]. This post is intimate and celebratory—the poster is proud of her transition—yet ironic and self-deprecating, referencing conspiracy theories built largely on massive distrust of medicine and health authorities. The posts' title is a reference to far-right commentator Alex Jones, whose exclamation that the government is "turning the freaking frogs gay" is frequently mocked in left-leaning online communities[9]. Finally, in the comments, the original poster shares the details of her vaccine regimen: the Moderna two-dose and an Astra-Zeneca booster[161]. Medicinefuck engages on multiple levels with multiple subjects, and

[9] As at further, probably unintentional, level: "gay" frogs fears arise from the use of a pesticide, atrazine, which is its own subject of theoretical and scientific critique[163,164]. Atrazine seems to lead to frog populations with significantly higher proportions of intersex individuals. So, in the journey through the internet, frog intersexuality turned to frog homosexuality implying (morally bad) human homosexuality, turned to mocking joke, turned to meme-y description of human gender transition.

this cyborg interplay of irony, intimacy, perversity, and boundary-breaking is the aspect to which medicinefuck is most closely related.

Chief among the dualisms the medicinefuck targets is the distinction between doctor and patient. It has been popularly problematized before: look no further than the idiom that "doctors make the worst patients." The crossover or breakdown of the doctor-patient dualism is well easily acknowledged because doctors frequently become patients; yet is maintained because we view that switch as difficult and suboptimal. The relates back to the medicinefuck imperative that medical advice should come from people who have sex, not doctors. But of course, doctors also have sex—it is in the rhetorical imagining of them as doctors within the doctor/patient dualism that renders them celibate. This dualisms has toxic effects for health care: lack of patient power and agency leads to poor decision making and poor health outcomes[165,166], and increasing patient power is one of the acknowledged benefits of trans online communities[103]. Haraway places the cyborg not in the dualism itself but across social locations— that "logically and practically impl[y]" each other. Medicinefuck as cyborg technology does not exist in the clinic, or the home (as the doctor/patient dualism would demand); instead, it exists across (and in many forms) the various places of internet community, across fiber optic connections and between the connected optical ports of humans seeing each other face-to-face. Through all of them, medicinefuck as a technological project binds and chafes people and subjects together.

The *Cyborg Manifesto* is deeply interested in the political category of women—it is on that subject category that the cyborg intervenes. Medicinefuck is focused on intervening in medicine, not women, but I will point to the cyborg's connection to Butlers' "open coalition"[167] for the political organization of feminism to understand medicinefuck's broad category of "medicine". The cyborg urges a broad consideration of medicine and health.

The cyborg has been utilized in discussing trans experiences with medicine before. Michelle O'Brien's *Tracing this Body* tells the story of O'Brien's medications—both synthetic hormones and HIV drugs on which she depends[40]. O'Brien writes about the contradictory

politics of capitalism which claim these drugs as property. In the cis case, the FDA regulates synthetic estrogen for the post-menopausal women who wishes to avoid the uncomfortable symptoms of hormonal changes, and for whom a massive industry has created itself, funded by insurance. In the trans case (of the early 2000s), hormones are off-label, must be illegally bought and imported from outside the U.S., and are most definitely not covered by insurance[40]. Hormones are not the only place where the same medicine is thought of differently.

Surgical procedures like rhinoplasties, other face surgeries, hair removal, chest augmentation etc. are often called "cosmetic" surgeries when performed on cisgender people, but there is disagreement to the extent that these surgeries can be considered "cosmetic" in the context of gender-affirming care[32]. This has important implications—public and private insurance will generally cover "reconstructive" surgeries like mastectomy or vaginoplasty but is less likely to cover "cosmetic" surgeries. However, for many gender-variant people, facial feminization, including rhinoplasties, or breast reduction/augmentation is important for their quality of life[46]. Preciado writes that this is evidence of "two clearly distinct regimes of power-knowledge [that] traverse the body and that they construct the nose and the genitals according to different somato-political technologies." Medicinal systems can alternatively reinforce these separate regimes/technologies, or as some do, disrupt it: the *Standards of Care* from WPATH encourage an expansive view of medically necessary surgeries, as does the American Psychological Association and the American Medical Association[168,169], but that it not always the case for specific insurance plans, and certainly was not the case even fifteen years ago.

In some ways, cosmetic/medical is its own dualism with defined boarders and lines; but as a dualism it is much more unstable owning the fact that the same chest augmentation is "cosmetic" for the cisgender body and "medically necessary" for the transitioning body. Online trans communities sometimes mention this—commenting on masculinization face fillers used by a cis man, one twitter user (reposted on reddit) asks if he had to "suffer through years of

psychological and medical gatekeeping" for his surgery[170]. The health system at large draws the border between cosmetic/medical—not by individual people. Medincinefuck attempts to change drawing.

O'Brien writes about the difficulty of engaging with these oppressive health systems. Conventional anti-capitalist activity—"a politics of purity and non-participation"—is inadequate in the face of "survival depend[ing] on substantially accessing global pharmaceutical industries."[40] The perverse, participatory, and performative medicinefuck can act here as a way to take power back from these systems. That is not to say that conventional anti-capitalist activity is not important, or not happening in online trans (or general) communities. O'Brien's acknowledges of the way that her technologically, medically created gendered body depends on global capital flows, even as her technogender is illicit and unapproved. But in the next two decades from O'Brien's original publication, trans medical needs for gender-affirming care have increasingly been subsumed into global capital: health systems can make more money from prescribing and charging for HRT then just allowing trans people to procure their own. Here, we also have a fortunate warning from Butler, who reminds us that countering violence "must be careful not to install another in its place." Because gender-affirming care is important for health, it becomes a mechanism of the health industry, and the health industry becomes its proponent[10].

And so O'Brien's cyborg deployment connects right back to Preciado's pharmacopornography. Pharmacopornographic capitalism is a model for extracting value from the technobody, which is itself a creation of the technogender formed by pharmacopornographic activity. In this case, gender-affirming care becomes the product sold from the body (and its supposed "infirmities"). However, there exist disrupting projects, like Preciado's gender bioterrorism—or what I call medicinefuck and genderfuck—which challenge formulations of

[10] The larger question of whether the increasing incorporation of gender-affirming care into capitalist structures is a net positive or negative is beyond the scope of this thesis, which more narrowly investigates a project which intervenes in that subsumption which the purpose of improving lives. Perhaps the harms of capitalist incorporation can be avoided with a good medicinefuck—we can have our cake and eat it too.

technobody, technogender, and (techno)medicine. In challenging technomedicine and the dualism of doctor/patient, cosmetic/medically necessary, medicinefuck is a cyborg project: both coming from cyborg people and creating a new cyborg as an intervention itself. Alternatively, perhaps medicinefuck is a fight over who controls the cyborg body/technomedicine. In the next chapter, I explore in close detail what this medicinefuck looks like and its impacts in several different forms on online media.

Chapter III Visting the Doctor and Other Close Readings

3.1 Close Reading: Vlogging the Sperm Bank

A look to Gigi Gorgeous' previously mentioned video on her sperm bank experience is instructive for understanding the sexual undertones of medicinefuck . "*MY SPERM BANK EXPERIENCE*" is a 16-minute-long monologue from Gigi Gorgeous about her experience donating sperm for in-vitro fertilization with her partner. Gigi Gorgeous is one of the larger trans influencers and comedians; she has 2.77 million subscribers on YouTube and over 2.2 million followers on Instagram. Her YouTube Channel includes makeup tutorials, stories from her life, Q&As about her personal life, and influencer style stunts, and she sometimes courts controversy. In this video, Gigi charts' the preparation, the actual visit, and follow-up news. I argue that her presentation of the story is an intense medicinefuck of the doctor's office and of IVF more generally.

Gigi starts by describing her goals in pursuing IVF, gushing about her doctor, and setting the scene. Immediately obvious is her discomfort with the entire situation. For her to visit the sperm bank is to "drop all of [her] pride, all of [her] womenhood"[109], something that is deeply uncomfortable for her to think about, or say. She skips her first appointment because she was so uncomfortable "go[ing] in there looking the way I do … and having everybody know." A lack of cultural competency and familiarity with trans people and issues is one of the major points of friction in trans access to care[105,171] She only goes through the second after receiving an

outpouring of support from her viewers[109]. This aspect of discomfort with the health system, and then relying on support from online communities is a common one across communities that share health information, not just trans communities.

She then details what another "awful" aspect of the experience. To ensure that she could provide a good sample, she not only had to stop taking her feminizing hormones but had to start taking testosterone supplements (designed for cismen with fertility problems). Gigi describes her desire to "stay on track with [her] transition", and how trans people can know that their "hormones are everything" to them[109]. But then, she does something very interesting. "Fine", she says, "I will stop all of my hormones so, you know, my shit can get juicy again", accompanied with laughter and miming[109]. This is where the medicinefuck truly starts. This description of the process refuses the medical language and the medical demeanor. While Gigi does eventually use the medical language of volume and live sperm count, she introduces the concept by talking about getting "juicy" again. Gigi is a comedian, and certainly, her word choice and performance is meant to prompt laughs. But laughter is equally a tool of disruption, and this disruption only grows throughout the video.

Her next big obstacle comes when she interacts with the receptionists at the sperm bank. She dislikes saying out loud that she's here for a sperm donation, but her gender presentation as hyperfeminine (and gendered expectations of who donates sperm) means that she needs to repeat herself repeatedly to many different health workers. This becomes a part of her comedy—each repetition is increasing awkward and uncomfortable, something that she can laugh about with her viewers: "I am here, to give sperm, from me, to be frozen, now." The repetition also indicates the sometimes-uncertain effects of passing. A part of Gigi's discomfort comes from her successful passing as a ciswoman—this passing requires her to clearly indicate that "contradiction" of her trans identity—and in doing so, refuse passing. Or perhaps, this is just an indicator of the contingent nature of passing; Gigi describes how in the waiting room she and her friend were being "so annoying and obnoxious" using gay slang sex jokes to describe the

doctor. In utilizing this humor, Gigi continues to pass, or more properly, navigate her identity presentation for the audience of sperm bank donors and receptionists. Gigi uses her comedic performance to turn a deeply uncomfortable medical experience into an experience community members can grasp and understand, one that is more familiar and safer.

In the donation room, Gigi highlights how uncomfortable and medicalized the procedure is. The doctor is "just like, going through the protocol, like what he tells people before they're about to ejaculate into a cup" in a room with harsh fluorescent lighting, tile floors, a strange leather recliner, sterile plastic sheets like "human pee pads" and "movies, for today?" offered by the doctor. Gigi strikes right at the heart of a problem that medicinefuck is well equipped to deal with: medical systems are bad at dealing with sex. She notes how distracting it was to have hallway noise seeping through the door and advises viewers to ask if their sperm banks have soundproofed rooms. Sex must be suborned to the medical discourse of sterility and protocol, but by telling this story, especially in a comedic manner, Gigi refuses and disrupts that discourse.

Gigi skirts around describing the actual masturbation but tells us that in the heat of the moment, she forgets to aim for the cup and her ejaculate hits the wall.

> "And I know that this is graphic but [b****] it's just the realness … I took the cup, and I was full-on like, scraping it off the wall because I was like, I'm not gonna let any little drop got to waste …I literally took the cup and I'm like scraping it off wall to get as much as I can to screw it on and I like, breathe the biggest sigh of relief of my life. I'm like, that is done, I am done, this is perfect."[109]

More than ever before, sperm donation, which the sperm bank has attempted to medicalize and as far from sex as possible, becomes entirely farcical. This is comedy, but also medicinefuck. Gigi has used her audio and visual performance (she mimes the scraping) of sex to interrupt the medical discourse. In her close reading of this video, Natalie Wyn—another trans youtuber—emphasizes the contrast between the "peak female storytelling style and this Real Housewives diction" and the story of "blasting a giant load onto the wall of a room full of leather and pornography" as comedically "genius"[110]. To Wyn's analysis of contrast, I add the context: a

sperm donation, managed by medical professionals, for the purpose of the extremely technologically dependent and medically intensive IVF procedure. This story is medicinefucking with laughter and farce. Medicinefuck brings dissonance into health systems, and Gigi's video is a prime example of medicinefuck.

Gigi also shares health information throughout the video. This includes a specific recommendation of the doctor managing their IVF, the impact of hormones, the need for testosterone supplements, and the details of sperm donation itself. In some ways, the sharing of health information is more important than any of the more performative disruptions. The simple act of having community member share a frank accounting of the procedure better equips individuals with knowledge and confidence in undergoing their own sperm donations. But Wyn notes that at least some of this information is usually learned elsewhere; for example, infertility from starting HRT "which girl, they tell you like seven times before you start hormones…"[110] Its unclear how important the health information in this video is to viewers, and Gigi herself strongly disclaims herself as a dispenser of health information: "I really haven't gotten into hormones on my channel very much because everybody's body is different … and I'm not that kind of [b****], I do not feel comfortable doing that."[109] However, within the context of medicinefuck, the style is inseparable from the content, making the health information an important part of the medicinefuck disruption.

Gigi's video continues to discuss further awkwardness but ends with a frank discussion of the results. Gigi's sample was not usable for freezing, which she learns via a phone call with an extremely supportive nurse. Wyn argues that this bad news recontextualizes "the ridiculous image of Gigi scrapping ejaculate" from funny and disruptive to a defensive mechanism against traumatic experiences[110]. The method of delivery—a very conscious play of sexual activity—is what makes this disruption medicinefuck. And in this case, the medicinefuck serves to aid Gigi in seeking support from her viewers while simultaneously providing a model that viewers can use to interact with the health system and deal with bad news.

This goes even further in the comment section. In Chapter II, I discussed the impact of YouTubes' creator-centered design and invisible moderation and suggested that it made the individual users more siloed around creators and less able to directly offer support or perform medicinefuck. There is some evidence of this in the comment section of Gigi's video. YouTube automatically sorts comments by "top": there exists very little information on what this sorting algorithm actually does, but it generally puts the most "liked" comments at the top of the feed. For this video, several of the most liked comments are of interest. First is one suggesting that doctors "should really push people to get their stuff frozen" prior to HRT, a sentiment echoed several times in other comments[109]. This is interesting for several reasons, firstly because it is primarily aimed at other viewers. Many comments on the video are messages of direct support or affirmation, but by directing this comment about raising awareness of the infertility to the general community, these commentors are attempting to engage the larger community in the issues raised by Gigi's video. Perhaps its not surprising that these comments have some of the largest comment chains in the section attached to them. Second is one left by a viewer who "works at a fertility center" who wants "to reassure [Gigi] that there ARE still options…", and hopes that Gigi will "consider a second opinion"[109]. Another commenter repeats this idea, dispensing IVF advice and suggesting going to a different clinic. These are interesting for different reasons—these comments engage more directly with the idea of disruption. Suddenly, the doctor is the viewer, the creator is the patient, the community is the voyeur. Or, since the viewer is also a community member, and since other viewers also engage with these more specific IVF suggestions—the community is both voyeur of the "medical consultation" and a participant in it. Perhaps this isn't medicinefuck, per se, but rather its effects. Medicinefuck is Gigi telling this story, and the community, while disrupting medical hierarchies, is not going so far. Again, its hard to say how many people are getting medical advice from random YouTube comments under a influencers storytime video; but the impact of medicinefuck is here: the

ability to turn a medical experience into an opportunity for laughter and connection with others. Medicinefuck may target at medical systems, but its purpose is in bettering people's lives.

At the same time, all these comments appeal quite strongly to medical authority. There is a contradiction here: in a video destabilizing the doctor's office by bringing sex into that space, this community's response is to tell each other to go back to the doctor! The community suggestion that doctors "should really push people" to freeze eggs and sperm is even more complicated; what would this look like in context? A young trans teenager goes in for a consultation for hormones, and it told immediately that "You should freeze your gametes!"? This is itself an expression of a normativity that assumes not only that teenagers should be (always) considering their reproductive future *while teenagers*, but that (biological) reproduction should orient all people. This is an example of an important way that genderfuck and medicinefuck differ—genderfuck is comparatively much more comfortable with doing away with gender and its structures then medicinefuck is comfortable with tearing down hospital systems. And this ambiguity continues in Wyn's close reading. Wyn notes a contradiction in her own experience freezing her sperm prior to her transition. "There's no way to feel like a women when you're hastily rubbing one out in room designed for men to ejaculate in," especially since she was "pre-everything", but the receptionist at the sperm bank was the first person to ever call her by her chosen name: "Natalie, here's a cup for you to bust a nut in"[110]. For Wyn, the medical system is simultaneously a source of dysphoria and discomfort and also a tool for affirmation. Maybe, this should not be surprising—gender-affirming care can be medicine that affirms. And to return to the contradiction inherent in the online identity of "egg"[11]—to seek affirming care implies that your current situation is *not* affirming: a realization that has uncomfortable in and of itself. Whether Wyn and the commenters' responses are strictly medicinefuck may be beside the point—they are certainly products of Gigi's medicinefuck disruption. Perhaps, medicinefuck only cracks the shell separating medicine from the people. Or perhaps in some cases medicinefuck is

[11] See Chapter 2, Subsection 2.2 about Reddit communities.

revolutionarily disruptive, and in others it simply wedges a crack open for minor alterations of power.

3.2 Close Reading: Passing Advice on Reddit

If genderfuck arises from a fundamental critique of the project of passing and being stealth, where does that leave medicinefuck? What does a refusal to pass look like in the context of medical discourses? There are multiple ways to not pass—refusing a position as purely a doctor or a patient, or refusing the hierarchy of power that accompanies that binary, for example—but in this close reading of a Reddit post, I investigate how medicinefuck can refuse medicine and medical systems as an answer entirely. This problematizes medicinefuck as a tool of liberatory politics and as tool that improves an individual's life.

The subreddit r/transtimelines is for redditors to post video or picture timelines of their transition. Martina is a 42 year-old trans women living in Germany who frequently posts transition timelines and seeks advice on passing from a variety of subreddits, including r/transtimelines, r/lgbt, and r/transpassing, and has over 46 total thousand "points" from other redditors' upvotes on her posts and comments, indicating an active and popular community member[172]. Her April 9th, 2022 post is titled: "*42yo mtf, passing is not getting easier after 3 years of hrt*", and spawned 149 comments from community members[22]. Most of the high-level comments are positive, saying things like she passes "for sure", is a "smoke show", and looks "amazing and young", and is "10/10 a beautiful women", and one redditor who just says "😍😍😍😍😍😍😘😘"[22]. This is quite typical for an r/transtimelines post: positive, gender affirming language (or emojis) that emphasizes the original poster's gender identity and sexual attractiveness—medicinefuck in a weaker formulation. But what makes this post interesting for understanding medicinefuck is how Martina is adamant that she doesn't pass.

Martina says that she "doesn't pass according to people around her," and points to interaction in grocery stores, on the street, and in her very transphobic workplace as proof. Interestingly, she strikes as the heart of debates around passing: "Passing is not about my

feelings, it's not up to me. If I get clocked I don't pass"[22]. This is one of the dangers of using passing as a form of validation—it removes agency from the individual—and one of the reasons that trans communities increasingly focus on gender euphoria as a tool for self-conception. And that focus is implicit in other redditors' discussions with Martina. One tells Martina that "I feel like this [fear of not passing] might be more a symptom of your dysphoria than a real thing," and another adds that "the way [Martina] talk about [her]self reminds me how I'm feeling when I'm very dysphoric" and that "we can be our own worst critics"[22]. These commenters, and others, are trying to help Martina reorient her relationship to her body and her dysphoria. One is even more explicit, telling another commenter that Martina is "doing some kind of weird public self-destruction routine," and admonishes Martina for her negativity and refusal to accept support offered by the community. This is at least partly due to Martina's activity in other posts and subreddits, where at times she seems dismissive of transfeminines who don't get gender-affirming care that she deems as "necessary"[173]. Even in extremely supportive communities, there can be friction between community members—it is not all positive.

This focus on passing, as opposed simply "being ourself"—as one commenter puts it—makes Martina focus on all her perceived faults. I return to Snorton's analysis which recognizes the ways in which passing becomes a source of "gender fungibility." Fungibility comes from the realm of economics—the ability to substitute one good for another. For Martina, not/passing denies makes her gender unbearably *un*-fungible; she feels denied of the ability to transition from one gender to another, or to market her gender in the workplace or in the shop as identical to that of a ciswoman through the "logic of consumption"[21]. It seems that Martina ties her self-worth up in passing, and for a multitude of reasons, since she believes herself to not be passing, she cannot conceptualize her own self-worth. And Martina seems to be working quite hard to pass—she is continuing to seek advice, has been on hormones in a very hostile medical environment for over three years, had recently got a rhinoplasty to help feminize her face, and is considering further facial feminization surgeries (FFS) to change her jawline and

eyebrow ridge[22]. For many reasons, this thesis cannot change Martina's conception of self, nor truly provide a solution for Martina, but Martina's experiences strike right at the heart of why genderfuck and other anti-gender projects exist—because gender is an unsatisfying and oppressive regime.

But what about medicinefuck? Martina doesn't seem to be aiming to disrupt medicine, through sexual means or otherwise, and while commenters are performing affirmations of Martina's womanhood—and in Martina's posts on other subreddits, asking her about her medical interventions and hormone doses[173]—there isn't a ton of medical disruption at first glance. But here, passing is again instrumental. In Chapter 2, I describe passing as presenting your body as one type when society has designated the body as a different, specific type. This acknowledges both that passing originated in racial passing, and, crucially, passing can theoretically apply to any identifier of bodies. So, what does passing look like in the context of a medical discourse—that is, not how does one pass as a gender, race, or class, but how does someone pass as a medical actor? Consider how medicine is constructed: medical interventions are meant to take a body designated as "sick" and transform it (through interactions with medicine) into a body designated as "healthy", or at the very least, less sick. This construction is not uncontested—philosophers of medicine have long grappled with the role of medicine and doctors in interacting with those not ill, or not yet ill[174]. But certainly, one aspect of medicine is deeply concerned with turning sick bodies into healthy bodies. To pass, in medical discourse, could mean to pass as a sick body that has been turned into a healthy body. Or alternatively, as a healthy body that requires no intervention at all. Or even, to pass as a "sick" body when you have a healthy body to receive an intervention.

This bears examination. To return once again to debates surrounding dysphoria and its presence or lack-thereof as a requirement to receive gender-affirming care; there are at least anecdotal reports of trans people who construct their sickness—that is, dysphoria—in a particular way to get care[175,176]. Medicinefuck, especially of the sort that involves Preciado's

gender bioterrorism, blows that apart. This isn't to deny that that is some trans people's experiences: but rather that trans people are encouraged to pass both as cis and as sick. But the general movement of depathologizing and demedicalizing gender-affirming care aimed at both the American Psychiatric Association that publishes the DSM-5 and the WPATH new Standards of Care both emphasize that people don't need to be "sick" with Gender Dysphoria. There is an additional movement against the requirements that individuals begin to "socially transition" prior to beginning hormones[177,178]. These requirements mandate a particular type of "sick" body and require that individuals that seek transition technologies pass as that type of sick body—and then, eventually, pass as the healthy body "fixed" by treatment. Preciado and his friends refused this passing in their gender hacking/medicinefuck. This isn't to deny that that is some trans people's experiences: but rather that trans people are encouraged to pass both as cis and as sick.

But in Martina's case, this isn't particularly applicable. It is not clear whether Martina receives her hormones through insurance, but she frequently mentions the high costs she faces in leaving Germany and paying for FFS[172]. More interesting for medicinefuck is the question of passing as a healthy body after intervention. For community members, Martina's HRT and rhinoplasty, as well as her styling and presentation, have turned the "sick" body—the image of Martina, prior to transition, in "boymode" with short hair and stubble—into a healthy body of a passing women. But Martina does not feel passing and does not feel healthy. She is extremely focused on eventually being able to pay for surgery to deal with her "easily clock[able]" "prominent brow ridge"[22,173]. Martina fucks medicine by denying it the ability to make her healthy, and by refusing to pass as healthy. She is incredibly insistent that she doesn't pass and thus isn't healthy because the medicine didn't work well enough.

Additionally, Martina is convinced that she will never pass until FFS, and that most trans women are unable to pass—even with HRT—without FFS[173]. This is another contradiction in Martina's medicinefuck—medical intervention is unable to make her healthy, but simultaneously the only way for her to get healthy because Martina is dismissive of the

suggestion that she seek therapy to help her deal with her dysphoric thoughts[22]. Hormones, the original nexus of Preciado's pharmacopornography, are insufficient, only the even more medical surgeries will suffice. Pharmacopornography may offer insight here: as hormones have become a tool of medicinefuck—increasingly accessible outside of a doctor's prescription—capital engines have focused increasingly on plastic surgery techniques including FFS, breast reduction/augmentation, and vagino/phalloplasties, because those are comparatively much harder to remove from their power structures. At some level, medicinefuck doesn't even seek to remove them—people want highly trained surgeons when they go under the knife for complex and risky cosmetic surgeries. Martina's insistence on FFS may prove that the pharmacopornographic system which extracts Martina's technogender—or desire for a different arrangement of technogender—continues to function simultaneously with, and perhaps supported by, medicinefuck.

What does Martina look to as barriers? Primarily, the "hypocrite" German society with transphobic people and work environments, that has major legal and financial barriers to transition[22]. Martina cannot change her name, is called by her deadname, is forced to use the wrong restroom at her workplace, and is called out in public as a trans women[22]. In this, we see the major limits of medicinefuck—even in such a case where she feels like she can pass, and can easily access gender-affirming care, or even if she happily rejected needing any gender affirming medical care at all: it doesn't mean much if she receives such a deluge of transphobia each day. Medicinefuck refuses to set medicine up as an answer; but if medicine is not an answer, what is? Perhaps this is when genderfuck projects to destabilize the importance and centrality of gender could help; but for many trans people, they have no desire to participate in genderfuck. Medicinefuck can't solve this larger, social problem.

Medicinefuck may indicate a refusal to pass as sick, as healthy, or as successfully treated. Martina's experiences show how medicinefuck—and disruptions of medical hierarchies more generally—do not have clear results and calls into question the degree to which medicinefuck is

truly liberatory for human lives. It even raises the question of whether medicinefuck—especially the refusal of medicine creating health—is beneficial. Martina is her own person, and her experiences may not be applicable to many other people—but her experiences are real and cause her great distress and unhappiness.

3.3 Close Reading: Self Medicating Hormones

What might it look like to refuse medicinefuck? As discussed with Martina, medicinefuck's effects can be ambiguous, and more generally, some people don't want to disrupt the systems they live in. Or perhaps more accurately, it better for their health to continue to work within that system. In Charlie Allan's *"The Truth About Self Medicating Hormones FTM,"* he discusses his experiences with self-medicating testosterone and his eventual switch to accessing hormones via prescription. Allan is one half of the Scottish YouTube vlogging channel Trans Life & Wife with 60 thousand subscribers that he runs with his wife. Trans Life & Wife includes videos about their relationship and their individual pursuits, as well as Allan's transition journey, including hormone and beard transplant timelines. Through a close reading of this video, more contradictions of medicinefuck, and self-medication more generally, appear.

Allan starts the video, which is shot as a single 23-minute long take, by saying that he will be covering a "taboo subject within the community": self-medication[91]. Allan's discomfort with talking about self-medication comes up over and over again throughout the video—he views self-medication as caring serious health risks, and he describes his medical complications arising from self-medication, including poor reactions to anesthetic during top surgery and mild liver damage[91]. Allan is a dispenser of medical information in this video, and as a dispenser, his advice is largely to not self-medicate. So why did Allan? He points to two main factors—mental well-being and cost.

Allan says that his original desire for testosterone came from a place of "pure desperation and depression", where he had begun to self-harm; a place where accessing testosterone seemed like the only way to survive[91]. Allan's discussion of his mental health grounds the video, and he

refers to the idea of survival repeatedly. Medicinefuck—that is, disrupting medicine by accessing testosterone, and then talking about it—seems perfectly positioned for helping Allan. It is in a similar state of mental instability that Preciado undergoes his first testosterone regime after the death of his close friend. But Preciado is aimed more squarely at "foil[ing] what society wanted"[84] from him, not necessarily from a place of dysphoria and discomfort. Allan does not have such radical goals—he wants to survive.

So why does Allan self-medicate instead of seeking a prescription? First and foremost, he points to cost. He walks viewers through the process (and cost) of getting a prescription from a private clinic, and even adds up the total cost—£1435 , plus £5 per dose of testosterone, and £200 biyearly for blood tests[91]. Even worse, the National Health Service, which is free at the point of care, had year-plus waiting lists to even see a GP for a diagnosis as dysphoric, never mind getting a hormone prescription[91]. Frustration with endocrinologist wait times and wait times for general gender affirming care is a frequent complaint among U.K. trans people[136,179], and it is this medical failing that frequently drives people to private clinics. But compared to the expensive private clinic, Allan can get a three-month supply of testosterone for less than £30[91]. Allan self-medication comes from an urgent need and limited resources.

Preciado's pharmacopornographic capitalism and medicinefuck are in some ways stymied here. What does it mean if price makes the hormone inaccessible to bodies? The model of capitalism which medicinefuck seeks to interrupt seems to be contrary to the lived situation where it is difficult for consumers who wish to consume to actually consume. If medicinefuck seeks to open access to medicine and pharmaceuticals, perhaps it supports a model of easy (and permanent) capitalist consumption. Preciado does not seriously engage with questions of access beyond describing gender hacking/bioterrorism as increasing access, but access is instrumental for understanding medicinefuck. Medical technologies and the ways in which Allan accesses them construct Allan's body. For example, he describes his adverse reaction to anesthetic during his top surgery by noting that his care team knew his blood was "a bit funny" but couldn't

predict the reaction because Allan had been self-medicating with testosterone[91]. Furthermore, Allan describes being "addicted" to getting cheap testosterone, an addiction that he is uncomfortable with but cannot stop[91]. And in this addiction, Allan orients himself around medical authority.

This is especially evident as Allan justifies his self-medication. He contrasts his testosterone use with nicotine and drug abuse in both health risks and legality. "We're all adults" who can choose what risks are taken, and "there are people out there that are putting illegal substances into their body each weekend—at least what I am doing is legal"[91]. Allan recognizes the health risks are not particularly worse than the risks accompanying other drug use. The mark of legality given to hormones—while administered by the state—originates from medical authority. Allan seems to ask that if testosterone was so dangerous, would it not be illegal? In this, he uses the medical system as justification for his testosterone self-medication. Haraway's cyborg asks "why should our bodies end at the skin?"[162]. Allan's cyborg body, under the skin of which he injects his testosterone, encapsulates more than just the body and the molecule—it also includes the medical authority which Allan orients himself around. Medicinefuck is a disruption of the medical system because it a reimagining of the body and the technologies applied to the body—such a reimagining necessarily shapes medical systems., Allan may not really be doing medicinefuck in this case—but as he talks about testosterone, he is talking about medical systems.

Allan is constantly seeking medical authority. In purchasing testosterone, he warns viewers about the challenges of finding "pharmaceutical grade," pure hormones. He chooses to buy his testosterone from abroad because testosterone in the U.K. tends look like it is labeled for bodybuilders—"pow pow pow, strong"—rather than "pharmaceutical" labeling[91]. This medical labeling is important for Allan's comfort level, and he credits this choice to his good liver health. Allan wants his viewers to access testosterone through medical channels. Even his formulation of "addiction" depends on medical definitions of addiction, and furthermore constructs his body

and gender dysphoria as the "main illness" that testosterone "makes easy"[91]. He highlights the tacit approval that he has received from a psychiatrist he once saw, which eased his conscious about accessing testosterone off label. Allan has taken the molecule to control his body outside the medical system—even if he constantly looks to it.

Finally, Allan eventually gets a prescription for testosterone. He even "proves" that he is no longer self-medicating by showing a screenshot of an email from his clinic about his blood test results[91]. Allan is extremely attached to medical systems and authorities, and despite his self-medication strongly encourages people to get a prescription if they can. He acknowledges the valid reasons under which someone would self-medicate, but even in self-medication he urges a return to medical authority. At the same time, his story of his self-medication can be a model for viewers in their hormone use. Is Allan performing medicinefuck? It's not entirely clear—the video both disrupts and reinforces medical power for the viewer and does not explicitly or implicitly invoke sex. But his experience is most definitely a disruption of medicine in many of the same ways Preciado's experiences were. Ultimately, this video is an example that disrupting medicine can be unsafe and uncomfortable, and that not everyone (in the trans community or across the larger internet) wishes to radically reshape medicine.

3.4 Close Reading: Gender (Clinic) Webinar

How does medicinefuck impact doctors and their jobs? In answering this question, I look towards a 2018 video created by the UCLA Health YouTube channel entitled *"Gender Health: Gender Affirming Hormone Therapy | UCLA Health"*[180]. Ultimately, it is difficult to pinpoint anything in UCLA's materials as arising from specifically medicinefuck, but the video supplies an opportunity to better understand the rhetoric of interactions between trans people and gender affirming doctors, from the opposite direction of Allan's self-medication video.

UCLA Health, which is comprised of several hospitals and medical centers and linked to the UCLA academic system, is one of the highest rated health systems in the U.S. and serves over 670,000 unique patients a year, while the Gender Health Clinic serves trans and

genderqueer children and adults[181,182]. The video, which has sixty-five thousand views, features two endocrinologists, Dr. Shira Grock and Dr. Stanley Korenman, who specialize in masculinizing and feminizing hormones respectively and describe the effects of hormones and host a quick question and answer at the end[180]. This video is one of the first results for "gender affirming hormones," "trans hormones," but is not the most popular. Some of the most viewed videos on this subject are from trans bloggers—both men and women[183–185]—which have hundreds of thousands of more views. Certainly, a dry, 35-minute recorded webinar is not the most engaging of content forms, but it still manages to have a decent view count in context

The first thing a viewer sees are the two doctors sitting on either side of a monitor displaying a PowerPoint. Grock is in a white lab coat and blouse; Korenman, who is much older, is in a suit and tie[180]. They look thoroughly like doctors—which is probably only peripherally on purpose. Because this video is a recorded webinar, rather than a more produced video, it is likely that the doctors were filmed wearing their normal work clothes. But whether they dressed themselves for a workday or a webinar, their clothing choice reinforces the authority that both possess—an authority, that, broadly speaking, medicinefuck repudiates.

Grock introduces the video—firstly, they will define their terms; then, Korenman will talk about the effects and risks of feminizing hormones; Grock will do the same for masculinizing hormones; and finally, they will answer some questions from webinar participants[180]. Their definitions are serviceable, if staid—there is no "trans*", but they highlight the difference between gender identity and expression and briefly mention the DSM-5 change of diagnosis from "Gender Identity Disorder" to "Gender Dysphoria"[180]. This change—a depathologization, if small—comes through again as they describe the goals of hormones (both feminizing and masculinizing): in neither description do they mention dysphoria. Instead, hormones are for "attaining desired level of" masculinity/femininity and "minimizing" the opposite, contingent on bone protection[180]. But, in both contexts, the final goal is a specific range of blood testosterone/estrodial[180]. The reference to desired degrees of gender expression and bone health

is important—and they highlight that each individual is different—but they are seeking to replicate in trans patients the "normal" hormone levels of cismen and ciswomen. This hormone therapy is thus the perfect example of Preciado's technogender—it demands a "normal" level of sex hormones, and then creates that "normal" with pharmaceuticals. This isn't to say that the two doctors are blind to nonbinary and genderqueer people who may seek hormone therapy; rather, it suggests that both the clinic and most of its patients are seeking that replicative technogender. Medicinefuck is aimed at (techno)medicine, not necessarily technogender—there may be room in medicinefuck to support conceptions of technogender. At the same time, the doctors highlight nonbinary people, and the differing dosages that nonbinary people are prescribed. But even here, the pharmaceutical is used to create the nonbinary body; technogender, but one that operates against the traditional technologically delineated binary.

This concept of normality comes up again. Testosterone increases levels of red blood cells and increases blood pressure. While they do monitor these numbers, this is not a "active" concern for Grock because the increases simply put patient in the "normal male range" for blood cell counts and blood pressure[180]. Any pharmaceutical or medical intervention has associated risks—but in this case, the doctors don't even consider the risk a risk because it normal for a certain type of body. Hormone therapy can also impact bone health, but both doctors are quick to note in the Q&A that this doesn't concern them, because for both feminizing and masculinizing hormones, the molecules involved actually increase bone density and while there is little solid data on fracture data, bone density is considered an acceptable proxy[180]. So, do trans bodies on hormones have better bones? Do the "desired levels" of masculinity include denser bones and thicker blood? Trans people are unlikely to consider those changes as their goals, but in the rhetoric of Grock and Korenman, these effects become expected parts of hormone therapy and indicate that the therapy is working as expected. Through the hormone regimen, trans people become medicalized cyborgs. The molecule is a "prosthetic"[84] gender (to borrow Preciado), that gives "intense experiences of complex hybridization"[162] (to borrow

Haraway) and, crucially, normalization. Normal is a cyborg construction of bodies and molecules. Medicine, or medicinefuck, or both, attempts to control that cyborg normality. In this video, medicine claims it for itself.

The video is careful in using gender-inclusive language. Grock, in talking about the effects of testosterone, talks about the "cessation of menses" among trans men, and also receives a question on the same topic during the Q&A[180]. She uses the word "menses" more than the typical "period;" and I propose several reasons. Firstly, it may be technically more accurate: menses refers to discharge, not necessarily the other, harder-to-track physical and emotional effects of the menstrual cycle. Secondly, it in some ways meant as a kindness—periods can be a source of dysphoria for trans men and Grock might use the more medical "menses" to create distance between a viewer and the description. This might be the exact opposite of medicinefuck because this is using medical language to comfort the human. Even the webinar format, which is radical in the context of the entire history of medicine, yet utterly quotidian in the context of today, is quite dyed-in-the-wool hospital business. This is part of the larger thesis of the video: a grand appeal to medical authority.

Throughout the video, there are references to a "normal" (and monitored) level of sex hormones, *expected* effects of hormones, a surfeit of medical language, and many different dosage methods—ranging from very medical-type injections overseen by doctors to a simple gel that is rubbed into the skin. As discussed earlier, Grock and Korenman dress like doctors, and present a PowerPoint—as part of a *webinar!*—against a bland, beige background that could be any hospital or business in the U.S. The UCLA Health YouTube channel has turned off comments for the video—there is no community interaction other than the four questions answered during the Q&A. And as post-covid quirk of YouTube[186], the video has YouTube created banner explain that the content is "from an accredited hospital" with a link to a National Academy of Medicine accreditation explainer. All this orients Grock and Korenman as medical authorities, dispensing knowledge to silent and waiting patients. This video is not a

medicinefuck, or about medicinefuck. Rather, it shows both the parry and riposte of a medical system to disruptions generally. After all, UCLA Health hardly would have put out medical information to the public if they could comfortably put it behind consultation requirements—which they are unwilling to do because this webinar is in effect advertising for them. Pharmacopornographic capitalism strikes back.

Conclusion

I don't remember the first time I ran across a trans meme about gender-affirming care. It was probably on Tumblr—I have a vague recollection of seeing a comic about safe binding a while back—or on one of Reddit's larger general LGBTQ meme subreddits. It might have been early in 2020, when I began watching trans TikTok compilations on YouTube. But these memes and jokes, beyond being a funny respite for a community that faces bigotry and transphobia everywhere, were the genesis for this project. In those, I saw a question and answer wrapped up in one: how do people share health information online? There were contradictions aplenty: misinformation and truth in the same posts; references to other (false) information sharing; appeals for help, for change, for disruption; and yet, frequent refrains of "talk to your doctor" and "talk to your therapist." This was a messy, disorganized, and vitally important type of interaction sweeping across the internet.

In 2020, another type of meme swept across the internet, and the world. Perhaps it's trite to bring up COVID-19 just because I'm talking about health and medicine, but COVID leant new urgency to an important question in public health: how do medical systems communicate with their patients? In the trans communities in which I had become a voyeur and sometimes-participant, there was this seed of an answer. For some trans people, the failing of medicine had a response in a medicinefuck form of performative, sexual, and joyful disruption. That is what medicinefuck is about. It only exists because medicine, in all its multiplicities and problems, isn't enough for human lives. It takes medical information, it takes the stories about

medicine, and it takes the undercurrents of sexual activity that is so frequently ignored, and combines all of these pieces together in a novel way to deal with a medicine that systematically discriminates against trans people.

Genderfuck is a project by trans and queer people to destabilize the institution of gender. Medicinefuck is intimately related to genderfuck, sharing with it the disruptive purpose, sexual undertones, and performative mechanisms. Medicinefuck happens across the internet, though different platforms—and their distinct designs and goals—shape how medicinefuck operates. Regardless of platform, Medicinefuck takes aim at our technomedicine and medical systems, and is an attempt to give power back to patients, defy a necropolitics that marks some participants in medical systems for death, and, at some level, disrupt the line between doctor and patient entirely. This doesn't mean medicinefuck has clear results: for some people, medicinefuck can make accessing care harder or muddy their ability to be satisfied with their care at all. Medicinefuck has a liberatory goal but may fall short.

And major questions remain. What are medicinefuck's concrete results? Is it a movement large enough to have significant results among the larger population, or is it more akin to the copyleft software movements, who are active and widespread, but simultaneously a tiny minority of all internet users? Does medicinefuck matter if the vast majority of people never interact with or are affected by medicinefuck? But maybe that's too large. Medicinefuck can matter if it changes just how one person interacts with themselves, their environment, and other people. And, as I've shown, it certainly effects more than one person.

But 'effecting more than one person' tells nothing about that person, or the effect. This thesis is simultaneously too broad and too narrow. Medicinefuck is occurring across the internet and in physical life, across communities, and across interests and concerns. In this, the thesis' narrow focus on trans people and gender-affirming care may limit the understanding of where medicinefuck and genderfuck differ, since trans communities so frequently link the performances. Additionally, this thesis examines a handful of subreddits and several YouTube

channels—but the trans community is far, far larger. What understandings have yet to emerge? On the other side of the spectrum, because I look at broadly at transfeminine, transmasculine, and nonbinary communities, I do not seriously consider questions of distinct forms and the ways in which gender influences medicinefuck. Equally, questions on how race influences medicinefuck, especially on a community level, are not deeply realized within this thesis, but deserve exploration.

But the questions of medical power, reach, and hierarchy that medicinefuck disrupts remain as relevant as ever. On April 20th, 2022, the Florida Dept. of Health published a memo recommending against providing gender-affirming care to children and adolescents—following in the footsteps of 15 State Legislatures and Governor's Offices across the U.S. that have or are considering banning gender-affirming care for youth[187]. What is notable about Florida's memo is its breadth: it says bluntly that "social gender transition should not be a treatment option for children or adolescents"[188]. Social gender transition—changing clothing, name, and hairstyle—is newly medicalized. Suddenly, medicine absorbs the daily choices of gender presentation—that everyone makes!—into medical "treatment options." Medicinefuck will be a valuable tool to disrupt such medical take-overs. Medicinefuck is a program that attempts to redistribute power and imagine new ways of distributing and accessing medicine, and more importantly, improving health.

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