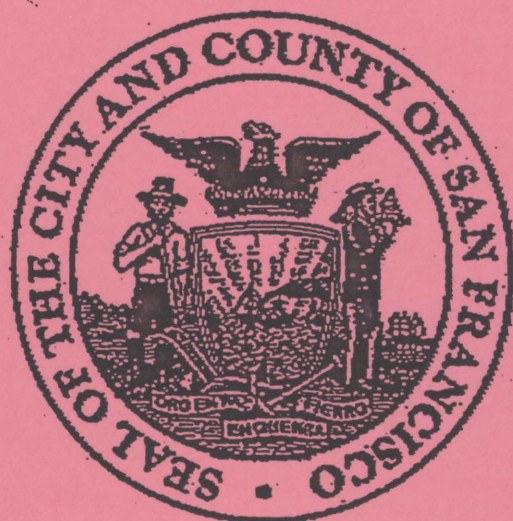


# Insurance Coverage for Transsexual Employees

*of the City and County of San Francisco*



October, 1997

Prepared for Health Service System Board  
by SF Human Rights Commission

Acknowledgment

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# Table of Contents

Executive Summary .....	1
Purpose .....	1
The Syndrome .....	1
Etiology .....	1
Diagnostic Criteria .....	1
Treatments and Costs .....	1
Outcomes .....	2
Legal Status .....	2
Access to General Health Care .....	2
Differential Treatment in Health Care .....	2
Purpose of this Document .....	3
Etiology .....	3
Diagnostic Criteria .....	5
Treatment and Costs .....	5
Outcomes and Measures .....	8
Access to General Health Care .....	10
Differential Treatment in Health Care .....	11
Conclusion .....	12
Appendices .....	13
A. SF Human Rights Commission's Letter to the Health Service System Board (August, 1996)	
B. Insurance Carriers Responses to questionnaire from San Francisco City and County re transsexual treatments and surgeries coverage	
C. Lisa Middleton's Letter to the SF Human Rights Commission	
D. SF Human Rights Commission Findings and Recommendations from 1994 Public Hearing	
E. Harry Benjamin International Gender Dysphoria Association Standards of Care	
F. Bibliography	

## **Executive Summary**

### **Purpose**

The purpose of this document is to provide information to enable the Health Service System Board to evaluate and negotiate insurance coverage that does not discriminate against transsexual employees of San Francisco City and County.

### **The Syndrome**

Transsexualism is a medical condition in which there is a strong and on-going cross-gender identification, i.e., a need to live and be accepted as a member of the opposite sex. There is a persistent discomfort with his or her anatomical sex and a sense of inappropriateness in the gender role of that sex. There is a medically documented necessity to have hormonal therapy and surgery to make one's body as congruent as possible with one's psychological sex.

### **Etiology**

Dr. Harry Benjamin, who introduced the syndrome to the general medical community in the early 1950s, favored a biological explanation of the syndrome, believing that the genetic and endocrine systems must provide a "fertile soil" (see sources listed in body of report) for environmental influences. The weight of current scientific evidence suggests a biologically-based, multifactorial etiology for transsexualism.

### **Diagnostic Criteria**

As for other medical conditions, standards of care have been promulgated which outline these criteria. Two main diagnostic systems for transsexualism are in effect: ICD 10 and DSM IV.

### **Treatments and Costs**

The currently accepted and effective model of treatment utilizes hormone therapy, electrolysis, and surgical reconstruction, and may include counseling and other psychotherapeutic approaches. In all cases, the length and kind of treatment provided will depend on the individual needs of the patient and will be subject to negotiation between the specialists involved, the patient's general practitioner, and the patient, generally according to the Standards of Care issued by the Harry Benjamin International Gender Dysphoria Association (hereinafter HBIGDA).

Surgery costs are in the range of \$7,500 to \$36,000 for Male-to-Female individuals (hereinafter MTF) and \$4,000 to \$75,000 for Female-to-Male individuals (hereinafter FTM), depending on procedures needed and surgical techniques used; hormone therapy averages less than \$250/year for either sex. Details on costs by procedure are included in the body of this report on page 5. In

considering these costs, it should be noted that some City and County employees for whom these treatments are applicable are known to be in various stages of treatment and do not need to undergo every procedure were these benefits available.

To date, we know of only 12 transsexual individuals who are employed in the City and County of San Francisco, among the 27,000 employees.

### **Outcomes**

Studies which have been carried out reviewing long-term outcomes indicate that a treatment model using the principles described above is highly successful, with some suggesting up to a 97% success rate (see sources listed in body of report). This compares very favorably with the outcomes of treatment for other chronic medical conditions.

### **Legal Status**

California, and most states in the US, recognizes the legal status of a person's "new" sex. Native Californians are able to have their birth certificates reissued by judicial decree when surgical sex reassignment has been attested to by affidavit from the attending surgeon. Marriage in the new sex is legal for opposite sex couples.

### **Access to General Health Care**

Under the current policy of excluding treatments related to surgical sex reassignment, it is possible that the condition of transsexualism may be used by carriers to deny coverage for conditions—even life-threatening conditions—that may or may not be related to the syndrome.

### **Differential Treatment in Health Care**

Coverage for treatments equivalent to those necessary to treat transsexualism are routinely provided in non-transsexual contexts, e.g., hormone replacement therapy, hysterectomy, breast reconstruction, etc.

## Purpose of this Document

The Human Rights Commission has expressed concern that the City and County may be discriminating against its employees by excluding them from employee health insurance plans treatments pertaining to surgical sex reassignment (see attached copy of August 1996 letter). It is the opinion of the Commission that singling out transsexual people and excluding coverage of their non-elective medical needs is suspect, and creates a situation in which full utilization of benefits is impeded for these employees, tantamount to unequal compensation for labor.

The information in this document is being provided as a courtesy to facilitate the removal of barriers to equal treatment for all employees. This exercise by the Human Rights Commission is consistent with its successful efforts to ensure legal protection in San Francisco for transgendered individuals. City and County employees are protected from gender identity discrimination mandated by a vote of the people in November of 1993. The general population of San Francisco is also protected due to ordinances passed by the Board of Supervisors in December of 1994.

This document provides an overview of current best practice in providing effective health care for persons with the transsexual syndrome. It describes the nature of the syndrome, its diagnosis, treatment and outcomes, recognizes its biological etiology, notes the legal status of transsexual people, and describes the difficulties transsexual persons face with respect to access to health care and disparate treatment, especially concerning insurance coverage.

## Etiology

Dr. Harry Benjamin introduced the syndrome to the general medical community in the early 1950s and advocated the compassionate treatment of it.<sup>1</sup> Dr. Benjamin favored a biological explanation for the syndrome, believing that the genetic and endocrine systems must provide a "fertile soil" for environmental influences, stating that "[i]f the soma is healthy and normal no severe case of transsexualism . . . is likely to develop in spite of all provocations."<sup>2</sup>

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<sup>1</sup> King, D., *The Transvestite and the Transsexual*, p. 46; Newcastle upon Tyne: Athenaeum Press 1996.

<sup>2</sup> Benjamin, H. (1953) 'Transvestism and Transsexualism,' *Journal of Sex Research*, 5:2, p. 13.

In their work on surgery techniques four years later, Drs. Gillies and Millard echoed Dr. Benjamin's point of view and suggested that transsexualism should be classified as an intersex condition, writing that "[t]he physical sex picture does not always bear a fixed relation to the behaviour pattern shown by an individual. One or another hormone may determine an individual's male or female proclivities quite independently of the absence of some of the appropriate physical organs. It may be suggested, therefore, that the definition of hermaphroditism should not be confined to those rare individuals with proved testes and ovaries but extended to include all those with indefinite sex attitudes."<sup>3</sup>

In an authoritative review of research in this field in 1985, Dr. Hoenig follows Dr. Benjamin in ultimately depending on a biological force or forces to account for transsexualism.<sup>4</sup> Summarizing and commenting on this and other medical viewpoints three years later, in 1988, Dr. Docter indicates that the overall weight of evidence is that there is "the formation of some kind of gender system within the brain that is fundamental to ultimate gender identity and gender-role development."<sup>5</sup> It is a viewpoint of this kind that Dr. Money suggests in an authoritative paper "The Concept of Gender Identity Disorder in Childhood and Adolescence After 39 Years" where he states "[c]ausality with respect to gender identity disorder is subdivisible into genetic, prenatal hormonal, postnatal social, and postpubertal hormonal determinants" and suggests "[t]here is no one cause of a gender role . . . . Nature alone is not responsible, nor is nurture alone. They work together, hand in glove."<sup>6</sup> More recently, in a paper given to the Council of Europe's XXIIIrd Colloquy on European Law, Dr. Gooren has suggested that "[t]here is now evidence to believe that in transsexuals the differentiation process of the brain taking place in the first years after birth has not followed the course anticipated of the preceding criteria of sex (chromosomal, gonadal, and genital)."<sup>7</sup> Thus although sex assignment at birth by the criterion of the external genitalia is statistically reliable, in people experiencing transsexualism it is not: they are exceptions to the statistical rule. The weight of current scientific evidence, therefore, suggests a biologically-based, multifactorial etiology for transsexualism.

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<sup>3</sup> Gillies, H. and Millard, D.R. (1957) *The Principles and Art of Plastic Surgery*, Vol. 1, London, Butterworth, p. 370-1.

<sup>4</sup> Hoenig, J. (1985) 'The Origin of Gender Identity' *Gender Dysphoria*, ed. Steiner, B.W., New York: Plenum Press.

<sup>5</sup> Docter, R.F., (1988) *Transvestites and Transsexuals, Towards a Theory of Cross-Gender Behavior*, New York: Plenum Press, p. 63.

<sup>6</sup> Money, J. (1994) 'The Concept of Gender Identity Disorder in Childhood and Adolescence After 39 Years,' *Journal of Sex and Marital Therapy*, 20 (3): 163-177.

<sup>7</sup> Gooren, L.G.J (1993) 'Biological Aspects of Transsexualism and Their Relevance to its Legal Aspects,' *Proceedings of the XXIIIrd Colloquy on European Law: Transsexualism, Medicine and the Law*, Strasbourg; Council of Europe.

## **Diagnostic Criteria**

Two main diagnostic systems for transsexualism are in effect: ICD 10 (International Statistical Classification of Diseases and Related Health Problems, published by the World Health Organization) and DSM IV (Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association). Diagnostic criteria which combine features of both systems are as follows: Transsexualism is a medical condition in which there is a strong and ongoing cross-gender identification and a need to live and be accepted as a member of the opposite sex. There is a persistent discomfort with his or her anatomical sex and an inability to conform to the gender role of that sex. There is a need to have hormonal treatment and surgery to make one's body as congruent as possible with one's psychological sex. The diagnosis of transsexualism is confirmed when gender dysphoria has been present for at least two years and has been partially alleviated by cross-gender identification.

As with other medical conditions, standards of care have been promulgated by associations of medical professionals experienced with those conditions. In the case of transsexualism, the Harry Benjamin International Gender Dysphoria Association (HBIIGDA) is a professional association composed of board-certified medical practitioners in a variety of specialties and licensed mental health professionals who provide services to gender dysphoric patients. HBIIGDA has published Standards of Care that provide treatment guidelines and time lines, and criteria for patient qualification for treatment. (A copy of the current standards is attached in Appendix E.) In this instance, the net effect of these requirements is to drastically limit the number of insureds in the pool who will qualify for sex reassignment related treatments and procedures.

## **Treatment and Costs**

Clinicians practicing in this area of medicine generally follow a treatment pattern consistent with the HBIIGDA Standards of Care. This treatment pattern calls for a period of initial evaluation, diagnosis, and therapeutic counseling. The number of such sessions can vary; however, for transsexual individuals absent significant comorbidities, the number of such sessions rarely exceeds 20 per year. The syndrome does not require ongoing therapeutic counseling.

After observation, treatment, and consistent diagnosis for a period of 3 months (HBIIGDA Standard #6, page 8, paragraph 4.6.2), a regimen of hormone therapy may be prescribed. For FTM individuals, a prescription of the injection of 1cc/200mg/ml testosterone every 2 weeks is typical (testosterone patch may also be used). For MTF individuals, a typical prescription will consist of 2.5 to 5mg of estrogen daily.

After a period of three months of cross-living and hormone therapy, an individual demonstrating consistent diagnosis, an absence of conflicting morbidity, a severe dysphoria associated with their birth gender, and a fully successful transition to their new gender, may be appropriate for surgical interventions (HBIQDA Standard 8, page 9, paragraph 4.8.1). The length and kind of treatment provided will depend on the individual needs of the patient and will be subject to negotiation between the specialists involved, the patient's general practitioner, and the patient.

Hormone costs for MTF individuals (Premarin™) average less than \$200/year at wholesale prices. Sometimes androgen blockers are also prescribed, which cost: approximately \$500/year at wholesale prices. Exogenous hormone administration requirements will drop significantly following gonad removal.

Hormone costs for FTM individuals (injectable generic testosterone) average less than \$70/year at wholesale prices. Some individuals require testosterone transdermal patches at an approximate cost of \$540/year. Exogenous hormone administration requirements will drop significantly following gonad removal.

The following cost figures were provided by practitioners upon request of the Human Rights Commission, and to the best of our knowledge include surgeon's fees, anesthesia, and facility (surgical and/or hospitalization) fees.

For Male-to-Female (MTF) transsexuals, depending on the physicality and the overall health of the patient, surgery may include:

- Vaginoplasty (construction of a vagina – most often includes clitoroplasty and labiaplasty):
  - \* Penile Inversion method – cost range: \$7,500 to \$15,000
  - \* Sigmoid Colon Transplant method – cost range: \$20,000 to \$30,000
  - \* Labiaplasty (construction of labia; only if performed separately from vaginoplasty) – cost range: \$1,350 to \$5,000
- Mammoplasty (breast augmentation; as found to be medically necessary) – cost range: \$3,500 to \$6,000

These procedures are generally completed in one or two surgery visits. The surgery time generally averages less than five hours and requires hospitalization for about one week.

For Female-to-Male (FTM) transsexuals, depending on the physicality and the overall health of the patient, surgery may include:

- Bilateral Mastectomy (chest reconstruction to remove breasts and adjust nipple size and position) – cost range: \$4,000 to \$7,000

This procedure is usually performed on an out-patient basis and surgery time averages 2 to 5 hours.

- Hysterectomy & oophorectomy (removal of uterus and ovaries):
  - \* Via Laparoscopy – estimated cost: \$4000 and up (actuarial data on this item is available to the carriers)
  - \* Via Abdominal Incision – cost range: \$10,000 to \$18,000
- Phalloplasty or Metoidioplasty (construction of a penis, with possible urethroplasty — extension of the urethra, and scrotoplasty — construction of the scrotum)

Cost ranges for genital reconstruction by technique:

- \* Radial Forearm Flap Transfer with urethral extension and scrotoplasty – cost range: \$29,000 to \$38,000
- \* Pedicle Flap Phalloplasty (with scrotoplasty; usually does not accommodate urethral extension) – cost range: \$12,000 to \$25,000
- \* Metoidioplasty (wherein genital conversion is accomplished via clitoral release and scrotoplasty):
  - \* Without urethral extension – cost range: \$9,000 to \$12,000
  - \* With urethral extension – cost range \$9,350 to \$16,000
  - \* Clitoral release only: \$5,500

Metoidioplasty is usually performed on an out-patient basis, and may be done in one or two stages; phalloplasty may be done in one to three stages, the first stage requiring a hospital stay of between 10 to 15 days, the second stage requiring a stay of 1 day, and the third requiring a stay of 5 to 7 days.

\* Electrolysis (hair removal) may be required for certain genital procedures with certain patients to avoid obstruction of urethral canal. Costs vary widely depending on procedure and can range from \$2,500 to \$8,500.

\* Vaginectomy (removal of vagina; if found to be medically necessary; almost always performed in conjunction with other procedures) – estimated cost: \$3,000.

It must be emphasized that costs vary widely depending on the desired results, the geographic region in which the procedure is performed, and the sequence in which the procedures are performed. This is particularly true with respect to FTM surgery; for example, it is much less costly to have the hysterectomy done simultaneously with the genital reconstruction.

Potential costs will be ameliorated by the fact that: (1) some City and County employees for whom these treatments are applicable are known to be in various stages of treatment and do not need to undergo every procedure were these benefits available. Also, (2) in some instances, coexistent medical conditions such as HIV disease, hemophilia, liver disease, extreme hypertension, and certain blood disorders, will preclude individuals from undergoing certain aspects of the sex reassignment treatment.

Most of these procedures are not new or experimental, nor are they prohibitively risky or costly. They have been in use for decades. In fact, similar coverage is routinely provided in non-transsexual contexts, such as in treating gynecomastia, breast reduction and mastectomy, hysterectomy/oophorectomy, breast cancer treatments, testicular implants, urinary tract conditions, hormone replacement therapy, hormonal imbalances and deficiencies, injury to the genitals of non-transsexual people, polycystic ovarian syndrome, etc. Actuarial data on these treatment modalities is available to the carriers and could be applied to the transsexual context to assist the carriers in calculating the actuary costs that would result from lifting these exclusions.

## **Outcomes and Measures**

(Information on outcome studies is abstracted from an unpublished report: “An Analysis of Outcome Studies Following Transsexual Treatment” by Yoseñio Lewis and Robert Haaland.)

Over the past two decades, there has been an increasing emphasis on the quality of life for patients as the measure of effectiveness of healthcare. The aim of outcome studies is generally to evaluate whether sex reassignment surgery alleviates the symptoms of gender dysphoria. Another dimension that is not discussed in earlier studies is that the outcome studies do not pay attention to differences within the

transsexual community. In other words, researchers often treat transsexuals as a monolithic group. Generally, the older studies divide transsexuals into two groups, i.e., MTFs and FTMs. However, more recent studies discuss multiple diagnoses or concomitant personality conditions.

More recent studies, mostly using objective data, indicate dramatically different results from the older studies. In short, even when criteria that have nothing to do with gender dysphoria are used, the outcome research indicates a high success rate. In fact, one researcher suggests a 97% success rate.<sup>8</sup> Other studies confirm that only a few transsexuals were not satisfied with their life after surgery.<sup>9</sup> One recent study suggests that while unsuccessful outcomes are atypical, they are often explained by concomitant personality disorders or lack of social or psychological support. Yet another study indicates that "[t]here is distinct evidence of the stabilizing effect of gender reassignment surgery."<sup>10</sup> This same study proposes that suicide attempts occur much less frequently in transsexuals who have had SRS as compared against those who have not.

This analysis of outcome studies addressing the efficacy of SRS in alleviating the symptoms of gender dysphoria suggests that the variables utilized to measure success (as well as the definition of success) must naturally take into account subjective criteria (e.g., the reduction of incongruence between one's psychological sex and one's physical sex). Studies that based their rates of success on purely objective criteria such as employment, community integration and sustained relationships failed to acknowledge the overwhelming impact that discrimination against transsexuals has in fulfilling those criteria.

The application of subjective criteria (which involves the patient in the decision-making processes) in the more recent studies indicates a more accurate methodology and therefore a more valid and reliable outcome. The utilization of such criteria lends legitimacy to the studies' claims of attempting to discover whether or not SRS actually does alleviate the symptoms of gender dysphoria. Per the outcomes of the more recent studies, SRS does indeed alleviate many of the symptoms of gender dysphoria and may provide increased opportunities for transsexuals to fulfill the objective criteria.

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<sup>8</sup>Green, R. and Fleming, D. T. Transsexual Surgery Follow-Up: Status in the 1990s, Annual Review of Sex Research, ed. J. Bancroft, Vol 1, 1990, 163-174.

<sup>9</sup>Recheck Z, Starcevic V, Maric J, Kelin K. The outcome of sex reassignment surgery in Belgrade. Arch Sex Behav 1996 5:515-25; Bodlund (1995); Lindemalam (1986); Kockett(1988).

<sup>10</sup>Kockott, M.D., and Fahrner, E.M., PhD. Transsexuals who have not undergone surgery: a follow-up study. Arch of Sexual Behavior 1987 16 (2): 511-522.

The Human Rights Commission has requested and received practitioner-provided information on rates of risks and complications incurred in treating transsexualism. From this data, we have formed the impression that with respect to genital surgery, risks and complications occur no more frequently than for comparable chronic conditions. Moreover, many of the treatments now barred by insurance company exclusions involve no more risk or higher rate of complication in a transsexual context than they do presently in non-transsexual contexts. The characterization of transsexual surgery outcomes as less than satisfactory is in part owing to sub-standard service delivery which occurs when uninsured sufferers go to unqualified practitioners to obtain services in secret for fear of exposure or recrimination, or to reduce expense. Removing the exclusion of these services would enable transsexual people to uniformly receive, without stigma, the high standard of care that qualified practitioners can provide.

### **Legal Status**

In California, and most other states in the US, legal status in the new sex is granted conditionally, when the patient is under medical care, to facilitate a change in documents like driver's licenses and passports so that the stated gender will confirm the patient's true gender (which does not match genital sex). Native Californians are able to have their birth certificates reissued following judicial decree when surgical sex reassignment has been attested to by affidavit from the attending surgeon. Marriage in the new sex is legal for opposite sex couples. In all areas other than health care coverage, the legal status of transsexuals is now established.

### **Access to General Health Care**

Under the current policy of excluding treatments related to surgical sex reassignment, it is possible that the condition of transsexualism may be used by carriers to deny coverage for conditions—even life-threatening conditions—that may or may not be related to the syndrome. These may include but are not limited to: cancer of the breast, uterus, ovaries, throat, colon, or prostate, heart disease, extreme hypertension, polycystic ovarian syndrome, uterine fibroids, liver disease, arthritis, osteoporosis, urinary tract conditions, certain blood disorders, and hormonal imbalances.

An employee may be listed as male and insured as male because he has the legal status of a man, but he may still need to obtain a PAP smear as part of his overall health care because of the state of his body. He should not be discouraged from seeking baseline preventive health care, nor should his pursuit of needed health care be shrouded in fear of discriminatory retaliation should his transsexual status be revealed.

These policies mean that people are deterred from seeking treatment for many

conditions because they fear having their transsexual status revealed. Disclosure of transsexual status could mean that carriers might accuse the insured of fraud and demand back payment for earlier claims. Many conditions that are not life-threatening may become life-threatening if they continue to go untreated. Evidence of the adverse impact of this policy was brought to the attention of the Human Rights Commission during the May, 1994 public hearings on discrimination against transgendered people.

### **Differential Treatment in Health Care**

As noted above, most of the procedures used in sex reassignment are not new or experimental, nor are they prohibitively risky or costly. They have been in use for decades. In fact, similar coverage is routinely provided in non-transsexual contexts, such as in treating gynecomastia, breast reduction and mastectomy, hysterectomy/oophorectomy, breast cancer treatments, testicular implants, urinary tract conditions, hormone replacement therapy, hormonal imbalances and deficiencies, injury to the genitals of non-transsexual people, polycystic ovarian syndrome, etc.

It has been brought to our attention that carriers may hold transsexual people to a higher standard of documentation of medical necessity prior to delivery of services solely on the basis of one's transsexual status. For example, one transsexual man relayed to us his experience trying to obtain a medically necessary hysterectomy. He was required to wait several months before approval was granted for the procedure, all the while suffering from intense pain and excessive bleeding, leaving him at high risk for the development of further complications. The operative report revealed that his uterus had attached to his abdominal wall. Were it not for his transsexual status, he feels it is doubtful that this protracted waiting period would have been required.

The concept that transsexual procedures are experimental has often been held up as rationale for denial of coverage. Surgical sex reassignment has been performed since the 1940s. Organ transplants have been performed only since the 1970s, but these procedures are routinely covered.

With respect to any concern that transsexual people require lifelong medication, specifically hormones. It should be noted that there are numerous conditions that require lifelong administration of medication. A partial list includes: allergies, diabetes, hypertension, thyroid conditions, hypogonadism. Fears that this treatment will overburden the carriers should be allayed in view of the fact that, for example, according to American Druggist, February 1997, Premarin™ was the most prescribed drug in America in 1995, and second most-prescribed in 1996. In fact, nearly 10% of the top-200 most-prescribed drugs in the US in 1996 were estrogen-related. It is difficult to see how adding a handful of people to these statistics will excessively tax carriers.

## **Conclusion**

The Human Rights Commission takes the position that uniform application of standards in insurance coverage should be enforced with regard to medical needs and treatments in transsexual and non-transsexual contexts. Therefore, the Commission calls for the removal of exclusions which bar coverage of services related to sex reassignment in health insurance plans for City and County employees.

Appendix

## Conclusion

The Human Rights Commission takes the position that uniform application of standards in insurance coverage should be enforced with regard to medical needs and treatments in transsexual and non-transsexual contexts. Therefore, the Commission calls for the removal of exclusions which bar coverage of services related to sex reassignment in health insurance plans for City and County employees.

## Appendices



Central Complaints  
Dispute Resolution/Housing  
Minority/Women/Local Business Enterprises  
Lesbian Gay Bisexual Transgender & HIV Discrimination

Edwin M. Lee  
Director

August 8, 1996

City and County of San Francisco  
Health Service System Board  
1155 Market Street, 3rd Floor  
San Francisco, California 94103

Dear Board Members:

**Appendix A**

**SF Human Rights Commission's Letter  
to the Health Service System Board  
(August, 1996)**

We are writing to ask you to take a leadership role in eliminating an inequity in health coverage for City employees and their families. The Commission's Lesbian, Gay, Bisexual, and Transgender Advisory Committee was recently co-chaired by the Community Task Force, a community organization that has been working on the problem of discrimination against transgender City employees and their families, and we agree that this is a serious issue which needs to be addressed as soon as possible.

In 1994, the Commission played a leading role in advocating for the rights of transgender persons before the Board of Supervisors. We held a public hearing in which we received voluminous testimony about the discrimination suffered by transgender persons in San Francisco. The testimony included both verbal and written evidence of the lack of coverage for transgender persons by most insurance carriers in the United States. We were shocked to learn that this discriminatory policy is the City and County of San Francisco's policy as well.

Following the public hearing, we issued a report. One of our recommendations was that insurance carriers should provide coverage for transgender treatments including hormone therapy and gender reassignment surgery. We have learned that every health insurance plan offered to City employees specifically excludes these treatments from eligibility for reimbursement. These policies perpetuate a mean-spirited view of the transgender community that has no place in San Francisco.

It is crucially important that transgender individuals who require hormonal treatments and/or surgery be able to get them. Many transgender people have serious psychiatric problems because such treatments are not available to them. The costs of these treatments can be prohibitive, and the alternative often is hormones bought on the street and surgeries by "back-alley" practitioners. For City employees and their families who do not have access to treatment, the cost for the City can be much higher than the treatment themselves, in that psychiatric emergency services and extensive rehabilitation treatments are the



Edwin M. Lee  
Director

August 8, 1996

City and County of San Francisco  
Health Service System Board  
1155 Market Street, 3rd Floor  
San Francisco, California 94103

Dear Board Members:

We are writing to ask your assistance in eliminating an inequity in health coverage for City employees and their families. The Commission's Lesbian Gay Bisexual Transgender Advisory Committee was recently contacted by the Transgender Community Task Force, a community organization which advocates for transgender rights. The Task Force presented their view of the problem of discrimination against transsexual City employees and their families, and we agree that this is a serious issue which needs to be addressed as soon as possible.

In 1994, the Commission played a leading role in advocating for the rights of transgender persons before the Board of Supervisors. We held a public hearing in which we received voluminous testimony about the discrimination suffered by transgender persons in San Francisco. The testimony included both verbal and written evidence of the lack of coverage for transsexual treatments by most insurance carriers in the United States. We were shocked to learn that this discriminatory policy is the City and County of San Francisco's policy as well.

Following the public hearing, we issued a report. One of our recommendations was that insurance carriers should provide coverage for transgender treatments including hormone therapy and gender reassignment surgery. We have learned that every health insurance plan offered to City employees specifically excludes these treatments from eligibility for reimbursement. These policies perpetrate a mean-spirited view of the transgender community that has no place in San Francisco.

It is crucially important that transgender individuals who require hormonal treatments and/or surgery be able to get them. Many transgender people have serious psychiatric problems because such treatments are not available to them. The costs of these treatments can be prohibitive, and the alternative often is hormones bought on the street and surgeries by "butchers" akin to back-alley abortions. For City employees and their families who do not have access to treatment, the cost for the City can be much higher than the treatments themselves, in that psychiatric emergency services and extensive rehabilitation treatments are the



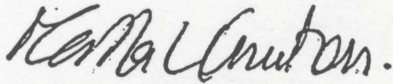
Health Service System Board  
August 8, 1996  
Page 2

alternatives. Conversely, the cost to the City for paying for these treatments would be relatively low given the small number of transgender employees and transgender family members.

The Human Rights Commission strongly recommends that the Health Service System Board act quickly to eliminate the exclusions for transsexual treatments and surgeries that presently exist in all City health plans. The City Plan itself should be changed immediately, and negotiations with outside carriers should begin as soon as possible. We offer any assistance and information we can provide, and suggest that you contact Dr. Barry Zevin at the Department of Public Health's Tom Waddell Clinic for medical information regarding this policy.

We look forward to working with you to eliminate discrimination in health coverage for City employees and their families.

Sincerely,



Martha Knutzen  
Chair

cc: Mayor Willie L. Brown  
Board of Supervisors  
Dr. Sandra Hernandez, Department of Public Health  
Dr. Barry Zevin, Department of Public Health  
Transgender Community Task Force

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The Human Rights Commission strongly recommends that the Health Service System Board act quickly to eliminate the exclusions for transgender treatments and surgeries that presently exist in all City health plans. The City plan itself should be changed immediately, and negotiations with outside carriers should begin as soon as possible. We offer any assistance and information we can provide, and suggest that you contact Dr. Barry Sevin at the Department of Public Health, Tom Waddell Clinic for medical information regarding this policy.

**Appendix B**

**Insurance Carriers Responses to questionnaire from  
San Francisco City and County  
re transsexual treatments and surgeries coverage**

Sincerely,

  
Martha Kuzman  
Chair

cc: Mayor Willie L. Brown  
Board of Supervisors  
Dr. Sandra Hernandez, Department of Public Health  
Dr. Barry Sevin, Department of Public Health  
Transgender Community Task Force

(w/11p/ep/maur)

KAISER PERMANENTE  
1200 EL CAMINO REAL  
SOUTH SAN FRANCISCO, CA 94080

## Fax Cover Sheet

DATE: February 11, 1997

TO: Randy Smith

PHONE: [REDACTED]

FAX: [REDACTED]

FROM: MARIA LOBANOVSKY  
KAISER PERMANENTE

PHONE: (415) [REDACTED]

FAX: (415) [REDACTED]

RE: Sexual Reassignment Benefit

CC: Julie Sigoloff, Dennis Lum, Caz Cazanov, Beth Roemer, Jim DeSmidt

Number of pages including cover sheet: 2, plus 12 (Standards of Care attachment)

### Message

PER YOUR REQUEST, THE FOLLOWING IS A SUMMARY OF WHERE WE ARE WITH THE DEVELOPMENT OF PROVIDING THE ABOVE BENEFIT.

THERE ARE SIX OUTSTANDING ISSUES: WORKING WITH THE CARRIER/ADMINISTRATOR OF THIS BENEFIT FOR ALL OTHER HEALTH PLANS, TPMG TRAINING TIME, DEFINING THE BENEFITS, DEFINING THE EXCLUSIONS, CONFIRMING THE ACTUAL RATE, AND EMPLOYER/MEMBER COMMUNICATIONS.

### ESTABLISHING A CLEARLY DEFINED COVERED BENEFIT

SINCE THIS WOULD BE A NEW BENEFIT, WE WOULD LIKE TO WORK WITH WHOMEVER THE HEALTH SERVICE SYSTEM ELECTS AS THE THIRD PARTY ADMINISTRATOR FOR THIS BENEFIT, COVERING ALL OTHER CITY EMPLOYEES, EXCLUDING KAISER MEMBERS. THIS IS IMPORTANT IN ORDER FOR ALL PLANS TO PROVIDE COMPARABLE AND EQUAL COVERAGE AND TO RULE OUT THE POSSIBILITY OF ADVERSE SELECTION BY HAVING EXACTLY THE SAME BENEFITS ACROSS THE BOARD. IF WE ARE NOT ABLE TO HAVE SUCH AN OPPORTUNITY, THE PROCESS COULD TAKE LONGER, AS WE WOULD NEED TO REVIEW THE ALTERNATE COVERAGE IN FINALIZING THE DEVELOPMENT OF THE COVERAGE THROUGH KAISER PERMANENTE.

### TPMG ISSUES

THE EXPERT ON TRANSSEXUAL SURGERY WITHIN KAISER PERMANENTE IS DR. ROBIN DEA. SHE WOULD BE THE PHYSICIAN WHO WOULD DEVELOP INTERNAL PROCEDURES AND COMMUNICATIONS FOR THE PERMANENTE MEDICAL GROUP. GIVEN THE DEMANDS ON HER SCHEDULE AND THE MAGNITUDE OF THIS EFFORT, WE ESTIMATE A LEAD TIME OF SIX MONTHS IN ORDER TO BE ABLE TO DELIVER/ADMINISTER THIS BENEFIT FOR KAISER MEMBERS. WE PROPOSE THAT THE BENEFIT BE DEVELOPED ON A PILOT BASIS AND BE LIMITED TO SPECIFIC KAISER FACILITIES WHICH WOULD REFER MEMBERS, MOST LIKELY TO THE GENDER DYSPHORIA ASSOCIATION IN PALO ALTO. TIME WOULD ALSO BE REQUIRED FOR WORKING OUT ANY OUTSIDE CONTRACTING PROVISIONS.

**BENEFITS**

THE ACTUAL BENEFITS STILL NEED TO BE AGREED UPON. IT IS PROPOSED THAT THE BENEFIT BE LIMITED TO COVERAGE OF THE SURGICAL PROCEDURE, PSYCHIATRIC SUPPORT, AND HORMONAL PRESCRIPTIONS. IF THE PSYCHIATRIC COVERAGE WOULD DIFFER FROM THAT ALREADY WITHIN OUR CONTRACT, A SPECIAL AMENDMENT WOULD BE WRITTEN FOR THIS BENEFIT.

**EXCLUSIONS**

THE SPECIFIC EXCLUSIONS REMAIN TO BE DEFINED. IT HAS BEEN SUGGESTED TO EXCLUDE SERVICES SUCH AS ELECTROLYSIS OR OTHER COSMETIC-IN-NATURE PROCEDURES RELATED TO SEXUAL REASSIGNMENT.

**RATES**

IN THE ABSENCE OF DEFINED BENEFITS AND EXCLUSIONS, WE ESTIMATE THE RATE TO BE APPROXIMATELY .50 ON THE FIRST STEP. IF THE BENEFIT DESIGN DOES NOT FOLLOW THE GUIDELINES NOTED ABOVE, THE ACTUAL COSTS COULD BE SLIGHTLY HIGHER.

**EMPLOYEE COMMUNICATIONS**

EVEN AN IMMEDIATE AND SUCCESSFUL CONCLUSION IN DESIGNING THIS BENEFIT WOULD LEAVE VERY LITTLE TIME FOR EFFECTIVE AND TIMELY COMMUNICATIONS TO BE DEVELOPED AND DISTRIBUTED FOR THE UPCOMING OPEN ENROLLMENT. THESE COMMUNICATIONS WOULD BE FOR CITY EMPLOYEES/RETIREES IN GENERAL AND FOR KAISER MEMBERS SPECIFICALLY (TO BE DONE BY US). ALTHOUGH WE RARELY CHANGE BENEFITS MID-YEAR, WE WOULD BE WILLING TO EXPLORE THAT POSSIBILITY, IF NEEDED, BUT MORE TIME WOULD BE REQUIRED TO CONFIRM THE FEASIBILITY OF A MID-YEAR BENEFITS CHANGE THAN IF THE BENEFIT WERE IMPLEMENTED IN JULY OF 1998.

AS ALWAYS, PLEASE DO NOT HESITATE TO CALL ME OR JULIE SIGOLOFF (510-987-4640) WITH ANY QUESTIONS AS WE MOVE THESE DISCUSSIONS ALONG.

Questionnaire

J. The City's Human Rights Commission has asked the Health Service Board to provide coverage for transsexual treatments and surgeries. Can you provide the coverage? What would be the cost of this coverage (3-tier rates)? If you cannot provide this coverage what is the basis for not providing this coverage?

Health Net is willing to explore coverage of transsexual surgical procedures as a covered benefit under certain conditions if the Health Services Board desires to add this as a benefit option. However, before adding this benefit, we caution the Board to consider the following clinical information regarding outcomes of this complicated and costly procedure.

Transsexual surgical procedures are typically performed over an extended period of time, usually involving multiple surgical procedures. The protocol for transsexual surgeries looks something like the following stages.

The initial stage for an individual who is considering this procedure involves extended psychological and medical profiling. The psychological treatment/consultation stage involves a series of counseling sessions over several months with a goal of addressing the patient's expectations and desires as they relate to having this procedure done.

The next stage is a medical preparation phase, which also involves months of medical visits. The medical preparation phase, especially in cases of male to female sexual reversals, involves months of hormonal evaluations and treatments.

The third stage is the surgical stage, which actually takes place again over many surgeries and many months. Surgeries are complicated, and procedures are in multiple stages. Partial surgeries are common; complete sexual reversals take many operations over many months.

Depending upon the patient's psychological and medical preparation, we caution the Health Services Board that there is a high dissatisfaction level with transsexual surgical procedures. Less than expected results are common, often focusing on areas of "looks" or even of "functioning." In addition to these negative clinical and psychological outcomes, complications from the surgical procedures themselves, which involve such things as infections and loss of functioning, are also quite common. A final note of caution is that there are now a very limited number of providers in the Bay Area who are willing to provide transsexual treatments. Stanford Medical Center is just one example of a noted facility which formerly performed this surgical procedure, and has subsequently discontinued the practice for the above reasons.

**Questionnaire**

Because of the lengthy evaluation, treatment, and surgical phases, predicting the cost of this benefit is difficult, if not impossible, for Health Net. However, if the Health Services Board wishes to include transsexual treatments and services as a covered benefit, we would be happy to take on a Third Party Administrator relationship for Health Service System. Health Net will provide, if asked, a contracted discounted network and administer all claims payments as a pass through for City and County of San Francisco. After a period of time, when we have an understanding of the cost basis and frequency of this benefit request, we may be able to provide the City with this service on an insured basis.

Health Net invites further discussions with the Health Services Board should you decide to implement this as a covered benefit.

**K. What, if any, operational changes have been made within the health plan to improve health care cost management? Include a brief description of your 1996 and planned 1997 activities. For example:**

- **Initial or continued changes in specific types of provider reimbursement, such as new capitation arrangements for physicians of allied services**
- **New or upgraded data processing systems to enhance the plan's ability to manage either the utilization or quality of care**
- **Enhanced staffing levels, or turnover at key leadership position, such as medical director, large care management coordinator, etc.**

Health Net has made and continues to make numerous operational changes to improve health care cost management. Some of these indirectly relate to improving health care cost management, like our NCQA accreditation process and HEDIS reporting initiatives. Others have a long-term impact, such as our Wellness program. Most of the operational changes that are highlighted in the following paragraphs, however, directly relate to Health Net's ongoing efforts to improve health care cost management and, in turn, offer considerable "value added" incentives for employer groups.

- **NCQA Accreditation**

In December of 1995, Health Net was granted a full one-year accreditation from the NCQA, which is defined as having "No major deficiency in any category." The NCQA scoring does not make allowances for exceeding standards.

Health Net adheres to all NCQA standards.



**HEALTH NET®**  
California's Health Plan

February 12, 1997

Mr. Randall Smith  
Executive Director  
Health Service System  
1155 Market Street, 3<sup>rd</sup> Floor  
San Francisco, CA 94103

**RE: Transsexual Surgical Benefit Coverage**

Dear Randy:

Health Net has been researching the possibility of implementing benefit coverage for the above procedure. To supplement our response contained in the RFP dated December 4, 1996, we have prepared a brief "White Paper" which highlights some of the issues which must be overcome in order to provide this benefit to your employees in a future contract year. Due to the numerous issues which must be explored and agreed upon, it would be Health Net's recommendation that you consider this benefit no earlier than the 1998-99 contract year beginning in July, 1998.

Under the terms of our RFI, Health Net will provide this benefit on an Administrative Services Only (ASO) basis if the Health Service board wishes its adoption. We will be happy to collaborate with Kaiser as well as we mutually explore the issues which face both Health Plans. Please let me know what the board decision is, and I will inform the appropriate parties at Health Net for further action.

Please let me know if you have any questions. I can be reached at (510) [REDACTED].

Sincerely

Lisa R. Schmidt  
Senior Account Manager  
Regional Sales and Marketing

cc: Dr. Stan Padilla, Health Net  
Chris Cordes, Health Net



**HEALTH NET®**  
California's Health Plan

### Transsexual surgery

In response to your request, we researched transsexual surgery for coverage under the health plan. The barriers to offer this procedure as a benefit are listed below.

*Issues to be resolved in*

A) Gender Dysphoria Program Inc. is the only program we identified in California, that offers this procedure. This precludes the opportunity to use other programs as a benchmark to assure quality of service.

B) It is difficult to assess the true cost of the procedure due to the multiple stages of the procedure, different choices of the procedure, required extensive medical and psychological evaluations and treatment outside the program, and, the high risk of complications from this procedure. However, our preliminary finding for the procedure alone would cost anywhere between \$15,000.00 - \$75,000.00. Possible complications and the extensive hormonal therapy and evaluation would be an additional cost.

C) According to the program some of the procedures are relatively new and /or experimental. This relative newness and uniqueness of the procedure and the lack of substantiated clinical experience/expertise in the management of these procedures precludes Health Net from optimal medical management of this benefit.

*Credentialed*

D) Due diligence is recommended for the Plastic Surgery Center (the facility) where the procedures would be performed.

E) No outcome data was furnished by the program to evaluate and monitor the clinical success and recipient satisfaction. Without this outcome data, it is impossible to evaluate the long reaching result and estimate the associated cost.

**Do you have a chiropractic rider? If yes, what is the cost based on a three-tier rate structure?**

Yes, FHP Health Care offers four different chiropractic rider options. They are as follows:

	<u>EE</u>	<u>EE+1</u>	<u>EE+2</u>
Option 1 - \$5 copayment, 20 visits	\$ 3.50	\$ 7.29	\$ 9.77
Option 2 - \$5 copayment, 30 visits	\$ 4.05	\$ 8.45	\$11.32
Option 3 - \$10 copayment, 20 visits	\$ 3.36	\$ 6.99	\$ 9.37
Option 4 - \$10 copayment, 30 visits	\$ 3.78	\$ 7.87	\$10.55

EE = eligible employee

**J. The City's Human Rights Commission has asked the Health Service Board to provide coverage for transsexual treatments and surgeries. Can you provide this coverage? What would be the cost of this coverage (3-tier rates)? If you can't provide this coverage, what is the basis for not providing this coverage?**

In order for FHP Health Care to provide an accurate response, the City & County of San Francisco will need to provide a specific definition of transsexual treatments and surgeries.

**K. What, if any, operational changes have been made within the health plan to improve health care cost management? Include a brief description of your 1996 and planned 1997 activities, for example:**

- Initial or continued changes in specific types of provider reimbursement, such as new capitation arrangement for physicians or allied services

FHP Health Care is continuously seeking methods of improving health care costs, such as transitioning all of the former TakeCare members onto FHP's formulary. We have also expanded our transplant case management unit to more effectively manage the unique needs of members who have undergone transplants. In addition, we constantly renegotiate rates with our medical groups and hospitals to ensure that FHP Health Care always receives the benefits of the most advantageous contracts with our providers. For 1997, all contracts have been amended to reflect that all FHP|TakeCare members will roll over to FHP as of 1/1/97.

- J. **The City's Human Rights Commission has asked the Health Service Board to provide coverage for transsexual treatments and surgeries. Can you provide this coverage? What would be the cost of this coverage (3-tier rates)? If you can't provide this coverage, what is this basis for not providing this coverage?**
- 

We do not provide this coverage. Aetna has not filed a benefit for these services with the DOC as they are not for the treatment of an injury or illness.

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- K. **What, if any, operational changes have been made within the health plan to improve health care cost management? Include a brief description of your 1996 and planned 1997 activities, for example:**

- **Initial or continued changes in specific types of provider reimbursement, such as new capitation arrangements for physicians or allied services.**
  - **New or upgraded data processing systems to enhance the plan's ability to manage either the utilization or quality of care.**
  - **Enhanced staffing levels, or turnover at key leadership positions, such as medical director, large case management coordinator, etc.**
- 

**1996 Initiatives**

- **Actna Health Plans of California - North received a three-year full accreditation from the National Committee for Quality Assurance (NCQA), a non-profit organization dedicated to assessing and reporting on the quality of managed care organizations. This is the highest designation awarded by NCQA and as of September 1996, only 42% of the plans reviewed had received this distinction. NCQA reviews health plans for 50 specific standards in the area of quality management and improvement, credentialing, preventive health services, utilization management, members' rights and responsibilities and medical records.**
- **The California Cooperative HEDIS Reporting Initiative (CCHRI)- Actna US Healthcare collaborated in this 1996 effort to produce health plan 1995 performance data. Results demonstrated above average results for cervical cancer, childhood immunizations, cholesterol screening, and mammography screening. Average results were obtained for diabetic retinal exam and prenatal care.**
- **A dedicated Quality Management Medical Director is expected to be appointed by year end. The local medical director will continue to chair the Clinical Quality Management Committee and interface with Quality Management and other functional departments as required.**
- **The Sales and Customer Relations department reorganized into three distinct districts, deploying resources as appropriate in closer alignment with their assigned customers and territories.**

Lisa Middleton  
822 Mountain View # 4  
Daly City, CA 94014

October 27, 1997

Mr. Larry Brinkin  
LGBT/HIV Discrimination Unit  
Human Rights Commission  
City and County of San Francisco  
22 Van Ness Avenue, Suite 800  
San Francisco, California 94102

Dear Mr. Brinkin,

**Appendix C**  
**Lisa Middleton's Letter to the**  
**SF Human Rights Commission**

I have had the opportunity, as the Human Rights Commission's  
Task Force, to review the responses of Kaiser Permanente, Health  
Net, and the HSSB's RFP regarding coverage  
for actual residential

For the record, professionally, I am the senior clinical officer for one of the largest  
workers' compensation carriers in California. My responsibilities include the  
management of all corporate managed care programs and approval of Medical Director  
issued treatment protocols. I have been responsible for the development of a specialized  
preferred provider physician network including in excess of 3000 physicians and for the  
negotiation of contracts with health care organizations valued in excess of \$20 million.  
Lastly, I am, myself, transgender, and successfully completed a gender transition in my  
current professional assignment, in June 1995.

Kaiser Permanente:

Kaiser Permanente provided the most comprehensive response to the HSSB's RFP. In  
defining our outstanding issues to be resolved they went further than any of the  
respondents in accurately defining the questions.

1. Clearly Defined Benefit:

Kaiser's concern that the benefit be clearly defined and common to all plans is certainly  
prudent and appropriate. HSSB staff would appear to be the most qualified to coordinate  
with the various plans to develop standard benefit language.

2. TPMG Issues:

TPMG's Dr. Robin Dea, is well regarded as an authority on transgender issues. She is an  
original member of the Harry Benjamin International Gender Dysphoria Association  
(HBIODA). A critical factor in the success of my expanded benefit program is the  
expertise of the individuals responsible for policy development and internal

October 27, 1997

Lisa Middleton

[REDACTED]  
Daly City, CA 94014

Mr. Larry Brinkin  
LGBT/HIV Discrimination Unit  
Human Rights Commission  
City and County of San Francisco  
25 Van Ness Avenue, Suite 800  
San Francisco, California 94102

Dear Mr. Brinkin,

I have had the opportunity, at the request of the Human Rights Commission's Transsexual Insurance Task Force, to review the responses of Kaiser Permanente, Health Net, FHP Health Care, and Aetna Health Plans to the HSSB's RFP regarding coverage for sexual reassignment services.

For the record; professionally, I am the senior claims officer for one of the largest workers' compensation carriers in California. My responsibilities include the management of all corporate managed care programs and approval of Medical Director issued treatment protocols. I have been responsible for the development of a specialized preferred provider physician network including in excess of 3000 physicians; and for the negotiation of contracts with health care organizations valued in excess of \$90 million. Lastly, I am, myself, transsexual; and successfully completed a gender transition, in my current professional assignment, in June 1995.

**Kaiser Permanente:**

Kaiser Permanente provided the most comprehensive response to the HSSB's RFI. In defining six outstanding issues to be resolved they went farther than any of the respondents in accurately defining the questions.

**1. Clearly Defined Benefit:**

Kaiser's concern that the benefit be clearly defined and common to all plans is certainly prudent and appropriate. HSSB staff would appear to be the most qualified to coordinate with the various plans to develop standard benefit language.

**2. TPMG Issues:**

TPMG's Dr. Robin Dea, is well regarded as an authority on transsexual issues. She is an original member of the Harry Benjamin International Gender Dysphoria Association (HBIGDA). A critical factor in the success of any expanded benefit program is the expertise of the individuals responsible for policy development and internal

communications. Given the specialized nature of this benefit, it is reasonable that only certain Kaiser facilities provide direct patient services. Their estimate of six months to complete the process of internal procedure, communication and contracting issues is consistent with the time required to complete such activities for other non-transsexual related benefit programs.

### 3. Benefit:

Establishing agreed and well understood benefits is both important and equitable. The current proscription of "all services related to sexual reassignment" is an example of the difficulties associated with benefit language drafted with incomplete understanding of treatment issues. Current language begs the question, *for the clinician providing treatment* – "what is a *service related to sexual reassignment?*" Some clinicians and payers understand existing language to restrict only the actual surgery and hospitalization. Others commonly interpret the same language to preclude all HBIKDA defined services, i.e., all diagnostic and therapeutic counseling, as well as hormone therapy, in addition to restricting coverage for the actual surgical procedure. Some payers have interpreted the same language to prohibit *permanently* a post-operative transsexual from the entire range of gender specific health care services.

Absent a common understanding of provided and excluded services, inequitable treatment of members and adverse selection become issues; as plans and providers interpret differently the covered services, and members in turn seek out those plans with the most generous benefit interpretations.

### 4. Exclusions:

Cosmetic restrictions are standard to health care coverage. The HBIKDA standards do not describe commonly procured cosmetic procedures (by both transsexual and non-transsexual populations) to be medically necessary. A coverage distinction between that which may be desirable and that which is medically necessary is appropriate.

### 5. Rates

I do not have sufficient information to judge the appropriateness of the Kaiser proposed rates. The rate proposal does not identify the actuarial assumptions used with regard to patient universe or benefit utilization. Kaiser does however, in comparison to the Health Net, propose to retain actual risk within Kaiser Permanente.

### 6. Employee Communications:

Kaiser's concerns regarding midyear changes and the time required to complete employee communication packages are reasonable. For benefit related written communications, the Health Plan will be required to obtain routine Department of Corporations approval.

## **Health Net:**

Health Net indicates a willingness to explore coverage; significantly however, in comparison to the Kaiser proposal, Health Net proposes to provide Administrative services only. It is appreciated that projecting costs for this benefit is demanding. Nonetheless, Health Net does not appear to have developed any statistical assumptions regarding the City's subject population universe, benefit package range or expected benefit utilization. Health Net should be familiar with utilization trends in the initial stages of a newly covered medical procedure. Transferring the risk back to the City allows Health Net to secure benefit trending data, with a guaranteed administrative fee, at minimal corporate risk.

Health Net provides a "white paper" on transsexual surgery. Their paper fails to identify those responsible for its development, their experience in the treatment of transsexual individuals or knowledge of the HBIQDA standards. This is of concern as the Health Net white paper appears inconsistent with the current state of the medical art in the treatment of transsexual patients.

Health Net's description of the treatment process is not a "treatment protocol" as that term is used within managed care environments. The paper fails to describe a reasonable number of visits during either the diagnostic or therapeutic counseling stages. It does not define any reason to expect the number of such visits to likely exceed existing restrictions on the maximum number of mental health sessions. The HBIQDA standards do call for hormone therapy to begin at least one year prior to surgery. Health Net fails to identify a reasonable pattern of laboratory testing or follow up examination. Such services are not unique to transsexuals; and Health Net fails to identify any reason to conclude such costs would be inconsistent with those experienced by non-transsexual individuals beginning a common hormone therapy regimen.

Health Net's description of the surgical stage presents difficulties. Male-to-Female, medically necessary surgeries, primarily require one surgical visit. Female-To-Male, medically necessary surgeries, generally require two to three surgical visits. Health Net's comments regarding a high level of patient dissatisfaction with transsexual surgery is not supported by clinical experience or professional citation; and fails to recognize the role of effective evaluation and the HBIQDA protocols in avoiding such dissatisfaction. Comments regarding the "high risk of complications" are equally unsupported. Professional literature describing SRS surgical procedures does not indicate a comparatively unusual level of complication associated with this surgery.

The Gender Dyphoria Program, Inc. program is the primary surgery center within California. There are, however, at least three comparable programs within the US. Comparative cost and benchmarking studies are hardly precluded. Stanford Medical Center and some other University research hospitals did approximately 10 years ago discontinue expansive gender programs. It is however, somewhat disingenuous for

Health Net to imply Stanford Medical Center and others prejudicially discontinued performing SRS procedures. They are obviously aware that new surgical procedures commonly originate, before migration to more mainstream clinical settings, in a university research medical facility. If Health Net can identify a trend of providers prejudicially leaving this area of practice; a substantiated diminishing of provider choice; or contemporary professional literature supporting a level of concern regarding this treatment within the medical community they should do so.

**FHP Health Care:**

FHP Health care provides no information in their response. It indicates a lack of awareness of the state of accepted medical treatment standards or of the HBIQDA Standards of Care.

**Aetna:**

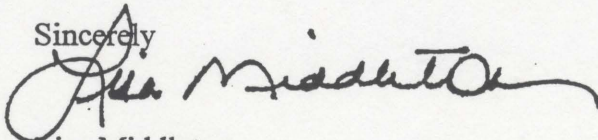
Aetna identifies that they do not provide coverage for transsexual services. They indicate such services are neither an injury or illness, in apparent contradiction to the Diagnostic Statistical Manual IV, common medical practice and HBIQDA standards.

Lastly, in a number of appellate cases the courts have affirmed that health plans enjoy latitude in determining covered medical services. The courts have cautioned health plans however that their actions need to be judged against a standard of "arbitrary and capricious.....The touchstone of 'arbitrary and capricious' conduct is unreasonableness". (Barnett v. Kaiser Foundation Health Plan. 1994 WL 400819 [9th Cir.]). They have looked with suspicion upon plan actions that single out "the exclusion of treatment for a specific condition" Rush v. Parham (5th Cir. 1980) 625 F. 2d 1150 and Cowan v. Myers (232 Cal. Rpt. 299. 1987). They have consistently supported plan decisions when based on "accepted medical standards." (Jacob v. Blue Cross and Blue Shield of Oregon (92 Or. App, 259. 1988).

Health plans have a responsibility of reasoned action, based on prevailing medical evidence. There are public policy implications, which extend beyond the City's transgendered employees, where health plan determinations, absent sound financial justification, are made contrary to prevailing medical evidence.

I trust my review of the health plans responses has been helpful to you in your efforts, and look forward to future opportunities to be of assistance.

Sincerely



Lisa Middleton

Health Net to imply Stanford Medical Center and others preferentially discontinued performing SRS procedures. They are obviously aware that new surgical procedures commonly originate, before migration to more mainstream clinical settings, in a university research medical facility. If Health Net can identify a trend of providers preferentially leaving this area of practice, a substantiated diminishing of provider choice, or contemporary professional literature supporting a level of concern regarding this treatment within the medical community they should do so.

RHP Health Care:

RHP Health care provides no information in their response. It indicates a lack of awareness of the state of accepted medical treatment standards or of the HBIGDA Standards of Care.


### Appendix D

#### SF Human Rights Commission Findings and Recommendations from 1994 Public Hearing

As a result of the public hearing, the Commission identified that the services provided by the health plans are not in compliance with the standards of care. The Commission also identified that the health plans have not provided adequate information to the members of the health plans regarding their rights and the services available to them. The Commission found that the health plans have acted in an arbitrary and capricious manner in their denial of benefits. The Commission also found that the health plans have not provided adequate information to the members of the health plans regarding their rights and the services available to them. The Commission found that the health plans have acted in an arbitrary and capricious manner in their denial of benefits. The Commission also found that the health plans have not provided adequate information to the members of the health plans regarding their rights and the services available to them. The Commission found that the health plans have acted in an arbitrary and capricious manner in their denial of benefits.

Health plans have a responsibility of reasoned action, based on prevailing medical evidence. There are public policy implications, which exceed the City's unregulated employees, where health plan determinations absent sound financial justification, are made contrary to prevailing medical evidence.

I trust my review of the health plans responses has been helpful to you in your efforts and look forward to future opportunities to be of assistance.

  
Lisa Middleton

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## Chapter 4—Findings and Recommendations

This Chapter lists the findings and recommendations of the San Francisco Human Rights Commission as derived from the preceding public testimony.

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### Findings

The Human Rights Commission, having conducted a public hearing on May 12, 1994, to investigate discrimination against the Transgender Community, and having considered verbal and written testimony, hereby finds:

1. That the City and County of San Francisco, by legislation, policy and practice, has consistently valued diversity and tolerance and has worked to eradicate discrimination based on prejudice in employment, housing, and public accommodations.

2. That the term Transgender is used as an umbrella term that includes male and female cross dressers, transvestites, female and male impersonators, pre-operative and post-operative transsexuals, and transsexuals who choose not to have genital reconstruction, and all persons whose perceived gender or anatomic sex may conflict with their gender expression, such as masculine-appearing women and feminine-appearing men.

3. That gender identity is different from sexual orientation, and sexual orientation discrimination ordinances do not protect transgendered persons. Gender identity is the deeply felt knowledge of an individual that he or she is male or female; in transgendered persons, the gender identity and the anatomic sex may not be in alignment. Sexual orientation is not an indicator of gender identity: for example, a male-bodied person who is attracted to men and has a male gender identity is not considered transgendered; a male-bodied man who is attracted to women and who has a female gender identity which is expressed through cross-dressing and/or the desire to live full-time as a woman, is considered transgendered. It is the expression of gender identity that results in discrimination because that expression is perceived as conflicting with the expectations placed upon the individual solely because of the form of his or her body, particularly the genitals.

4. That actual and legal discrimination do currently exist in the City and County of San Francisco with regard to gender presentation and transgender or transsexual status or identity.

Investigation Into Discrimination Against Transgendered People

5. That existing laws and policies often undermine the dignity and privacy of, and do not include protections for, transgendered persons. The sovereign dignity of the individual and his or her right to privacy are cornerstones of American values.
6. That there are no accurate statistics reflecting the demographics of the transgendered population, but informal surveys of the membership of local transgender organizations and of local community service agencies indicate that there are approximately 6000 transgendered individuals in San Francisco. This number is increased substantially by including persons who may be perceived as transgendered and may therefore experience adverse discrimination.
7. That transgendered persons are present in every demographic group: every race, every class, every culture, every sexual orientation, and every epoch of recorded history includes evidence of the existence of transgendered persons.
8. That in the current social climate, persons who are perceived to be transgendered are considered by some as less than human and therefore assumed to be fair game for objectification, violence, and discrimination. Hate violence is perpetrated against transgendered persons as much as, if not more than, any other group.
9. That the efforts of the Human Rights Commission to address complaints involving transgendered persons are seriously hampered by lack of legislation to support and protect the basic human rights of transgendered persons. In some cases, the Commission has been successful in mediating resolution, but without the force of law the power of the Commission to compel humane treatment is severely limited.
10. That some transgendered persons may be driven to suicide in response to the severe discrimination they may face on a daily basis.
11. That many members of the transgender community are afraid to testify at public hearings for fear of retribution against themselves or their families, especially for fear of loss of employment and loss of child custody.
12. That transgendered persons are subject to severe discrimination in employment, housing and public accommodations.
13. That transgendered persons have experienced harassment by members of the San Francisco Police Department and the Sheriff's Department, and that it is possible that crimes against transgendered persons have not always been taken seriously by these

agencies.

14. That transgendered persons have experienced great difficulty in obtaining medical and social services from hospitals, public health agencies, rape crisis centers, battered women's shelters, homeless shelters, and other organizations in San Francisco. Many of these providers treat transgendered patients and clients with great reluctance, sometimes pointedly harassing them and embarrassing them in waiting rooms, or condoning harassing behavior on the part of other patients and clients.

15. That representatives of some City and County agencies admit their employees are not uniformly educated about or sensitive to the needs of transgendered persons.

16. That the transgender community is often aligned with the Lesbian/Gay/Bisexual community, but still experiences discrimination within the Lesbian/Gay/Bisexual community and its institutions.

17. That both the news media and entertainment media tend to perpetuate stereotypes in their coverage or treatment of transgendered persons and issues. The ill-informed biases expressed in the media then become a sanction perpetuating discrimination.

18. That some transgendered women who are raped, battered, homeless, or otherwise in need of services, as well as transgendered men who require medical attention for female anatomy, are frequently denied services from women's support agencies based on their transgender status or identity. While some agencies providing services for women are working to educate themselves with respect to the transgender community and to combat the internal prejudices that lead to denial of services to the transgendered community, the Commission finds that greater effort must be made to eliminate discrimination based on transgender status or identity.

19. That transgendered youth frequently are unable to find sources of support for their difference. Feminine boys are often harassed and tortured by their peers and by their parents. Masculine girls are usually teased and/or ignored. Both boys and girls are called queer and left alone to traverse the difficult terrain between gender identity and sexual orientation. With no language to talk about their feelings, no social support, and little (if any) education about sex and gender, transgendered youth are at high risk for attempting suicide, being rejected by family or peers, becoming runaways, becoming subject to medical incarceration, getting stuck on the bottom rungs of the economic and social ladder in this society. One agency in San Francisco reported receiving nearly 2000 calls in the past year from transgendered or gender-questioning youth. These youth express deep isolation, the desire to connect with other youth who share their feelings, and a desperate need to escape harassment, abuse and rejection because of

Investigation into Discrimination Against Transgendered People

who they are. The demand for transgender services is roughly 20% of the total demand for youth services at this agency which serves lesbian, gay, bisexual, and transgendered youth. This indicates that comprehensive gender-issues-related social services are necessary for the community-at-large.

20. That once an individual is labeled with the medical diagnosis transsexualism, insurance companies discriminate against them by excluding them from coverage for the necessary treatments and procedures and for any complications or conditions that may arise from these treatments and procedures.

21. That the economic hardship imposed on some transgendered (particularly male-to-female transsexual) persons due to discrimination in employment and in medical and insurance services frequently forces them to live in poverty or to turn to sex work to survive.

22. That the wives, partners, husbands, children, and other loved ones of transgendered people feel the intolerance and harassment shown by people out of ignorance just as deeply as does the transgendered person. They fear for their own safety and security as well as for that of the transgendered person they love and on whom they may depend economically.

23. That transgendered parents live with an often debilitating fear of the loss of custody or contact with their children, and may in fact lose that custody or contact solely because of prejudice. There is no evidence to show that transgendered persons as a class are not fit parents. This discrimination is arbitrary and may unnecessarily damage the relationship between parent and child.

24. That legislation to protect the transgendered community has been enacted in other locations: Minneapolis in 1974, Seattle in 1986, Santa Cruz in 1992, and Minnesota in 1993.

25. That Proposition L did give protection to the employees of the San Francisco City and County government against discrimination based on gender identity. Since Proposition L was passed in 1993 by a vote of the People of San Francisco, it is their will to protect transgendered persons.

26. That professionals who may serve the transgendered may also become stigmatized by their peers for their association with the transgendered community, and this stigmatization, or fear of it, often prevents attorneys, physicians, nurses, psychotherapists, etc., from treating or serving transgendered patients or clients.

Investigation Into Discrimination Against Transgendered People

Attorneys, in particular, are reluctant to advocate on behalf of transsexuals whose surgical treatment has gone awry.

27. That the Human Rights Commission needs to work actively with employers, businesses, non-profit organizations, and public agencies to educate them as to the validity of the transgender experience and the value of cultural diversity in the area of gender, and to lead the way in demonstrating how the myths and prejudices surrounding the transgender community can be broken down to reveal the human beings who are struggling for their civil rights.

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## Recommendations

1. That the City and County of San Francisco develop and enact legislation amending the City's Human Rights Ordinances to add "gender identity" as a protected class with the intention of granting specific human rights protection to persons who are transgendered, and empower the Human Rights Commission to serve as the administrative agency to investigate and mediate discrimination claims that arise.
2. That the City and County of San Francisco budget for a position with the Human Rights Commission for the purpose of coordinating education and investigating and mediating claims, and that outreach be done to the transgender community in the hiring process for this position to ensure that transgendered applicants are considered.
3. That the Human Rights Commission ensure that its staff is adequately trained in transgender issues to enable them to perform transgender sensitivity trainings in San Francisco and to investigate and mediate discrimination claims.
4. That the Human Rights Commission produce and distribute information and resource materials for transgendered persons, their families, and their associates concerning their legal and civil rights.
5. That the Human Rights Commission serve as a clearing house for the general public and the media to contact for information regarding transgender education and human rights.
6. That the City and County of San Francisco conduct sensitivity training for its employees to demystify the subject of transgender experience and prepare both management and front-line employees to appropriately handle situations that may arise involving transgendered persons or the reactions of others to them.
7. That employees of the City and County of San Francisco are made to understand that discrimination against transgendered people is grounds for disciplinary action.
8. That the San Francisco Police and Sheriff's Departments conduct transgender sensitivity training for all personnel to ensure that transgendered persons are treated with respect, that their complaints are taken seriously and acted upon with reasonable dispatch, that if a transgendered person is detained or incarcerated he or she is housed in a manner which is consistent with the individual's gender identity, that his or her prescribed medication is provided, and that if the transgendered person's safety is

Investigation Into Discrimination Against Transgendered People

compromised or at risk, he or she will be immediately protected and not subject to any physical or psychological harm perpetrated by other inmates or officers. Transgendered persons should have the right to be placed in protective custody upon request.

9. That the San Francisco Police and Sheriff's Departments use terminology that is appropriate to an individual's gender identity on departmental forms and police reports, and refrain from insulting or compromising the privacy and dignity of persons who may have physical anomalies. It is respectful to ask a person whose gender identity is in question which gender they prefer; it is not respectful to ask "What are you?," or to make assumptions and enter descriptions of physical anomalies as part of a report, except when such anomalies are material to an investigation.

10. That the Office of Citizen Complaints conduct transgender sensitivity training for its personnel for the purpose of improving relations with the transgender community and improving the Office's ability to comprehend and process complaints filed by transgendered persons.

11. That the Department of Social Services conduct transgender sensitivity training for its personnel to ensure that transgendered persons are treated with respect, that their complaints are taken seriously and acted upon with reasonable dispatch, that their fitness as parents is not judged solely on the basis of prejudice against transgendered persons, and that transgendered clients do not endure physical or psychological abuse in the process of obtaining services.

12. That arbitrary gender-specific dress codes should not be imposed where they are not necessary. Employers approached by employees who are undergoing a gender transition should assist the employee by accepting their gender identity as expressed by their clothing and helping other employees to understand the transition process. In such instances in which there is a reasonable requirement for a dress code or for specific gender separation in facilities (such as locker-room dressing areas, etc.) then reasonable accommodations should be made so that the transgendered person's dignity and privacy are preserved, and the concerns of others are also considered. All of the parties should work cooperatively to address the issue.

13. That employers, businesses, and public agencies not restrict the access of transgendered persons to public restroom facilities that are appropriate to the person's gender identity. Like anyone else, transgendered persons using restroom facilities are primarily concerned with relieving and grooming themselves, and with ensuring their own personal safety.

14. That the Department of Public Health conduct transgender sensitivity training for all

**San Francisco Human Rights Commission**

**Investigation Into Discrimination Against Transgendered People**

personnel to ensure that transgendered persons are treated with respect and dignity, that their complaints are taken seriously and acted upon with reasonable dispatch, that their physical health needs are not overlooked due to prejudice against transgendered persons, that transgendered clients and patients do not endure physical or psychological abuse in the process of obtaining services.

15. That the Department of Public Health continue to conduct inservice trainings covering the treatments, medications, procedures, and new medical, social, and psychological developments with respect to the transgendered community.

16. That medical service providers, including hospitals, clinics, and private practitioners, ensure that they and their support staff are adequately trained to handle transgendered patients, to protect their health, and to ensure that their programs eliminate all unnecessary forced disclosure of transgender status as a requirement for receipt of services, to ensure that transgendered persons are not disqualified from receiving services based upon transgender status or identity, or upon perceived transgender status or identity, and to ensure that transgendered persons are treated with dignity and respect regardless of what surgery or treatments they have had or have not had.

17. That the Department of Public Health and all other medical service providers refrain from treating transgendered patients and clients as if they are "on display" or otherwise objectify them or subject them to dehumanizing treatment, preserving the client or patient's dignity, privacy and confidentiality, and that they also require employees and contractors to comply with this non-discrimination policy.

18. That the Department of Human Resources ensure that its investigators are trained in transgender issues, publicize to City and County employees the rights of transgendered persons, and ensure that transgendered persons are not disqualified from employment, or discriminated against by any City agency, based upon transgender status or identity, or upon perceived transgender status or identity.

19. That the administrators of homeless shelters, battered women's shelters, substance abuse treatment programs, rape crisis centers, and other providers of social services in San Francisco ensure that their staff is trained in transgender sensitivity, that their program eliminates forced disclosure of transgender status as a requirement for receipt of services, and ensure that transgendered persons are not disqualified from receiving services based upon transgender status or identity, or upon perceived transgender status or identity.

20. That private employers in San Francisco add "gender identity" to their lists of protected classes and provide sensitivity trainings, institute hiring outreach to the

transgendered community by advertising in local transgender community publications, and ensure that their transgendered employees, customers, and clients are treated with respect.

21. That the Lesbian, Gay, and Bisexual communities educate themselves concerning transgender issues and experience, and encourage their political clubs to more actively fight for transgender rights, and that Lesbian, Gay, and Bisexual businesses and organizations affirmatively encourage the participation of transgendered employees, clients and members.

22. That the transgender community continue and strengthen its efforts to educate others with respect to gender identity and its distinction from sexual orientation, and with respect to the empowering inclusivity that is uniquely the province of the transgendered.

23. That philanthropic and grant-making organizations and individuals consider funding transgender-related projects and social services.

24. That insurance companies acknowledge that transsexualism is a medical condition for which medical treatment is warranted and for which insurance coverage should be available. To serve as a model for other insurance carriers, the Commission recommends that the Health Services System Board modify the City Plan to cover transsexual treatment and procedures.

25. That while the Commission does not intend to recommend that all transgendered persons be regarded as disabled, the Commission does recommend that if a transgendered person does become disabled, for instance as the result of transsexual-related treatment or procedures, or for any other reason, that treatment for the resulting condition should be covered under the Americans with Disabilities Act, and the Commission recommends that the City lobby Congress and the State Legislature to amend federal and State disability laws accordingly.

26. That the District Attorney budget an increased amount for Community United Against Violence (CUAV) to enable its administrators to hire additional staff to provide outreach, education, and client services involving transgendered persons.

27. That public and private school administrators ensure that the condition of being transgendered is presented as another aspect of human biology that occurs naturally throughout society, and provide support services and/or referrals to transgendered and questioning youth so they do not have to suffer in isolation.

Investigation Into Discrimination Against Transgendered People

28. That professionals serving transgendered persons should be held to their professional ethics: it is one thing to avoid transgendered clients because of lack of expertise –it is discrimination to avoid them because of aversion to their condition. For example, attorneys should represent transgendered persons as they would anyone else, by seeking appropriate damages as they would in any other case in which the client has suffered injury. The Commission therefore also recommends that any State board or licensing agencies take the appropriate measures to prohibit discrimination against transgendered persons as patients or clients and as members of the associations.

29. That while there is a presumption of confidentiality by insurance companies, physicians, therapists, counselors, and social service agencies, etc., because of the potential consequences of involuntary disclosure of an individual's transgendered status it is doubly important that persons who are privy to such information about a client or patient should respect the privacy and confidentiality of transgendered persons and must not use knowledge of an individual's transgendered status to harm or control her or him.

30. That transgendered persons should not have to be certified by medical, psychological, or other service providers in order to enjoy the rights and privileges of society.

Revised draft (1/90)

## STANDARDS OF CARE

The hormonal and surgical sex reassignment  
of gender dysphoric persons

### Appendix E

Original draft prepared by  
The Boarding Committee of the Harry Benjamin  
International Gender Dysphoria Association, Inc.

#### Harry Benjamin International Gender Dysphoria Association Standards of Care

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## STANDARDS OF CARE

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# Standards of Care: The hormonal and surgical sex reassignment of gender dysphoric persons.

## 1. Introduction

As of the beginning of 1979, an undocumentable estimate of the number of adult Americans hormonally and surgically sex-reassigned ranged from 3,000 to 6,000. Also undocumentable is the estimate that between 30,000 and 60,000 U.S.A. citizens consider themselves to be valid candidates for sex reassignment. World estimates are not available. As of mid-1978, approximately 40 centers in the Western hemisphere offered surgical sex reassignment to persons having a multiplicity of behavioral diagnoses applied under a multiplicity of criteria.

In recent decades, the demand for sex reassignment has increased as have the number and variety of possible psychologic, hormonal and surgical treatments. The rationale upon which such treatments are offered have become more and more complex. Varied philosophies of appropriate care have been suggested by various professionals identified as experts on the topic of gender identity. However, until the present, no statement of the standard of care to be offered to gender dysphoric patients (sex reassignment applicants) has received official sanction by any identifiable professional group. The present document is designed to fill that void.

## 2. Statement of Purpose

Harry Benjamin International Gender Dysphoria Association, Inc., presents the following as its explicit statement on the appropriate standards of care to be offered to applicants for hormonal and surgical sex reassignment.

## 3. Definitions

**3.1 Standard of care.** The standards of care, as listed below, are *minimal* requirements and are not to be construed as optimal standards of care. It is recommended that professionals involved in the management of sex reassignment cases use the following as *minimal* criteria for the evaluation of their work. It should be noted that some experts on gender identity recommend that the time parameters listed below should be doubled, or tripled. It is recommended that the reasons for any exceptions to these standards, in the management of any individual case, be very carefully documented. Professional opinions differ regarding the permissibility of, and the circumstances warranting, any such exception.

**3.2 Hormonal sex reassignment.** Hormonal sex reassignment refers to the administration of androgens to genotypic and phenotypic females, and the administration of estrogens and/or progesterones to genotypic and phenotypic males, for the purpose of effecting somatic changes in order for the patient to more closely approximate the physical appearance of the genotypically other sex. Hormonal sex-reassignment does not refer to the administration of hormones for the purpose of medical care and/or research conducted for the treatment or study of non-gender dysphoric medical conditions (e.g., aplastic anemia, impotence, cancer, etc.).

**3.3 Surgical sex reassignment.** Genital surgical sex reassignment refers to surgery of the genitalia and/or breasts performed for the purpose of altering the morphology in order to approximate the physical appearance of the genetically-other sex in persons diagnosed as gender dysphoric. Such surgical procedures as mastectomy, reduction mammoplasty, augmentation mammoplasty, castration, orchidectomy, penectomy, vaginoplasty, hysterectomy, salpingectomy, vaginectomy, oophorectomy and phalloplasty—in the absence of any diagnosable birth defect or other medically defined pathology, except gender dysphoria, are included in this category labeled surgical sex reassignment.

Non-genital surgical sex reassignment refers to any and all other surgical procedures of non-genital, or non-breast sites (nose, throat, chin, cheeks, hips, etc.) conducted for the purpose of effecting a more masculine appearance in a genetic female or for the purpose of effecting a more feminine appearance in a genetic male, in the absence of identifiable pathology which would warrant such surgery regardless of the patient's genetic sex (facial injuries, hermaphroditism, etc.).

**3.4 Gender Dysphoria.** Gender Dysphoria herein refers to that psychological state whereby a person demonstrates dissatisfaction with their sex of birth and the sex role, as socially defined, which applies to that sex, and who requests hormonal and surgical sex reassignment. Gender dysphoria, herein, does not refer to cases of infant sex reassignment or reannouncement. Gender dysphoria, therefore, is the primary working diagnosis applied to any and all persons requesting surgical and hormonal sex reassignment.

**3.5 Clinical behavioral scientist.\*** Possession of an academic degree in a behavioral science does not necessarily attest to the possession of sufficient training or competence to conduct psychotherapy, psychologic counseling, nor diagnosis of gender identity problems. Persons recommending sex reassignment surgery or hormone therapy should have documented training and experience in the diagnosis and treatment of a broad range of psychologic conditions. Licensure or certification as a psychological therapist or counselor does not necessarily attest to competence in sex therapy. Persons recommending sex reassignment surgery or hormone therapy should have the documented training and

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\*The drafts of these Standards of Care dated 2/79 and 1/80 require that all recommendations for hormonal and/or surgical sex reassignment be made by licensed psychologists or psychiatrists. That requirement was rescinded, and replaced by the definition in section 3.5, in 3/81.

experience to diagnose and treat a broad range of sexual conditions. Certification in sex therapy or counseling does not necessarily attest to competence in the diagnosis and treatment of gender identity conditions or disorders. Persons recommending sex reassignment surgery or hormone therapy should have proven competence in general psychotherapy, sex therapy, and gender counseling/therapy.

*Any and all* recommendations for sex reassignment surgery and hormone therapy should be made only by clinical behavioral scientists possessing the following minimal documentable credentials and expertise:

- 3.5.1. A minimum of a Masters Degree in a clinical behavioral science, granted by an institution of education accredited by a national or regional accrediting board.
- 3.5.2. One recommendation, of the two required for sex reassignment surgery, must be made by a person possessing a doctoral degree (e.g., Ph.D., Ed.D., D.Sc., D.S.W., Psy.D., or M.D.) in a clinical behavioral science, granted by an institution of education accredited by a national or regional accrediting board.
- 3.5.3. Demonstrated competence in psychotherapy as indicated by a license to practice medicine, psychology, clinical social work, marriage and family counseling, or social psychotherapy, etc., granted by the state of residence. In states where no such appropriate license board exists, persons recommending sex reassignment surgery or hormone therapy should have been certified by a nationally known and reputable association, based on education and experience criteria, and, preferably, some form of testing (and not simply on membership received for dues paid) as an accredited or certified therapist/counselor (e.g. American Board of Psychiatry and Neurology, Diplomate in Psychology from the American Board of Professional Psychologists, Certified Clinical Social Workers, American Association of Marriage and Family Therapists, American Professional Guidance Association, etc.).
- 3.5.4. Demonstrated specialized competence in sex therapy and theory as indicated by documentable training and supervised clinical experience in sex therapy (in some states professional licensure requires training in human sexuality; also, persons should have approximately the training and experience as required for certification as a Sex Therapist or Sex Counselor by the American Association of Sex Educators, Counselors and Therapists, or as required for membership in the Society for Sex Therapy and Research). Continuing education in human sexuality and sex therapy should also be demonstrable.
- 3.5.5. Demonstrated and specialized competence in therapy, counseling, and diagnosis of gender identity disorders as documentable by training and supervised clinical experience, along with continuing education.

The behavioral scientists recommending sex reassignment surgery and hormone therapy and the physician and surgeon(s) who accept those recommendations share responsibility for certifying that the recommendations are made based on competency indicators as described above.

#### 4. Principles and Standards

##### *Introduction*

- 4.1.1 **Principle 1.** Hormonal and surgical sex reassignment is extensive in its effects, is invasive to the integrity of the human body, has effects and consequences which are not, or are not readily, reversible, and may be requested by persons experiencing short-termed delusions or beliefs which may later be changed and reversed.
- 4.1.2 **Principle 2.** Hormonal and surgical sex reassignment are procedures requiring justification and are not of such minor consequence as to be performed on an elective basis.
- 4.1.3 **Principle 3.** Published and unpublished case histories are known in which the decision to undergo hormonal and surgical sex reassignment was, after the fact, regretted and the final result of such procedures proved to be psychologically debilitating to the patients.
- 4.1.4 **Standard 1.** Hormonal and/or surgical\* sex reassignment on demand (i.e., justified simply because the patient has requested such procedures) is contraindicated. It is herein declared to be professionally improper to conduct, offer, administer or perform hormonal sex reassignment and/or surgical sex reassignment without careful evaluation of the patient's reasons for requesting such services and evaluation of the beliefs and attitudes upon which such reasons are based.
- 4.2.1 **Principle 4.** The analysis or evaluation of reasons, motives, attitudes, purposes, etc., requires skills not usually associated with the professional training of persons other than clinical behavioral scientists.

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\*the present standards provide no guidelines for the granting of non-genital/breast cosmetic or reconstructive surgery. The decision to perform such surgery is left to the patient and surgeon. The original draft of this document did recommend the following however (rescinded 1/80):

"Non-genital sex reassignment (facial, hip, limb, etc.) shall be preceded by a period of at least 6 months during which time the patient lives full-time in the social role of the genetically other sex."

4.2.2. **Principle 5.** Hormonal and/or surgical sex reassignment is performed for the purpose of improving the quality of life as subsequently experienced and such experiences are most properly studied and evaluated by the clinical behavioral scientist.

4.2.3. **Principle 6.** Hormonal and surgical sex reassignment are usually offered to persons, in part, because a psychiatric/psychologic diagnosis of transsexualism (see DSM-III, section 302.5X), or some related diagnosis, has been made. Such diagnoses are properly made only by clinical behavioral scientists.

4.2.4. **Principle 7.** Clinical behavioral scientists, in deciding to make the recommendation in favor of hormonal and/or surgical sex reassignment share the moral responsibility for that decision with the physician and/or surgeon who accepts that recommendation.

4.2.5. **Standard 2.** Hormonal and surgical (genital and breast) sex reassignment must be preceded by a firm written recommendation for such procedures made by a clinical behavioral scientist who can justify making such a recommendation by appeal to training or professional experience in dealing with sexual disorders, especially the disorders of gender identity and role.

4.3.1. **Principle 8.** The clinical behavioral scientist's recommendation for hormonal and/or surgical sex reassignment should, in part, be based upon an evaluation of how well the patient fits the diagnostic criteria for transsexualism as listed in the DSM-III-R category 302.50 to wit:

"A. Persistent discomfort and sense of inappropriateness about one's assigned sex.

B. Persistent preoccupation for at least two years with getting rid of one's primary and secondary sex characteristics and acquiring the sex characteristics of the other sex.

C. The person has reached puberty."

This definition of transsexualism is herein interpreted not to exclude persons who meet the above criteria but who otherwise may, on the basis of their past behavioral histories, be conceptualized and classified as transvestites and/or effeminate male homosexuals or masculine female homosexuals.

4.3.2. **Principle 9.** The intersexed patient (with a documented hormonal or genetic abnormality) should first be treated by procedures commonly accepted as appropriate for such medical conditions.

4.3.3. **Principle 10.** The patient having a psychiatric diagnosis (i.e., schizophrenia) in addition to a diagnosis of transsexualism should first be treated by procedures commonly accepted as appropriate for such non-transsexual psychiatric diagnoses.

- 4.3.4. **Standard 3.** Hormonal and surgical sex reassignment may be made available to intersexed patients and to patients having non-transsexual psychiatric/psychologic diagnoses if the patient and therapist have fulfilled the requirements of the herein listed standards; if the patient can be reasonably expected to be habilitated or rehabilitated, in part, by such hormonal and surgical sex reassignment procedures; and if all other commonly accepted therapeutic approaches to such intersexed or non-transsexual psychiatrically/psychologically diagnosed patients have been either attempted, or considered for use prior to the decision not to use such alternative therapies. The diagnosis of schizophrenia, therefore, does not necessarily preclude surgical and hormonal sex reassignment.

#### ***Hormonal Sex Reassignment***

- 4.4.1. **Principle 11.** Hormonal sex reassignment is both therapeutic and diagnostic in that the patient requesting such therapy either reports satisfaction or dissatisfaction regarding the results of such therapy.
- 4.4.2. **Principle 12.** Hormonal sex reassignment may have some irreversible effects (infertility, hair growth, voice deepening and clitoral enlargement in the female-to-male patient and infertility and breast growth in the male-to-female patient) and, therefore, such therapy must be offered only under the guidelines proposed in the present standards.
- 4.4.3. **Principle 13.** Hormonal sex reassignment should precede surgical sex reassignment as its effects (Patient satisfaction or dissatisfaction) may indicate or contraindicate later surgical sex reassignment.
- 4.4.4. **Standard 4.\*** The initiation of hormonal sex reassignment shall be preceded by recommendation for such hormonal therapy, made by a clinical behavioral scientist.
- 4.5.1. **Principle 14.** The administration of androgens to females and of estrogens and/or progesterones to males may lead to mild or serious health-threatening complications.
- 4.5.2. **Principle 15.** Persons who are in poor physical health, or who have identifiable abnormalities in blood chemistry, may be at above average risk to develop complications should they receive hormonal medication.
- 4.5.3. **Standard 5.** The physician prescribing hormonal medication to a person for the purpose of effecting hormonal sex reassignment must warn the patient of possible negative complications which may arise and that physician should also make available to the

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\* This standard, in the original draft, recommended that the patient must have lived successfully in the social/gender role of the genetically other sex for at least 3 months prior to the initiation of hormonal sex reassignment. This requirement was rescinded 1/80.

patient (or refer the patient to a facility offering) monitoring of relevant blood chemistries and routine physical examinations including, but not limited to, the measurement of SGPT in persons receiving testosterone and the measurement of SGPT, bilirubin, triglycerides and fasting glucose in persons receiving estrogens.

4.6.1. **Principle 16.** The diagnostic evidence for transsexualism (see 4.3.1. above) requires that the clinical behavioral scientist have knowledge, independent of the patient's verbal claim, that the dysphoria, discomfort, sense of inappropriateness and wish to be rid of one's own genitals, have existed for at least two years. This evidence may be obtained by interview of the patient's appointed informant (friend or relative) or it may best be obtained by the fact that the clinical behavioral scientist has professionally known the patient for an extended period of time.

4.6.2. **Standard 6.** The clinical behavioral scientist making the recommendation in favor of hormonal sex reassignment shall have known the patient in a psychotherapeutic relationship for at least 3 months prior to making said recommendation.

#### ***Surgical (Genital and/or Breast) Sex Reassignment***

4.7.1. **Principle 17.** Peer review is a commonly accepted procedure in most branches of science and is used primarily to ensure maximal efficiency and correctness of scientific decisions and procedures.

4.7.2. **Principle 18.** Clinical behavioral scientists must often rely on possibly unreliable or invalid sources of information (patients' verbal reports or the verbal reports of the patients' families and friends) in making clinical decisions and in judging whether or not a patient has fulfilled the requirements of the herein listed standards.

4.7.3. **Principle 19.** Clinical behavioral scientists given the burden of deciding who to recommend for hormonal and surgical sex reassignment and for whom to refuse such recommendations are subject to extreme social pressure and possible manipulation as to create an atmosphere in which charges of laxity, favoritism, sexism, financial gain, etc., may be made.

4.7.4. **Principle 20.** A plethora of theories exist regarding the etiology of gender dysphoria and the purposes or goals of hormonal and/or surgical sex reassignment such that the clinical behavioral scientist making the decision to recommend such reassignment for a patient does not enjoy the comfort or security of knowing that his or her decision would be supported by the majority of his or her peers.

4.7.5. **Standard 7.** The clinical behavioral scientist recommending that a patient applicant receive surgical (genital and breast) sex reassignment must obtain peer review, in the format of a clinical behavioral scientist peer who will personally examine the patient

applicant, on at least one occasion, and who will, in writing state that he or she concurs with the decision of the original clinical behavioral scientist. Peer review (a second opinion) is not required for hormonal sex reassignment. Non-genital/breast surgical sex reassignment does not require the recommendation of a behavioral scientist. At least one of the two behavioral scientists making the favorable recommendation for surgical (genital and breast) sex reassignment must be a doctoral level clinical behavioral scientist.\*

4.8.1. **Standard 8.** The clinical behavioral scientist making the primary recommendation in favor of genital (surgical) sex reassignment shall have known the patient in a psychotherapeutic relationship for at least 6 months prior to making said recommendation. That clinical behavioral scientist should have access to the results of psychometric testing (including IQ testing of the patient) when such testing is clinically indicated.

4.9.1. **Standard 9.** Genital sex reassignment shall be preceded by a period of at least 12 months during which time the patient lives full-time in the social role of the genetically other sex.

4.10.1. **Principle 21.** Genital surgical sex reassignment includes the invasion of, and the alteration of, the genitourinary tract. Undiagnosed pre-existing genitourinary disorders may complicate later genital surgical sex reassignment.

4.10.2. **Standard 10.\*\*** Prior to genital surgical sex reassignment a urological examination should be conducted for the purpose of identifying and perhaps treating abnormalities of the genitourinary tract.

4.11.1 **Standard 11.** The physician administering or performing surgical (genital) sex reassignment is guilty of professional misconduct if he or she does not receive written recommendations in favor of such procedures from at least two clinical behavioral scientists; at least one of which is a doctoral level clinical behavioral scientist and one of whom has known the patient in a professional relationship for at least 6 months.

### ***Miscellaneous***

4.12.1. **Principle 22.** The care and treatment of sex reassignment applicants or patients often causes special problems for the professionals offering such care and treatment. These special problems include, but are not limited to, the need for the professional to cooperate with education of the public to justify his or her work, the need to document

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\* In the original and 1/80 version of these standards, one of the clinical behavioral scientists was required to be a psychiatrist. That requirement was rescinded in 3/81.

\*\*This requirement was rescinded 1/90.

the case history perhaps more completely than is customary in general patient care, the need to respond to multiple, nonpaying, service applicants and the need to be receptive and responsive to the extra demands for services and assistance often made by sex reassignment applicants as compared to other patient groups.

4.12.2. **Principle 23.** Sex reassignment applicants often have need for post-therapy (psychologic, hormonal and surgical) follow-up care for which they are unable or unwilling to pay.

4.12.3. **Principle 24.** Sex reassignment applicants often are in a financial status which does not permit them to pay excessive professional fees.

4.12.4. **Standard 12.** It is unethical for professionals to charge sex reassignment applicants "whatever the traffic will bear" or excessive fees far beyond the normal fees charged for similar services by the professional. It is permissible to charge sex reassignment applicants for services in advance of the tendering of such services even if such an advance fee arrangement is not typical of the professional's practice. It is permissible to charge patients, in advance, for expected services such as post-therapy follow-up care and/or counseling. It is unethical to charge patients for services which are essentially research and which services do not directly benefit the patient.

4.13.1. **Principle 25.** Sex reassignment applicants often experience social, legal and financial discrimination not known, at present, to be prohibited by federal or state law.

4.13.2. **Principle 26.** Sex reassignment applicants often must conduct formal or semiformal legal proceedings (i.e., in-court appearances against insurance companies or in pursuit of having legal documents changed to reflect their new sexual and gender status, etc.).

4.13.3. **Principle 27.** Sex reassignment applicants, in pursuit of what are assumed to be their civil rights as citizens, are often in need of assistance (in the form of copies of records, letters of endorsement, court testimony, etc.) from the professionals involved in their case.

4.13.4. **Standard 13.** It is permissible for a professional to charge only the normal fee for services needed by a patient in pursuit of his or her civil rights. Fees should not be charged for services for which, for other patient groups, such fees are not normally charged.

4.14.1. **Principle 28.** Hormonal and surgical sex reassignment has been demonstrated to be a rehabilitative, or habilitative, experience for properly selected adult patients.

- 4.14.2. **Principle 29.** Hormonal and surgical sex reassignment are procedures which must be requested by, and performed only with the agreement of, the patient having informed consent. Sex reannouncement or sex reassignment procedures conducted on infantile or early childhood intersexed patients are common medical practices and are not included in or affected by the present discussion.
- 4.14.3. **Principle 30.** Sex reassignment applicants often, in their pursuit of sex reassignment, believe that hormonal and surgical sex reassignment have fewer risks than such procedures are known to have.
- 4.14.4 **Standard 14.** Hormonal and surgical sex reassignment may be conducted or administered only to persons obtaining their legal majority (as defined by state law) or to persons declared by the courts as legal adults (emancipated minors).
- 4.15.1. **Standard 15.** Hormonal and surgical sex reassignment may be conducted or administered only after the patient applicant has received full and complete explanations, preferably in writing, in words understood by the patient applicant, of all risks inherent in the requested procedures.
- 4.16.1. **Principle 31.** Gender dysphoric sex reassignment applicants and patients enjoy the same rights to medical privacy as does any other patient group.
- 4.16.2. **Standard 16.** The privacy of the medical record of the sex reassignment patient shall be safeguarded according to procedures in use to safeguard the privacy of any other patient group.

## 5. Explication

### 5.1. Prior to the initiation of hormonal sex reassignment:

- 5.1.1. The patient must demonstrate that the sense of discomfort with the self and the urge to rid the self of the genitalia and the wish to live in the genetically other sex role have existed for at least 2 years.
- 5.1.2. The patient must be known to a clinical behavioral scientist for at least 3 months and that clinical behavioral scientist must endorse the patient's request for hormone therapy.
- 5.1.3. Prospective patients should receive a complete physical examination which includes, but is not limited to, the measurement of SGPT in persons to receive testosterone and the measurement of SGPT, bilirubin, triglycerides and fasting glucose in persons to receive estrogens.

5.2. Prior to the initiation of genital or breast sex reassignment (Penectomy, orchidectomy, castration, vaginoplasty, mastectomy, hysterectomy, oophorectomy, salpingectomy, vaginectomy, phalloplasty, reduction mammoplasty, breast amputation):

5.2.1. See 5.1.1., above.

5.2.2. The patient must be known to a clinical behavioral scientist for at least 6 months and that clinical behavioral scientist must endorse the patient's request for genital surgical sex reassignment.

5.2.3. The patient must be evaluated at least once by a clinical behavioral scientist other than the clinical behavioral scientist specified in 5.2.2. above and that second clinical behavioral scientist must endorse the patient's request for genital sex reassignment. At least one of the clinical behavioral scientists making the recommendation for genital sex reassignment must be a doctoral level clinical behavioral scientist.

5.2.4. The patient must have been successfully living in the genetically other sex role for *at least* one year.

5.3. During and after services are provided:

5.3.1. The patient's right to privacy should be honored.

5.3.2. The patient must be charged only appropriate fees and these fees may be levied in advance of services.

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<sup>1</sup>DSM-III-R Diagnostic and Statistical Manual of Mental Disorders (Third Edition-Revised) Washington, D.C. The American Psychiatric Association, 1987.

Original draft dated  
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Revised draft (1/90) dated  
January 20, 1980

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March 9, 1981.

Revised draft (1/90) dated  
January 25, 1990

2.2. Prior to the initiation of genital or breast sex reassignment (Penectomy, orchiectomy, castration, vaginoplasty, mastectomy, hysterectomy, oophorectomy, salpingectomy, vaginectomy, phalloplasty, reduction mammoplasty, breast amputation)

2.2.1. See 2.1.1. above.

2.2.2. The patient must be known to a clinical behavioral scientist for at least 6 months and that clinical behavioral scientist must endorse the patient's request for genital surgical sex reassignment.

2.2.3. The patient must be evaluated at least once by a clinical behavioral scientist other than the clinical behavioral scientist mentioned in 2.2.2. above and that second clinical behavioral scientist must endorse the patient's request for genital sex reassignment. At least one of the clinical behavioral scientists making the recommendation for genital sex reassignment must be a doctoral level clinical behavioral scientist.

## Appendix F

### Bibliography

2.2.4. The patient must have been successfully living in the genetically other sex role for at least one year.

2.3. During and after services are provided:

2.3.1. The patient's right to privacy should be honored.

2.3.2. The patient must be charged only appropriate fees and these fees may be levied in advance of services.

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