FTM

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REPORT FROM THE WORKSHOP, FEMALE TO MALE (FTM) ISSUES

BY SPENCER BERGSTEDT, ESQ., ATTORNEY AT LAW
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NOTE: WHAT FOLLOWS IS AN ADAPTATION OF THE REPORT GIVEN BY SPENCER BERGSTEDT TO THE 5TH INTERNATIONAL TRANSGENDER LAW CONFERENCE HELD IN HOUSTON OVER THE JULY 4TH WEEKEND, 1996. PANELISTS WERE: STEPHEN WHITTLE, PROFESSOR OF LAW, UNITED KINGDOM; JAMISON GREEN, WRITER AND PRESIDENT OF FTM INTERNATIONAL, SANDY KASTEN, ATTORNEY AND SPENCER BERGSTEDT, ATTORNEY.

On July 5, 1996, for the first time in the five year history of the Law Conference sponsored by ICTLEP, a three hour period of time was devoted to the discussion of the issues faced by the Female to Male (FTM) Transgender community. While three hours is a start, it is only a start. Only a fraction of the issues facing transmen could be covered in that time period. It is our sincere hope that this will not be a token event, but one that will be repeated in the future.

MARGINALIZATION OF FTM'S

Transmen have consistently been marginalized within the Transgender community. A common misperception both inside the trans community and outside it is that TS/TG equals MTF. As everyone has hopefully learned here this weekend, this is not the case.

There has been precious little visibility for transmen and our issues. FTM's are often nothing more than an afterthought - if we are included at all. But transmen are stepping forward and becoming active and visible. But it is time for the entire trans community, particularly the women, to recognize the presence and contributions of transmen.

Panelists (left to right): Stephen Whittle, Professor of Law, UK; Jamison Greene, Writer and President, FTM International; Sandy Kasten, Attorney; Spencer Bergstedt, Attorney

Look at the available literature about TS/TG communities and people. Look at the media coverage of TS/TG communities and people. Look at the stereotypes about TS/TG communities and people. Look at the images presented of TS/TG communities and people. Listen to the way in which TS/TG issues are discussed or

presented when you attend conferences, workshops, and speeches. Do you see and hear the language of inclusion? Are transmen mentioned at all?

Look at the Benjamin Standards of Care - are they written to address FTM's at all?

Look at the lack of basic education about transmen and our issues that exists within the trans community and which was so abundantly in evidence during the FTM panel workshop on July 5.

Spencer Bergstedt, Attorney

MARGINALIZATION appears within the stereotypes held within the MTF community which presumes that transmen gain massive amounts of male privilege upon transition and that FTM's gain great economic transition along with their facial hair. That is patently false. As Jamison Green noted, "One must be born into the old boys club to be part of the old boys club." While no doubt some transmen find more socioeconomic success after transition, the vast majority do not.

Many transmen were marginalized prior to transition because they were perceived as women, often as lesbians or masculine-appearing women or gender variant in some way. As such, FTM's are often on the bottom of the economic totem pole. This situation may not, and most often does not, improve upon transition.

Further MARGINALIZATION can occur for those FTM's who identify their sexual orientation as gay or bisexual. Doctors may not treat them or provide them with certain services. Socioeconomic success can also be hindered, sometimes severely. And in the case of the TS/TG community there still exists an appalling lack of basic education which marginalizes queer transmen - witness one audience members assertion that it makes no sense for transmen to transition if they are going to be gay identified - i.e., what's the point. As we should all hopefully know by now, gender identity and sexual orientation are separate, yet linked, issues.

Another way in which MARGINALIZATION rears its ugly head is in the creation and/or use of terminology to define transmen and the FTM community. In overwhelming numbers, TG/TS men prefer the terms simply men/man. But if that isn't enough then the terms transmen/transman when referencing themselves and FTM when referencing the community. MTM is not a term that is preferred, is seldom, if ever, used and was in fact, a product of the MTF community.

A minimal starting point then of the greater TS/TG community addressing the issues and needs of the FTM community then is:

1. To utilize the language and terminology favored by transmen themselves;

2. To use the language of inclusion to help eliminate the MARGINALIZATION of transmen within and without the trans-community;

3. To recognize that FTM issues will at times be different from those of MTF's, even as they may regard similar topics such as health care;

4. To ensure that all TS/TG people get basic educational information about who FTM's are, what medical treatments and procedures are available to us and what community resources exist for FTM's.

HEALTH CARE AND FTM'S

A primary area of concern to transmen relates to health care. These concerns can be broken down into 4 main categories:

1. Definitional issues related to the Benjamin Standards.

2. Treatment options.

3. Access and availability to health care.

4. Accessibility to legal resources.

1. Benjamin Standards

The Harry Benjamin Stands of Care related to the treatment of transsexuals do not specifically reference medical treatment for FTM's. Given that the Standards are often a focal point for medical service providers, many issues of great concern are raised for transmen.

For example, should FTM chest surgery be equated with genital surgery for MTF's and thus the surgery restricted in terms of availability, ease of access, and insurance reimbursement? For many FTM's, the possibility of successful cross-living has already been crossed and many have lived as men full-time or part-time for quite some time prior to ever seeking access to formal medical transition. Should their surgery be delayed? For other men, successful cross living will NOT be possible without having chest surgery at the outset of formal medical transition - either because their breasts are so large that they cannot easily be bound to a passable size or because the binding itself may cause serious medical problems. Should these men have their surgery delayed by application of standards written to apply to the MTF community and to MTF genital surgery?

2. Treatment options

Medical options for transmen present further problems.

A) Surgical options are limited and inadequate;

i.) Chest:

Often this surgery is done locally by surgeons who do not have the knowledge or skill to create a male-appearing chest instead of simply removing breast tissue. There is a vast disparity in the skill of surgeons in dealing with nipple tissue, to the point where some men have been left without any nipples at all.

ii.) Hysterectomy:

A costly, complicated, invasive procedure that is not done on demand (contrary to some popular beliefs expressed at the workshop). Further, if the surgery is done by a surgeon who does not understand the available genital surgeries for FTM's, a transman's ability to choose certain options may be eliminated due to the placement of incisions by the surgeon.

iii.) Phalloplasty:

Is costly, fraught with complications and inadequate in many transmen's eyes. While it may yield a phallus, the phallus will not look like a normal penis, will likely not have sensory function, has no erectile capability, has a high probability of tissue necrosis and may have other surgical complications associated with it. In addition, as the tissue to create it is often taken from the inside of one of the man's forearms, his arm will be permanently scarred, and possibly disfigured or rendered wholly or partially disabled. Some men have had their clitoris removed by the surgeon, leaving them with no sexual sensation at all.

iv.) Metaoidioplasty:

Is for many transmen, the best choice to date. The neo-penis (former clitoris) is released, the inner labia used to extend the shaft and the outer labia used to form a scrotal sack into which testicular implants are placed. Most men having undergone this surgery report satisfaction with the surgery as they generally maintain sexual function and sensation, however, some doctors refuse to do the surgery as they believe that it yields an inadequate penis.

v.) Urethroplasty:

This surgery lengthens and reroutes the urethra to allow the transman to urinate in a standing position. Success varies and many a man has ended up permanently catheterized or wearing Depends because of the uneven results.

B) The costs of most surgical options is exorbitant;

Chest surgery can run anywhere from $3,500- 6,000. Hysterectomy - $5,000-7,500 plus 3-4 days hospitalization and at least 2-3 weeks away from work. Metaiodioplasty - $7,000-10,000. Phalloplasty - $50,000-150,000. Urethroplasty - $3,000-5,000.

These costs severely limit the ability of FTM's to access these surgical options, especially when combined with the low socioeconomic status that plagues many FTM's.

C) Often, because of the inadequacies of the surgical options, serious complications that may result and often multiple surgeries that are required, FTM's end up incurring additional and overwhelming financial, emotional and physical costs. E.g., fistulas, tissue necrosis, permanent catheterization, paralysis, loss of use of arms and/or hands, and permanent disability are all possible. All for the sake of fulfilling the cultural imperative, enforced by the medical community, to create a penis since it is presumed by many that the size of the dick equals the masculinity of the man.

D) Often the surgical options for transmen are more invasive - e.g., hysterectomy - and require longer hospitalization and recovery time periods than equivalent surgery for MTF's.

As such, many men live the bulk of their adult lives as men but may never be legally male because of their inability to access medical treatment. (Each country and each state within the US decides what requirements a transman must meet - if it is possible at all - to have his gender status legally changed.)

3. Accessibility and availability of heath care services can depend on a number of things: Costs of services; Barriers created by the Benjamin Standards; Women's Free Clinics not wanting to treat

transmens gynecological needs; and the place where the transman lives and the skill, knowledge and acceptance of his local medical community.

(l) Sandy Kasten, Attorney and (r) Spencer Bergstedt, Attorney

4. A final barrier can be found in the inaccessibility for FTM's (particularly in the US) to seek redress in the courts to gain access to treatment or to seek compensation when treatment leads to mutilation, disability, permanent damage or death. This is directly linked to the costs of litigation and the unavailability of public funding for potential litigants.

FTM's in Canada and the EEC may have greater access to their courts and administrative review processes, but still may not elect to utilize those option because of fear, embarrassment, depression, potential employment discrimination or stigmatization.

WHEN DOES AN FTM LEGALLY BECOME A MAN?

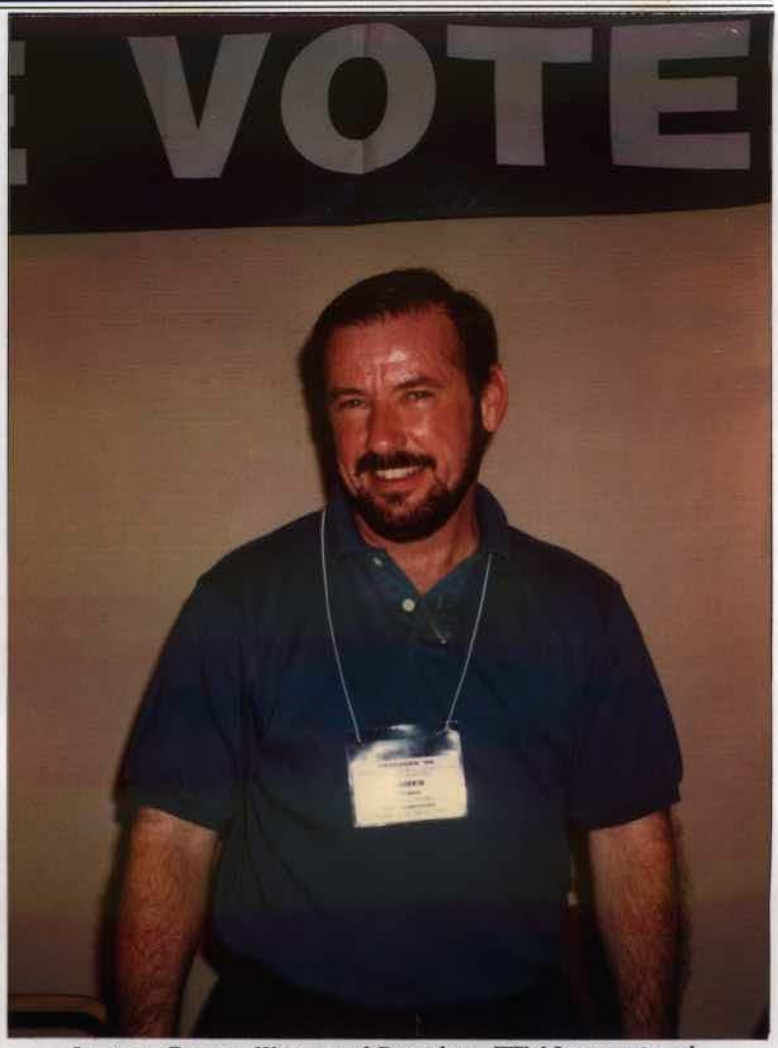
This varies from place to place and is of primary concern to transmen. In some places, no surgery is required to have the transman's gender status changed - merely living full time and being treated by a doctor or psychologist is enough. In other places, chest surgery may be required. In still others, chest surgery and hysterectomy. In still others, genital surgery must be done and in yet others, no amount of surgery at all will be enough.

Yet, despite these requirements, nowhere is there to be found any legal cumulative definition of what is a man, what is a woman? So the question remains as to whether a uniform rule on what is necessary to make a transman legally male should be created? Is it necessary? Is it desirable? These are questions which are currently in their infancy. The discussion will likely continue for some time to come.

VIOLENCE AND FTM'S

On the whole, 20-30% of all couples experience domestic violence. Yet the figures related to domestic violence and FTM's are very low - likely due to vast under reporting. In part this stems from the lack of shelter services available to battered FTM's and lack of anger management services for FTM's who batter.

Rape is a similarly under reported crime perpetrated against FTM's - often as "punishment" for their transgendered status. Rape crisis centers do not know how to adequately treat the unique needs of FTM's and police response and sensitivity can be appallingly lacking. Witness the treatment received by Brandon Teena by the Sheriff's office in Nebraska. After his rape, Mr. Teena was doubly victimized and marginalized by an insensitive Sheriff's department which not only did not properly investigate his rape, but arguably contributed to Mr. Teena's subsequent murder by his rapists by treating the investigation in a lax manner.



Jamison Greene, Writer and President, FTM International

JAIL AND FTM'S

If a preoperative FTM is convicted of a crime - he will go to women's prison, where he may be denied medical treatments for his transition - e.g., hormones.

Further, different standards of the law seem to apply to FTM's. Witness the trial of Sean O'Neil who was essentially convicted of having consensual sex. Mr. O'Neil was under 20 years of age but over 18 when he had sexual contact with at least two women under the age of 16 (the age of consent in Colorado). Had Mr. O'Neil been a non-transsexual it is doubtful that his "crime" would ever have been reported. He faced numerous charges with potentially long jail time. Although Mr. O'Neil was lucky to have a Judge come up with creative solutions to incarcerating him, he is left with an exorbitant list of probationary restrictions. Witness further the similar case of Jimmy nee Jennifer Saunders in England. Mr. Saunders was also convicted for what was consensual sexual activity because of his transgendered status. Mr. Saunders received a sentence of 6 years in prison. After legal appeals were instituted, the sentence was changed to 9 months. When Mr. Saunders left prison, he had served over 10 months.

APPROPRIATION OF FTM'S BY THE LESBIAN COMMUNITY

The final point of discussion related to the appropriation of transmen by the lesbian community. History rings out with the names of transmen who, upon their deaths, have been heralded as lesbian heroes despite the blatant facts that the men, though born into female physiologies, lived their lives as men. Billy Tipton, Alan Hart, Brandon Teena, Jack Bee Garland, amongst others. The history of transmen's lives must be recognized as being that of transmen. To do otherwise further marginalizes an already marginalized community.

CONCLUSION

While the inclusion of the workshop at this conference is a start, it is only a start. We managed to cover but a fraction of the issues facing transmen today, in part because we spent an inordinate amount of time doing basic education about FTM's and our community. The issues of transmen will sometimes be the same as others in the trans communities, sometimes they will dovetail and still others will be uniquely ours. Care should be taken that the concerns of transmen are considered and included in discussions regarding the TS/TG community, not as an afterthought, but on equal footing.