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# The Romance of the Amazing Scalpel

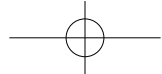
## “Race”, Labour, and Affect in Thai Gender Reassignment Clinics

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### We All Pay the Same Price

The clinic is a pink and white four-storey villa on the main highway through Chonburi, a provincial city on the eastern gulf coast of Thailand, one hour’s drive from Bangkok.<sup>1</sup> A cosmetic-surgery clinic for trans people seeking surgical feminization, it is one of the town’s most impressive buildings.<sup>2</sup> The highway is a smog-filled, eight-lane span crossable only by way of a pedestrian overpass. In this chaotic landscape, the clinic radiates an unlikely serenity. Inside, patients relax in the air conditioning and check their e-mail on the Wi-Fi network. After undergoing facial feminization surgery, breast augmentation, or, the most complex procedure, genital vaginoplasty, at a private hospital in Chonburi, patients use this clinic not only for consultations with nurses and the surgeon, but also as a lounge or a salon. A number of Thai attendants wait on the patients. Some are nurses, some are administrative assistants, and some are present to fulfil requests for cushions, water, or entertainment, or to provide for less tangible needs such as reassurance or affection.

The non-Thai trans women I spoke with who obtained surgery at this particular clinic described it as a very welcoming place.<sup>3</sup> Although the surgeon’s technique is said to be outstanding, patients reported that they do not pay for his surgical skill in creating sensate vaginas and clitorises as much as for the entire “care package”. This care package comprises full service from the moment one is met at Bangkok airport through lengthy hospital and hotel stays. It ends when a patient gets on a plane to return home, wherever that may be. The service, numerous patients told me, is second to none—even by the high, tourist-targeted medical standards of Thailand. “We provide the Rolls-Royce treatment here,” a clinic manager told me.<sup>4</sup>



This clinic is one of seven or eight gender reassignment clinics in Thailand that service an overwhelmingly foreign clientele. Over the past ten years, gender reassignment surgery, or GRS, has become a very profitable procedure for Thai reconstructive surgeons.<sup>5</sup> Thailand is now known by many as one of the premier sites worldwide to obtain vaginoplasty and other cosmetic surgeries; indeed, many surgeons advertise that Bangkok is the “Mecca” of transsexual body modification.<sup>6</sup> While at least one surgeon in Bangkok specializes in masculinizing surgeries for female-to-male transsexuals or trans men, most surgeons performing gender reassignment surgeries in Thailand cater to trans women—that is, persons assigned male gender at birth who now live as women. These clinics see hundreds of patients per year, most from overseas.<sup>7</sup> Most clinics, such as the Preecha Aesthetic Institute at Piyawate Hospital in Bangkok, are housed within private hospitals with similarly large proportions of non-Thai patients. These clinics provide one of a range of medical services offered to foreign visitors to Thailand, now an international centre for “medical travel”, or “medical tourism”. They constitute a destination for many people globally who cannot, or who choose not to, access gender reassignment surgeries close to where they reside.

To gain a reputation for managing surgery candidates well involves careful attention to patient care. During major surgery, a process that involves a considerable and prolonged experience of pain, the practice of care demands, above all, attention to a patient’s comfort. To offer comfort, of course, is distinct from the state of being “comfortable”: One does not guarantee the other. Neither is comfort merely a state that pertains to the corporeal. It registers an affective disposition, and so does its opposite, discomfort. Comfort eases one’s passage as one moves through the world. However, if there is difficulty in moving, one may experience discomfort. “If whiteness allows bodies to move with comfort through space,” Sara Ahmed writes, “and to inhabit the world as if it were home, then these bodies take up more space. Such physical motility becomes the grounds for social mobility” (2000, 136).

To attend critically to the minute differentiations between comfort and discomfort within the gender clinic I describe above, then, might unfold into more than the mere narration of individual affects. Not all of the trans women I interviewed professed to feel comfortable there. Som, for example, told of difficulty with the aftercare procedures associated with her vaginoplasty, and also of feeling that she could not expect the same service as would be proffered to non-Thai, or white, patients. Som is Thai and grew up in the poor rural north of Thailand. She moved from her village as a teenager, first to Chiang Mai to study and then to Bangkok for work.<sup>8</sup> She met an Australian who became her boyfriend on [www.thailadyboy.com](http://www.thailadyboy.com), a *kathoey* dating site, and he encouraged

her to migrate to Australia to live with him. He also paid for her gender reassignment surgeries at the clinic described above. During our interview, she initially said that her experience of surgery had been excellent. During recovery, she said, she felt like a “princess”. Later, we began to discuss the fact that 95 percent of her surgeon’s patients are non-Thai, the majority of them affluent American, British, or European trans women. Thailand is famous for its large population of *sao praphet sornng* (“second type of women”), or *kathoey*, male-to-female gender-variant people.<sup>9</sup> It seemed remarkable that non-Thais constituted the overwhelming majority of patients undergoing GRS at the most well-known clinics. As Som commented on this, she revised her previous narrative about the level of care at the clinic she had attended:

A. A.: *When I talked to Dr —, he said that most of his patients are farangs [foreigners], some from Japan, some from Europe, America, Australia. But not many Thais.*

Som: *Because he is very expensive! He put his prices up!*

A. A.: *Many of them put their prices up, I heard. Also Dr —?*

Som: *Dr —, I didn’t like. He doesn’t even care about the Thais.*

A. A.: *What surgeons do Thai kathoey or ladyboys go to?*

Som: *Well, they can do [surgery] in a public hospital, which is quite a reasonable price, and the result might not be . . . not so good. And sometimes I hear from Thai ladyboys and some people, they said that in photos, it looks weird, it’s not the same as . . . [Gesturing to herself]*

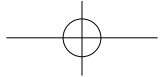
A. A.: *Not the same as your surgery?*

Som: *No. It looked terrible. Indeed.*

A. A.: *What do you think about this, that the best [clinics] seem to be for farangs [foreigners], and some surgeons don’t seem to care about Thais?*

Som: *Dr —’s staff [at the clinic] too. When I come to meet them, they will be very nice to foreigners. But they forget about Thais . . . Because they think foreigners have lots of money, more than Thai. But we all pay the same price! So, we should deserve to have the same service. But we don’t have the right to say that.<sup>10</sup>*

Another patient, Emma, is Vietnamese and had been living in Australia for twelve years when she had gender reassignment surgery in Bangkok in 2006. She travelled to Thailand from Australia and stayed in one of Bangkok’s premier medical-tourism hospitals, having surgery with the one of most well-known surgeons practicing GRS in Bangkok. Emma was travelling without a support person. By the time I met her, during her recovery from surgery, she had decided that coming to Thailand was a bad idea. She said she would advise trans people in Australia to obtain surgery with Australian surgeons:



Dr — is very busy and it's very difficult to get him to come to see me. I am very annoyed. Also, the nurses do not come to see me. I ring and it takes half an hour for them to come . . . I didn't bring anyone with me to take care of me after the operation. They told me on the phone that the nurses would take care of me, but where are the nurses?<sup>11</sup>

To place these comments in context, the majority of Australian trans women involved in my project were scathing about Australian surgeons' technique. Most agreed that the hospital care available in Thailand far surpassed that available even in Australian private hospitals. Karen, a white trans woman living in Brisbane, Australia, who obtained GRS in an equally well-resourced hospital in Phuket, commented that the hospital felt more like a hotel. "[There were] heaps of nurses, everybody always had lots of time . . . You could ask for something and five minutes later it was in the room."<sup>12</sup> Som's and Emma's stories did not match the overwhelmingly positive narratives I heard from Americans, Britons, and Australians who attended the same clinics at the same time and underwent the same procedures and who were apparently paying for the same service.

Ahmed appends the lines cited above on comfort and whiteness with a cautionary caveat. "This extension of white motility should not be confused with freedom. To move easily is not [necessarily] to move freely" (2000, 136). It is clear that even white-skinned or affluent gender-variant subjects are not guaranteed freedom. Across the globe, gender reassignment technologies such as hormones and surgery are notoriously difficult for gender-variant people to access. With few exceptions, most governments refuse to cover gender reassignment under public health funding (Lombardi 2007; Namaste 2000). Private health insurance corporations are equally reluctant to cover what is regarded as "elective" treatment (Butler 2006; Gorton 2006). If the provision of gender reassignment surgery began in Thailand as a market serving the large number of local *kathoey*s, over the past ten years it has transformed into a niche medical-tourism market targeted to well-off citizens of affluent nations. Yet the fact that gender reassignment surgery is big business in Thailand does not account for why, in a clinic that is reputed to provide the best care and clearly has the capacity to do so, Som felt that the staff cared more about foreigners than Thais. Neither does it account for why Emma articulated that her needs were not valued. It is dangerous to generalize a distinct frame of experience from two personal accounts, and this is not my intention. Nevertheless, these stories highlight a number of critical questions. Even when gender reassignment technologies are freely available to anyone who can meet the financial cost, which gender-variant bodies carry more value than others? Within the growing globalization of biomedicine along neoliberal lines, which racialized subjects

constitute the ideal to whom the labours of care and respect are made available, and which subjects fall outside of that sphere of care and respect?

In the first part of this chapter, I argue that Thai gender reassignment surgery must be theorized as a market, embedded in the historical and economic context of its local development. Next, I investigate how Thai tourist-marketing strategies are always already inflected by a Euro-American, orientalist discourse, wherein Thailand is imagined as the ultimate space of exotic transformation and the fulfilment of desire across multiple sites. In marketing tourism, this becomes a self-orientalizing strategy. Discussing the strategies GRS clinics use to market their services, I suggest that a similar dynamic is at play. I then turn to non-Thai trans women's accounts of GRS in Thailand to highlight the pervasive sense that being present in Thailand somehow facilitates the experience of psychic transformation towards femininity for non-Thai trans women. I ask, What about this sense of transformation specifically comes to bear for *non-Thai* trans women? Finally, I argue that to answer the question of the value of racialized bodies sufficiently, we need to understand the affective labours expended at Thai gender reassignment clinics. The care, the nurturing, and the transmission of affect to non-Thai trans women patients fulfils a medical function *and* facilitates the self-transformation of those patients into more feminine-“feeling” subjects. Affect can be defined as “bodily capacities to affect and be affected or the augmentation or diminution of a body’s capacity to act, engage, and to connect” (Clough 2007, 2). Affective labour here registers as both “emotional” work (Hochschild 2003) and as a form of biopolitical production, wherein particular practices reproduce the discursive effects of particular forms of subjectivity.

Before moving on, a few words are in order grounding this chapter geographically and in relationship to queer and gender-variant travel criticism. As the chapters in this volume attest, Thailand is currently undergoing a boom in urban queer sexual cultures in the context of a continuing market in queer tourism. Scholarship on the transnational gendered or sexual dimensions of Thai tourism and migration most often explores tourist involvement in the Thai sex-work economy (McCamish 1999). Aside from some mainstream media coverage, Thailand’s gender reassignment tourist market has received little critical attention. Although gender-variant tourism needs to be understood as a distinct (if related) geographical and political circuit, queer tourism offers some useful conceptual tools. Queer tourism, Jasbir Puar notes (2002), is the most visible form of sexual or gendered transnational circulation. However, Puar cautions that queer tourism discourses most often privilege white, middle-class, and affluent queer-tourist practices while relegating the spectre of the (non-white) other to the status of the desired object, encouraging and reproducing

“colonial constructions of tourism as a travel adventure into uncharted territory laden with the possibility of taboo sexual encounters, illicit seductions, and dangerous liaisons” (2002, 113). This reminder provokes us to remain alert to the (neo)colonial constructions floating beneath many tourist discourses.

Theorizing trans or gender-variant tourist circuits must take into account the fact that within Euro-American gender-variant discourses, the trope of a “journey” is almost ubiquitous as a metaphor to narrate transsexual transformation from man into woman or vice versa (Prosser 1999; King 2003) in autobiographies, films (such as *Transamerica*, 2005, directed by Duncan Tucker), and novels. According to Prosser, the “desire to perceive a progressive pattern of becoming underlies the pervasive metaphors of journeying or voyaging in [transsexual] autobiographies” (1999, 91). The trans journey metaphor often encodes within it dominant understandings of East, West, home, and elsewhere. In tracing those encodings, we need to draw attention to how flows of global capital intersect with the broad range of gender reassignment technologies (O’Brien 2003). But just as global capital flows in inconsistent transnational trajectories, gender reassignment practices and technologies are equally diverse, inconsistent, and geographically dispersed. Deciphering the complexities of how neoliberal capitalism intersects with gender-variant practices and identities cannot proceed effectively without analysis of the geocultural trajectories of those practices.

These critical frameworks informed my research methods. During clinic observation sessions in Thailand, I would often speak with the patients present as well as surgeons and staff. This enlarged the field of GRS candidate interviewee subjects to include people from many different regions globally. I also investigated access to surgical modification for Thais—particularly *kathoey*s, but also *toms*, or trans masculine people.<sup>13</sup> Surgeons performing GRS for a Thai clientele do not tend to advertise as widely on-line or in English, and possibilities for Thais to afford gender reassignment surgery are limited. It is crucial to bring the reader’s awareness of these inequities into contact with an analysis of the “Rolls-Royce treatment” in the most luxurious clinics. While Rolls-Royce clinics are a small niche within a much larger local market, their operation nonetheless still warrants analysis.

### Gender Reassignment Technologies and Medical Tourism in Thailand

Within the context of Euro-American theorizations of trans body modification, it is impossible to imagine surgical procedures taking place entirely outside the history of the medicalization of gender variance as gender dysphoria or gender identity disorder. It is equally impossible to imagine surgeries not mediated by

psychiatric frameworks governing the categories of gender identity “disorders”, which, in turn, have determined who is eligible for diagnosis with gender identity disorder and thus who may access surgeries. Across Europe, North America, Australia, and New Zealand (and increasingly in other regions), most surgeons require surgical candidates to conform to the World Professional Association for Transgender Health (WPATH) Standards of Care. WPATH began as the Harry Benjamin International Gender Dysphoria Association and is a transnational organization of medical “experts” on gender identity, including psychiatrists, endocrinologists, surgeons, and others; until recently there were very few trans participants. Periodically, WPATH releases a Standards of Care document, which provides the most widely accepted regulating criteria for what are termed “gender identity disorders” (WPATH 2006). These criteria recognize desires for gendered body modification under the rubric of transsexuality, where genital surgery is assumed to be desired by most candidates. The mechanisms for assessing an individual’s suitability for gender transition include psychiatric assessment and the fulfilment of a “Real Life Experience” in the gender one wishes to be recognized as.<sup>14</sup>

Access to gender reassignment surgeries in Thailand differs from this broad Euro-American context of medicalization in a number of ways. Despite a history of Thai scholars importing Euro-American psychological arguments against homosexuality and gender variance and deploying them in local research (Jackson 1997a; Jackson and Sullivan 1999, 10–11), gender reassignment is not regarded by most Thai specialists as necessarily requiring psychiatric evaluation. Neither are *kathoei* or *tom* desires for GRS universally understood within a medicalized discourse of transsexuality. *Kathoei* as a category is far more fluid and covers a wider range of cross-gender practices than the English-language category “transsexual”. *Kathoei* is sometimes understood as a “third sex” and has been used in the past to refer to effeminate homosexual men as well as those assigned male at birth who feel like, or want to be, women (Jackson 1997b, 170). *Kathoeyes*, or *sao praphet sorng*, are not defined within Thai culture by their desires to have gender reassignment surgery, but rather by their feminine behaviour. Many begin taking feminizing hormones in adolescence and, by adulthood, may have been living as feminine persons for years. In this cultural context, psychiatric evaluation is regarded as unnecessary. “Patients in Thailand see the plastic surgeon first, not the psychiatrist, because to them, they are normal people,” Dr. Preecha Tiewtranon, the surgeon whose clinic is noted above, explained in a 2006 interview. He added, “[They say], ‘Psychiatrists are for insane crazy people. I am not insane!’”<sup>15</sup> The state-subsidized GRS programme at Chulalongkorn University Hospital in Bangkok requires Thai GRS candidates to be assessed for gender identity disorder, but this particular programme operates

on only around thirty patients per year. However, anecdotally it seems that only around 30 percent of *kathoey* desire vaginoplasty.<sup>16</sup> In a study conducted by Nantiya Sukontapatipark on *kathoey/sao praphet sorng* subjectivity, only eight of twenty informants had had genital reassignment surgery (Nantiya 2005, 99). In fact, *kathoey* are far more likely to seek “aesthetic” surgical procedures such as rhinoplasty, breast augmentation, eyelid surgery, and silicon injections before full genital reassignment. “Improving” physical appearance through aesthetic surgery is seen as fashionable and desirable for *kathoey* generally.

Non-medicalization, and the greater emphasis placed on *kathoey* beauty, rather than the importance of “female” genitals, have both helped transform gender reassignment surgery services in Thailand into a large, unregulated, and highly commodified industry. This industry operates within an equally sprawling, unregulated, and commodified local cosmetic-surgery industry. For this reason, and to contextualize this local industry in relation to the more recent development of a tourist-oriented gender reassignment surgery market, I want briefly to outline the history of gender reassignment surgery in Thailand. According to Nantiya, surgical gender reassignment was first performed in Thailand in 1972, on one individual moving from female to male and one individual moving from male to female. Prior to 1972, individual requests for gender reassignment surgery were assessed by a state committee that had apparently refused all applications (Nantiya 2005, 65). After 1972, candidates were assessed by psychiatrists. Although surgery was practised in state-run hospitals, candidates for surgery had to pay for it themselves. In the late 1970s and early 1980s, surgeons began to practise gender reassignment in private practice and state-run psychiatric assessment programmes. Of these, only the programme at Chulalongkorn University Hospital remains in operation.

In the late 1970s, Dr. Preecha Tiewtranon, who was then established as a reconstructive-surgery specialist in Bangkok, trained himself in vaginoplasty technique after a number of *kathoey*s asked him to perform surgical revisions on neo-vaginas that were, in his term, “mutilations”.<sup>17</sup> Dr. Preecha trained younger surgeons in this technique, many of whom subsequently established private clinics. As well, what are known as “shophouses” sprang up. Shophouses are cheaper private clinics run by surgeons, who will often rent rooms in private hospitals to perform surgery. Nantiya’s Thai informants generally preferred to obtain surgery in shophouses. Informants “considered that the surgeons’ shop houses had more facilities than the hospitals, especially the state hospital” (2005, 99).

In the mid-1990s, non-Thais began travelling to Thailand in larger numbers to seek GRS. A Thai surgeon quoted by Nantiya attributes this to the large number of *kathoey*s who obtained GRS and then migrated to Europe and North America.



Others observe that the explosion of (largely English-language) Internet trans culture in the mid-1990s enabled Thai surgeons to advertise more broadly and led to a sharp increase in the number of non-Thais seeking GRS there. Non-Thai trans women began to travel in Thailand in large numbers to obtain GRS. A small number of surgeons gained a reputation outside Thailand and began to attract a large non-Thai customer base. For example, Dr. Suporn Watanyasakul performed twenty to thirty GRS procedures in 1996, mainly on Thai patients. By 2006, he had expanded his operation and was operating on around 220 patients per year.<sup>18</sup> These patients were almost exclusively non-Thai, coming from Europe, North America, and other locales outside Asia. The explosion of popularity of Thai gender reassignment surgeons among non-Thais has pushed up prices for gender reassignment surgery and enabled its rebranding as a luxury service rather than a budget option. One clinic catering mainly to non-Thais raised the price for vaginoplasty from US\$2,000 in 2001 to US\$15,000 in 2006.<sup>19</sup> Other surgeons followed suit. While even US\$2,000 is expensive by Thai standards, the higher prices mean that only very affluent Thais can now afford surgeries with the five or six surgeons with international reputations. Clinic web sites now constitute the main marketing tool to gain non-Thai customers and offer comprehensive information, usually in English, about every aspect of a GRS trip. In seeking recognition as an elite and globally competitive cohort of biomedical specialists, Thai gender reassignment surgeons must also present an image indicating that they comply with internationally recognized standards. Most surgeons who cater to a non-Thai customer base also now require patients to supply evidence of psychiatric assessment and a “Real Life Experience” in line with the WPATH Standards of Care.

The availability of gender reassignment surgery in Thailand also needs to be framed within the context of medical tourism. Medical tourism, sometimes known as health tourism or medical travel, is the most popular term to describe the growing trend among citizens from affluent nations to travel to less-wealthy nations to access cheaper health services of all kinds. The slogan “first world medical treatment at third world prices”<sup>20</sup> encapsulates how medical tourism packages the lower global value of non-“North” currencies, services, and human labour as a commodity. In Thailand, medical tourism has exploded since the year 2000, facilitated by successive governments eager to find a new source of international revenue in the wake of the 1997 Asian economic crisis. By one estimate, the country currently hosts 400,000 medical tourists every year (Bookman and Bookman 2007, 3). On a different estimate, more than a million foreign visitors received medical treatment in Thailand in 1996 (Wilson, forthcoming).<sup>21</sup> As Wilson points out, expatriate demand for a high standard of medical care in Bangkok meant that the biomedical infrastructure already

existed in Thailand prior to the development of a specific medical tourism market (Wilson, forthcoming). The development of Thai gender reassignment technologies as a market also predates the larger medical tourism industry by a number of years.

### **Touristic Orientalism and Feminine Transformations**

I turn now from a historical and economic context of GRS and medical tourism to consider some of the specific discourses pervading Thai tourist-marketing strategies, GRS marketing strategies in particular. Although one could argue that gender reassignment surgery candidates visiting Thailand for medical reasons are not tourists, the trans women I interviewed certainly participated in tourist activities. As a popular late twentieth-century tourist destination, Thailand had accrued a particularly dense field of the “conflicted and compulsively repetitious stereotypy” that constitutes Orientalist discourse (Morris 1997, 61). Thailand often figures in this discourse as a space of magic, exotic transformation, and the fulfilment of (Western) desire. Rosalind Morris points to the fantasy of Thailand as a “place of beautiful order and orderly beauty” and simultaneously a place wherein anything goes, whose spaces and people are “responsive to all desires” (1997, 61). This fantasy is always racialized and gendered, often iconized in the image of the responsive Thai woman and, according to Morris, the *kathoey*.<sup>22</sup> Here we witness the production of “ideal” feminine gender through an exoticization of otherness that simultaneously facilitates a moment of self-transformation for the Euro-American subject. Hamilton remarks that this “libidinization” of Thailand is so familiar that it repeats itself in *farang* discourse everywhere (1997, 145).

Thai tourist marketing strategies reflect this libidinization, even in nonsexual arenas, where the promise to the tourist focuses on health. A Tourism Authority of Thailand article promoting health tourism expounds upon Thailand’s “traditional” assets thus:

The Kingdom’s legendary tradition of superior service and gracious hospitality is working its magic in a new sector. Timeless Thai values and traditions are very much alive in places where it is least expected—in hospitals and clinics around the country. Patients are welcomed as ‘guests’ and made to feel at home in unfamiliar surroundings. The reception is gracious and courteous. Medical staff consistently provide superior service, often surpassing expectations.

Spa operators likewise report that guests are charmed by the traditional ‘wai’—a courteous greeting gesture that conveys profound respect, infinite warmth, hospitality and friendliness. The ‘wai’ is

perceived by visitors to be uniquely and distinctively Thai. The magic is taking hold.<sup>23</sup>

Infinite warmth, magic, grace, and courtesy: All are stereotypically feminine traits. Even if Thai workers meant to embody such attributes are not female and the intended visiting recipients of Thai warmth or grace are not male, this language instantiates a sexualized and racialized economy within the touristic exchange. It comprises part of a strategy I call self-orientalizing, following Aihwa Ong. For Ong, self-orientalization accounts for the fact that “Asian voices are unavoidably inflected by orientalist essentialism that infiltrate all kinds of public exchanges about culture” (1999, 81). Self-orientalization involves the performance of the stereotype of an ethnicity or a nationality to be recognized by the cultural edifice in which the stereotype originates. By framing the Thai medical-tourism experience as particularly beneficial because of Thai rituals and traditions, the marketing language narrates the stereotype of a Thailand freed from the realities of Bangkok smog, traffic, and political instability.<sup>24</sup> Numerous instances of this strategy can be found in generalized tourist marketing, but, as the example above illustrates, it is particularly apparent in health and medical tourism.

Marketing strategies used by Thai gender reassignment clinics follow a similar pattern. When I was interviewing surgeons in Thailand, I found that most were keen to emphasize Thailand’s liberal attitudes towards gender variance in comparison with the West. When asked what makes Thailand such a popular place for GRS, for example, Dr. Preecha said, “Thailand is a very open and tolerant society . . . There is no Thai law against the operation.”<sup>25</sup> Dr. Sanguan Kunaporn, a surgeon who runs Phuket Plastic Surgery and, with Dr. Suporn, is considered by many non-Thai trans women as among the best, explained to me that gender reassignment is a successful industry in Thailand because of surgical technique and the competitive price. He added:

[Also] the hospitality of the people, not only the staff in the hospital but also the Thai people. Very friendly and welcoming! Compromise, high tolerance. I found that a lot of patients of mine say that this is the place they would like to live, if they could choose this. Not only in the hospital, but also in the country. They feel safe here when they’re walking, or shopping.<sup>26</sup>

We might, however, take these positive interpretations with a grain of salt. Most of the *kathoeyes* and *sao praphet sornng* I have spoken with in Thailand describe the difficulties of gender-variant daily life in detail. In fact, many see the “West” as having a far more liberal and “open-minded” culture than Thailand. Homosexual and gender-variant people are not overtly discriminated against

in Thai law, and *kathoeys* are certainly more visible in Thailand than in North America, Europe, Australia, or New Zealand. Although it may be true that young gender-variant Thais are accepted by family and society without the violence, disavowal, and shame that characterize transphobic Euro-American responses to gender variance, stigma still attaches gender variance in many parts of Thai society. Forms of discrimination against gender-variant and people attracted to same-sex relations do exist (Jackson 1999a, 2003a). In the same manner that ordinary tourists are encouraged to understand Thai culture generally as timelessly friendly and responsive, Dr. Sanguan's discursive production of Thai culture as universally tolerant of gender-variant subjects seems intended to resonate with potential clients—who are coded implicitly as non-Thai.

A brief survey of graphic representations on GRS clinic web sites offers other examples of self-orientation in the context of marketing. As noted above, web sites, along with word-of-mouth, constitute the main marketing strategy for Thai GRS surgeons. Here, an explicit connection is made between the "traditional" beauty of feminine Thai bodies and the promises of self-transformation through feminizing surgical procedures. The Phuket Plastic Surgery Clinic web site banner features the face of a smiling, beautiful Thai woman on a background of white orchids, along with a slide show of landscape photographs.<sup>27</sup> The section of Hygeia Beauty's web site concerned with GRS features three glamour shots of equally beautiful women who might be read as *kathoeys*, all with long, coiffed hair, evening dresses, and flawless makeup in the style of the "feminine realness" genre of *kathoeys* beauty pageants.<sup>28</sup> That the images of bodies represented here are non-trans women or *kathoeyes* is not as relevant as how they might be read by prospective customers. The images associate ultra-femininity, the destination (Thailand), and surgical transformation in a promise to the non-Thai browsing trans woman that having GRS in Thailand will not only facilitate her transformation into full womanhood but will also transform her into a *more beautiful* woman.

It is salient to note here that what is now regarded as "traditional" feminine beauty in Thailand emerged relatively recently in historical terms and is a modern discourse and performance that originated more in Thai responses to nineteenth- and twentieth-century Euro-American beauty standards and practices than in any "ancient" local Thai culture (Jackson 2003a, Van Esterik 1996). Recalling Annette Hamilton's remarks on the libidinization of Thailand as it is represented by Thai women characters in English-language expatriate novels, we could read the laughing Thai women on clinic web sites as standing in metonymically for Thailand, as both objects of desire for non-Thai trans women and the potential vehicle of their own somatic self-transformation. The key difference is between desire and identification. In the novels Hamilton critiques,

the exchange is a heterosexual relationship. Here, the exchange is about the non-Thai subject's own feminization—both somatically and, perhaps, psychically.

In exploring how non-Thai trans women relate to marketing discourses associating Thailand metonymically with feminine beauty, I found that the association between travelling to Thailand and self-transformation was reflected back by many non-Thai trans women themselves. Although most were self-conscious of the urbanized modernity of much of Thailand's actual geography, many talked about their experiences in Thailand as radically distinct from their daily lives at home. Karen, the Australian trans woman referred to above, described travelling to Thailand as "a magical experience". Other participants commented that, aside from the novel techniques of Thai surgeons, having GRS in Thailand, this "magical" place, was precisely what marked their surgical experiences as a special rite of passage. When I asked her to identify what made getting GRS in Thailand different from having it in Australia, Gemma, a trans woman living in inner-city Sydney, asserted that Thai surgeons were more technically skilled in gender reassignment surgery than Australian surgeons. When I asked her how she felt overall about travelling to Thailand for GRS, she added:

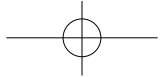
It's something kind of tangible and symbolic, to take a journey [to have gender reassignment surgery] . . . Do things and see people in a situation outside your normal circumstances . . . Psychologically it makes quite a difference to go through a process like that and be outside yourself a bit and come home in a different circumstance, having passed a landmark. With a lot of people who have been over [to Thailand] and have had that same experience, you really notice the feeling that they've done a concrete, tangible thing, you know, and been through quite a symbolic journey . . .<sup>29</sup>

Melanie, a trans woman from the American Midwest, expressed her feelings about how travelling to Thailand had changed her thus:

[Thailand] imprints on you very deeply . . . It's such a change you know. People come here and it's such a changing experience. And you go outside [the hotel] and it's very urban and you're in a different environment. But still, I don't know, it kinda charms you in a way.<sup>30</sup>

When I asked her to expand on what precisely had charmed her, or imprinted on her so deeply, she said:

It's the people . . . There's just a level of kindness and friendliness that I haven't observed really anywhere else . . . And [Thai] people, they just, people brighten up, and they wanna help.<sup>31</sup>



It is a convention of the “classical” Western transsexual narrative that genital surgery is the most significant marker of gendered transition: the dramatic final step, what really makes one a woman (or a man, in the case of trans men who obtain genital surgery). The normative psychiatric definition of what a transsexual is depends on the existence of the desire to possess the genitals of the “other” sex. The “traditional” transsexual narrative that emerged in the second half of the twentieth century classically features a case history involving cross-gender behaviours exhibited in early childhood to the desire to live life as a “real” man or woman in adulthood (Spade 2006, Stone 1992). Genital surgical transformation features within that narrative as the desire that confirms one is “truly” transsexual. It is clear that as many ideas about forms of hormonal and surgical transformation exist as there are gender-variant individuals, but the traditional transsexual narrative still dominates many Euro-American gender-variant communities and social and scientific theorizations.<sup>32</sup>

As I noted above, the geographical “journey” is almost ubiquitous as a metaphor within English-language trans narratives to relate the transsexual transformation from man into woman or vice versa (Prosser 1999, King 2003). The trans women involved in my project seemed to associate the imagined cultural and spatial milieu of Thailand with femininity (implicitly encoding the “West” as the masculine part of a heteronormative East/West dyad). Thus, Thailand is understood as having a transformative power specific to trans (feminine) embodiment. This, in turn, hinges on the perceived transformative power of travelling in general: the alchemical, or magical, properties of journeying to an exotic location. Thus, the imagined geography of Thailand combines a set of orientaling discourses that permit surgical candidates to imagine themselves as becoming more feminine in that space.

A photomontage produced by one of Dr. Suporn’s patients illustrates precisely this metonymic association of popular Thai iconographies, GRS and psychic feminization.<sup>33</sup> Created by a trans woman called Rebecca on an America Online home page, the photomontage accompanies her account of two trips to Thailand for gender reassignment surgery. The page’s text reads:

I had SRS with Dr. Suporn Watanyusakul on January 11, 2005. I had the most wonderful time in Thailand and made friends with some of the most amazing people . . . If you go to Chonburi leave your inhibitions and worries at the gate. Lose yourself in Thai culture. Enjoy every moment of your experience whether you’re heading over for SRS, FFS, AM or just visiting! Thailand is a wonderful place.<sup>34</sup>

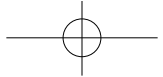
The montage presents glamour shots of Rebecca after her GRS and facial feminization surgery, known as FFS, spliced with symbols emblematic of

stereotypical “Thai culture”. Vividly coloured shots of orchids, Thailand’s most popular botanical commodity, surround the centre of the montage, where Rebecca poses with a fan and a spray of cherry blossom in her hair, in a dress that gestures towards a cheongsam or a kimono. Surprisingly, the outfit looks nothing like Thai “traditional” costume or a tourist interpretation thereof; perhaps this underscores the slippage between the imagined aesthetic of Thailand itself and that of a more generic “Asia”. Accompanying an account of Rebecca’s experience having surgery in Thailand, the montage associates her journey with her feminization. The incoherently “Asian” iconography is the vehicle through which Rebecca makes explicit the message that she is now a true woman. It also serves to confirm her sense of the power of the exotic to supplement her white-skinned femininity.

To draw attention to the *mélange* of significations at work in Rebecca’s photomontage is not to dismiss her experience of surgery, or of travelling in Thailand, or to dismiss the aesthetic Rebecca deploys to communicate the importance of her trip. Neither do I intend to discount the personal significance of my informants’ experiences. Their affective experiences of connection with Thailand are as valid as the felt sense of connection I experience as a traveller to Thailand as a tourist and researcher, and to other locations that are not my “home”. Yet to acknowledge the depth, or “truth” of an affective experience is not to naturalize it as an existing outside discourse, quarantined from critical consideration. To return this discussion to questions about the value of particular racialized bodies within the setting of the gender reassignment surgery clinic, I want to suggest here that a form of subjectivation in which one can metonymically associate travelling to Thailand for GRS with the power to supplement one’s femininity already assumes that subject is non-Thai, non-*kathoey* and non-Asian. To imagine Thailand in such precise ways places one within a specifically Euro-American, Orientalist discourse. A sometime resident of Bangkok such as Som, who books into a private hospital and an expensive hotel mostly frequented by non-Thais, would almost certainly experience a very different set of expectations, desires, and affective associations about GRS than that reflected in Rebecca, Gemma, and Melanie’s accounts. Crucially, Thai culture, landscape, and traditional forms of sociability were not coded as exotic for Som. The marketing discourses that targeted specifically non-Thai, or Euro-American clients, were not developed with her in mind.

### Affective Labour in the Clinic

Thus far, my argument has been limited to the sphere of symbolic representation: web-site images and photomontages. To relate this to material practices, and



to ground my analysis in a critique of economies of feminized and racialized transnational labour, I turn to an analysis of encounters between Thai staff and non-Thai patients in the clinic featured at the beginning of this chapter. As I noted above, many of the clinic's staff are young Thai women (and occasionally *kathoeyes*) who fulfil patients' needs. During a visit to this clinic, the British patient-liaison manager and two or three staff members arranged a lunch for me. During lunch I made inquiries about their working conditions, as most of the staff seemed to be on call twenty-four hours a day. The consensus from those assembled was that every clinic employee is expected to be friendly, hospitable, and available whenever a patient expresses a need, no matter how trivial and no matter what the time of day. The Thai financial administrator (who is also the surgeon's wife) described the working atmosphere as "a big family".<sup>35</sup> She also stressed that being employed at the clinic involved hard work and that if an employee did not respect the system, he or she would not last long.

The patient-care manager was a young Thai woman, Mai, who happened to embody precisely the polite, attractive, and courteous standard of so-called traditional Thai femininity. Mai informed me that because the clinic was so busy, she did not take vacations. Sometimes, she said, she was invited to accompany patients on sightseeing trips within Thailand as a guide and assistant, and this gave her a break. Because Mai spoke the most fluent English of all the personal caregivers, patients seemed to approach her most often. Throughout the afternoon, her mobile phone rang constantly with calls from patients. Many of Mai's labours seemed to be mediatory. This involved literal Thai-English interpretation between patients and staff members, as well as the task of "translating" Thailand itself for the benefit of the patients as a kind of tour guide: cultural practices, the layout of the town, where to find the best restaurants, and so on.

Since patients at the clinic usually spend at least a month convalescing after surgery, entertainment activities are very popular. These include trips to the local cinema, or to nearby Pattaya to watch *kathoey* cabaret shows and to shop. A Thai massage specialist is employed by the clinic, just as many Thai hotels and guesthouses employ in-house masseurs. Other activities involve learning about feminine skills: the clinic runs small classes on Thai cookery and makeup application. Patients can arrange manicures, pedicures, and hair appointments. To note only these scheduled activities, however, neglects the constant hum of sociality taking place in the clinic, at the hotel, and in the hospital, all of which involved the Thai attendants aiding the mostly non-Thai, Anglo-European trans women patients in whatever they desired to do. This might include playing with each other's hair, or doing each other's nails, or engaging in chitchat. Mai and other employees were not expected merely to behave in a caring way; it



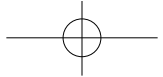
seemed that they were also expected (and saw it as their duty) to make friends and to behave as women friends do.

These tasks can be identified as affective labour. As I indicated above, affective labour can be defined as work that blurs the line between a purely commercial transaction and an exchange of feeling. It involves practices of care, the exchange of affect, and work that forms relationships of some kind. Affective labour, or emotional labour, as Arlie Hochschild theorizes it (2003, 138) constitutes part of what has been called the feminization of labour (Cheah 2007, 94); its presence as a micro-political practice is intimately related to broader shifts within globalization, migration, and the gendered division of labour. Mai and her fellow workers are part of the global population of “third world women workers” (Mohanty 1997), or, within Cheah’s theorization of the new international division of reproductive labour, “foreign domestic workers” (2007, 94).

Thailand’s service industry, on which tourism so heavily relies, is powered mainly by young women who migrate from rural areas and who perform various forms of service that blur the boundaries between commercial and non-commercial labours (Wilson 2004: 84). While these workers are not strictly “foreign domestic workers”, since they may not migrate transnationally, rural-to-urban migration may be just as significant as transnational migration in marking these workers as “other” to the metropolitan elites of Bangkok, while also providing the means with which rural migrants can aspire to be modern and socially mobile themselves. For these subjects, domestic work, service-industry work in tourism or hospitality, including sex work, are key industries (along with textiles and other manufacturing activities). As Ara Wilson points out, affective labour is a hallmark of many different service industries in Thailand. She additionally points out that forms of caregiving are naturalized within these economies as traditional Thai behaviours, which conceals their function as commodities:

[T]he modes of hospitable engagement found in medical tourism—or sex tourism—are often attributed to Thai culture. The labor involved in gracious caretaking is naturalized in this cultural attribution. Without denying the possibility that structures of feeling or the effects of social hierarchies might produce patterned modes of comportment and interaction, it remains worth considering their commodification. (Wilson, forthcoming)

One of the most important affective labours expected of the Suporn Clinic staff was to model femininity itself for the benefit of the patients as a kind of pedagogical practice. The Thai workers were not present just to care for the trans women patients. Through repetition of gendered behaviours, they performed a



particular, racialized feminine gender that supplemented the patients' sense of themselves as female. This performative gender modelling may or may not be conscious and certainly is not surprising, given the context. It is also reflective of the generalized orientalizing of Thai femininity within tourist cultures. Simultaneously, there is something specific to the production of gender-variant subjectivity happening here. It becomes clearer if we imagine affective labour as biopolitical production: practices that produce and reproduce particular forms of subjectivity. Sandro Mezzadra locates affective labour within theorizations of postfordism undertaken by Paolo Virno (2004), among others:

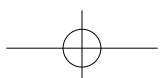
Virno stresses the fact that subjectivity itself—with its most intimate qualities: language, affects, desires, and so on—is 'put to value' in contemporary capitalism . . . [T]his happens not only with particular jobs or in particular 'sectors' (e.g. in the sector of services), being rather a general characteristic of contemporary living labor . . . [T]he concept of 'biopolitics' itself should be accordingly reworked. (Mezzadra 2005, 2)

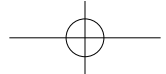
This reading of Virno by Mezzadra reworks biopolitics in a different direction to Foucault's deployment of the concept to speak about the regulation of populations, as opposed to individuals (Foucault 1995 and 2007). It also steers away from a practical definition of affective labour as work that involves the creation of relationship. Mezzadra also argues that affective labour plays a role in differentiating subjectivities from each other:

In a situation in which the boundary between friendship and business is itself being blurred . . . specific problems arise, which can nurture specific disturbances. (Mezzadra 2005, 1)

This is what I gesture towards when I ask, "What forms of labour are being performed in a gender clinic in Thailand to produce a particular *non-Thai* trans-feminine subjectivity?" As I have argued throughout this chapter, such a biopolitical production of trans-feminine subjectivity is made possible through the cultural specificities of Thai gender norms. Further, it is an intersubjective process that occurs principally between Thai women, or their images, and non-Thai trans women. Patients attend makeup classes to distract themselves from discomfort and to pass the time, which flows excruciatingly slowly during convalescence. The always already racialized, commodified circulation of feminine-gendered practices unfolds as an unobtrusive excess to the main concern of gender reassignment surgeries. But it is central to the "care package" offered by the clinic.

It is possible to read this scene in a number of ways. We could regard this intersubjective process as a moment of solidarity between equally disenfranchised



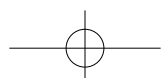


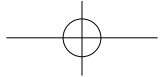
feminine-identifying subjects under global capitalism. We might also think of it as a moment in which individuals mutually benefit from an economic and social exchange, freely exchanging money for the feeling of being cared for, and wages for acts of caring. Alternatively, we might regard it as a moment in which affective and biopolitical pedagogies producing an idealized, imagined femininity conceal the economic dimensions of the exchange. It is difficult to ignore the fact that the trans women who purchase the surgical product and its attendant services are by and large affluent, by Thai standards, and white. They have privileged access to consumption practices in ways that their Thai caregivers might only aspire to.

I want to steer away, however, from presenting this as a situation in which “first world” trans people exploit “third world” caregivers. Economically, the clinic owners benefit most from this exchange. For their part, the Thai workers at various clinics (and in health tourism more generally) might regard this kind of work as of higher status than other forms of caregiving work, since it is highly paid by Thai standards. Despite the romanticized vision of Thailand evinced by many of the non-Thai trans women I spoke with, they were also grateful to find treatment in a space in which their needs were met and where they were valued as human beings, unlike hospitals in the United States, Europe, and Australia. Additionally, we cannot point to Euro-American gender-variant cultures as commodified without acknowledging that more localized *kathoey* practices of embodied transformation rely just as much on the commodification of gender-variant subjectivity as the gender clinic catering to non-Thai tourists described in the introduction to this chapter. However, recalling Som’s and Emma’s experiences of not feeling cared for, it seems evident that the intersubjective practices of affective labour supplementing patients’ sense of themselves as women within the space of gender reassignment clinics relies on a form of racialization which, no matter how pervasive elsewhere, differentiates between the bodies of more and less valuable, more and less ideal, trans subjects.

### On Gender-Variant, Cross-Border Solidarity

This chapter began by proposing that gender reassignment clinics in Thailand deploy self-orientalizing images to market surgical services to non-Thai tourists. I then argued that a corollary of this process is that some non-Thai trans women who obtain surgery in Thailand narrate their experiences in terms of a magical, transformative (and finally orientalizing) journey, which has everything to do with their sense of being gendered subjects. Finally, I discussed the affective and micro-political practices within the gender reassignment clinic scene that facilitate the reproduction of that Orientalist narrative. In making this argument,





I drew attention to the commodification of gender reassignment surgery as a tourist industry in Thailand, consistent with its commodification elsewhere, but configured in ways specific to the history of Thai gender reassignment surgery and dominant perspectives on gender variance. Most important, I suggested that the biopolitical production of trans subjectivities in this transnational context relies not only on commodification and forms of labour, or on the reproduction of gender norms, or on racialization, but also on simultaneous racialization, gendering and political economy. Each works through, and is inseparable, from the other.

When I asked in my introduction how particular gender-variant bodies circulate within the transnational commodified gender reassignment surgery market, I was thinking already in the context of the low value ascribed to gender-variant bodies within Euro-American surgical cultures. Access to surgical procedures is often dichotomized between what one wishes for and what one bears because it is the only option available. Under these circumstances, it is necessary to place the micro-politics of gender reassignment surgery in Thailand within the context of ongoing political struggles for trans and gender-variant self-determination. It is essential to engage with the power structures that have made gender reassignment surgery into a commodity globally. One of the most important of these is the privatization of health care globally. It is equally as important to target the widely held assumption that gender reassignment surgeries are a “choice” trans people make, and the opposite but equally as pervasive assumption that one cannot be a “real” man or woman, or person, without surgery to make one’s genitals congruous with the gender one identifies with. Ideally, gender reassignment technologies would be state-subsidized. But this would not solve the problem that some nations can afford state-funded health care and some cannot. This is the context of global neoliberalism, in which every subjectivity or practice provides another way to extract surplus value. Under these conditions, work within national boundaries is insufficient. More gender-variant, cross-border solidarity work is needed to trace, and cut across, these productive, exploitative flows of transnational capital.

