"YOUR HEALTH" WORKSHOP REPORT

SATURDAY, JUNE 17, 1995

Speakers:

- *Lisa Middleton, Health and Insurance Law Moderator, ICTLEP*
- *Sandra Laframboise, High-Risk Project, Vancouver, B.C., Canada*
- *Sharon Ann Stuart, Rights Director, ICTLEP*

By Lisa Middleton:

I'm Lisa Middleton. This is Insurance and Health No. 5. It is Saturday, June 17th, the day after Newt Gingrich's 52nd birthday. Aren't we all so happy about that? Let's all have a round of applause for Newt's birthday. Not that much.

We have a number of things to cover. We want to review what went on in the health and insurance section over the last two days. It was really a lot of fun and, I think, very informative. I know people are going to be coming in, starting right after lunch. After such a wonderful speech from Judge Walker, it's going to take folks a little while to get in.

HEALTH INSURANCE REFORM

The first thing that happened in the insurance and health section was a review on Thursday morning of where we stand on insurance reimbursement for transgender health coverage. My good friend Laura Skaer said that things hadn't changed a whole lot in the last three or four years that she's been doing the employment section, but I think she may be a little lucky, because things haven't really changed as it applies to transgender health care reimbursement from insurance companies since 1983. So we still have quite of a bit of catching up to do. Last year when we came to this conference, there was a lot of publicity that was going on and there were questions coming up.

We were all expecting to see some type of federalization of health insurance in the country come out of Washington, D. C. There were different bills that were being debated. There were multiple bills from both the majority side, which at that time was Democratic, and there were bills from the minority side, and there were compromise bills from both the Republicans and Democratic moderates, and then there was the President's bill.

There was only one bill that was up last year that provided any coverage for transgender health

care. As we look today, all of those bills have gone away. We're not sure what's going to come up in the future. There are, though, in all of the bills that existed last year, as they were being debated, two provisions that were not very controversial, that we don't have, that are terribly important. And, recently the president announced that he's going to seek reintroduction of legislation that would provide for portability of health insurance coverage, so that when you move from one employer to another employer you would be able to take your health insurance coverage with you. And while that does not directly apply to transgender health care, any different than any other form of health care, for those of us who know that we are disadvantaged, often needing to move from one employer to another in employment, the question of portability is a major issue for our community and one that we should be joining forces with other individuals to support.

The other major item that was in all of the legislation last year and has been brought up by the president again this year, is the question of eliminating the general exclusion that exists in almost all health insurance policies for preexisting conditions. This had general agreement among the insurance industry, among Republicans, among Democrats, and somehow or another it didn't get through either house last year, because no bill got through. Again, it's an issue that affects numerous individuals as you move from one carrier to another carrier, and then run into that game of well, no, this is a condition that existed before, so it's your prior carrier that has coverage responsibility for it. And then the prior carrier says, "But you're not insured with us any more, so we're not responsible for it." And there is this gap that exists where individuals end up not receiving health coverage for a condition that has existed for some long period of time.

Speaking strictly as someone who is in the insurance insurance industry, we weren't opposed by and large to eliminating the preexisting condition exclusion. Most health insurance executives wanted to see it done away with. They just wanted to see it done away with by federal legislation, so it would apply to all carriers. We would all be similarly situated, and then it becomes a rather simple rating factor for us, and something that we can take care of actuarially. But if my company does away with it, your company doesn't, and another company doesn't down the street, you don't have an even playing field among the insurance carriers that we seek when we're dealing with these kinds of issues.

So that's my little speech on health insurance reform and hopes for reform, that they do come about this year. As we look at the caselaw specifically as it applies to transgender health care, the question that keeps arising is the general exclusion that exists in any form of health care, and we find once again that what's happened is what started in precedent caselaw back in the early 1980s, finding that SRS was not covered because SRS was an experimental procedure as judged by the courts in the most important case, Rush versus Parham, 1983, Federal Circuit Court of Appeals down in Atlanta, that found it was experimental at that time, based on the evidence of the psychologists and psychiatrists that testified.

Chief among them was John Mire and his work, which was done between 1972 and 1974. And it's that research, done over 20 years ago, that remains the standard for federal reimbursement policy; it applies to health care for transgendered people. The thing that has happened subsequent to that very specific decision that related only to SRS is, we've seen language come into various insurance

policies that doesn't say "we don't cover SRS", but says "we don't cover sex transformation", and then an extension that says "we don't cover any services related to sex transformation." But no one has defined what is a service that is related to sex transformation. An individual who's a cross dresser and has absolutely no intention whatsoever of ever having SRS, but needs to have some psychological counseling, some mental health therapy, is barred from being covered under their health insurance policy as it relates to mental health, because somehow or other this is in the vague area of sex transformation services. Or are they covered up until the point that they decide that they decide that they do want to go ahead with SRS? Are hormones excluded? Are they included? There is no precedent caselaw whatsoever.

The policies that have come into being have come into being not because of federal courts; they've come into being as underwriters in various insurance organizations have simply taken the language from one contract and then expanded upon that a little bit, and then expanded on that a little bit, and then expanded on that a little bit, without any testing of that language in caselaw. Editorial comment perhaps, before we jump to the conclusion that we should blame insurance organizations for discrimination.

We may want to look in the mirror and ask ourselves why we have not tested those exclusions in the courts ourselves, and why we have not organized ourselves to bring cases to bear that might ask them the question in a very coldhearted way – Do you have a justification for these exclusions? There are precedent cases that we need to be aware of that have been very helpful to us. Doe versus Minnesota is a Minnesota State Supreme Court case that found that transgendered health care cannot be excluded by its condition. It also found that it's not a cosmetic procedure to have SRS. Rush versus Johnson in 1980 Federal Circuit Court case, found that you could not exclude SRS simply because it was transsexual surgery.

You could not exclude it because it was administered to transsexual individuals. It could be excluded because it was experimental, but it could not be excluded on the basis that it was transgendered health care. In Penneky versus Presser in 1980, also a federal case out of Iowa, the Court found that the Iowa statutes under Medicare that barred SRS reimbursement were invalid, because they were adopted without due process. They were adopted without hearings. They were adopted without regulative process going on. They were adopted in blanket, saying that at all times, under all circumstances SRS is not medically necessary.

The Court found that to be an invalid procedure and excluded it. None of those precedents have been overturned and remain in effect today, and can be used by us and by our community, but what we do have is the one bar that says experimental procedures are not covered. There is case law as it applies to experimental procedures, that has found that it is the payors who have the final responsibility for determining what is a medically necessary procedure, but that in making those determinations as to what is an experimental procedure and what is not an experimental procedure, the payors are responsible for following due process in making their determinations. They may not be arbitrary.

They cannot be capricious, and they must adopt the guidelines with some degree and

reasonableness, as reasonableness is interpreted by the federal courts. Case after case has concluded that in making those determinations, the financial impact upon the payor is not a valid condition for excluding health care. Medical necessity, experimental procedures, cosmetic procedures as classes of procedures may be excluded, but that which is medically necessary, that is which medically appropriate, may not. Some of the important cases that we need to be aware of, as they relate to the question of experimental and the determination of experimental medicine are *Farrannette versus Kaiser Foundation that found that Kaiser – and this is not a transgender case but it does go to the question of experimental procedures – that an appropriate procedure for determining what is an experimental procedure includes a medical advisory committee that has responsibility for reviewing requests for health care.

Secondly, that protocols are developed independent of the organization that is the payor. In most instances, what the courts like to see is that the protocols were developed by a university teaching hospital, as opposed to being developed by the payor directly. And a number of university hospitals are very prominent in providing these kinds of protocols. The medical advisory committee that is in place has an opportunity to make exceptions on an individual case basis, and they can document that they do make exceptions on those.

And lastly, what I've said before, that financial impact on the organization is not something that is a factor in making a determination for what is paid and for what is not paid. Generally, in making a determination whether or not something is experimental or not experimental, what the courts are looking for are practices and procedures that are in accord with tested and accepted medical practice, that it's a medical condition, that's it's a treatable medical condition, and that there is an understanding of what the risks and benefits are of a particular course of therapy and treatment for that condition.

Things that are medically necessarily generally cannot be omitted from health care coverages. For instance, a health care package that says, We don't cover angiograms, or we do not cover coronary bypass surgeries, or things of that nature, generally is not accepted as being appropriate. What runs into constant friction though in the 1990s, is that medical technology is advancing at a tremendously rapid rate. New technologies come into place, and it takes a while before those new technologies become validated by medical practice. And usually those new medical technologies find their way into the medical arena with conditions that are very, very difficult.

We have individuals who have significant forms of cancer, for instance, and they are not covered. One of the most prominent that's going on today is the question of whether or not reimbursement is appropriate for high dose chemotherapy, in those instances where they attempt to destroy an individual's bone marrow and transplant their bone marrow back into the body after the imposition of extremely high doses of chemotherapy. It's been a number of those cases that have been out there. Generally, the payors have been found to be responsible for providing reimbursement for those procedures.

What we need to do in our community is participate and push forward outcomes research that will document the appropriateness and the effectiveness of transgender health care, support those

institutions that are doing research into health care for the transgendered community, and help provide what is in fact a basic information that demonstrates that transgendered health care is in the mainstream of health care as it applies today. That it's a medical condition, whether we call it psychopathological or not is for a few minutes later in the discussion, but that there are medical needs which can be addressed. That they can be addressed safely. That they can be addressed effectively and they work, and that we can document that they in fact have worked. When we can do those things, when we have that kind of literature, we can go into the insurance organizations, we can go into the federal courts, with a very strong position.

One of the difficulties that we have is the cost of getting into the court systems today. And we need to encourage poverty law firms and poverty law centers to take on our cases. Far too often it's individuals with very minimal resources who are disadvantaged. I'm going to move from that discussion to the second thing that came up on Thursday: an outstanding presentation that we had from Sandra and Debra, who are with a high-risk project in Vancouver, British Columbia. They did a wonderful presentation on the work that they do with transgender HIV patients. And unfortunately, I had to be out of the room for about the first half of their presentation . My notes were a little thin, and I imposed upon them to give us about a five-minute summary of what went on in their presentation. So if I can get Sandra and Debra to come up.

HIGH-RISK PROJECT UPDATE

By Sandra Laframboise:

Hi everybody, my name is Sandra Laframboise from Vancouver, British Columbia. I don't like standing up here. That for me is like power. I like to be at everybody's eye level. Anyway, just to continue with your health insurance coverage for SRS. In Vancouver, if you're in the working class, the government medical service plan reimburses you 25 cents out of every dollar spent for your surgery. If you're on social assistance and you have powerful advocates on your behalf, the government pays for all of your surgery within Canada, in another province. We can also advocate for your electrolysis to be paid for. And in some cases, I think one, we were able to successfully ask for this person's breast implant to be paid for; due to medical conditions she couldn't take hormones.

Now, what we do as a group is this: about a year and a half ago I graduated as a psychiatric nurse in British Columbia. I was the second transsexual who graduated out of that program in the whole of the province, and I wanted to give back to my community, so we joined a foundation. That's from a working class, upper middle class people and that's okay. We need that, you know; but they weren't doing anything for the people on the streets and that's where I come from. I've been a street person for 17 years of my life, and now I've had all this education.

I didn't know what to do, and I wanted to help my community. So two people who were HIV positive at that time, and me not, wanted to do something for people on the streets, so we started

doing a meal program once a week in the evening in the downtown east side. The results were so overwhelming that out of that came the need to create something bigger, so as we expanded; last year we found space. We were donated space, and we've opened a drop-in center that's opened five days a week for four hours a day, servicing HIV positive transgendered people, IV drug users, and sex street workers. Everything is run on a pure basis and it's consumer-driven, so everybody is equal, everybody's got input, everybody makes their decision. And all the programs that are done, are designed by the girls themselves. Everything is purely for transgendered people. And we just got incorporated this year in January, and funding is starting to come from the government and the various nonprofits, huge organizations. And just before coming to this conference, we had applied for a law project that came out of necessity, actually, in advocating in the interests of our girls. What happened to some of the girls, is that they ended up in hospital settings, and they were put with other males in rooms and yet these care givers, these professional care givers knew our girls, and they've been crossdressing for 15, 20 years, you know, and taking hormones, and yet they were still treated as males. So there came a need to do something about that, and we started advocating on their behalf, and the hospital actually listened to us.

Sarah LaFramboise
High-Risk Project, Vancouver, B.C., Canada

They took the girls out of those male rooms with the other males, and gave them privacy, and put them in a private room; in fact, thanked us for advocating on their behalf, and are looking into changing their private policies on transgendered admission in the hospital. So out of that, we started listening more and more to the girls and their discrimination. They survived. They continue surviving every day receiving this kind of discrimination, so we wrote a proposal to the law foundation of British Columbia asking for some money to look into this, and to decide if in fact there was discrimination, if we can make a legal amendment to the BC Human Charters of rights. And we've been approved for that.

So when we're going back, we're bringing back all the information from here, and we're going to be in contact with various people who have done such projects, and we'll be writing all about it. We have a lawyer. We have a consultant. And hopefully we'll be able to make that amendment and bring in the legal cost situation of transgendered people in British Columbia. So, thanks.

By Lisa Middleton:

Thanks, Sandra. We have here today a lady I'd like to introduce, Sandy Kasten. Sandy's done a tremendous amount of work for the transgendered community in the Bay Area of California. She is attorney in tax law in Berkely, California. I was asking Sandy a couple questions regarding taxes during lunch. I'm always trying to get mine down. A couple of years ago the IRS changed some rules regarding the deductibility of cosmetic health care procedures. And one of the examples that was used in the hearings as they were developed, was that electrolysis would be considered a cosmetic procedure that would not be deductible. So far we've not been able to find, Sandy's not found, any cases that have questioned on audit or in the courts, the issue of whether or not electrolysis is in fact going to be found to be deductible, and she is very interested in any cases that do come up on the question of electrolysis and the deductibility of electrolysis procedures. And I refer any cases coming up on that issue, Sandy would like to know about them. Sandy, stand up and let the recorder have your address. We will put that in the Proceedings so that they will be aware of your address and can make reference to you for that.

By Sandy Kasten:

I'm interested not only in the tax deductibility of electrolysis, but any kind of SRS or transgendered related medical procedure. If anyone is audited on any medical issues having to do transgendered medical care, call me at (510) 526-4822. Thank you.

TRANSGENDERED BEHAVIOR AND DSM-IV

By Lisa Middleton:

One of the first sessions we had in the afternoon was a presentation from Dr. Collier Cole. Dr. Cole is the director of the Rosenberg Clinic near here in Galveston, Texas. He's had a lot of experience over the years in working with the transgendered and transsexual community. He delivered a paper, "Transgendered Behavior and the DSM IV." And I believe this paper will be introduced into the Proceedings in whole. *(See appendix A – ed.)* That is the intention, but I'm going to try to summarize some of the things that Dr. Cole spoke about.

Dr. Cole refers to transgenderism as a relatively new phenomenon, as a relatively new term but an old phenomenon, something that has been around since the history of man. He also describes

how the transgendered behavior has tended to fall within the field of medicine as it has been dealt with by professional communities.

In 1980 as a result of that involvement, the Harry Benjamin International Gender Dysphoria Association was formed, and standards of care were developed. Those standards of care were developed to guide professionals in working with transgendered individuals. Specifically, minimum criteria were to be offered for determining when and how to recommend such interventions as hormone therapy and sex reassignment surgery for those seeking those treatments. The Diagnostic and Statistical Manual current edition, IV, identifies two primary types of individuals who are transgendered: first, transvestic fetishism, formally known as transvestism, or also referred to as heterosexual crossdressing, is listed under the paraphilias for sex deviant behaviors. This category also includes pedophilia, exhibitionism, voyeurism and other permanent sex offending problems.

Secondly, gender identity disorder, formerly known as transsexualism, also referred to as gender dysphoria, stands alone in its own classification. This phenomenon can be seen at various developmental stages, and so can be diagnosed at childhood and adolescence and adulthood. The attempt for both the APA and for the Harry Benjamin Society is to provide information to professionals in dealing with transgendered clients. Some transgendered individuals and consumers and activists have come to feel, and have come to make known to the professionals, that they believe a psychiatric description of the condition is stigmatizing.

According to Dr. Cole, the majority of transgendered individuals, though, rather than being activists, simply want to pursue medical therapies, blend into society, and live in quiet and anonymity. They are generally supportive of the question of having standards as it applies to their health care. They are not necessarily supportive of all of the current Harry Benjamin standards, and by and large have often expressed concerns and reservations about certain portions of those standards.

Those concerns and reservations regarding certain standards have also been expressed by a number of professional individuals who are experienced in the provision of treatment to transgendered individuals.

It has been noted by Professor Brown, a psychiatrist and gender specialist, in his study of heterosexual crossdressers, that various treatment approaches exist to "cure adults of this behavior." As an example, psychotherapy, aversion techniques, and pharmological agents have been, and I quote, "abysmal failures with none resulting in permanent behavior change."

Rather, most crossdressers enjoy their behavior, and come to the attention of mental health professionals only when a crisis involves that arises out of a third party, that is, a spouse that discovers and does not accept the behavior, work implications, and other outside individuals that create difficulties for the crossdresser.

Dr. Cole and his colleagues in the Galveston area have studied over 400 individuals presenting for

self diagnosis, and they found that evidence among the individual cases of problems associated with mental illness, genital mutilation or suicide attempts, that less than 10 percent of the population that was transsexual had these difficulties. This is in comparison to national studies that would indicate that as much as 25 percent of the general population may have some form of mental impairment, mental condition, mental disorder, mental disease, anxiety, depression, drug abuse, alcohol, so forth and so on.

But it's difficult, given this ratio of 10 percent in transsexual population, and 25 percent in the general population to argue that transsexual individuals are themselves additionally more mentally impaired than a standard population might be.

Linda Phillips
Director, Boulton & Park Society, sponsors of the Texas T-Party

They found that virtually all individuals who came to their clinic, came to pursue sex reassignment surgery. Only a handful were considering the nonsurgical option. Individuals seeking the nonsurgical option seem to be growing. The surveys that Dr. Cole have not necessarily been validated by all individuals, specifically Pauli has noted a significant incidence of mood disorder in gender dysphoric individuals. Levine has reported notable access to pathology in his group. All three argue that there needs to be an expanded view of transgender behavior, and that there need to be additional studies.

It's likely that medical involvement to some fashion or another will remain in place for transgendered individuals. Hormone therapies and surgeries are medical procedures, medical, and they occur only after a period of evaluation. No form of medical treatment is provided simply on demand without an interactive component between professional and the consumer, exploring both potential risks and benefits. For example, if hormone medications were so safe and simple, why does the FDA not assign these to over-the-counter status? Research clearly indicates, however, that there can be risks from this form of treatment, and some medical involvement and follow up is warranted to ensure the safety of the consumer.

Nonetheless, individuals who are consumers have recognized and raise the question as to whether or not the standards as they apply today are appropriate. There needs to be continuing dialogue between the consumer and the professional community. Also the question is raised by Dr. Cole of insurance reimbursement for these procedures, and he notes the importance of developing appropriate professional protocols to deal with the medical needs of transgendered individuals.

Finally, Dr. Cole notes that transgenderism is a variation on the human condition, and in the light of new thinking and new evidence, may not simply be a psychiatric disorder per se. It appears that individuals can hold down jobs, raise families, establish close relationships, pay taxes, and live successfully without any significant debilitating distress or impairment in functioning.

And lastly, from Dr. Cole, efforts must continue towards demystifying and destigmatizing transgendered behavior.

We followed Dr. Cole's presentation with a presentation from Linda Phillips, speaking as a consumer in the transgendered community.

And Linda pointed out the importance of coming to an understanding of yourself and the importance of the individuals themselves in reaching a sense of confidence, a sense of understanding, a sense of happiness with themselves. It is important for individuals who are transgendered to recognize that in working with therapists you cannot allow yourselves to be imposed upon by therapists who might have the solution of the day at their fingertips if that solution of the day does not necessarily apply to you and to your needs.

Additionally, numerous transgendered individuals are in happy, longstanding and loving marriages; those marriages are valued and they must not allowed to be ended because of the person running headlong into the belief that the only option available to them is to go forward with a surgical procedure that could be harmful ultimately to their marriage.

Linda points out surgery is a huge step and that it is too often undertaken without thinking that step through. I suspect few would agree with Linda that it's only after age 75 that an individual would be appropriate for SRS procedures, but I suspect many individuals would agree that there is terrible pain associated with making that decision too early and before one is ready for it.

The last presentation that we had on Thursday of this week was a presentation from Dr. Douglas Oosterhat.

Dr. Oosterhat is a very well known and very capable plastic surgeon operating in San Francisco. He has taken within the last few years to working extensively with the transgendered community in doing procedures on the face to help individuals with their facial appearances.

Dr. Oosterhat points out that it is much easier for a plastic surgeon to work with the genetic male in feminization than it is to work with the genetic female and masculinization, mostly due to the

fact that the feminization processes generally involve the taking away of bone and muscle from the face, procedures that he believes can be done safely and with minimal risk.

Contrary procedures of needing to add bone and muscle to the face would be required in masculinization procedures. It's still very difficult and much more problematic.

From the pictures, and we can't get those into words, Dr. Oosterhat has done some very, very remarkable work and some work that we know has brought much joy to a number of individuals. But he also points out the importance of overall good health, maintaining a positive diet, and understanding yourself and your body, before undertaking any significant medical procedure such as a plastic surgery operation.

We moved on to Friday morning, when we had a panel discussion on respecting choice. To this somewhat biased individual, I think perhaps that hour on respecting choice was my highlight of the three days that we've had here, and certainly of the health and insurance section. We had on our panel Phyllis Frye, our executive director, Jane Ellen Fairfax, and Martine Rothblatt.

Phyllis gave a presentation on the law as it applies to the various options that we come up with. And by the way, I'm going to apologize. I think, Phyllis, perhaps we should have had a fourth individual present and that would have been a female-to- male -- we will correct that mistake next year. Phyllis talked about the importance of the law as it applies to all of our community and pointed out that what helps one group is helpful to all groups; that when transgendered and transsexual individuals receive their rights to work openly and freely as who they are in the workplace, then that makes it much easier for the crossdresser who may not seek to work in their bigendered role. But I am concerned that when it becomes known in the workplace that they are bigendered, they do not find themselves without employment simply because of an activity that takes place away from the workplace. That as we open doors for one, we open doors for all.

Jane Ellen Fairfax came up and spoke about respecting one another, about her growth as an individual as she came to accept herself and both natures within herself, and her ability to be more effective, more functioning, and a happier person as she accepted both roles of her life in both facets of her life; both in her family relationships and in her professional relationships. Jane spoke very well about the growth and TRI-ESS and that TR-ESS has reached out to eliminating questions that may have existed in the past regarding discrimination against gay and lesbian individuals for TRI-ESS, and about working to open dialogue with the transsexual community, so that our community involves all of its elements.

Martine Rothblatt spoke of her ability to be all three. At one point in her life, she was a crossdresser,; at another, she was transgendered nonsurgically,; and now she is transgendered surgically. She also spoke of the warmth that she felt in each time of her life -- the importance of maintaining your family and friends, of working with family and friends as you move from one to the other, in respecting the decisions of each. Martine also spoke very informatively of the importance of taking your time with each step, and that you do not rush into any conclusion regarding your life. And it is only with careful planning, with research, and with an understanding

of yourself, your relationships and your friends, that you can move from one to the other successfully. She ha in fact ,moved successfully.

Phyllis then spoke of the growing importance of the transgendered non-operative option – how important that has been to her, and how so many people who have now taken the nonoperative option have demonstrated the ability of non-operative transgendered people and transsexual people to fully integrate the feminine or the masculine side of their life into a full life and to live fully as men or women in every single respect of that term, while at the same time, oftentimes being able to maintain and hold onto something that is valuable beyond any value and that is a marriage with a loving partner. It is important for each and every person in our community to respect the choice of each other.

I think perhaps one of the most incredible highlights of that whole presentation from all of the individuals was the acknowledgement that my individual choice is validated, not because other individuals have chosen to accept the same choice I have, but because each and every individual had that choice to make freely themselves without undue influence from any other individuals.

SURVEY RESULTS ON TG OPINION OF HARRY BENJAMIN STANDARDS

The next presentation that we had was a very, very fine presentation from Dallas Denny, executive director of AEGIS. Dallas presented her paper which was also presented earlier this year at the International Congress on crossdressing, gender and sex issues in Van Nuys, California. This is a survey of transgendered individuals on the Harry Benjamin standards and their view of the Harry Benjamin standards. There were 339 respondents to this survey. 184 of those individuals identified themselves as being transsexual; 28 as cross dressers, 40 as transgendered. That doesn't equal 339. We had some very creative people in our community, and they came up with a number of titles for themselves ranging all the way from human being to female-bodied man to androgyne to the metaphor. (That's my favorite, Marissa.) 78 percent or 212 of these individuals have been born male; 55 had been born female.

The balance did not identify which way they had been born. In each, 80 percent of the individuals were familiar and had heard of the Harry Benjamin standards of care. Over 80 percent, 83 percent to be exact, had been in therapy as it resulted their gender issue. According to the survey, 48 percent of the individuals, it was the therapist who told the respondent about the standards of care. But in fully 23 percent of the instances, almost one quarter, it was the individual transgendered consumer that told their therapist about the standards of care.

For 60 percent of the individuals that responded, someone in a support group told the respondent about the standards of care. And 67.7 of the respondents indicated that they had told another transgendered person about the standards of care.

Here are some of the key questions that came up that were asked of transgendered respondents:

1. The standards of care require a 90-day evaluation period by a therapist before the referral for hormone therapy. Do you think this standard is a good idea? 80.3 percent of the individuals with knowledge of the standards of care who were transgendered responded that they thought this was a good idea.

2. The question was asked, the standards of care require a one-year minimum period of full-time living in the new gender role before sex reassignment surgery. Do you think this standard is a good idea? 83.3 percent of the respondents said they believed this to be a good idea.

3. Te standards of care require a letter from a therapist for authorization of hormonal therapy and two letters from therapists for sex reassignment surgery. Do you think this is standard is a good idea? 77.7 percent of respondents replied affirmatively.

4. Do you think the standards of care serve a useful purpose? 95.2 percent of respondents replied affirmatively.

5. The standards of care require that an individual – that the individual wished to be rid of the genitals in order to receive hormonal therapy. Do you agree with this standard? Here only 36.1 percent of those familiar with the standards agreed.

6. Do you believe that breast reduction, or the contouring of a male chest in genetic females should be considered genital reassignment surgery, i.e., should require approval letters. And here, only 32 percent of respondents confirmed in the affirmative.

What we can conclude from that is that there is within a substantial part of the transgendered community support for standards as they exist although there have remained questions regarding individual standards and certainly a review of how people come to be aware of the standards of care indicates that both within the consumer and within the medical and therapeutic communities there remain widespread lack of knowledge of the standards of care. In fact there may even be greater (Actually, I'm editorializing here a second.) There may even be greater knowledge among consumers than there is among therapists about the standards.

We moved from a presentation on the standards themselves to a panel discussion involving Martine Rothblatt, Dallas Denny and me regarding the standards. And most specifically we began with a discussion from Martine of the ICTLEP standards of care.

Martine went back and recorded how the ICTLEP standards came into being:

1. There was widespread dissatisfaction with the Harry Benjamin standards.

2. The health standards as developed by ICTLEP were not intended to be healthcare standards, they were not attempting to provide treatment protocols. What we were attempting to do here at

ICTLEP, was to provide health law standards, standards as it applies to the legal permit profession relating to health care. They were intended to be independent of the Harry Benjamin standards and not as an alternative or competitive standard to the Harry Benjamin standards. It is a myth to believe that the ICTLEP standards call for surgery on demand when in fact they call for surgery to be the choice of the consumer. They were developed as a consumer bill of rights and most importantly as a consumer bill of rights. The ICTLEP standards called for each physician who is performing transgendered health care to be responsible for annually filing a report indicating the complication results resulting from their transgender healthcare procedures that they had performed, complications of surgery and complications in the administration of hormone therapy.

Tom Heinz (a.k.a. Sharon Ann Stuart), Attorney Rights Director, ICTLEP

Dallas Denny then spoke regarding the new recommended guidelines that AEGIS is in the process of publishing. These are guidelines that were written as a part of a book by *Jiana Israel who is a therapist in San Francisco, and Dr. Donald Tarver, a medical doctor in San Francisco, both heavily involved in the treatment of transgendered individuals. Dallas notes that the recommended guidelines, in opposition to the Harry Benjamin standards, and in part, in opposition to the ICTLEP standards, seek out methodologies for providing to both consumers and to therapists and physicians, guidelines for the treatment of many disadvantaged populations for the youth, for homeless, for urban people, for street workers, for both rural and nonrural people, for individuals who fall out of mainstream medical care. The recommended guidelines understand that the Harry Benjamin standards are widely accepted but that they also are in need of revision and offer assistance in the revision of the Harry Benjamin standards. They stand complementary to the Harry Benjamin standards.

Dallas, in her presentation, indicates that the ICTLEP standards make great sense as a transgender bill of rights but that they make less sense if they are approached as a medical standard of care.

I presented that we need to demythologize transgender health care; that we need to come to see transgendered health care in the same fashion that we come to see any other health care procedure. The transgendered health care has been too often stigmatized because of its association with the sexual issue. If we would look at this issue in the same fashion that we look at any other health care procedure, we would find it is appropriate for professionals to sit down and professionally to develop protocols standards, to do outcomes research into the effectiveness of the health care as it applies to transgendered individuals. We would find that insurance organizations have a responsibility and a duty to participate in that process as do consumers of transgendered health care. There needs to be dialogue and that dialogue should be based on scientific research and outcome studies of the effectiveness of transgender health care.

I argue that the ICTLEP standards also make great sense if we look at them as a consumer bill of rights, but I question their effectiveness as an appropriate vehicle for determining medical care and for being effective as a health care standard for use by health care professionals in the treatment of individuals.

I would argue that the ICTLEP standards have been misinterpreted by health care professionals and that ICTLEP should take affirmative steps to alleviate that misunderstanding. One affirmative step that we may consider to alleviate that misunderstanding is to change the title from "standards of care" to "ICTLEP Healthcare Consumer Bill of Rights." That's not a position that Martine subscribes to. It was not our intention in our presentation, neither Martine's, Dallas', nor mine to try to reach some form of artificial consensus. Consensus did not exist, except in the area of giving a full exploration of these issues without rancor and with an opportunity for open discourse. I think we did that, and I felt very comfortable in doing so.

I've got a couple of minutes left. I'm going to try to give a couple of minutes to Sharon, but I do have couple of things that I want to say. It's been wonderful to be a part of this community and to be a part of this program and this presentation. I certainly think as I look around, we've got a number of choices that have to be made, and it's very, very important that we have individuals who light a fuse in our community and who awaken each and every one of us to the importance of us taking an activist role in transgender issues, be they health care issues or issues of employment or law or discrimination in any area.

It's interesting: one can get confused at times as to whether or not this is a conservative movement or a radical movement?

I guess when I look at what goes on and the kinds of questions that we ask, I find that we are looking at words like "sacred" and "sacred" is often associated with something conservative. And yet each and every one of us knows that it's something sacred that is inside of us that we identify and that we bring forward and that we bring out. There is also another term that's often used in very conservative circles: the question of individual responsibility and the importance of each and every individual to take responsibility for their own lives. I've heard it said on a number of occasions: that it is that sense of individual responsibility that makes each and every transgendered person who steps forward out into the open to say, "I'm taking responsibility for my

life and I'm taking responsibility for my life to express that which is sacred inside of me." Nevertheless, it is those conservative things such as individual responsibility and sacredness that lead us to the very radical act of saying, "I will change my gender expression to that which makes me whole and makes me a part of the humanity that I'm capable of."

We have a duty, somehow or other, to integrate both within ourselves and within our community, both our radical and our conservative elements. And I'm convinced that when we can do it inside ourselves and do it inside our community that no one can stop us. I want to thank you. Sharon, you've got eight minutes.

PRISONER RIGHTS UPDATE

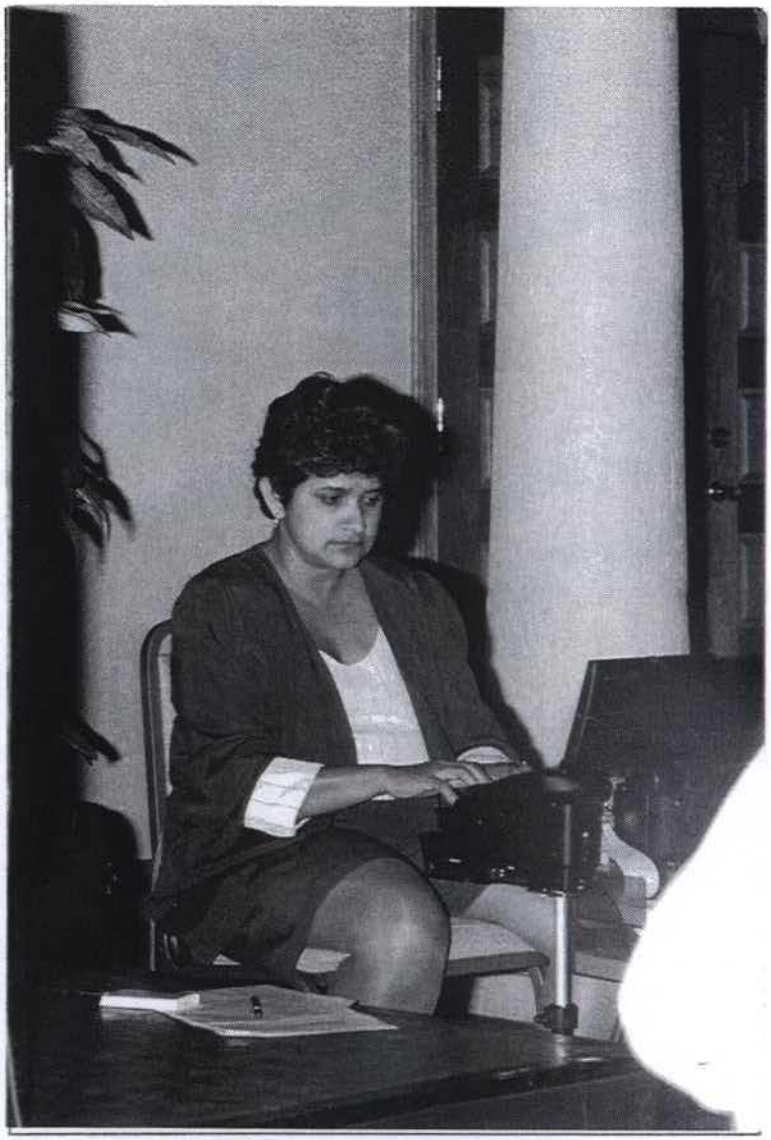
By Sharon Ann Stuart:

Once again my name is Sharon Stuart and I'm the rights director for the conference. We ran over time this morning. I apologize for that. We have one area left to cover and I just need a few minutes to give you the report. This is from the prisoner rights section of the rights projects.

Karen Kerin, Executive Director, It's Time America and Denise Copp, Houston TG Activist

That particular area is coordinated by Ray Hill. Ray is not here to present the report himself. The major presentation that was made on prisoner rights was made by a man named Garry Hill, no relation to Ray. Gary is from Lincoln, Nebraska and is active in the corrections field and is internationally known, and works with an organization

known as "The Alliance of NGOs on crime prevention and criminal justice". Now an NGO is a nongovernmental organization affiliated with the United Nations. Gary acts in an informational and consultive role with organizations that work with the United Nations with corrections associations, with law enforcement associations, with the suppliers of equipment and services to corrections and criminal justice systems. He also consults on an international basis in these areas.



Court Reporter Leticia Salas

Gary Hill goes through a number of international conferences as well as meetings in this country and he came to speak with us about his work to acquaint us with developments at the United Nations and his talk was extremely informative. The good news is that he is prepared to take our material, our standards of treatment or standards of care for prisoners to these organizations and to share that information with them freely. And he gave us a good deal of information about how to construct that material and design it, how to get it to him so he can make use of it.

He demonstrated in his talk a great deal of knowledge and empathy with other groups and with people in our situation, answered questions. And in many respects, this is one of the highlights of the conference for me. It really represents a breakthrough in our work with prisoners.

Ray reviewed some of the work that he does with prisoners in his various job roles and in his work with the conference. For those of us in my work I thought I might share a story with you. It's about a prisoner who was in a prison in Indiana. He is serving a seven- year sentence. He is transgendered. He sought counseling services in the Indiana prison system. After a struggle of sorts and a long delay,he was paired up with a counselor in the Indiana state system. And the counselor in general terms proceeded to demonstrate almost total ignorance of his situation.

The counseling took the direction of trying to convince him that he was something other than transgendered and focussing on other issues in his life as though the transgendered issue wasn't

there or wasn't significant enough to talk with him about. It became clear to my correspondent that he knew more about his own situation than the counselor provided by the state of Indiana. Unfortunately this example is illustrative of the problem that we have in our prisons, where people are not able to access the counseling services and rehabilitating services. Many states and state prison systems in this country are cutting back on services to prisoners, on their educational services and on their rehabilitative services. The emphasis in corrections these days is on incarceration and on removing violent criminals from the society, on segregating them and on longer sentences.

Prison populations are mushrooming. One of the interesting things that Gary Hill told us was that all over the world, in this country in particular, violence, or crime associated with violence is actually dropping. At the same time prison populations are rising.

If you read the media, you would get just the opposite impression. Violent crime in all age groups is dropping, except in the age group running from about 18 to 25. There has been some increase in violence among women but that seems to have leveled off as well in recent years. I don't have these precise statistics so these are generalities. I think what we're seeing in the prison system is less emphasis on rehabilitation, more emphasis on length of confinement, and segregation of criminals over a longer period of time from the society. Essentially this means that our transgendered people are faced with a situation where they are not going to get much help in prison in terms of dealing with that issue in their lives.

My correspondent in Indiana has been transgendered all of his life, has a history of transgenderism in his own family running through the male side of his family for three generations and including his son who exhibits transgendered tendencies. It's fairly clear from his history that transgenderism is the issue in his life which has led him to commit crimes or has contributed to his commission of crimes. Confusion over his identity has been a major factor in his criminal behavior in one way or the other; and yet, while the Indiana state system has prepared to spend over $20,000 a year maintaining him for seven years, they are virtually unable to provide him with any counseling or any help to address what in essence is the central problem in his life.

He is what they call a recidivist, a person who has been convicted three times, and the multipliers in his sentence sent him to jail for a substantial sentence. His most recent crime was stealing nail polish, hair dryers, a couple of hundred dollars from a beauty shop and breaking into a restaurant. Property related crimes serious enough deserving of punishment.

But considering that the state of Indiana and the taxpayers are going to put $150,000 into his maintenance and receive very little in return, you really have to wonder about the approach. We have a lot of work to do in the prisoner area, and anyone who is interested in working with that particular program should contact Ray Hill. You can get information about his work through the conference.

This concludes the presentation of Your Rights, and I want to thank Phyllis and the conference for the opportunity to present the programs that we did and for the opportunity to present our

reports.

By Phyllis Frye:

See me for the tapes and for the court reporter record. I don't have Ray Hill's address with me right now, but his phone number is: (713) 523-6969 Don't ask me how he got that number. His fax number is: (713) 523-6968. You can ask him for his e-mail address.

By Sharon Ann Stuart:

Thank you, Phyllis. One other item that I wanted to just mention and recognize is a report to the Harris County criminal court judges on transgendered people in the court and correctional systems in Harris County. That was prepared by Wendy Allen and Denise Copp. And of course Harris County is here in Houston. And Phyllis Frye, the executive director of ICTLEP also contributed to that and the bill of gender rights appears as an appendix in this document.

This is the kind of thing that we need to do all over the country and find people to write these things, and could serve as a model. And it's a very nicely done report.

That concludes the Your Rights presentation, and again I thank you for your time and attention.