Identity Crisis

In 1965, when Johns Hopkins became the first hospital in the nation to formally establish a sex change program, it shocked the nation. It also created a lab in which theories about nature vs. nurture— and body vs. mind— clashed in fascinating and ferocious ways. Four decades later, the implications are still being felt.

BY LAURA WEXLER

On Oct. 4, 1966, a gossip column in the New York Daily News carried the following item: "Making the rounds of the Manhattan clubs these nights is a stunning girl who admits she was male less than a year ago and that she underwent a sex change operation at, of all places, Johns Hopkins Hospital in Baltimore."

Soon after, Hopkins plastic surgeon Dr. Milton Edgerton received a phone call from Dr. Russell Nelson, president of the hospital.

"Dr. Nelson said, 'I just got a call from The New York Times,'" says Edgerton. "He said, 'Tell me, Milt, are we doing transsexual operations here?' I said, 'We are ... but I don't think we're ready to give any public announcements yet.'"

Since there was no stopping the story, Edgerton made a tactical decision: on Nov. 21, 1966, he and several colleagues held a news conference announcing the establishment of the Johns Hopkins Gender Identity Clinic (GIC). Before an audience of 100 reporters, the doctors defined transsexuals as "physically normal people who are psychologically the opposite sex" and explained that since "psychotherapy has not so far solved the problem," the clinic was investigating the benefits of surgery. "If the mind cannot be changed to fit the body," said plastic surgeon Dr. John Hoopes, the chairman of the GIC, "then perhaps we should consider changing the body to fit the mind." By the time of the news conference, Hoopes, Edgerton and OB/GYN Dr. Howard Jones had already operated on 10 patients, all of whom they reported were happy with their outcome. Three had married following their operations, Hoopes told reporters, and three more were engaged.

That same day, news of the GIC made the front page of The New York Times, as well as countless newspapers across the nation. The news was titillating because it concerned sex. But even more than titillating, it was surprising. Sex changes had previously been the terrain of tabloids and gossip rags. Now the most prestigious medical center in the world had become the first American hospital to give the surgery "official support."

In the wake of the announcement, the 10 doctors who comprised the GIC— including three psychiatrists, an endocrinologist, a urologist and renowned medical psychologist Dr. John Money— braced for an onslaught of negative publicity. Instead a deluge of letters arrived. They came from high school and college students, priests, architects, lawyers, nurses, beauticians and "impersonators." Some men sent photographs of themselves dressed as women; others wrote in handwriting that was distinctly feminine. Some enclosed

cash or checks, or testimonials from loved ones who supported their request for a sex change. Most wrote long accounts that detailed their suffering and conveyed a strong sense of urgency. Within a year or so, the Gender Identity Clinic had received 700 letters from desperate people all over the world who believed they were trapped in the wrong bodies and pleaded with the Hopkins doctors to help them.

But most of these people were destined to be disappointed because, far from offering surgery on demand, the GIC planned to operate only on transsexuals it unanimously deemed "good candidates." And deciding who was a good candidate raised questions that yielded no certain answers, only conflicting theories about the nature of transsexualism, and of gender identity in general.

Long before news of the GIC broke in 1966, Edgerton, who had become head of Hopkins' first division of plastic surgery in 1951, had gotten interested in what he calls "the transsexual situation," after being asked to see a patient in the outpatient surgery clinic one day in the early 1950s. "When I went in to see the patient, who was in every outward appearance female, I began to get the request for the removal of male genitalia, and if possible, the construction of a vagina," he says. Edgerton didn't perform the surgery, but the experience stayed with him. "I was puzzled by the problem and yet touched by the sincerity of the request."

Not long after Edgerton saw that first transsexual, a steady stream of patients began showing up in his office asking him to correct botched sex change surgeries that had been performed elsewhere, he says. Ex-soldier-turned-showgirl Christine Jorgensen's sex change in Denmark had made headlines in 1952, informing American transsexuals that sex changes were technically possible. But since doctors in the United States were unwilling to perform the surgery, American transsexuals went abroad, often to less-than-reputable clinics in Europe, Mexico or Morocco. "We went through the procedures that had already been committed and we tried to do repairs on a number of these individuals and in so doing, we got to know them," says Edgerton. "Not a single patient, no matter how bad the surgery that had been performed, regretted his or her trip to have the operation. And that was pretty impressive."

Though the exact causes and nature of transsexualism were as mysterious to Edgerton as to most doctors in mid-century America, he viewed the condition in the context of plastic surgery: Transsexuals' organs are not deformed, but they view them as deformed. He had seen again and again in his practice that removing or fixing a "deformity" relieved patients' suffering. Sex change surgery, he came to believe, would do the same.

At the same time Edgerton was becoming convinced about the benefit of sex change surgery, Hopkins' Money was developing the first of several landmark theories about sexual identity. Based on his work with children born with ambiguous genitalia (now known as intersex patients), Money theorized that a person's sex wasn't monolithically male or female, but determined by seven variables, including genetic, hormonal, internal and external genital, and gender identity. In most people, the variables matched and they had no question about their inherent male- or female-ness. But when the variables got mismatched, as in the case of transsexuals, a person's gender identity could be the reverse of all their other sex variables. As a corollary to this idea, Money theorized that once a person's gender identity was "imprinted" in the brain, it was impossible to reverse through therapy. The best course of action, Money came to believe, was to surgically create genitalia to match the patient's gender identity.

Edgerton, a former World War II surgeon with a genteel Southern drawl, and Money, a native New Zealander already legendary for his unorthodox ideas about sex, made an odd pair, and yet Edgerton's plastic surgery philosophy and Money's theories about sexual identity merged perfectly to become the GIC's core philosophy— If the mind cannot be changed to fit the body, then perhaps we should consider changing the body to fit the mind. The problem, however, was putting the philosophy into practice, determining who among the hundreds of desperate applicants was a candidate for surgery— "a true

transsexual"— and who was not.

The GIC doctors devised four criteria to guide the decision-making: Is the patient a candidate for psychotherapy? Is the patient authentically motivated? Is the patient psychotic? Will the patient undergo sociocultural crisis after receiving the operation? But these criteria didn't help to clearly distinguish transsexualism from other syndromes or disorders. That meant the GIC psychiatrists, who conducted the initial evaluation of each patient and thus were the gatekeepers to the surgery, were charged with issuing a diagnosis for a condition not widely understood, or even widely accepted as a separate psychological condition.

Given the uncertainty, at the clinic's monthly meetings the psychiatrists frequently chose to err on the side of wait-and-see, recommending therapy instead of advancing a patient onto the next stage of the process. That often set them in direct opposition to Money, as GIC chairman Hoopes recalls. "John Money would argue very forcefully that someone was a candidate ... that he knew the patient very well and if this program was going to make any headway this patient should be accepted," he says. At times Money, the psychiatrists and the surgeons couldn't even agree about pronouns. Some referred to patients by their biological sex and some referred to them by their gender identity.

Change-of-Sex Operations Performed On 2 Apparent Males at Johns Hopkins
By Nate Haseltine Washington Post Staff Writer
The Washington Post, Times Herald (1959-1973); Nov 22, 1966; ProQuest Historical Newspapers The Washington Post pg. A1

Both Patients Recovering Normally

Change-of-Sex Operations Performed On 2 Apparent Males at Johns Hopkins

By Nate Haseltine
Washington Post Staff Writer

The controversial change-of-sex surgery, widely performed in some foreign countries, is now being done and sanctioned by the Johns Hopkins University Hospital in Baltimore.

Two such operations were performed in the Hospital, changing apparent males to apparent females, officials there said yesterday, confirming a published report on the subject. Neither patient was made capable of reproduction.

In the male-to-female operation, which takes as long as four hours, external genitals are removed and a vaginal channel is formed.

Both patients, said to be in their 20s, were reported recuperating normally. They were given female hormone treatments before and after the operations.

The Baltimore institution, as part of its program in the field, set up a committee about a year ago to study the subject, which is taboo to many hospital boards. The committee found change-of-sex surgery to be a real need of victims of transsexualism, the freak embryonic development that gives male physical characteristics to babies otherwise destined to be females.

A "gender identity clinic" was set up to screen applicants for such surgery.

Most transsexuals who have surgery are apparent males who wish to be females. In these cases, pre- and post-operative hormone treatments gradually reduce the unwanted secondary male sexual characteristics and enhance female chemistry in the patient's body.

Transsexualism is not to be confused with transvestitism. A transvestite, not eligible for corrective surgery, is one who gets abnormal satisfaction from wearing clothing of the opposite sex. Transvestites are far more numerous than transsexuals.

The transsexual has an overriding desire for a change of sex, rather than a desire to

See SEX, A8, Col. 1

On top of resistance from within the GIC, the psychiatrists say they faced resistance from the patients themselves. "The patients didn't want to see a psychiatrist. To see one inferred they had mental problems," says one psychiatrist member of the GIC who did not wish to be quoted by name. "They took exception." Partly this was due to patients' conviction that surgery— not therapy— was the only thing that could end their suffering. But it was also due to the fact that many patients, who'd previously had negative experiences with psychiatrists, found the GIC psychiatrists' questioning just as invasive.

"Not only was the atmosphere clinical, it was also rather hostile," says Dr. Dana Beyer, 54, who came to the GIC in 1971 or '72. A 14-year-old boy in 1966, Beyer had read about Hopkins' sex change program in Newsweek. Five or six years later, he finally summoned the courage to take the train from New York, where he was attending college, to Baltimore.

"You can't conceive of the desperation one feels. I'm spending my life feeling like something is wrong with me and here, finally, is a chance for professionals to say, 'No, that's not the case,'" says Beyer, an eye doctor who "transitioned" to female in 2003 and now lives in suburban D.C. "Here you suddenly have this opportunity where professionals or experts might be able to help you. This was the place where I could finally get answers. I wanted to get my life fixed."

But when Beyer arrived at the GIC, he was given an intake application he says was so off-putting— so focused on sex, rather than on sexual identity— that he fled without ever seeing a doctor. Faced with the same invasive questioning, other patients took a different tack: they read the scant medical literature about transsexualism and fashioned themselves as "textbook transsexuals" so as to increase their chances of advancing to the next stage. "They would tell you they feel imprisoned in a male body," says endocrinologist Dr. Claude Migeon, who met with each patient just as every GIC doctor did. "They could talk in a female voice, they would flutter their eyelids. They were trying hard to please you, to be cute, and get their surgery. After a while, they convince you."

But not every member of the GIC was convinced. "I think transsexualism was viewed by some as a cause as opposed to a medical condition," says the psychiatrist who did not want to be identified. "I was always uneasy about what we were doing."

Perhaps the greatest uneasiness resulted from the GIC's early decision to explore whether sex reassignment surgery could transform patients who, as described in a 1968 journal article, had "inadequate social and moral judgment and a long history of petty and sometimes major criminal offenses." As Hoopes recalls, "We had quite a number of patients from The Block, transvestites, gay men, strippers, just a bizarre group of people. The great majority of people associated with Hopkins looked very much askance at the program. ... Everybody was wondering why we were involved with those 'queers,' as they called them."

In 1964, a 17-year-old boy named G.L., who had been convicted of a string of petty crimes seen to be "adjunctive" to his desire to be a woman— stealing women's coats, purses and, finally, $800 worth of wigs — presented the first opportunity to explore the social reform-through-surgery theory when Judge James K. Cullen of the Supreme Bench of Baltimore City (now Baltimore City Circuit Court) signed a court order

for his sex reassignment surgery.

Larry Kloze, who served as a probation officer with the court from 1963 to 1968, was G.L.'s probation officer. He borrowed a business suit from his girlfriend for G.L. to wear on the day of the surgery and dropped him off at Hopkins' Women's Clinic, where OB/GYN Jones was to perform his surgery. But G.L.'s surgery was "thwarted" due to what Money described as "intervention from the department of psychiatry on the basis of philosophical disagreement regarding sex reassignment." As one psychiatrist remembers, G.L. was referred to Hopkins' psychiatric clinic for treatment.

If the GIC members did unanimously agree to advance a patient after the first evaluation, the next stage involved a trial period of six months to a year or longer, in which the patient received hormone therapy— estrogen for male-to-female patients and testosterone for female-to-male— and was required to live and work in his or her gender of choice. The hormones put patients one step closer to the body they desired, and in doing so, relieved some of their tension, says Edgerton. But the trial period also caused great strain. Some patients had to sever ties with their families and friends in order to start again in their new gender. Some lost their jobs. And always they lived with the threat of being unmasked.

The patients "were sometimes very uneasy for fear they would be in an accident or get arrested and the police would discover that they were cross-dressing, as it were," says Edgerton. At the time, cross-dressing, also known as impersonation, was a crime in many jurisdictions. "So we had to arrange to give each of them identity cards from the clinic with telephone numbers that we could be reached at any time in case they got into some trouble ..." The cards were provided by the Erickson Foundation, an organization begun by a transsexual named Reed Erickson that funded the GIC, and they came in handy— Edgerton remembers getting at least a few calls from police officers around the country. After one male-to-female GIC patient was arrested in Baltimore in 1971, she was taken to male jail. Only after undergoing an exam by prison doctors was she granted her request to be transferred to a women's facility.

Many patients never progressed beyond this second stage— they changed their mind or went elsewhere for the surgery or couldn't afford the cost of surgery (which ranged from $2,000 to $10,000) or didn't comply with the rule that required them to live fully in their gender of choice. Those patients who did were evaluated again by each member of the clinic. Again, there were disagreements, and these were even more heated because voting "yes" meant that the patient was cleared for a radical, irreversible surgery that removed healthy organs and rendered a person sterile.

In technical terms, the male-to-female surgery— which comprised the majority of surgeries the clinic performed— involved amputating the penis and testes and creating a vagina from some of those tissues. It was a major procedure that took several hours but it was "simple and straightforward," as one surgeon says. In fact, the biggest challenge, says OB/GYN Jones, was preventing the newly created vaginal cavity from collapsing during the days and weeks afterward.

Patricia Thompson, head nurse in the gynecological operating room, assisted at every sex change surgery Jones performed and came up with the idea of using a wooden form with a plastic covering to keep the surgically constructed vagina open. "I used to sit at home at night and whittle balsa wood into the forms," says Thompson. Once the patient was fitted with the form, she customized a store-bought girdle with extra elastic reinforcement, which the patient would wear to hold it in place. After everything healed, says Thompson, "if you looked a year later, you might not be able to tell" that the genitalia was surgically created.

Unfortunately, that was not the case for the female-to-male transsexuals, who at the time constituted about one-fifth of the clinic's patients. The first stages of the operation included removal of the breasts, uterus and ovaries. Some patients were content to stop at this stage, but others wanted the construction of a phallus, a multi-stepped process that involved multiple skin flaps and left multiple scars on the patient's abdomen and legs. Thompson recalls one female-to-male surgery that required 214 sutures. "The needles came in packs of eight or 10 or something and I saved all the cardboard packs and counted them afterward," she says. "I threaded 214 needles that day."

Even when the operation went well, only a portion of the patients were able to urinate through the surgically constructed phallus, and fewer still could use it sexually. But surgeons Edgerton and Hoopes, who performed the majority of the female-to-male surgeries, believed the operation was worthwhile because it provided "psychological security" to their patients. As Hoopes wrote in a 1969 article, "The surgery, often considered outrageously excessive and meddlesome by the uninformed, must be undertaken regardless of the censure and taboos of present society."

After the flurry of publicity in 1966, the clinic managed to keep its work under wraps for several years. But in October 1969, it made headlines again when one of the patients, Dawn Langley Hall Simmons (formerly Gordon Langley Hall), announced she'd given birth to a "miracle child." The Hopkins doctors said her pregnancy was "definitely impossible" but the story still played widely in reputable newspapers. After all,

if doctors were making men into women, was it really so impossible that those surgically created women could give birth?

By then, the clinic had received 1,500 requests and performed 20 sex reassignment surgeries. The GIC doctors had published roughly 30 articles documenting their work and received visits from surgeons at the four other U.S. medical centers that had begun performing sex changes in the wake of Hopkins' "legitimization" of the procedure. Dr. Stanley Biber, who went on to become "the dean of sex changes," requested the surgeons' drawings from his office in Trinidad, Colo. Using them as a guide, in 1969 he performed the first of the 4,000 sex changes he would do before his death in 2006.

Also in 1969, psychiatrist Dr. Jon Meyer became chairman of the Gender Identity Clinic (Hoopes had left Hopkins the previous year) and took over the initial evaluation of prospective patients. Meyer, an expert in sexual disorders, says he began his role enthusiastic about testing the theories articulated by Money and others about the uniqueness of transsexuals. But as he talked with more and more patients, and at greater length, he observed that they "would start out talking about their wish for sex reassignment but would very rapidly get into anything people would talk about in therapy"— loss, abandonment, grief. Far from finding transsexualism to be the unique condition that Money and others described, Meyer says the patients were "familiar."

That year, Money conducted a follow-up study of 17 male and seven female patients who had received surgery at the GIC that reported, among other things, that after the operation, nine of the patients improved their occupational status and none declined; and seven male and three female patients married for the first time. "All of the 17 are unequivocally sure they have done for themselves the right thing," he added.

Two years later, Meyer began his own study of GIC patients that sought to measure "objectively" the benefits of surgery in the long term. Eight years after that, on Aug. 10, 1979, he announced his results, which were far different than Money's a decade before. "To say that this type of surgery cures psychiatric disturbance is incorrect. We now have objective evidence that there is no real difference in the transsexual's adjustment to life in terms of jobs, educational attainment, marital adjustment and social stability," he said. He later told The New York Times, "My personal feeling is that surgery is not a proper treatment for a psychiatric disorder, and it's clear to me that these patients have severe psychological problems that don't go away following surgery."

Meyer's conclusion codified the concerns some psychiatric members of the committee had voiced from the start and flew directly in the face of Money and Edgerton's core philosophy. Transsexualism, Meyer was saying, was a mental illness. Thus doctors ought to work with the patients to change their unhappiness, not change their bodies.

Thirteen years before, when Hopkins announced the Gender Identity Clinic, it had cleared the way for other medical centers to establish their own programs. By 1979, approximately 30 patients had been operated on at Hopkins, more than 1,000 had been operated on in university hospitals, and 15 to 20 major medical centers nationwide were performing the surgery. When Meyer spoke out against sex changes, many took it as the end of Hopkins' approval for the surgery and the end of an era. In effect, it was. The surgeries had been dwindling for several years, and after the study was published, Hopkins never performed another sex change.

Though Meyer's study was roundly criticized at the time, more than a quarter-century later it continues to shape the discussion of transsexualism. As recently as two years ago in Trinidad, Colo., a group of ministers used Meyer's study as the basis of a petition campaign to force Dr. Marci Bowers, the protégé of Dr. Stanley Biber and a transsexual herself, to stop performing sex change operations. The campaign failed, and Bowers, along with a host of other surgeons, continues to perform sex changes at private clinics and hospitals nationwide.

But private clinics don't conduct research, and one of the long-lasting effects of the closing of the Hopkins clinic, says Baltimore resident Deborah Rudacille, author of "The Riddle of Gender," was that the research on transsexualism "came to a dead halt and has only started again recently." As a result, not much more is known today about transsexualism, or the long-term effects of sex change surgery, than in 1966.

Four decades after the creation of the Gender Identity Clinic, its members continue to be as divided about its work as they often were during the monthly meetings. Hoopes, who returned to Hopkins in 1970 to replace Edgerton as head of the plastic surgery division, holds a far different view today than in 1969, when he wrote that sex change surgery "must be undertaken regardless of the censure and taboos of present society."

"Prior to the surgery, these patients were at least male or female, but after the surgery the males converted to females weren't really females and the females converted to males weren't really males," he says. "You've created a new breed. You've created something you don't know what to do with." He adds: "I never saw a successful patient. For the most part they remained misfits."

Other GIC doctors acknowledge that the social-transformation-through-sex-change-surgery theory didn't work. "I remember one was a petty thief and after the surgery, we ended up having a female petty thief," says Jones. "If they were prostitutes to start with," says Migeon, who continues to work as a pediatric endocrinologist at Hopkins, "they were afterward." (Actually, Money reported in an early article that one patient, following surgery, "was able to be a more effective prostitute.")

And yet these doctors also say that most of the patients who wrote letters pleading for help, who visited them in their offices, who risked everything— and in many cases, sacrificed everything— to undergo a surgery they believed would ease their suffering, their sense of not-rightness, were not "antisocial." Edgerton recalls the editor of a major news publication who was so grateful to get the surgery. Migeon remembers a teacher who later moved to the Midwest and had a successful career. Thompson, now retired and living in Arkansas, remembers a fellow nurse from a nearby hospital in Baltimore and a beautician who gave her tips on her hair. She remembers lunching with one post-operative patient at the hospital cafeteria and seeing her joy at being taken so fully for a woman that she was nearly asked on a date by a male doctor. "I think we were helping these people be who they wanted to be," they say.

In the wake of Meyer's announcement, Edgerton, who had left Hopkins in 1970 to become chief of the department of plastic surgery at the University of Virginia School of Medicine, where he started a Gender Identity Clinic, defended sex change surgeries, arguing that subjective assessments, which Meyer purposely did not consider, were the most important criteria for determining the surgery's benefits. "The self-confidence and sense of wholeness of the transsexual is what it's all about," Edgerton told Clinical Psychiatry. "This is really cosmetic surgery because these people are already living as members of the opposite sex. It is gender confirmation surgery, not gender change surgery."

Back at Hopkins, Money argued that Meyer had "distorted the findings of the study way out of proportion" in order to put an end to sex change surgeries at the hospital. But without the support of powerful surgeons like Edgerton or Jones— who had left Hopkins in 1978 to go to Eastern Virginia Medical School in Norfolk, where he and his wife, Georgeanna, created the first in vitro fertilization pregnancy in 1981— Money couldn't do much to save the program.

By 1979 he had lost some of the power he'd held a decade earlier. Some of his theories about sexual identity had been disproved, for one, and news of the disastrous results of the sex reassignment he'd advocated for one of a pair of twins— and his alleged unethical research methods related to it— was already leaking out. Too, Money, who died last July, faced a powerful opponent in Dr. Paul McHugh. When he came to Hopkins in 1975 to become head of the psychiatry department, McHugh intended, as he wrote in a 1992 issue of American Scholar, to help end sex change surgeries, a procedure he described "as the most radical therapy ever encouraged by 20th-century psychiatrists"— with perhaps the exception of lobotomies.

But what seemed radical in 1960 and 1970— remaking men with female genitalia; remaking women with male genitalia— can, in a different light, seem almost conservative, because it continues to anchor definitions of "man" and "woman" to anatomy. In November, New York City's Board of Health announced plans to allow people to change their sex on their birth certificates without undergoing genital surgery, meaning a person could legally be a woman even if she has a penis. And a person could legally be a man even if he has a vagina and a uterus and ovaries. The announcement met with a surge of concerns and controversy, and in early December the city's health board abandoned the plan, saying that to pursue it would place New York City in "uncharted territory."

In 1965, the Hopkins Gender Identity Clinic ventured into just that uncharted territory. And, as the New York City controversy, and a host of others, reveals, the questions the Hopkins doctors grappled with four decades ago— what is a man? what is a woman?— continue to remain unanswered.

JANUARY/FEBRUARY 2007

Let us know what you think…

NAME: EMAIL ADDRESS: REMEMBER ME

ADD COMMENT

PLEASE ENTER THE WORD YOU SEE IN THE IMAGE BELOW:

I appreciate the information in this article very much, and yet for me the question isn't "what is a man (or woman)" but why do you think it should be LEGAL for a man with a semi-erect penis to be prancing around naked in front of little girls in the women's showers at my local pool?

Because that's what is going on now, and I'm devastated, as is my daughter! I no longer care if they "feel better about themselves", I'm more concerned about the safety of my six year old daughter! Apparently her safety is less important than the feelings of some nutcase! But hey it's okay because he has a letter which says that his penis is magically female! And what message does this send to my daughter and all the other little girls? Why would anyone tell her that of course all the stereotypes about females are true, when those stereotypes have been disproved a million times by now???

Give these people therapy and keep them out of the women's bathrooms, showers, rape crisis centers and prisons—because the last place they need to be is sharing space with vulnerable women. It's easy to have "compassion" for them, until you notice how the underlying ideology and practical applications of it actually does harm real women and girls!

Posted by Anna C. on 06/02/12 at 09:19 PM

john money was a freak.my dad wouldnt leave me alone with him

Posted by karen on 11/08/09 at 09:02 PM

Laura
Thank you, thank you, thank you, a great job pulling this together. I underwent the surgery from male to female in 1983, as I look back it is impossible to grasp the folly of such surgery.
Then when I learned the surgery is cosmetic in nature (it is a masquerade) and can not change anyone's gender, I felt like a fool. So for my healing I wrote a book, that has helped more than I ever thought. Keep up the great work, bravo
Walt

Posted by Walt Heyer on 04/22/07 at 06:37 PM