TWENTY MINUTES

SEPTEMBER 1991 $2.00

CROSSDRESSERS TAKE A WALK ON THE WILD SIDE

TEMPORARILY TRANSFORMED

The Edmonton Sun, Friday, May 31, 1991

At least twice a year Jackie (left) leaves behind his role as a husband and father to slip into something a little more comfortable. Paddy Aldridge, founder of the Toronto Crossdressers Club, helps Jackie with his hair.

TORONTO (CP) - Most days Jackie spends juggling his roles as husband, father and night club manager. But at least twice a year the darkly handsome family man likes to unravel his silk stockings and walk on the wild side. Descending the stairs from the "transformation room" above the *Take a Walk on the Wildside* boutique in the city's downtown, Jackie is a desperately provocative vision of hot pink spandex. His wrinkled blonde Dyan Canon wig and weighted prosthetic breasts add to the illusion. Black fishnet gloves mask his strong hands while generous makeup, luxurious false eyelashes and pencilled brows soften his masculine, thirtysomething face.

That Jackie fears rejection from his family and friends should his real name be published is more than a secret paranoia. When he tried to tell his wife his fancy for feminine finery, she assumed he was gay and he was forced to pass it off as a joke. But at the Toronto Crossdressers Club, Jackie can let his Y-chromosomes be dominant.

At the Saturday-night social, about a dozen of the club's 50 members mingle in the basement party room. Some take turns being photographed in suggestive poses on leopard-print barstools. Others can barely sit still, repeatedly excusing themselves to check their look in a hall mirror.

TULA IN PLAYBOY

Caroline Cossey, better known as Tula, is featured in the September 1991 issue of *Playboy*. The first known transsexual to be pictured in the Entertainment for MEN magazine with an article that covers the *Transformation of Tula*. She says, "I spoke up to set the record straight, and now I'm speaking out for the rights of transsexuals everywhere. It's an honor to appear in *Playboy*. I'm very proud of it."

IN THIS ISSUE

Transsexual Support

TWENTY MINUTES

The XX (Twenty) Club, Inc.
PO Box 80690
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Springfield, MA 01138

THE STAFF

Editor: *Becky Ann*

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SAME SEX MARRIAGES

The San Francisco board of Supervisors called on the California state legislature to legalize same-sex marriages. The action made the board of supervisors the first governing body in the nation to call for legalization of such marriages. (*Advocate*)

All the news that's print to fit.

XX CLUB CALENDAR

MEETINGS

Saturday, Sept. 14

Saturday, Sept. 28

Saturday, Oct. 12

Saturday, Oct. 26

Regular meetings of the XX Club are held the second and fourth Saturdays of the month at 2 PM sharp to 5 PM.:

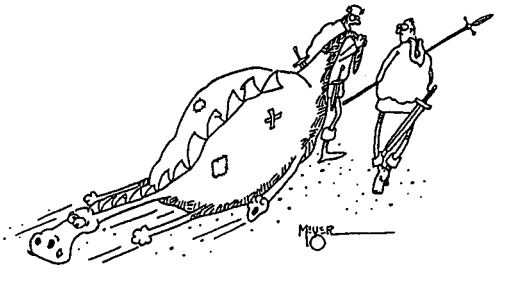
Christ Church Cathedral
45 Church Street
Hartford, CT 06103

(Located at the corner of Church and Main Streets in the downtown area across from G. Fox.) There is NO SMOKING allowed during the meetings, although smoking is permitted during breaks and after the meetings. The XX Club attempts to provide peer support and practical information about making the gender transition, as well as information about the Gender Identity Clinic of New England. Parents, siblings, spouses and significant others are also welcome to attend.

XX CLUB DUES

Christ Church Cathedral is now requesting that the XX Club pay $600 a year in rent to use their facilities for the club's twice monthly meetings. In order to fund this expense, club president, Anne, has reinstated memeber dues. Everyone who wishes to be a supporting member of the club should contribute $20 in yearly dues toward the rental expense. Dues do NOT include a subscription to *Twenty Minutes* which will be ceasing publication.

That's what happened when you didn't renew your subscription to Twenty Minutes - you killed the beast!



TREASURER'$ REPORT

Balance - from July		$1653.62
INCOME:		
Collections - meetings		.00
Dues		.00
Newsletter subscriptions		45.00
Brochures & Reprints		10.00
Savings interest		7.00
Total Income	$ 62.00	
EXPENSES:		
Rent-Christ Church		.00
Refreshments		.00
Newsletter & brochures		.00
Postage		56.00
Supplies		6.22
Bank Fee		2.55
Total Expenses	$ 64.77	
Net Loss for August		$ -2.77
Balance - end of August		$1650.85

TWENTY MINUTES TO END IN OCTOBER

Twenty Minutes, which does not officially represent the XX Club will cease publication with our October issue. This is not one of our April Fool or Halloween jokes, the newsletter will end at that time. Originally, *Twenty Minutes* (TM) was to cease publication in December 1989 when its founder, Veronica Brown moved to Toronto. Becky agreed to continue its publication until she moved to Florida as long as Veronica continued to submit her scathing editorials. Veronica and Paddy are now publishing the *CDC NEWS* as part of their Wildside business, thus Veronica does not have the time to write editorials for TM. Becky Ann and Lila will soon be moving to Florida and Sonia may be moving to Florida or Toronto or wherever. Subscribers will receive a Twenty Minutes version of the *CDC NEWS* through the balance of their subscriptions. As TM costs $2.00 per issue and the *CDC NEWS* costs $5.00 per issue, the number of issues that each subscriber receives will be prorated based on the dollar balance that remains. All subscription renewals should be made directly to:

CDC News
429 C Dundas Street East
Toronto, Ontario
Canada M5A-2A9

NURSE'S NOTES

HAPPY BIRTHDAY LILI ELBE

By Michelle Hunt RN

It is September, and already the morning air is crisp and cool in Dresden Germany. A Dutch artist signs into the Women's Hospital under the name of Lili Elbe...a name she has used since role changing the previous year. She is accompanied to the hospital by her wife and two close friends. In a few short days, she will under-go sex reassignment surgery, and become the person she has longed to be for many years. During the next six weeks, she will have four surgeries which will leave her without male genitals and a crude vagina that is lacking either depth or feeling. Her stay in the clinic will be nearly three months long.

Five years from now, Lili will once again enter the Women's Hospital for yet one more operation; she will have the uterus, ovaries, `tubes and womb from a genetic female implanted in her abdominal cavity. She will remain a patient for almost six months before she dies from complications.

Perhaps Lili Elbe would still be alive today if modern medical techniques and wonder drugs were available, but by comparison things were a bit more primitive when Lili tried to be a `complete' woman by having the internal sexual organs added to her former male body. Never the less, Lili made medical history by becoming the first post-operatives= TS to have healthy female reproductive organs placed in a male pelvis... just as she made history 5 years earlier when, on September 21, 1931 she became the first known transsexual to under-go sex reassignment surgery.

For sixty years we have increased in numbers, although nobody knows for certain, there are probably less than 30,000 of us world wide even now. The surgery itself, once a dangerous and lengthy ordeal consisting of numerous operations can now be performed in a single procedure. The etiology of our condition has been studied and a full understanding of the causes is close to a reality. As a group, we have matured to the point where a post-op can earn a living in a normal job rather than having to go into show business and capitalize on their sex change. Even the gutter press and the talk shows are no longer interested in us, unless there is something else about an individual TS that would be considered `off the wall'.

Although we have made numerous advances, we have lost a few battles along the way. Today, in 1991, there are about half the medical services available to the TS desiring surgery than there were even ten years ago. Insurance companies that think nothing of shelling out $250,000 to rebuild the complete internal organs of a newborn infant cringe at the thought of spending a few thousand dollars to help a policy holder of long standing rebuild their life by having SRS...after all, they can't be expected to pay for "experimental surgery". In most countries, a post-op TS can not get their birth certificate changed to reflect their new status, nor can they legally marry a member of their biological (now opposite) sex. It is not uncommon for a post-op TS who runs afoul of the law to be incarcerated in a male facility even though it exposes them to rape or physical abuse...a fact in nearly every state in the U.S.A., and almost every country in the world.

Sixty years can generate a lot of history for any group, and our unique situation almost guarantees that we will have more than the usual share of colorful characters, humanitarians and charlatans. As much as I would like to name some by their name, I wouldn't want to omit anyone, therefore I think I can safely say "Thank you for helping us when we needed help, and keeping us laughing when we needed to smile"...and you KNOW who you are.

So much for the past. Admittedly, much has happened during the past six tenth's of a century, but what does the future hold? Probably advances will be made in the ability of a post-op to become pregnant and to have children. Granted this is a reality now and is accomplished in the same manner in which a genetic female has an `Ectopic pregnancy' where-in a fertilized egg develops outside the uterus. It is possible to implant a fertilized egg with-in the abdominal cavity and through the careful regulation of hormones, allow the TS to carry a fetus to term, at which time it is delivered via Cesarean section. This would be a very dangerous condition however, and very few physicians would be interested in risking it.

As a practical matter, the next forty years will probably see the end of SRS. As our condition becomes better understood it is a sure bet that a means to manage gender & sexual dysphoria through medication or gene therapy will be found. Assuming that the current thinking about the origins for transsexualism, transvestism and homosexuality prove correct, the conditions can be diagnosed in utero and a course of treatment started that will result in the proper `imprinting' of sexual identity in the brain of the fetus prior to birth.

In the mean time, however, I would hope that I speak for all of us who have followed your lead and inspiration when I say "HAPPY BIRTHDAY LILI ELBE".

LILA, BECKY ANN & SONIA

MOVIES WE'D LIKE TO SEE

(BUT NEVER WILL...)

by Veronica Jean Brown

THE MEDICAL GRADUATE, is directed by Zukor and Antone Brocolli, the famous show business Siamese twins, and stars Dustin Hoffman as a bewildered young medical student named Barney Longmiller, about to graduate from UCLA Medical School. Through series of MTV music video stylized flashbacks, we see the young Barney suffering intense gender dysphoria beginning at the tender age of six when he dresses up in his mother's clothes after school.

A particularly fine and touching scene shows the youngster at a school chum's tenth birthday party. Barney disguises himself as a girl who hardly speaks to anyone and known at the school as shy Shirley, whom he knows to be sick. Everything goes along according to plan until the suddenly recovered girl shows up at the party a little late. Barney's charade is uncovered and he suffers much discomfort and taunting at the hands of his school mates who taunt him until grade ten.

Back at UCLA medical school, we see Barney taking out his gender dysphoric frustrations by administering female hormones to male gerbils and performing sex change surgery on them a few weeks later.

Much to his dismay, the surgically created critters are shunned by their family and friend gerbils. Barney next goes through a series of soul searching moments and almost decides not to go through with his transsexual plans.

After the grand climax of the graduation, and as the sun sets in the Western sky, we see a determined Barney Longmiller walking towards the campus experimental surgical laboratories, intent on performing sex change surgery on himself. Who would have thought that this never released film would have set the stage for Hoffman's appearance as *TOOTSIE* years later. It's apparent that the director(s) have clearly set us up for the sequel, I hope this one gets released. I can't wait, can you?

MS. EDWINDA is an adaptation of the old *Mr. Ed* television series about a supposedly talking horse. (Remember the episode where Mr. Ed appears in DRAM (Dressed As A Mare) as a mature motherly horse, but I digress).

Just as the popular *ODD COUPLE* Broadway play was made into a film starring Jack Lemmon and Walter Matthau, and eventually a televisions series, the story line of *Mr. Ed* has just been released as *MS. Edwinda*, with long time stallion winner of the Tri-Crown and Perfecta Daily Double Circuits, Finian's Rainbow.

Rumor has it, that to make the film more realistic, the noted animal surgeon, Doctor Billy Rheingold of Baltimore, gelded the retired Finian, much to the latter's dismay, who had anticipated a golden retirement passing along all those purse winning genes to a bevy of beautiful bays.

The late Mel Blanc was slated to provide the voice of *MS. Edwinda*, but the studio got some unknown to to the honors.

The writers of the film center the plot around the usual talking animal premise, but with a catch. The animal in question is actually a male horse masquerading as a female, and who also suffers with a long time desire to be a real female horse.

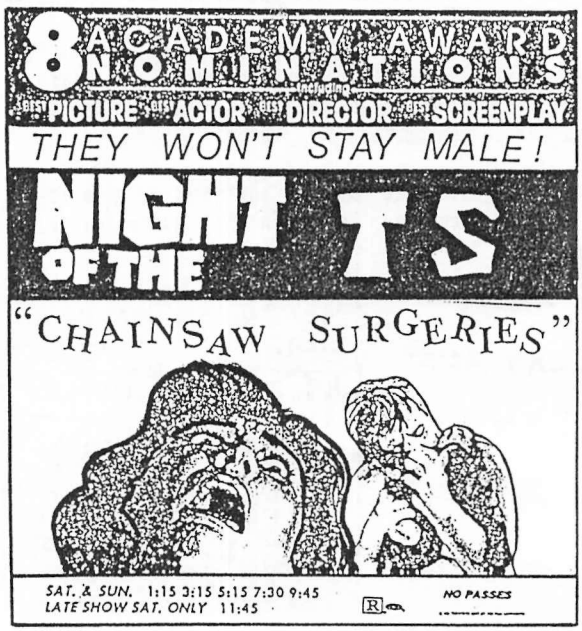
The make-up artists did their best to make Finian look as feminine as possible, but fell far short of their mark. It may have been just as well that they hadn't gelded poor old Finian for all the good that did. But the audience didn't seem to mind, as with the first weekend of screenings across the country, including Canada, Alaska, and the Arctic circle tundra settlements, *MS. Edwinda* took in a record breaking $5,091.76, at nine theatres, with an average draw of $70.01 per screening. Don't miss this one.

THE CLASS OF 71' is a rather unusual film and a real sleeper. Twenty years after the class graduated from Ridgemere High, they all return to the Holiday Inn just outside of the little mid Western town of Ridgemere. They were two hundred and ten in number at the fifteenth reunion in 1986, one hundred and nine females and one hundred and one males.

But something went awry in those five years. Everyone one of them returned to the 91' reunion, but this time, there were one hundred and nine males and one hundred and one females. Every member of the class had gotten a sex change!

What was it that caused the mass sex change of the Class of 71'? Was it that strange meteorite that crashed in the parking lot back in 1986, with all that fluorescent green slime oozing out of the cracks? Was it that strange bubbly concoction that the would be mad scientist, Ashely Thornberry poured into the punch bowl that night? Or perhaps it was the residual radiations from those middle 1980's particle beam experiments conducted at the nearby United States Air Force Base.

Whatever the reason behind the mystery, you'll be kept spellbound in your seat until long after the credits are done rolling by.



DEVELOPMENT OF AN INFORMATION DATA BASE ON TRANSSEXUAL SURGERY FINAL REPORT

INTRODUCTION AND EXECUTIVE SUMMARY

April 30, 1979

Prepared for
Health Standards and Quality Bureau
Health Care Financing Administration
Department of Health, Education & Welfare
Contract: #HCFA-500-78-0068
By
Health Information Designs, Inc.
Washington, D.C. 20006

"This report is made pursuant to contract #HCFA-500-78-0068. The amount charged to the Department of Health, Education, and Welfare for the work resulting in this report is $33,433.00. The names of the persons, employed by the contractor with managerial or professional responsibility for such work, or for the content of the report are as follows: Aida A. LeRoy, Pharm.D and M. Lee Morse, Pharm.B."

I. INTRODUCTION

Transsexual surgery became a modern reality 25 years ago when Christine Jorgenson's sex reversal shocked the world. Since that time, transsexuality has become both a dilemma and controversy in medicine, psychiatry, and law [17].

The term transsexual reportedly was first used by Cauldwell in 1950, and was to become popularized by Harry Benjamin in the 1960s. As early as 1916, however, Marcuse described a type of psychosexual inversion. Predating this reference to transsexualism were the descriptions by Westphal of "contrare Sexualempfindung" and by Krafft-Ebing of a form of cross-dressing which he called "metamorphosis sexualis paranoica" in 1894. Many cases have been since reported of individuals who achieved attention either as cross-dressers or for a compulsion to label themselves as members of a sex different from their anatomy [39].

It appears, therefore, from history, that there were numerous individuals with a strong desire to change their sex before the surgery made such changes possible. Whether surgery is the answer for such individuals is something that history does not elucidate.

Transsexualism, today, remains a poorly understood, uncommon, and controversial entity. Transsexual patients are considered to represent only one form of gender dysphoria. Although they present with normal genitalia and somatic features of one sex, they experience a chronic, intense desire for change to the opposite sex by hormonal and surgical means. The consensus of published studies suggests that transsexuals show no measurable evidence of hormonal or chromosomal abnormalities, thus there are no clear-cut physical tests available for the diagnosis of a transsexual. The diagnosis of transsexualism, therefore, is one of ruling out of other conditions, and is made on the basis of psychological and psychiatric criteria rather than physical criteria. Many physicians working with these patients agree to the futility of psychotherapy, drugs, shock therapy, and hypnosis in providing long-term relief from their intense sense of conflict [260].

The objective of this evaluation effort was to develop an information data base with which to assess the current status of transsexualism and transsexual surgery relative to the provisions for Federal reimbursement under Title XVIII of the Social Security Act. The development of this data base focused on the medical, legal, ethical, and social issues surrounding transsexualism and their applicability to Federal reimbursement policy.

This Final Report of Project SCOPE (Sex Change Operation Policy Evaluation) is presented in two volumes. Volume I consists of:

A. An Executive Summary of the Project, with a discussion of issues related to reimbursement policy.

B. Background information which includes a review of the literature from the period of 1966 through 1978; responses to the Interview Instrument by the Project's consultants; and official positions from the major medical specialty organizations.

Volume II contains summaries and abstracts from selected current journal articles from the information data base. Each article abstracted has been indexed by major subject(s) heading.

II. EXECUTIVE SUMMARY

The development of an information data base on transsexual surgery has resulted in the compilation and review of all relevant medical, social and legal issues relating to this subject. The specific focus of this project, however, relates to those issues which impact on the development of federal reimbursement policy for transsexual surgery.

This executive summary will highlight the results of this comprehensive examination of transsexual surgery. The format of this summary will consist of:

2

A. Definition of transsexualism and distinction from other sexual disorders.

B. Review of existing forms of treatment/management.

C. Discussion of coverage issues:

1. Disability policy considerations

2. Medicare coverage criteria.

D. Discussion of other relevant issues.

The executive summary is designed to provide a condensed review of the information data base developed for this project. For a more detailed and documented treatment of these issues the reader is referred to the Review of the Literature, Project Consultant Interview notes and the abstracts contained in Volume II of the Final Report.

A. Definition

The term transsexualism relates to individuals presenting a consistent or episodic display of femininity (male-to-female) or masculinity (female-to-male) with a body image in which, for the male transsexual, the penis is viewed as alien and dispensable, and for the female transsexual the breasts and menses are alien or dispensable, irrespective of coital history. Transsexuals have been reported to exhibit 'gender dysphoria', a psychological state whereby a person demonstrates dissatisfaction with their sex at birth and the sex role as socially defined.

A definitive distinction between transsexualism, transvestism and homosexualism exists and must be emphasized in this report. Transvestites cross-dress fetishistically for sexual arousal and may exhibit either homo- or heterosexual behavior. Homosexuals respond erotically to individuals of the same sex. Characteristically, both the transvestite and homosexual view their body images with pleasure and pride in contract to the transsexual's total repulsion with his/her anatomical sex features.

B. Treatment/Management

There are no definitive standardized diagnostic tests available for evaluating the transsexual. The primary source of initial diagnostic information is the objective interview with the patient, augmented by interviews with close kin. Persons seeking sex reassignment surgery often resort to subterfuge in order to achieve their goals. At present, the major diagnostic test, and perhaps the most valuable, is the two year real-life test during which time the person seeking sex reassignment surgery undergoes social, recreational, vocational, economic, familial, and hormonal rehabilitation in the new gender role.

As with many other disorders for which the etiology remains unelucidated, the treatment for transsexualism is symptomatic. Attempts to resolve the dysphoria transsexual patients feel have been directed toward realignment of either the psychology or genital anatomy of the individual.

Psychological treatment of patients is quite diverse and includes intensive psychoanalytic psychotherapy, ego-supportive psychotherapies, management psychotherapy, and group psychotherapy. The goals of these therapies range from attempts to stabilize a presurgical patient to total reorientation back to the original gender role. Many researchers believe that psychotherapy can offer successful treatment for the gender dysphoric individual up through adolescence. There are other researchers, however, that contend that psychotherapy has not proved helpful in allowing the transsexual to accept that gender identity is consistent with his genital anatomy.

Hormonal treatment, on the other hand, appears to be successful in relieving suffering in the transsexual patient. The aim of hormonal therapy is suppression of the existing sexual features (hormonal castration) and initiation of development of the sexual features belonging to the other sex. The hormonal treatment of the male transsexual results in a decrease in erections and ejaculations, an increase in the amount of breast tissue and in the pigmentation of the areolae and nipples, a redistribution of the subcutaneous fat to the female pattern, a decrease in muscle strength, an increase in hair growth at the scalp, and a decrease in menstruation, an increase in body hair growth, a deepening of the voice, and an increase in libido.

Surgical sex reassignment, in the male, consists of castration, penectomy, and vulvovaginal construction. In the female, the surgery consists of bilateral mammectomy, hysterectomy, and salpingo-oophorectomy, which may be followed by phalloplasty, and the insertion of testicular prostheses.

In the plastic reconstruction portion of male-to-female surgery, scrotal tissue is used to form labia majora, and penile skin, labia minora. An artificial vagina may be formed either from a skin graft from the thigh, using the method of McIndoe, by inversion of the penile skin or by inversion of both penile and scrotal skin.

The majority of female-to-male transsexuals undergo only mastectomy and hysterectomy. Phalloplasty, poses a great challenge to urologists, gynecologists, and plastic surgeons. This procedure has not been perfected, and often includes multiple, prolonged plastic surgical operations and postoperative complications.

C. Discussion of Coverage Issues

1. Disability Policy Considerations

Under the current provisions of Title II and XVI of the Social Security Act, transsexuals may petition for disability compensation. It is important to note that all disability petitions are considered by the state agency under contract to perform disability reviews for the Social Security Administration (SSA). Yearly, SSA reviews a sample of state disability determinations and my act only to overrule any deny disability coverage. Coverage may not be granted by SSA to petitioners denied eligibility by the state agency.

In order to be found eligible for disability compensation an individual must demonstrate that he/she cannot conduct gainful employment due to a physical or mental impairment. Often this key criteria is misunderstand by disability petitioners to mean an inability to find gainful employment. This distinction is particularly important with regard to potential transsexual petitioners, in that characteristically transsexuals report great difficulty in finding employers who are willing to hire them. Inability to find work is not equatable to one's inability to perform gain employment and the SSA guidelines will not permit the granting of disability to individuals who cannot find gainful employment.

The evaluating physician (the petitioner's physician) must certify that the petitioner's physical or mental impairment has existed (or is expected to exist) for a minimum of 12 months. Specific medical evaluation criteria for certifying the impairment are published by SSA and becomes the basis for granting disability. Medical evaluation criteria are specified by body system. Transsexuals would most likely petition under Section 12.04 - Functional Non-Psychotic. Within this category there are eight specific impairments (symptoms, signs, or laboratory findings). The petitioner need only satisfy one of these impairment criteria to be judged disabled. Of the eight impairments within this category, only three appear applicable to the transsexual:

1) Recurrent and persistent periods of anxiety, with tension, apprehension, and interference with concentration and memory.

2) Persistent depressive affect with insomnia, loss of weight, and suicidal preoccupations.

3) Persistent phobic or obsessive ruminations with inappropriate, bizarre, or disruptive behavior.

Although SSA has not developed a specific policy regarding disability eligibility for transsexuals, characteristics of transsexualism and its treatment and management identified by the information data base developed for this project provide some insight into this issue area.

The medical evaluation criteria identified above generally preclude one from conducting gainful employment when these manifestations are refractory to conventional means of remedial treatment. With respect to the transsexual, conventional management (hormonal, psychiatric counseling, etc.) although recognized as not being completely ameliorative, has been generally reported to reduce the specific manifestations of anxiety, depression, obsessive behavior, etc., which would have otherwise rendered the patient unable to work. The responsibility, therefore, of the disabled person, to seek out and obtain appropriate remedial medical services is a prerequisite of eligibility and a requisite of continued eligibility within the program.

Disabled persons seeking out remedial medical treatment turn to Title XVIII for assistance with these medical expenses. It is at this juncture that the issues of disability policy and Medicare coverage merge. If there are medically accepted, safe, efficacious, and non-experimental remedial treatments available to the disabled person, Title XVIII under the provision for the disabled will pay according to schedule for the remedial medical services. Successful treatment, rendering the patient free from the impairment that precluded them from working would result in the termination of the disability compensation.

As previously discussed, the surgical component of the treatment of transsexualism remains, within the greater medical community, an experimental procedure. Consequently, Medicare would not routinely provide reimbursement for these surgical procedures. Moreover, at the present level of the state of the art of transsexual surgery, the potential for incapacitating complications of the surgical procedure represents a greater risk of prolonging disability compensation than the primary disorder itself.

The guarded effectiveness of hormonal and psychiatric treatment in the transsexual, together with the high risk of surgical complications during sex reassignment surgery suggest that the transsexual is a poor candidate for disability compensation. This observation is supported by the absence of notable challenges by either the SSA, the state agencies, or the petitioner to the present policy application to transsexualism. At best, the transsexual may be eligible for a short-term disability compensation, during which time they must seek out remedial treatment short of surgical sex reassignment. Becoming a candidate for surgical sex reassignment at any of the more respectable university-based clinics would by definition (referring to the employment-self sufficiency criteria of the clinic render the transsexual ineligible for disability compensation.

2. Medicare

Eligibility for Medicare benefits is determined on the basis of the following policy:

> *Need of the individual is not a factor of entitlement. Those groups eligible are: (1) Persons over 65 with entitlement to monthly benefits under Social Security; (2) Those persons eligible for monthly benefits based on disability continuing for 24 or more months; (3) Persons entitled due to End-Stage Renal Disease. A small number of other persons over 65 are also eligible under certain other specified conditions.*

Within this broad framework, certain services are specifically excluded from Medicare coverage. Such specific exclusions are delineated in Section 1862 of the Act. In addition, Section 1862 mandates that no payment is allowable for services which are not "reasonable and necessary." Medical necessity is addressed by Title XI-B of the Act. The administrative definition of "reasonable and necessary" applied in determining payment eligibility of

claims includes the following requirements:

That the service (procedure-treatment) be safe;

that the service (procedure-treatment) be efficacious;

that the service (procedure-treatment) be non-experimental, and

that the service (procedure-treatment) be accepted by the medical community.

Safety

Complications of hormone therapy in transsexuals have not been reported to any significant extent in the literature. The complex associations between hormonal factors and carcinogenesis, however, are familiar from theoretical considerations. Therefore, concerns center around liver disease, coagulation defects, gall bladder disease, cerebrovascular hemorrhage, carcinoma and cardiovascular disorders with estrogen therapy; and liver disease, loss of protection against heart attacks and lipid disorders with androgen therapy.

Although hormonal therapy is thought to serve as a reversible, probationary period to test the patient's adjustment to the changes and demands imposed by the desired sex role, estrogen therapy causes testicular atrophy with permanent infertility (after one to six months) and breast development with proliferation of mammillary ducts and accumulation of fatty tissue (after six to twelve months) which can only be reversed surgically. Beard development in the female and deepening of the voice do not revert to normal with discontinuation of the androgen therapy.

As the number of surgical sex reassignment procedures have increased, so have the reports of complications. Very often the complications are quite severe, rendering the patient incapable of functioning in the opposite sex role. In many cases, these complications have incapacitated the patients to the extent that they have given up their jobs and seek repeated and prolonged medical care to rectify these problems. There appears to be a greater incidence of complications for these procedures compared to the average incidence of overall surgical complications.

Serious complications associated with the male-to-female procedures include rectovaginal fistulas, urethrovaginal fistulas, meatal stenosis, osteitis pubis, urethral stricture, and vaginal stenosis. Minor complications have included partial loss of skin lining the vaginal canal, transient bladder infections, hematomata or superficial necrosis of the labia, and dehiscences of small portions of the incision.

In 10-20% of male-to-female transsexuals, the one stage operation fails, usually because of inadequate perineal dissection, flap necrosis or infection, leading to the loss of vaginal depth and introital stenosis.

One published study (1974) reported a complication rate of 47% in male-to-female transsexuals and a rate of 25% in female-to-male transsexuals. In female-to-male transsexuals the most frequent complications included scrotal fusion, dehiscence, rejection of testicular implants, and phalloplasty infection. With the tubed flap method of penile construction such complications as strictures, fistulae, calculi formations, urinary incontinence and infections have been reported, as well as hematomas, infections, necrosis, loss of skin graft, and dehiscence of tube.

Efficacy

Debate continues over the medical necessity of transsexual surgery. Transsexual patients often present in severe mental distress and have reportedly resorted to autocastration and suicide during active states of emotional conflict. In such cases where transsexual surgery could alleviate this 'life-threatening' emotional condition, the medical necessity would seem obvious. To date, however, the evidence supporting a positive outcome in the acutely distressed patient is not conclusive. Moreover, it has not been determined whether sex reassignment surgery significantly lessens the incidence rate of suicide among transsexuals.

Persuasive arguments have also been presented by proponents of transsexual surgery supporting the medical necessity of transsexual surgery on the grounds that it enables the transsexual to engage in 'satisfying' sexual activities. Paradoxically, however, several researchers have noted that the desire to engage in satisfying sexual activities is not a crucial factor in the transsexual patient's decision to seek reassignment surgery. Many transsexuals present asexually, motivated by an overriding disgust for their offensive sexual anatomy. As noted previously, supporting evidence suggesting that transsexual surgery results in the patient's ability to engage in satisfying sexual activity is lacking.

Although hundreds of sex change operations have been performed, little is known about the long-term postoperative adjustment. The data on behavioral and psychological outcomes of transsexual surgery are at present somewhat tentative. There have been some reports of inadequately diagnosed patients who have prematurely undergone sex reassignment surgery and post-operatively experienced a sudden change of conviction. Data on long-term adjustment has been reported as being sporadic and inconclusive. As late as 1978, Stoller had observed that it is not yet known how many patients requesting sex change surgery will be improved and how many will be harmed.

Recent cases have been reported of patients who, although subjectively pleased with the surgical sex reassignment, have developed paranoid psychoses a few years after surgery. The incidence of suicide attempts among postoperative transsexuals has been reported to be as high as 16% and as low as 5%. This raises the question of whether surgery truly lessens suicidal potential in transsexuals.

The literature review conducted during this project underscored the

absence of definitive information on the efficacy of transsexual surgery. This observation is supported by the abundance of articles reporting the absence of a conclusive etiology and diagnostic procedures for transsexual surgery and by the paucity of articles reporting on the outcome of these surgical procedures.

Experimental

Researchers in several recent medical publications suggest that transsexual surgery is still considered experimental, in that it is not known how many and what percent of the transsexual patients are 'cured' or 'rehabilitated' by the surgical procedure. The information data base developed for this project similarly does not support an unconditional departure from the experimental classification assigned to transsexual surgery. The basis for this observation is the almost total absence of published controlled outcome studies relating the efficacy of transsexual surgery to the medical and emotional expectations of the physicians, therapists and patients involved in this area of medical treatment.

The labeling of transsexual surgery as totally experimental is somewhat misleading, in that the experimental label suggests that surgical procedures such as penectomies, castrations, vaginal reconstructions, etc. do not have predicable outcomes and therapeutic purpose. To the contrary, many of the surgical procedures associated with sex reassignment surgery are well established and routinely performed by surgical specialists for treatment of other disorders (i.e., carcinomas).

Medical Acceptance

Although there have been several commissions on Human Sexuality conducted by organized medical organizations recognizing transsexualism as an entity, physicians in general, as reflected by the major organized medical associations, have not developed a definitive position regarding transsexual surgery. In part, this may be due to the isolation of published medical studies in specialty journals and an almost total absence of published studies in the established medical journals in this country. It is interesting also to note along these lines, that the legal position of physicians performing sex reassignment surgery has as yet not been clarified, particularly with regard to existing state statutes dealing with 'mayhem' which could be applicable to transsexual surgery.

D. Other Relevant Issues

there are several additional issue areas which require consideration in the development of federal reimbursement policy for transsexual surgery. These issue areas include:

1. Legal
2. Social/Ethical
3. Prevalence/Cost
4. Patient Self-Sufficiency
5. Abuse Potential

A brief discussion of each of these issue areas is presented below.

1. Legal

There is very little in the way of cases or analytical articles on this specific topic. On transsexuals and the law generally, there are a variety of cases and about a dozen articles. The cases usually deal with either the legal aspects of a name change for a transsexual, or employment discrimination following sexual conversion surgery. The articles cover these topics and others, including legal definitions of sex, the legality of surgery, transsexuals and criminal law, physician's liability, civil records such as birth certificates and insurance policies, inheritance, and family law problems such as contracting marriage, dissolution of marriage, custody of children, and support payments.

There are only five reported court decisions, from 1946 to date, involving sexual conversion surgery and medical assistance benefits. These decisions all occurred within the past three years.

Of these five decisions, four found in favor of transsexual claimants seeking state medical assistance and one opposed such assistance. The four in agreement came down on a number of different grounds. The fifth case, although from an eminent court, seems to be on somewhat tremulous ground, in effect holding that denial of benefits to a transsexual was not arbitrary as long as the claimant was not suicidal or insane.

2. Social/Ethical

The emphasis placed on the transsexual patient's emotional expectations reflect a changing societal attitude regarding health care. Fox, and others have clearly pointed out that there has been a general tendency in society to move from sin to crime to sickness. Whether the illness of transsexuals is an objective reality, a subjective state, or a societal construct has yet to be definitively determined.

Fox also points out that casting persons in the 'sick role' is regarded as a powerful latent way for society to exact conformity and maintain the status quo. On the other hand, to the patient, the 'sick role' is a partial and conditional legitimization of their failure to perform their normal functions, according them a right to exemption and care.

The 'sick role' is particularly relevant to this discussion of reimbursement issues, in that under current federal reimbursement policy, Title XVIII coverage to persons under 65 and not handicapped, extends only to persons found to be disabled. Without sufficient understanding of the medical and motivational factors surrounding a patient's petition for transsexual disability status, the legitimacy of assigning this status to transsexuals is suspect.

3. Prevalence/Cost

The incidence and prevalence of transsexualism are difficult to establish for a number of reasons. Specifically, because:

a. The syndrome is not sufficiently common to lend itself to the usual

methods of epidemiological research;

b. Most transsexuals do not readily come forward for help, and

c. The syndrome is relatively unknown to doctors and it is difficult to diagnose.

Reports on the prevalence of male transsexualism have ranged from 1 in 25,000 to 100,000. Female transsexualism prevalence rates have been reported in the range of 1 in 103,000 to 1 in 400,000.

There have been varied estimates on the sex ratio of transsexualism. The ratio of male transsexuals to female transsexuals has been reported as 2.5:1, 3:1, 3.7:1, 4:1, 5:1, and 6:1.

An undocumentable estimate of the number of transsexuals ranges from 3,000 to 6,000 adult Americans.

Prioritization of scarce resources has become an increasingly important issue in health care in this country. As with real transplantation, abortion, infertility surgery and hemophiliac treatment, transsexual surgery must be evaluated and prioritized for federal reimbursement purposes. The heightened commitment to health care in the U.S. as a right together with the medicalization of deviance have been major contributors to the growth of health care expenditures.

Curiously, the cost implications of transsexual surgery have not been comprehensively studied. Cost estimates fluctuate widely from patient to patient depending on the length and depth of the presurgical screen, length of the 'real life' test experience, type and duration of hormonal therapy, complexity of the surgery, and postoperative psychological and medical management of the patient. For example, hormonal costs, including quarterly consultations with an endocrinologist, are estimated at $300/year (Karam). Preoperative psychological counseling, which is considered crucial in evaluating and preparing the transsexual patient, range in costs between $1,000 to $10,000 or more depending on the degree and nature of the psychological problem(s) exhibited by the patient.

For the male-to-female transsexual, surgeons' fees have been reported to range between $2,000 to $4,000. Estimated costs for the 10 day hospitalization, operating room fees, anesthesia, and lab tests begin at $2,000 and in some large referral hospitals could exceed $5,000. Estimating surgical costs for the female-to-male transsexual is far more speculative. Phalloplasty is not a well-established surgical procedure; often requiring multiple surgical encounters to meet even the most basic, functional expectations of the patient.

It is important to note when considering the cost implications of transsexual surgery, that there is a high incidence of postoperative complications associated with the surgical procedures employed in sex reassignment surgery. Estimates of costs associated with these more frequently occurring complications (i.e., fistulas, vaginal stenosis, etc.) could range in the tens of thousands of dollars (Huggins).

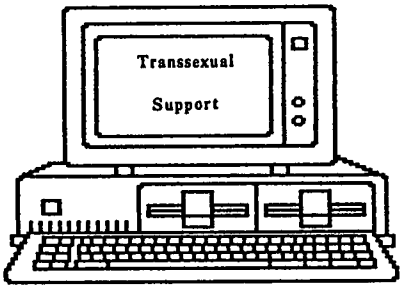
4. Patient Self-Sufficiency

the issue of patient self-sufficiency arises from the initial preselection criteria used by the major university, hospital-based, gender dysphoria programs. Unpublished experiences with surgical outcomes at these highly respected institutions suggest that patients who present as disabled and thus cannot demonstrate a minimum of self-sufficiency, share a greater likelihood of unsuccessful surgical outcomes. This is generally due to the patient's unrealistic expectation that the surgical altering of their anatomical appearance will 'overnight' enable them to interact with and become a productive member of society. Preliminary, unpublished findings suggest that transsexual patients who find employment, particularly in their desired sex roles, present a greater likelihood of a successful surgical outcome. Johns Hopkin's Gender Identity Clinic requires all patients who enter the two-year presurgical 'real-life' test to secure some form of productive employment in their desired sex roles. Failure to meet some form of productive employment criteria precludes patients at Johns Hopkins from entering the surgical stage of their program.

5. Abuse Potential

A major concern noted by project consultants in reference to government reimbursement for transsexual surgery involves the potential for abuse by untrained and incompetent health care providers. From a historical perspective, concern for the introduction of new "clinics" specializing in prescreening and counseling of transsexual patients is justified. Given the caution and meticulous attention to medical protocol characteristics of the major university-based, gender identity/dysphoria clinics, potential for catastrophic injury top patients resulting from the uncontrolled involvement of make-shift clinics cannot be overlooked during the reimbursement considerations. Without exception, this project's consultants felt that transsexuals should be evaluated, treated, and studied by multidisciplinary teams of medical specialists at university-based hospitals, following strict protocols for experimentation involving human subjects, before any decision regarding the blanket use of federal funds for the routine screening, surgical and post-surgical management of the transsexual patient should be considered.

SOURCE: J2CP Information Services



LESBIAN AND GAY PEOPLE COME FROM ALL TYPES OF FAMILY BACKGROUNDS

By Ann Thompson Cook, ACSW

It is a myth that everyone is oriented one way or the other. That myth was exploded back in the 1940s when Alfred Kinsey and his associates reported their survey of American adults' sexual behavior. Kinsey found that many heterosexual people had at least some attraction to the same sex, and that many homosexual people had some attraction to the other sex. Most of us fall somewhere in between the two ends of a seven-point continuum:

0 fully heterosexual, with no homosexual experience
1 predominantly heterosexual with incidental homosexual experience
2 basically heterosexual, with significant homosexual experience
3 bisexual, with significant heterosexual and homosexual experience
4 basically homosexual, with significant heterosexual experience
5 predominantly homosexual, with incidental heterosexual experience
6 fully homosexual, with no heterosexual experience

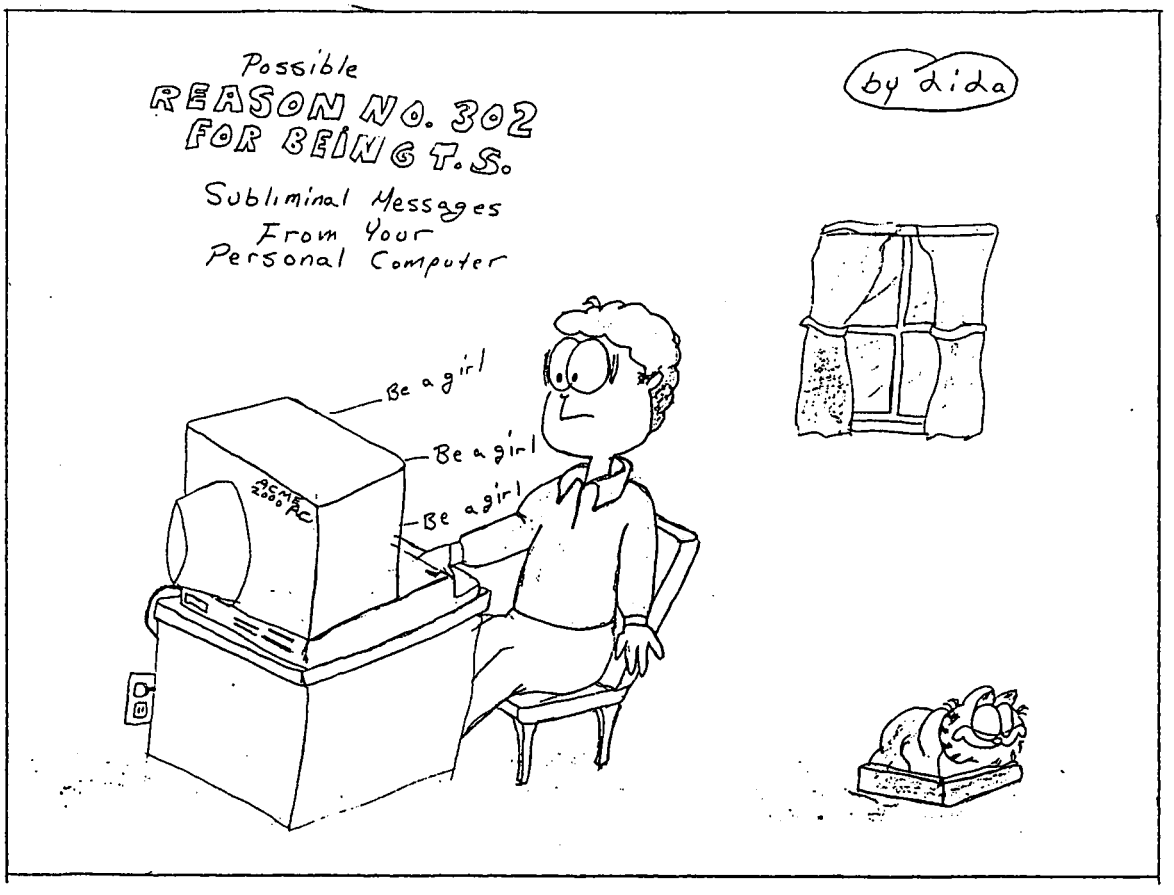
Homosexual or heterosexual "experience" is much more than a question of whom we "have sex" with. Our experience also includes fantasies, dreams, attractions, intimacy, sensuality and identity. It's hard to know exactly, but the most current estimates suggest that at least ten percent of women and men are exclusively homosexual. We do not know the percentage of people who consider themselves bisexual.

Why do people "choose" to be homosexual? Homosexuality is a natural phenomenon, occurring in every species of animal, including humans, in every part of the world. Most Gay and Lesbian people say that, looking back, they knew about their sexual orientation fairly early in childhood, even if they didn't have a word for it. A person's orientation - Gay/Lesbian or otherwise -- is not chosen but discovered Our choice, then, is not whether to be heterosexual, bisexual, or homosexual, but how to be whoever we are. We make decisions about how to behave, and the question is whether we will choose to behave in ways that are exploitative or caring, selfish or nurturing, violent or loving.

What causes homosexuality? Lesbian and Gay people come from all walks of life, from all types of family backgrounds. A lot of researchers have tried very hard to find a "cause" for homosexuality and they have all failed. There is some evidence for biological determinants, some for environmental.

Why don't homosexual people change? This question implies that there is something wrong -- perhaps an illness that should be cured -- but there is nothing wrong. Homosexuality is a normal variation.

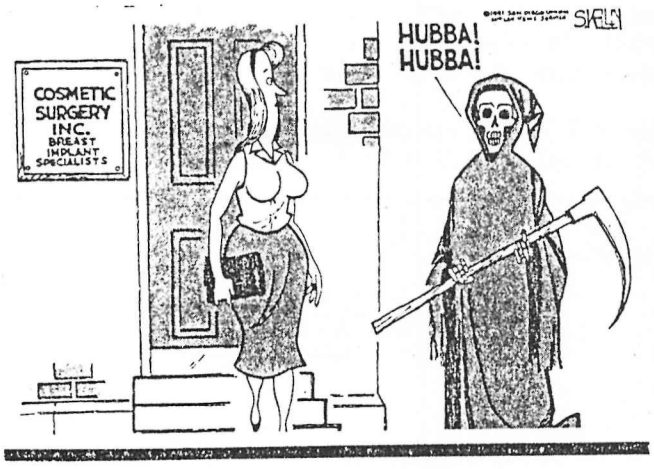
(EDITOR'S NOTE...This article reprinted in part from *The Gay Community News* of Hawaii.)



Advisory panel seeks better breast implants information

By W. Dale Nelson (AP)

GAITHERSBURG, MD. - A federal advisory committee, struggling with what it says is inadequate data on the health effects of breast implants, is urging creation of a nationwide registry to keep track of women who received the silicone devices. Dr. Susan Honig, a professor of medicine at Georgetown University. and others said studies by the FDA and by the Bristol-Myers Squibb Co., manufacturer of the polyurethane-coated implants Meme and Replicon, failed either to establish that the devices can cause cancer or to show conclusively that they cannot. Sale of the implants were suspended in April. About 200,000 women have these implants, which are coated with polyurethane foam to prevent unsightly and painful lumps. Altogether, about 2 million American women have silicon breast implants. The committee's consensus was that the risk of removing the implants would be slightly higher than the risk of cancer from leaving them in place.



FEMALE ORGASM

By Janet Shibley Hyde
Understanding Human Sexuality
McGraw-Hill Book Company, (C) 1979

The process of orgasm in females is basically similar to that in males. It is a series of rhythmic muscular contractions of the orgasmic platform. The contractions generally occur at about 0.8 second intervals; there may be three or four mild orgasm or as many as a dozen in a very intense, prolonged orgasm. Other muscles, such as those around the anus, may also contract rhythmically.

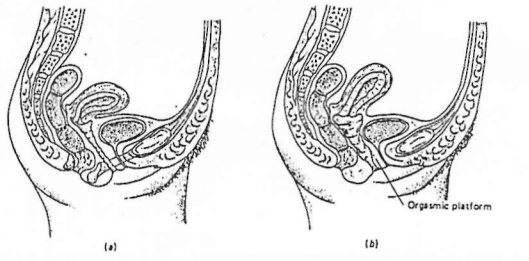
In females, the orgasmic platform is a swelling or thickening of the tissues surrounding the outer third of the vagina. Thus the size of the vagina entrance actually becomes smaller, and there may be a noticeable increase in gripping of the penis. Another change is the elevation of the clitoris. The clitoris essentially retracts or draws up into the body, with the shaft becoming about 50 percent shorter.

Other changes include a further swelling of the breasts. Finally, the color of the inner lips changes, from pink to bright red. The last change indicates that orgasm is close. If proper stimulation continues and other conditions are right, the woman will have an orgasm soon after the color change.

Female orgasm is a funny thing. As with love, you can almost never get anyone to give you a solid definition of what it is. This is probably related to several factors, most notably that female orgasm leaves no concrete evidence of its occurrence like ejaculation; indeed, the very existence of female orgasm has sometimes been questioned. Also, women often do not reach orgasm as quickly as men do.

Just what does orgasm in the female feel like? The main feeling is a spreading sensation that begins around the clitoris and then spreads outward through the whole pelvis. The woman may be able to feel the contraction of the muscles around the vaginal entrance. The sensation is very intense and is more than just a warm glow or a pleasant tingling.

Orgasm is not the last phase of sexual response. Following orgasm is the resolution phase, during which the body returns physiologically to the unaroused state. The first change in women is a reduction in the swelling of the breasts, particularly of the areola. As a result, the nipples may appear to become erect, since they seem to stand out more as the surrounding flesh moves back toward the unstimulated size. This may provide the kind of sign wanted by those who are concerned about proof of female orgasm.



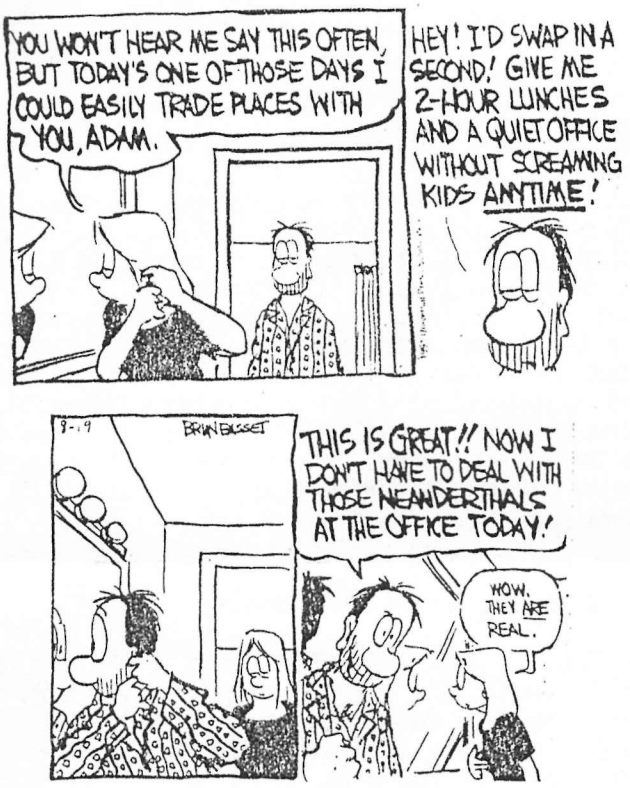
UNAROUSED STATE HIGHLY AROUSED

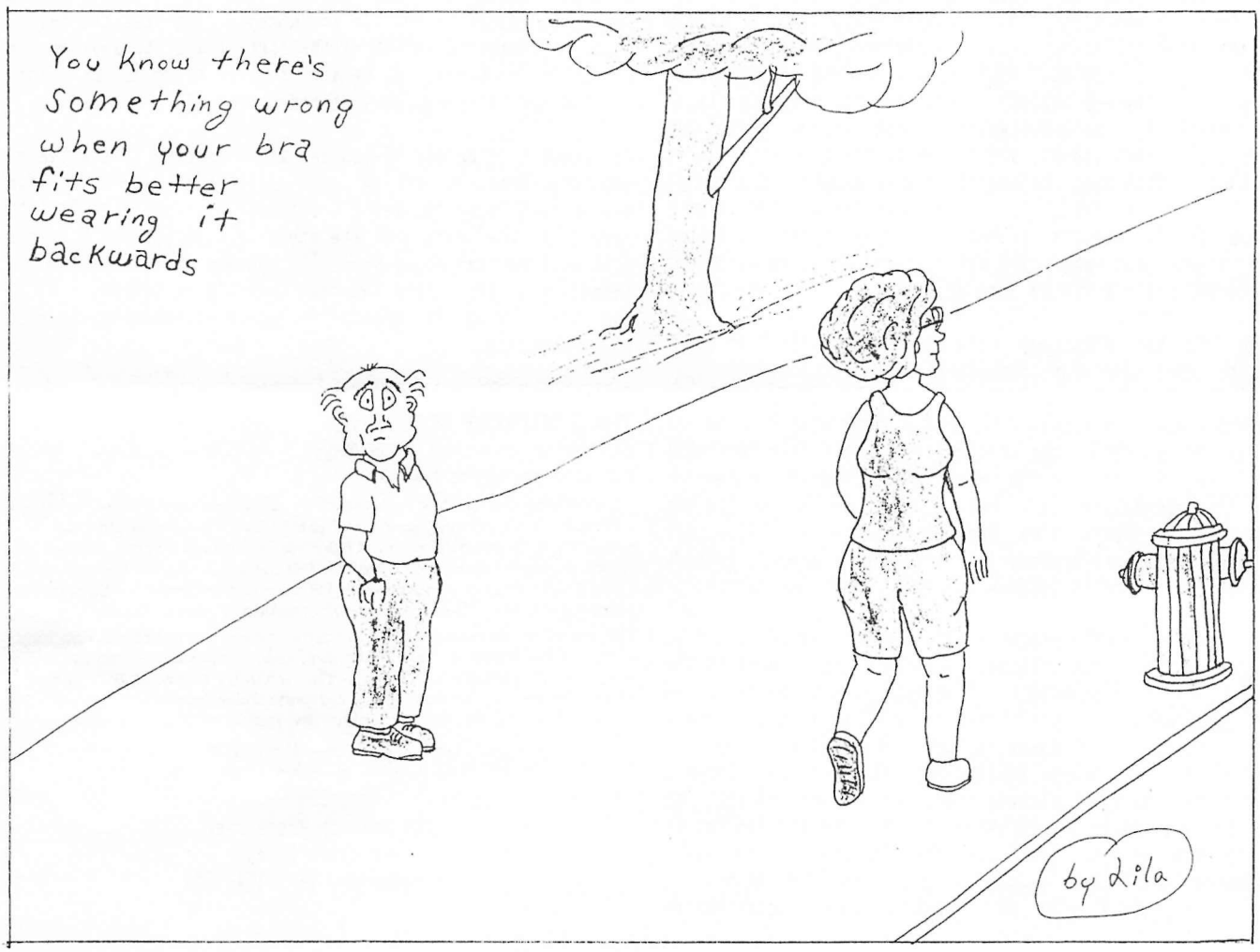
TOP 10 BEST REASONS TO GET MTF SURGERY REVISITED

by Boom Boom LaRue

10- Your Uncle Fred, who you never liked anyway, will disown you.
9- You will now get all that praise and admiration directed at you from all those Urban gentlemen on all the street corners of the city.
8- Your chances are greatly increased for a guest shot on Donahue.
7- The opportunity to shave strokes of your golf game driving from the Ladies' tee.
6- You will be rewarded with a mandatory divorce from your "bitch from hell".
5- The honor of being introduced as "Honey" in business meetings
4- Geraldo is looking mighty good.
3- You'll qualify for those intriguing, breathy, middle-of-the-night-phone-calls.
2- You can avoid moving expenses to Canada associated with dodging the draft.
1- Hair Spray.

ADAM





A VISIT TO A WALK ON THE WILDSIDE

By Sonia

Well, as unlikely as it may sound, I recently paid a visit to Take a Walk On The Wildside. (For those of you who may be unfamiliar with this establishment, Wildside is a Transvestite social club / retail store / bed & breakfast / makeover service.) We (Becky and I) did not visit Wildside in order to make use of their rather unique services... we went to visit former *Twenty Minutes* editor Veronica Brown and her spouse, Paddy Brown. In all honesty, I have to admit that I was quite pleasantly surprised by the layout and operation of all of their services. As a Transsexual, I often find any Transvestite oriented clubs and/or services to be a total turn-off... I am NOT a man who likes wearing womens' clothing, I AM a woman, and so have little if anything in common with TV's.

Well, now that we have the obligatory Transvestite-bashing out of the way, let the tale begin...

We left at about 9:00 am on a Saturday... the skies were mostly sunny, and it would reach 100 F before the day ended. Our big mistake was in not taking a car with air conditioning- when you drive for 10 hours with the windows open, your hair ends up looking and feeling like something out of a B-grade horror movie. We arrived just as the last Wildside retail customers were leaving and received the nickel tour from our esteemed (yah right) former editor. The facility was clean and surprisingly spacious. (From the outside, the building looks MUCH smaller.) Veronica showed us the makeup tables, retail store, makeup tables, guest rooms (with makeup tables), makeup tables, bathrooms (with big mirrors), makeup tables, guest lounge (with big mirrors), makeup tables, and a look at their private living quarters (which does not contain a single makeup table!) At the time we arrived, Paddy was out on the town with a troupe of club members. We had originally planned to go out that night, but when all was said and done, we were just too tired. (It's a REALLY long drive)

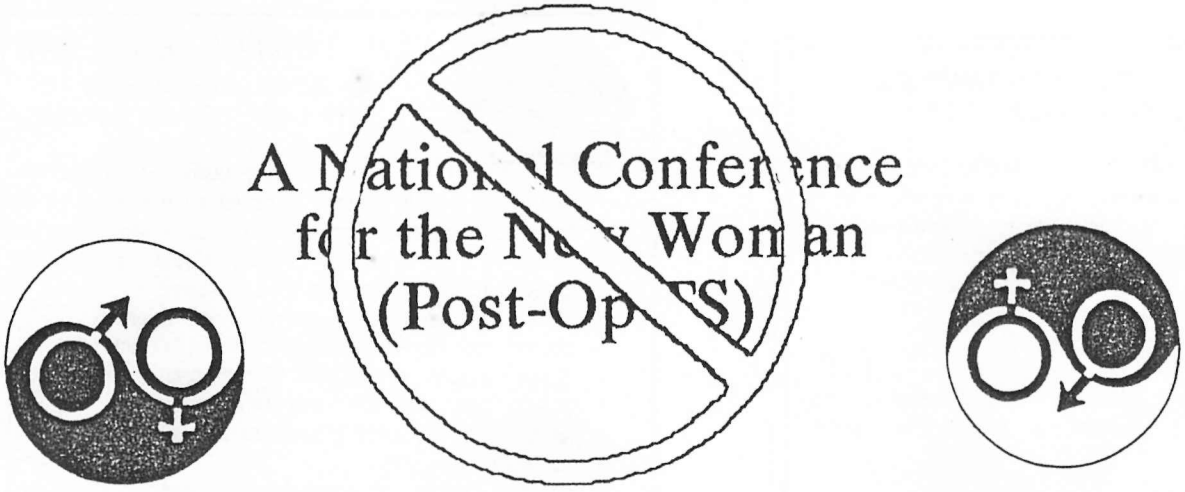
Paddy and her entourage returned at about 10:00 pm and I got to meet her for the first time. The only way I can really put it is she's a trip... you can take that in whatever way you fancy. Paddy has a heart of gold, and she really cares about the crossdressers she (works for/takes out). We all sat in the lounge and talked for an hour or so. The atmosphere felt better than either of the two transvestite groups I've had the occasion to visit... All of the guests were dressed in a presentable manner, (nobody was walking around in teddies or latex) and no mustaches.

Becky and I went upstairs and left the party to itself... we had a busy day planned. The next day we went to the Royal Ontario Museum (ROM) while Paddy and Veronica stayed home and worked on their newsletter. I know this has very little to do with Wildside, but I just had to comment on the wonderful picture taking possibilities that Toronto offers to the alert photographer... but enough of that. We met up with Paddy and Veronica that evening and decided to go to the islands just offshore in lake Ontario. Paddy suggested going for a walk along the boardwalk to see the amazing nighttime view of Toronto... as I had my camera with me, I took advantage of this to take some of my most beautiful pictures of the whole trip. (Oops we weren't going to talk about that... sorry.) The most amazing thing was that as we were waiting for the ferry to come back, Paddy met 2 or 3 people she knew... Becky commented to me on the fact that in this city of 3 million, Paddy seemed to meet someone she knew just about everywhere she went, and if she didn't, she made new friends.

The next day, we went shopping and picture taking in downtown Toronto. We met up with Paddy and Veronica early that evening and went out to dinner and a comedy club at Paddy's suggestion. (Well actually, she had made the reservations a week or two before, but that doesn't sound quite as nice.) After a good meal and a wonderful show, Veronica decided to go home, and the rest of us decided to hit a local bar/dance club. Well, given that I was the only heterosexual in our little threesome, we ended up at a lesbian bar. We danced just long enough for me to begin to loosen up and start to enjoy myself, then we went to a gay bar... one which to my delight (and Becky's apparent dismay) had a male strip show. Well, I got down to some serious making-an-ass-of-myself-and-whooping-it-up-very-loudly. After the strippers were done, they announced that there was a table dancer available. I made a fatal error... I asked Paddy what in heck was a table dancer... she didn't tell me... SHE SHOWED ME!!! Before I realized what was happening, this exceptionally cute guy was gyrating in front of me in a most provocative...almost lewd way! I have to admit it was quite an experience... kind of like sex without having to take off your clothes. I knew I wasn't going to respect myself in the morning, but what the hey... when in Rome, Right??? After that, I was too weak in the knees to continue, so we went back to Wildside and turned in. The next morning, we went home.

At about this point, if you are still reading this article, you are probably asking what all this has to do with transsexual support. Well, the answer is - not a whole lot. Basically the moral of the story is...If you don't take a little time to enjoy yourself, you may find that life has passed you by... and the next time I'm in Canada, I'll be too busy lying in a hospital bed in excruciating pain to enjoy anything.

The Human Outreach and Achievement Institute presents...



When: September 20-22, 1991
Where: Essex, Massachusetts
Why a National Conference?

* To come together for the first national gathering of New Women in the USA
* To explore new avenue toward better economic and professional status
* To share postsurgical and medical problems and issues
* To improve in personal social development areas
* To discuss the diversity of lifestyles available to the New Woman

Sour Grapes...(from the Great White North)

by Veronica Jean Brown

At the time, the idea of a national conference for the New Woman seemed like a good idea. Being marriedto a wonderful woman, I of course, wantedto have her take part. When we called and spoke with Ariadne Kane of the Outreach Institute, we were pleasantly surprised by the warm welcome we received. We were equally pleased that a special couple's rate was extended to us for our stay at what looked like a marvelous place in Essex.

A few weeks after we sent in our money, we received a letter from someone at the Outreach, who was questioning the status of Paddy's surgery. It was beginning to look like that Paddy, my spouse, and a genetic female, was not totally welcome at the New Woman conference.

We were later informed that the board of directors felt that the post-op New Woman would feel uncomfortable with having a genetic woman sitting in on what was considered to be "special and delicate" matters. If the love of my life, my friend and business partner was to be excluded from most of these seminars, then I wasn't going to attend. Here we have another fine example of special interest "exclusion" in the gender pond. Here is yet another reason why the smart post-ops get out of the "gender pond" as soon as possible.