Transgender Medicine

Nick Gorton, MD, DABEM
Lyon-Martin Health Services
nick@lyon-martin.org

- Elective in Transgender Medicine - Sarah@lyon-martin.org
  - Residents
  - Medical, NP, PA students

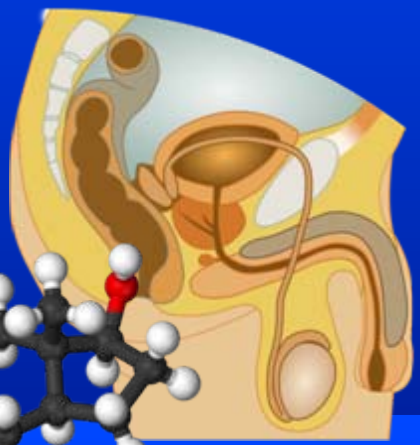
Overview

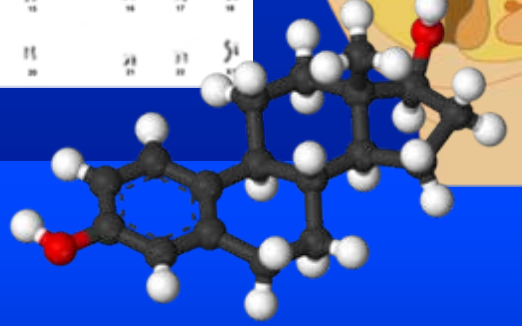
- Definitions and History
- State of Transgender Care Today
- Basic Treatment Overview
- Resources

- Timing and questions

Definitions

- **Sex** – male, female, intersex, transsexual





- **Gender** – masculine, feminine, androgynous

*** Non Binary**

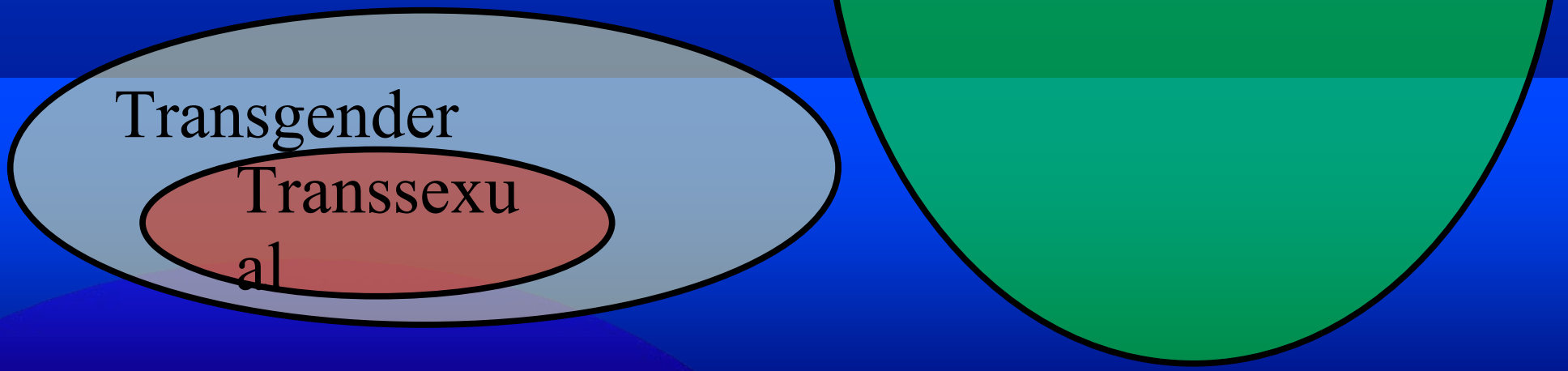
Definitions

- Gender Identity 
- Gender Expression




Definitions

- Trans**gender**
- Trans**sexual**
- Cisgender/Cissexual



Definitions

- Transgender woman, MTF, transwoman, woman





- Transgender man, FTM, transman, man





Historical Context

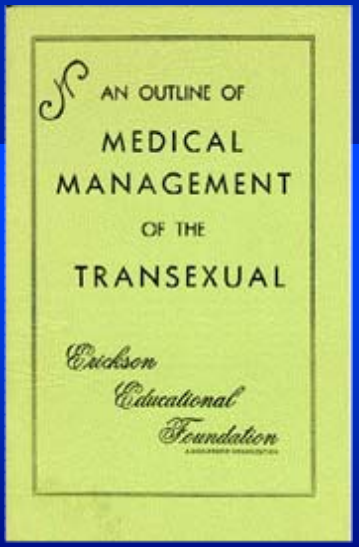
- Harry Benjamin
  - Alfred Kinsey, refers to him 1st patient in **1948**
  - Benjamin H. "Transsexualism and transvestism as psychosomatic and somatopsychic syndromes." Am J Psychother. 8(2):219-30. **1954**
  - "The Transsexual Phenomenon" - **1966**

Historical Context

- Trans care in academia
  - 1953 – Hamburger C, et al. "Transvestism: hormonal, psychiatric, and surgical treatment." J Am Med Assoc. 152(5):391-6.
  - 1959 – Randell JB. "Transvestitism and trans-sexualism: A study of 50 cases." British Med J. 2(5164):1448-52.

Historical Context - US

- Transgender care in academia - 1960s
  - 1965 – John's Hopkins program opens
  - 1965 – First SRS is performed at JHU
  - 1960s – 70s – gender programs at university medical centers: Stanford, Northwestern, University of Minnesota, Hopkins, etc.



Historical Context

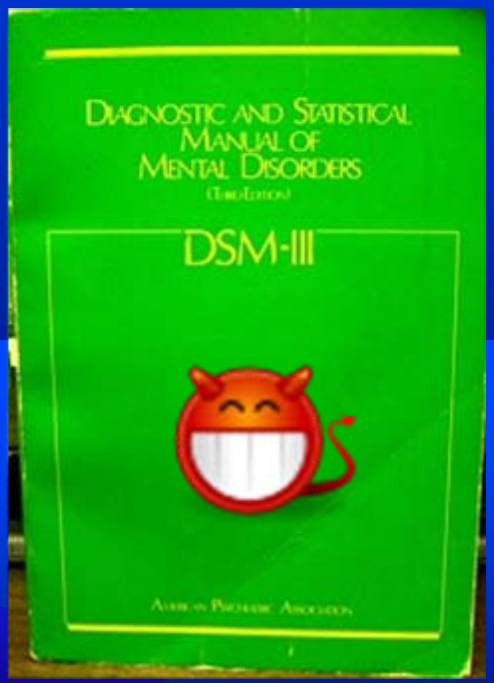
- Professional Organization & Standards - 1970s
  - 1971 – HBIGDA formed
  - 1979 – Standards of Care Version 1

Harry Benjamin International
Gender Dysphoria Association, Inc.
A Non-Profit Corporation

The World Professional Association
for Transgender Health, Inc.
a nonprofit organization

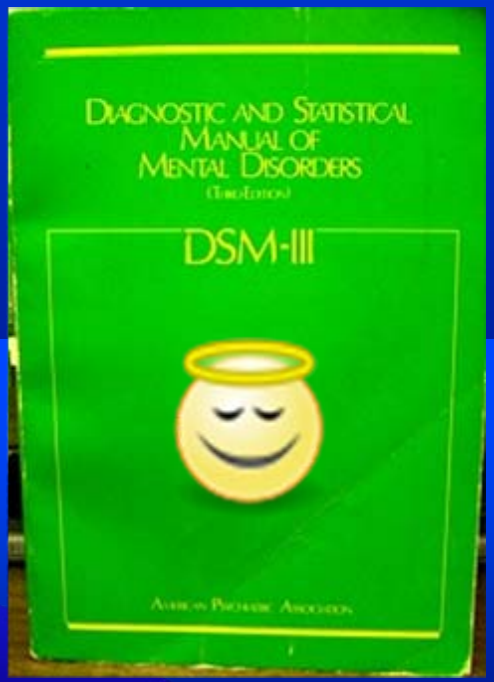
Historical Context

- Increasing Recognition
  - 1980 – Diagnostic and Statistical Manual of Mental Disorders - 3rd Edition



Historical Context

- Increasing Recognition
  - Inclusion in DSM-III legitimized care



Historical Context

- What the #&*@! happened in the early 80s....?

Hopkins Changes

- Paul McHugh
  - Director of the Department of Psychiatry and Behavioral Sciences at Johns Hopkins University School of Medicine, and Psychiatrist-in-Chief of the Johns Hopkins Hospital, 1975-2001

Hopkins Changes

- Paul McHugh
  - Council Member, the President Bush's Council on Bioethics

Hopkins Changes

- Paul McHugh – Academic work
  - Praised by NARTH:
    - http://www.narth.com/docs/desiresch.html
  - The Desire for a Sex Change: Psychiatrist says sex-change surgery is a collaboration with a mental disorder, not a treatment.

Hopkins Changes

- NARTH
  - Provides much of the 'professional scientific' support for the Ex-Gay movement.
  - Homosexuality is simply a behavior choice.
  - 'Reparative therapy' helps people 'make the right choice.'

NARTH
National Association for Research & Therapy of Homosexuality

Hopkins Changes

- NARTH

Don't be gay,
Sparky!
Don't be gay!

NARTH
National Association for Research & Therapy of Homosexuality

Hopkins Changes

- Member, US Catholic Conference of Bishop's blue-ribbon review board (est 2002) to monitor implementation of new clerical sex abuse policy
- “Bombshell discovery” that the abuse crisis wasn’t about pedophilia or about repeated systematic cover-up by Bishops, but...

Hopkins Changes

- Member, US Catholic Conference of Bishop's blue-ribbon review board (est 2002) to monitor implementation of new clerical sex abuse policy
- "Bombshell discovery" that the abuse crisis wasn't about pedophilia or about repeated systematic cover-up by Bishops, but "homosexual predation on American Catholic youth."

Hopkins Changes

- Paul McHugh

???

Hopkins Changes

- "The post-surgical subjects struck me as caricatures of women. They wore high heels, copious makeup, and flamboyant clothing; they spoke about how they found themselves able to give vent to their natural inclinations for peace, domesticity, and gentleness—but their large hands, prominent Adam's apples, and thick facial features were incongruous (and would become more so as they aged)."

Paul McHugh. "Surgical Sex." *First Things: A Monthly Journal of Religion and Public Life* 147 (November 2004): 34-38.

Hopkins Changes

- Paul McHugh

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Hopkins Changes

- Paul McHugh: transwomen not 'real women'
  - “First, they spent an unusual amount of time thinking and talking about sex and their sexual experiences.
  - Second, discussion of babies or children provoked little interest from them; indeed, they seemed indifferent to children.
  - But third, and most remarkable, many of these men-who-claimed-to-be-women reported that they found women sexually attractive and that they saw themselves as 'lesbians.'”

Paul McHugh. "Surgical Sex." *First Things: A Monthly Journal of Religion and Public Life* 147 (November 2004): 34-38.

Hopkins Changes

- Paul McHugh – because ***'real women'***
  - Don't think and talk about sex.
  - Are universally interested in childrearing.
  - Aren't lesbians.

Paul McHugh. "Surgical Sex." *First Things: A Monthly Journal of Religion and Public Life* 147 (November 2004): 34-38.

Hopkins Changes

- "[O]nce I was given authority over all the practices in the [Johns Hopkins] psychiatry department I realized that if I were passive I would be tacitly co-opted in encouraging sex-change surgery in the very department that had originally proposed and still defended it. I decided to challenge what I considered to be a misdirection of psychiatry and to demand more information both before and after their operations."

Paul McHugh. "Surgical Sex." *First Things: A Monthly Journal of Religion and Public Life* 147 (November 2004): 34-38.

Hopkins Changes Everything

- Paul McHugh
- Enlists JHU researcher Jon Meyer to undertake a study of post-operative transgender women
- Meyer J, and Reter K. “Sex reassignment. Follow-up.” Arch Gen Psychiatry. 36(9):1010-5. **1979**.
- Compared 50 patients seeking SRS, operated with non-operated

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Meyer's Study

- Non Validated Outcome Scale
  - SES (Male to Female)
  - Legal
    - Arrested -1
    - Arrested and Jailed -2
  - Mental Health
    - Psychiatric contact -1
    - Outpatient treatment -2
    - Inpatient treatment -3

Meyer's Study

- Non Validated Outcome Scale
  - Cohabitation
    - Gender Appropriate +1
    - Non-Gender Appropriate -1
  - Marriage
    - Heterosexual marriage +2
    - Same-Sex Marriage -2

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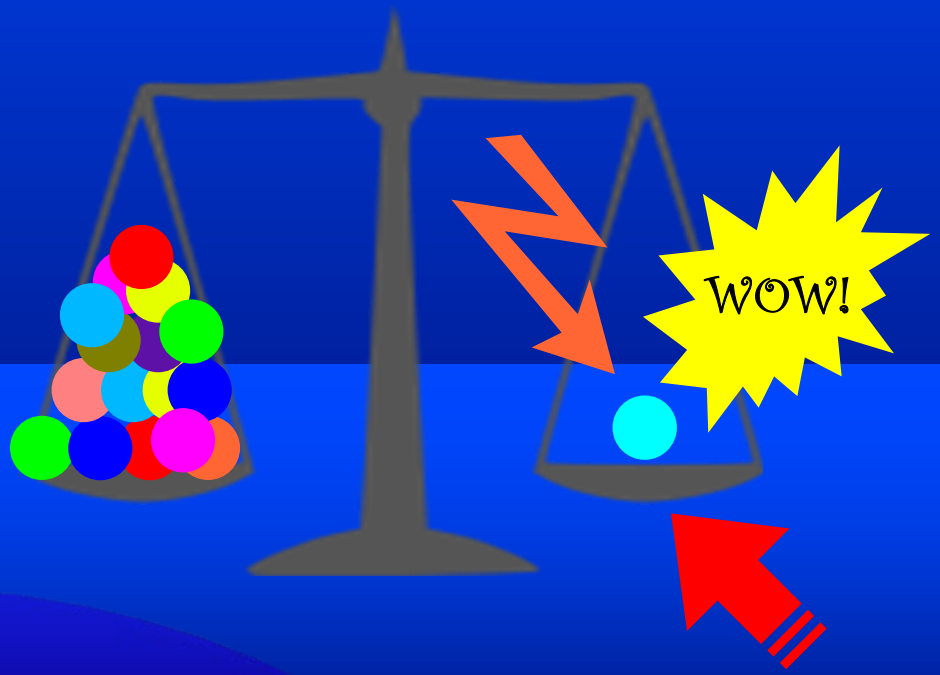
Meyer's Study

- Results
  - Despite *rather creative study design*
  - In each subgroup operated either did the same or better than the non-operated
  - In overall score operated did slightly better than non operated, but this ***did not reach statistical significance***
- Underpowered – **Type II error**
- Over-hyped

Meyer's Study

- At odds with other research studies of outcomes after SRS for transgender people



Meyer's Study

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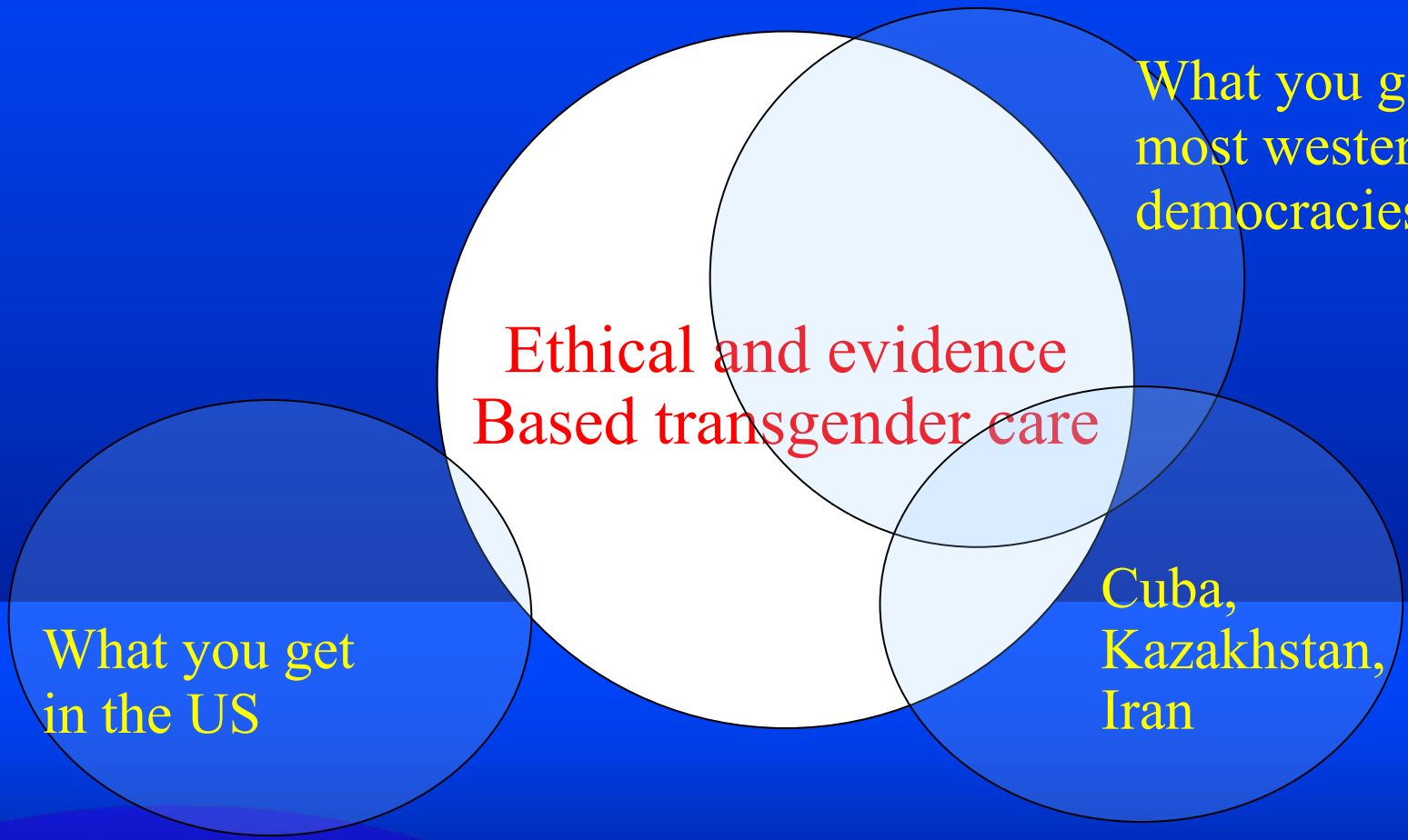
Collapse of Transmedicine in American Academic Centers

- Transgender health care perceived as
  - Dangerous and ineffective
  - Bad science
- Closure of US academic gender programs*
  - Insurance exclusions **instituted** in United States
  - Almost all care funded by individuals

*Except for PHS at U of M

Transgender Health Care Today



Primary Care and Hormone Therapy

- You already know 90% of what you need to know (or you will by the end of training)
- Most medical care of transgender patients has nothing to do with being transgender
- 100% of the medical treatments and most of the surgeries are used in cisgender patients

But now I have a patient in my office!

- Ask for help
  - Experienced clinicians
  - TransMedicine yahoo group
  - Your patient
- Buy a book
- Go to a conference
  - WPATH
  - GLMA, TransHealth
  - Others
- Consult Dr Google

health services LYON MARTIN

Vancouver CoastalHealth
Promoting wellness. Ensuring care.

Community Health Network of San Francisco

SFDPH's Tom Waddell Clinic Protocols

The World Professional Association for Transgender Health, Inc.
a nonprofit organization


Whats Getting Me Through Medical School
Evidence Based Medicine
Wikipedia
GraphJam


Google
vancouver coastal health transgender
Advanced Search
Language Tools
Google Search
I'm Feeling Lucky


Vancouver Coastal Health
Promoting wellness. Ensuring care.
Vancouver Coastal Health delivers quality health services to the people and communities we serve. Read more...
High Contrast: T
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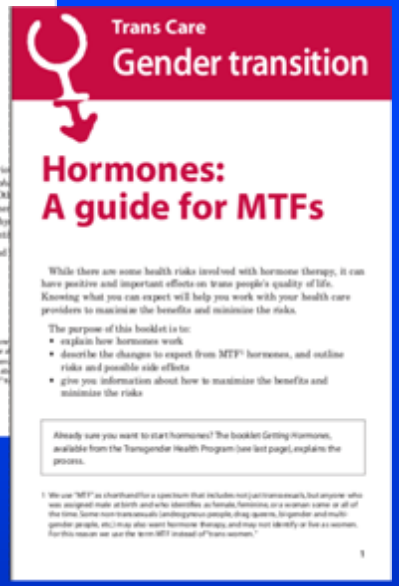
CAREERS
FOUNDATIONS
VOLUNTEERS
CONTACT VCH
Transgender Health
About
Programs & Services
Education & Support
Online Library
Frequent Questions
Resources
Contact
Hot Jobs
Transgender Health Program
Transgender Health Program Library
The Transgender Health Program was launched by Vancouver Coastal Health in June 2003 to bring together transgender people and loved ones, health care providers, health planners, and researchers to work on improving transgender health services in BC. We welcome anyone who has a transgender health question or concern. Our services are free, anonymous, and confidential.

Clinical Protocol Guidelines

- Care of the patient undergoing sex reassignment surgery (SRS) - 686K
  Cameron Bowman & Joshua Goldberg
- Caring for transgender adolescents in BC: Suggested guidelines - 877K
  - Clinical management of gender dysphoria in adolescents
    Annelou L.C. de Vries, Peggy T. Cohen-Kettenis, & Henriette Delemarre-Van de Waal
  - Ethical, legal, and psychosocial issues in care of transgender adolescents
    Catherine White Holman & Joshua Goldberg
- Counselling and mental health care of transgender adults and loved ones - 1030K
  Walter Bockting, Gail Knudson, & Joshua Goldberg
- Endocrine therapy for transgender adults in BC: Suggested guidelines - 1030K
  - Physical aspects of transgender endocrine therapy
    Marshall Dahl, Jamie L. Feldman, Joshua Goldberg, & Afshin Jaberi
  - Assessment of hormone eligibility and readiness
    Walter Bockting, Gail Knudson, & Joshua Goldberg
- Social and medical advocacy with transgender people and loved ones: Recommendations for BC clinicians - 975K
  Catherine White Holman & Joshua Goldberg
- Transgender primary medical care: Suggested guidelines for clinicians in BC - 1470K
  Jamie L. Feldman & Joshua Goldberg
- Transgender Speech Feminization/Masculinization: Suggested Guidelines for BC Clinicians - 844K
  Shelagh Davies, M.Sc., S-L.P.(C) & Joshua Goldberg



How does this all work?

- Consult with specialist for complex cases
- When you are starting your own practice, its OK to take easy ones who 'follow the SOC'

www.wpath.org

Typical Narrative ('following SOC')

- Accept your own trans identity and seek help
  - Internet, local groups, organizations
- Find a therapist and receive a dx (and letter)
  - 3 month 'Real Life Experience' **OR**
  - Psychotherapy (duration TBD, usually 3+months)
- Find a physician
  - Start hormone therapy
  - Non-genital surgery (same time as HRT)
- 1 year successful – genital surgery

Typical Narrative (following SOC)

- Does everyone do it this way?
- If they don't should you still treat them?

Harm Reduction

- WPATH-SOC explicitly endorse harm reduction especially with experienced clinicians

Medical Treatments: Fundamentals

- Set realistic goals
  - What will, might, and won't happen
- Emphasize primary and preventative care
- Use the simplest hormonal program that will achieve goals
  - Every option doesn't work for every patient
  - Cost, ease of use, safety

Medical Treatments: Fundamentals

- Patience is a virtue
  - Puberty comparison
  - Take a long term outlook – safety and efficacy
- Side effects are in the eye of the beholder
  - Baldness
- Screening:

Medical Treatments: Fundamentals

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Medical Treatments: Fundamentals

- Hormone treatments are one of the easiest parts
- FTM – Testosterone up to normal male dose
  - Dose that masculinizes and stops menses is enough
- MTF – More difficult because must suppress testosterone production to get best results
  - Anti-androgen(s) – Spironolactone most common in US
  - Estrogens titrated to higher than normal replacement doses for women (usually 3-5x higher)

Medical Treatments: MTF

- Estrogens at high dose
  - 3-5x normal female replacement doses
  - Partially to feminize
  - Partially to better suppress testosterone production
- Anti-Androgen
  - Spironolactone and others
  - Orchiectomy
- Results variable
  - Age at starting is important
  - Genetics plays a big part

Hormones: MTF - Estrogens

- Oral - $
  - Premarin 1.25 – 10mg/d (usual 5-6.25) $$
  - Estradiol 1-5mg/d (usual 2-4)

- IM – Delestrogen $$
  - 10-40mg q2weeks (usual 20)
  - Can't easily 'stop' in an emergency when patient immobilized
- Transdermal – Estradiol patch $$$
  - 0.1-0.3mg/day (1-3 patches/week – overlapped)
  - Probably the safest for transwomen predisposed to thrombo-embolic and CVD dz (age>40, smoking, FH, etc.)

Hormones: MTF - Estrogens

- Beneficial effects
  - Breast growth
  - Suppress androgen production
  - Change of body habitus (muscle and fat)
  - Softening of skin
- Contraindications/Precautions
  - Same as in cisgender women
  - Individual risk/benefits (MTF get greater benefits r/t mental health than menopausal cisgender women.)
  - In transwomen with absolute CI – at least suppress testosterone fully

Hormones: Estrogens Adverse Effects

- THROMBOEMBOLIC DISEASE
- Hepatotoxicity (especially ORAL) – incr TA, adenomas
- Prolactinoma (if dose is too high)
- Decreased glucose tolerance
- Lipid profile
- Gallbladder Disease
- Worsening migraine/seizure control
- Acne
- Breast Cancer
- Mood
- Decreased libido

Hormones: MTF - Anti-Androgens

- Antiandrogens - All
  - Decrease T production or activity
  - Slow/stop MPB, and decrease unwanted hair growth
  - Decrease erections/libido
  - Improve BPH
- Spironolactone 50-300 mg/d divided bid
  - Cheap, reasonably safe
  - Hyper-K+, diuresis, changes in BP
  - Decreased H/H (T → erythropoetin)
- Cyproterone

Hormones: MTF - Anti-Androgens

- 5-α-reductase inhibitors
  - Finasteride, dutasteride, etc
- Finasteride (Proscar/Propecia)
  - Stops conversion of T → DHT
  - 5mg tabs ≃ $1 generic
- GnRH Agonists
  - $$$$$$
  - Great for both gender adolescents because can fully suppress production of sex hormones

Hormones: MTF - Surgery?

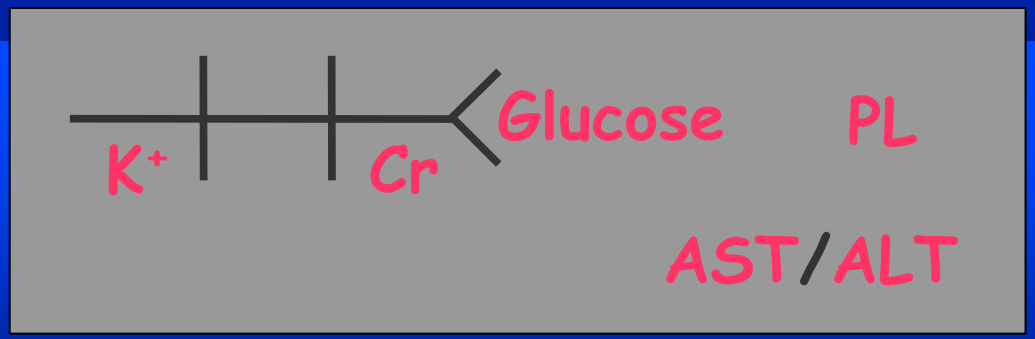
- Stop E two weeks before any immobilizing event (incl SRS) resume a week after ambulating regularly
- Continue (maybe increase dose) anti-androgen

Hormones: MTF - Monitoring

- Every Visit
  - BP, Weight, BMI
  - Safety
  - Mental health
  - General screening based on age, organ, gender, and sex appropriate norms
- Patient education
  - S/Sx of TEDz
  - Healthy Habits
  - Vision changes or lactation

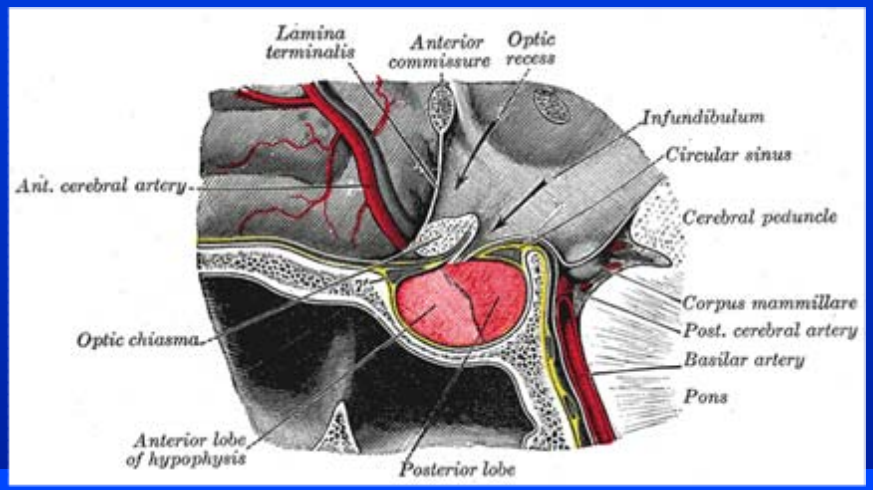
Hormones: MTF - Monitoring

- Clinical monitoring most important
- Same adverse events in cisgender pts w/ same meds (use what you know!)
- Labs
  - 0, 2, & 6 mo initially then (semi)annual or p changes
  - CBC, **CMP**, Lipids
  - **PL** and T

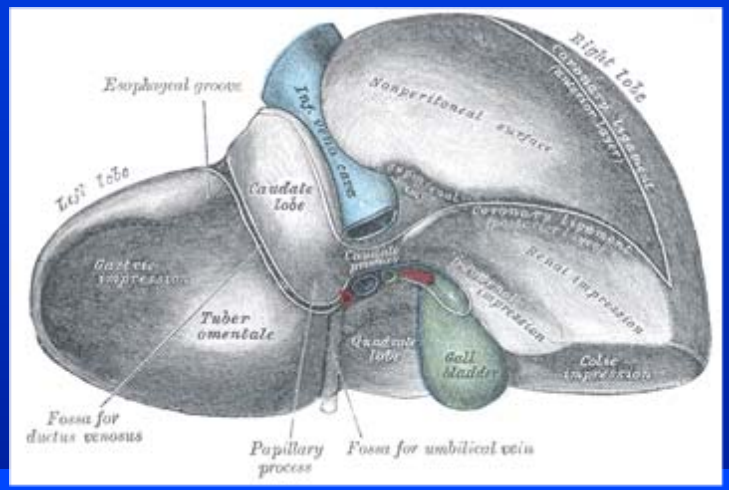


Hormones: MTF - Monitoring

- Pituitary Adenoma
- 1st Pass Metabolism



PL



AST/AST

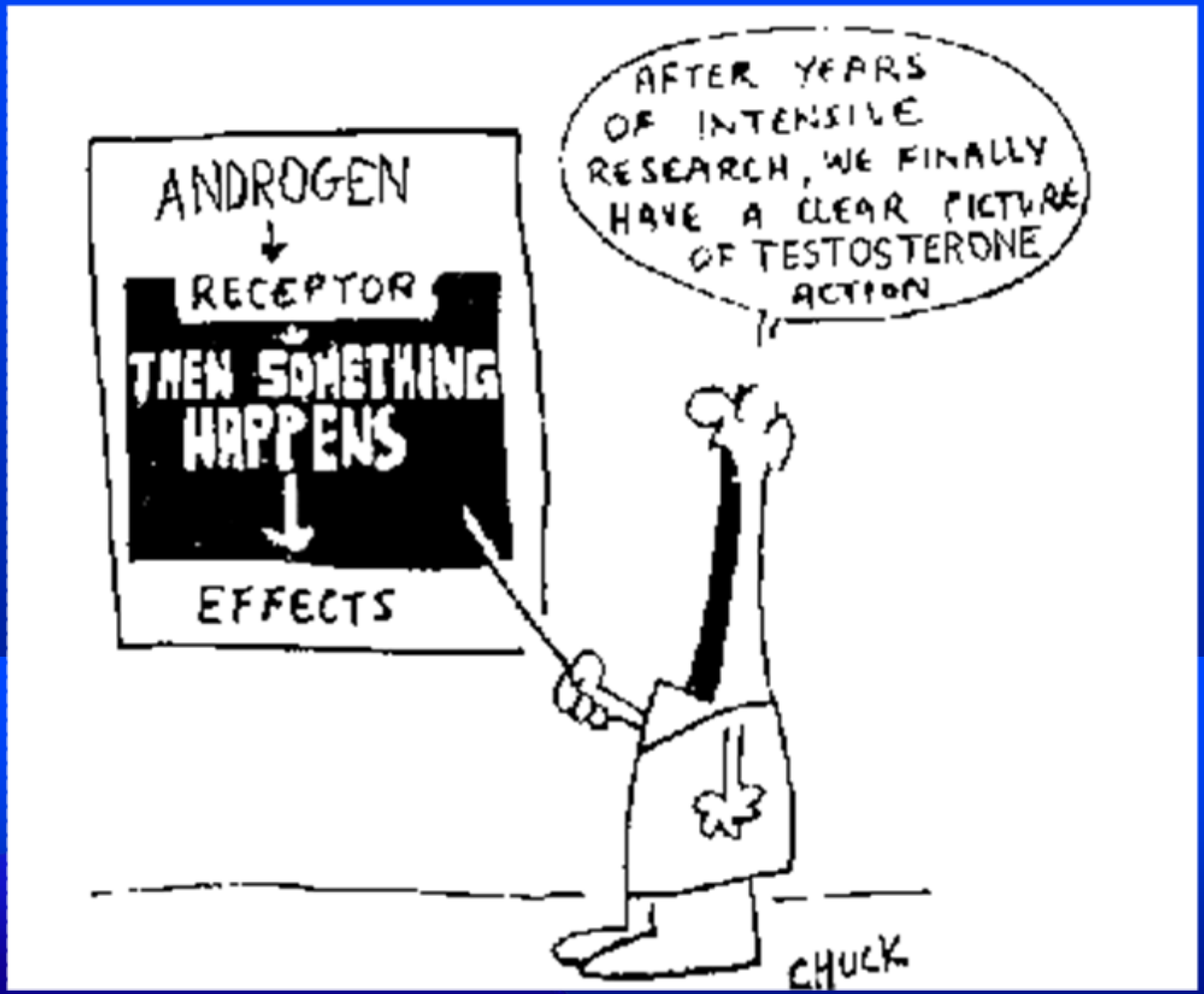
Hormones: MTF – Adverse effects

- Elevated PL: Stop Estrogens (not anti-androgen)
  - If levels normalize, resume E at lower dose
  - If levels remain high MRI to r/o PL-oma
- Elevated LFTs
  - Look for other cause!
  - If due to E, lower dose or stop until LFT normal

Hormones: MTF - Efficacy

- What is adequate treatment?
  - **Pt outcomes** – breast growth (peak 2-3 yrs), changes in skin, hair, fat/muscle, libido
  - The floor – testosterone levels (female range)
  - The roof – prolactin level
    - >20 possibly too much (ask @ 'extra' E use or other meds)
    - >25 probably too much
    - >30 definitely too much

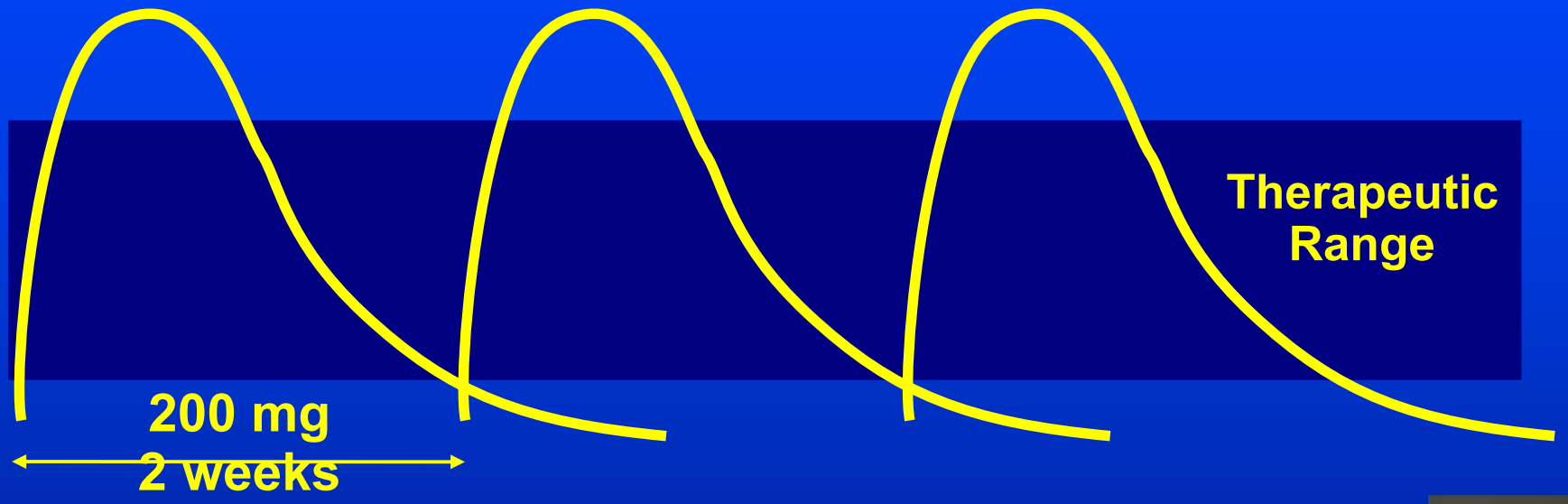
Medical Treatments: FTM

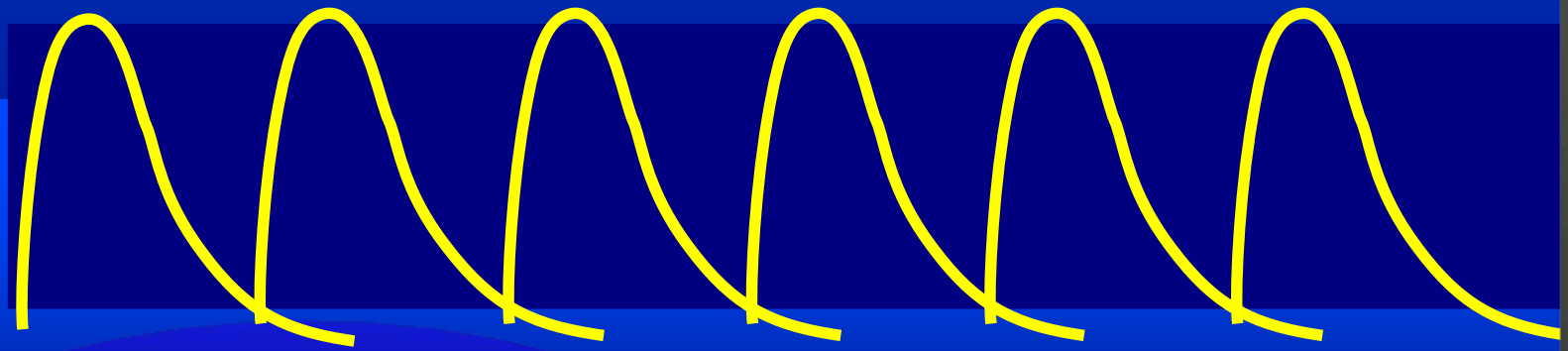


Hormones: FTM

- Testosterone Injected Esters (cheapest)
  - Cypionate
    - Cheapest - $60 for 10ml (~4mos supply)
  - Enanthate
    - Slightly more expensive
  - Other forms (Soon in US!)
    - Intramuscular testosterone undecanoate (Nebido)

Hormones: FTM





Hormones: FTM

- Transdermal
  - Expensive: $7 day retail, $1/day compounded
  - Less variable levels
  - Daily administration
  - Risk of inadvertent transfer to others

5%, 1g QD

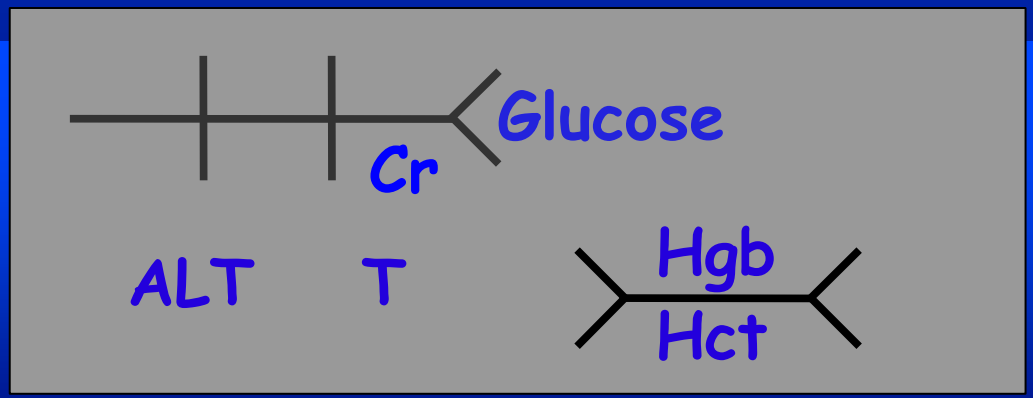
1%, 5g QD

Hormones: FTM - Monitoring

- Every Visit
  - BP, Weight, BMI
  - Safety
  - Mental health
  - General screening based on age, organ, gender, and sex appropriate norms
- Patient education
  - Vaginal bleeding
  - Healthy habits
  - Tx available for acne, MPB

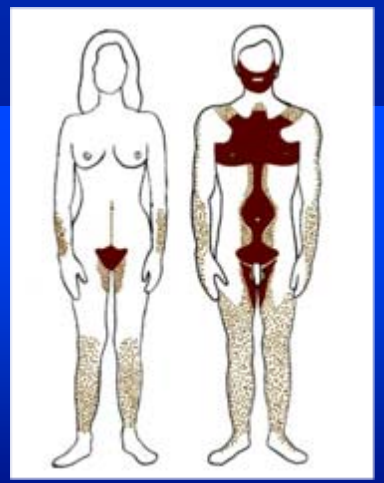
Medical Treatments: Fundamentals

- Clinical monitoring most important
- Same adverse events in cisgender pts w/ same meds (use what you know!)
- Labs
  - 0, 2, & 6 mo initially then (semi)annual or p changes
  - CBC, CMP, Lipids
  - T (trough) in FTM



Beneficial Effects (any delivery...)

- Voice deepening
- Change of body habitus
- Male pattern hair growth
- Clitoromegaly
- Amenorrhea
- Emotional benefits
- Enhanced libido



Hormones: FTM – Adverse effects

- Acne – MC side effect (chest/back)
- CV - worsening of surrogate endpoints - lipids, glucose metabolism, BP
- Weight gain
- Polycythemia (***normals for males***)
- Unmask or worsen OSA
- Enhanced Libido
- Male pattern hair growth and loss

Hormonal Treatments: Is this safe?

- Van Kesteren P, et al. "Mortality and morbidity in TS subjects treated with cross-sex hormones." Clin Endo (Oxf). 47(3):337-42.1997.
  - DESIGN: Retrospective, descriptive study @ university teaching hospital that is the national referral center for the Netherlands (serving 16 million people)
  - SUBJECTS: 816 MTF & 293 FTM on HRT for total of 10,152 pt-years
  - OUTCOMES: Mortality and mobidity incidence ratios calculated from the general Dutch population (age and gender-adjusted)

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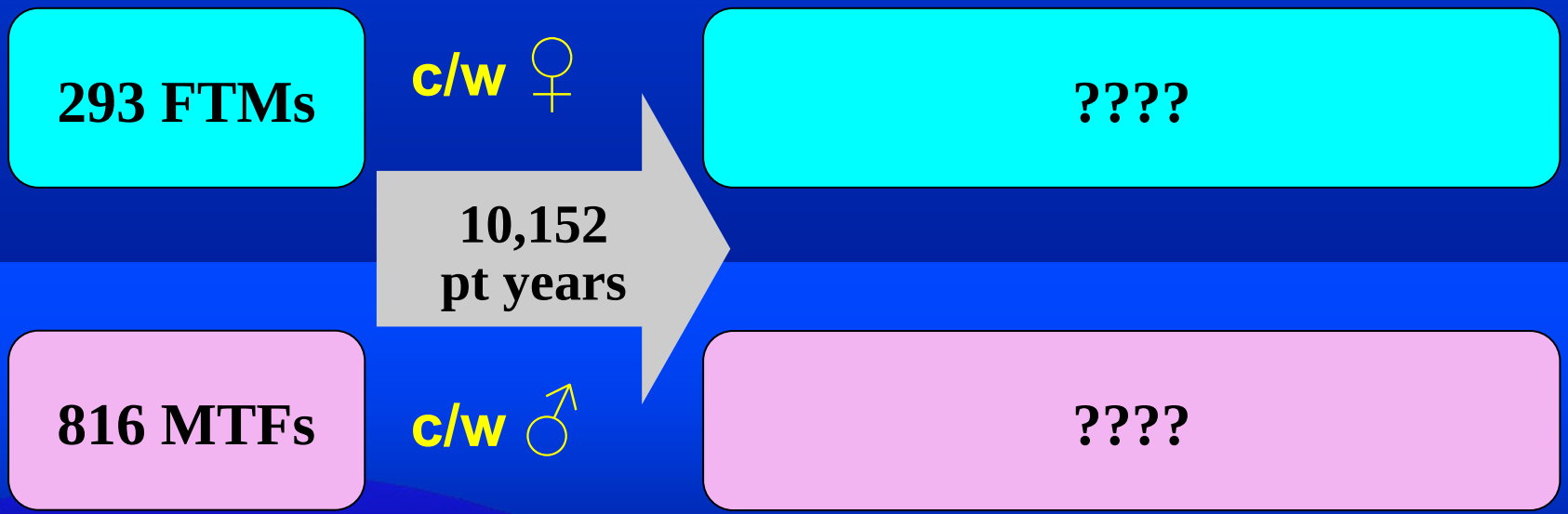

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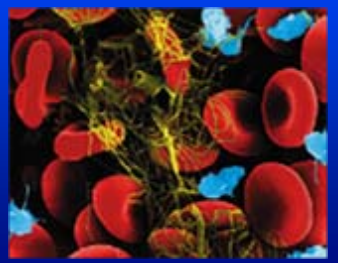
  - MTF/FTM total mortality no higher than general popl'n
  - Largely, observed mortality not r/t hormone treatment
  - VTE was the major complication in MTFs. Fewer cases after the introduction of transdermal E in MTFs over 40
  - In MTFs increased morbidity from VTE and HIV and increased *proportion of* mortality due to HIV

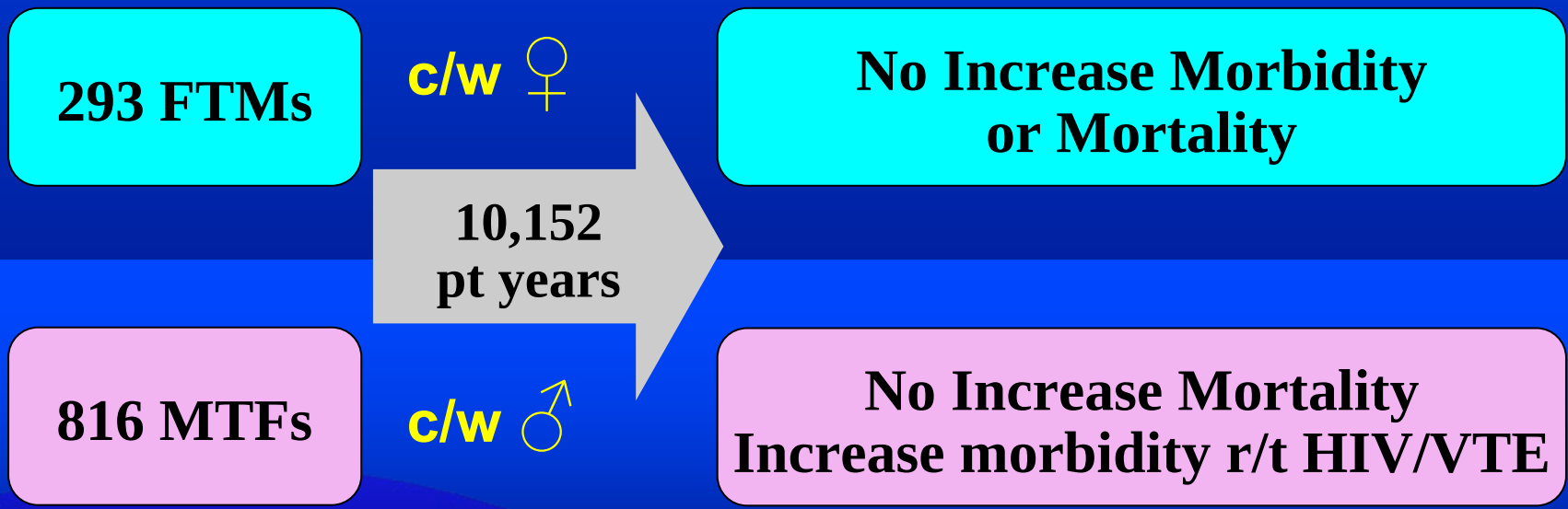
HIV



VTE

Hormonal Treatments: Is this safe?

- Van Kesteren P, et al. "Mortality and morbidity in TS subjects treated with cross-sex hormones." Clin Endo (Oxf). 47(3):337-42.1997.

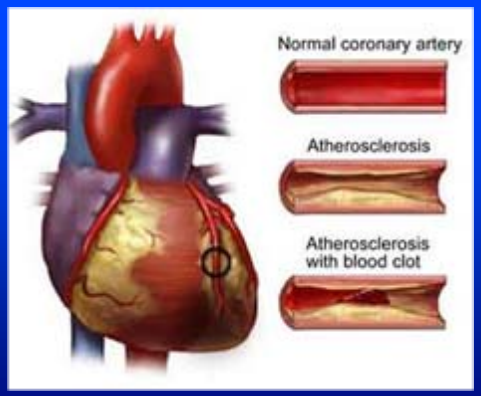


Hormonal Treatments: Is this safe?

- Gooren L, et al. "Long term treatment of TSs with hormones: Extensive personal experience." J Clin Endo & Metab. 93(1):19-25. 2008.
  - Same clinic group as 1997 paper – now 2236 MTF, 876 FTM (1975-2006)
  - Outcomes: M&M Data, surrogate markers assessing risks of osteoporosis and cardiovascular disease, cases of hormone sensitive tumors and other potential risks

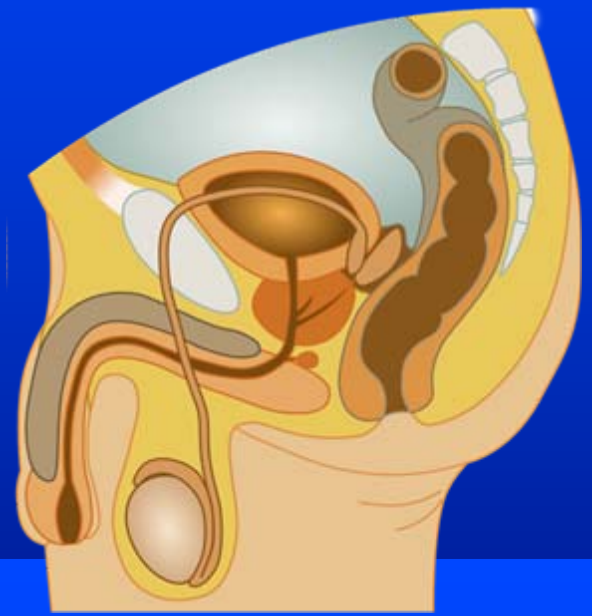
Hormonal Treatments: Is this safe?

- Gooren L, et al. Cardiovascular Risks
  - Analyzed studies of surrogate markers for CVDz in MTF/FTM: Body composition, lipids, insulin sensitivity, vasc function, hemostasis/fibrinolysis, others (HC CRP)
  - Some worsen, some improve, some are unchanged (overall worse)
  - MTF do worse than FTM
  - Hard clinical endpoints show no difference
  - Counsel patients about modifying CV risk



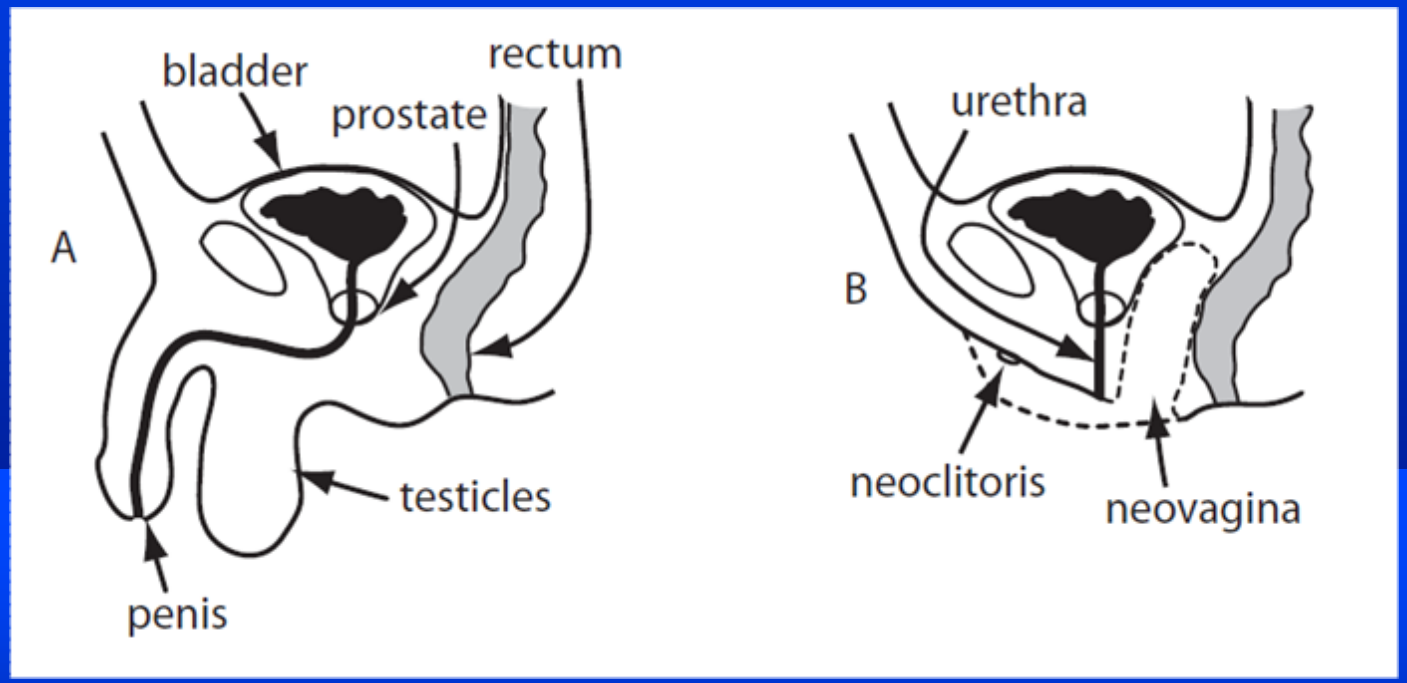
Hormonal Treatments: Is this safe?

- Gooren L, et al. Hormone Dependent Tumors
  - Lactotroph Adenoma
    - Extremely rare
    - Check PL!
  - Prostate Cancer
    - Prostatectomy is not a part of SRS
    - Screen based on the organs present
    - Screen based on individual risk factors
    - Withdrawal of testosterone may decrease but doesn't eliminate the risk of BPH and malignancy



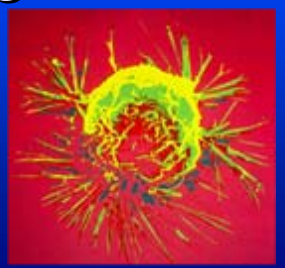
Hormonal Treatments: Is this safe?

- DRE is a little different



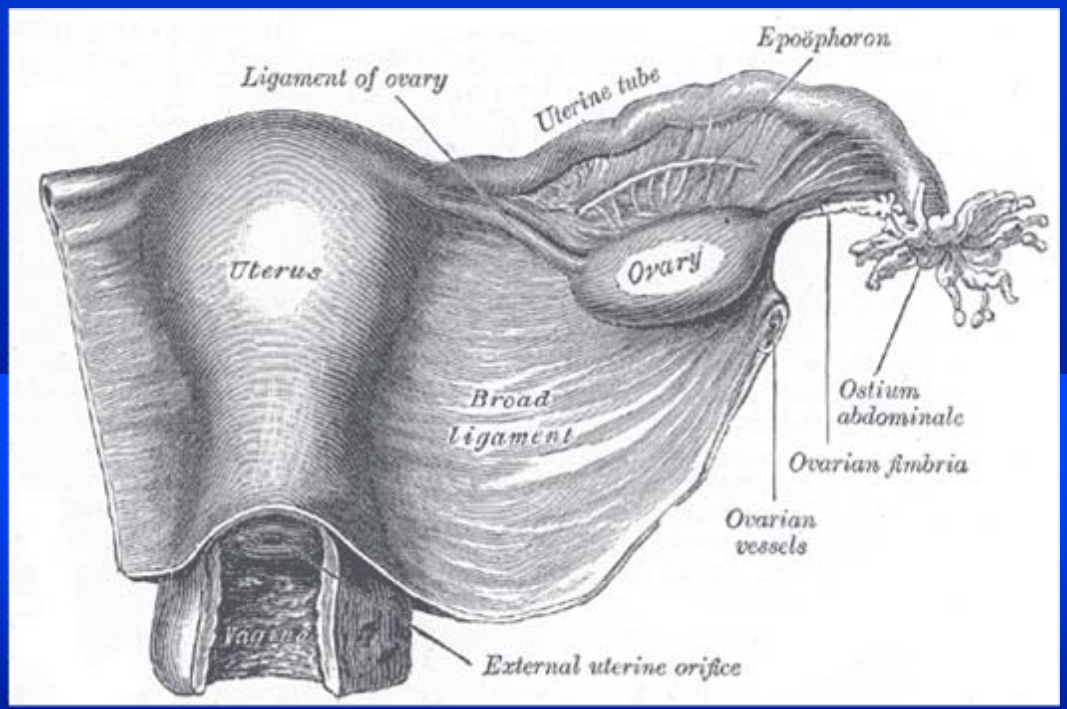
Hormonal Treatments: Is this safe?

- Gooren L, et al. Hormone Dependent Tumors
  - Breast cancer
    - MTF - Estrogen exposure: **dose** and **duration**
      - Conservative: screen as cisgender women of same age/risk
      - Progesterone increases risk
    - FTM
      - Reported in 1 case 10 years after mastectomy
      - Mastectomy reduces but doesn't eliminate risk
      - Some injected testosterone is aromatized to estrogen
      - Family history



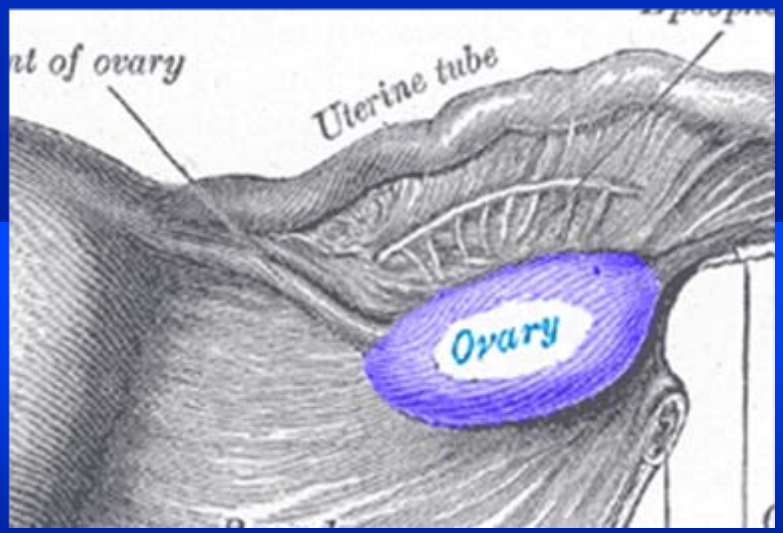
Hormonal Treatments: Is this safe?

- Gooren L, et al. Gynecologic Tumors
  - Gynecologic Tumors
    - Cervical
    - Ovarian
    - Endometrial

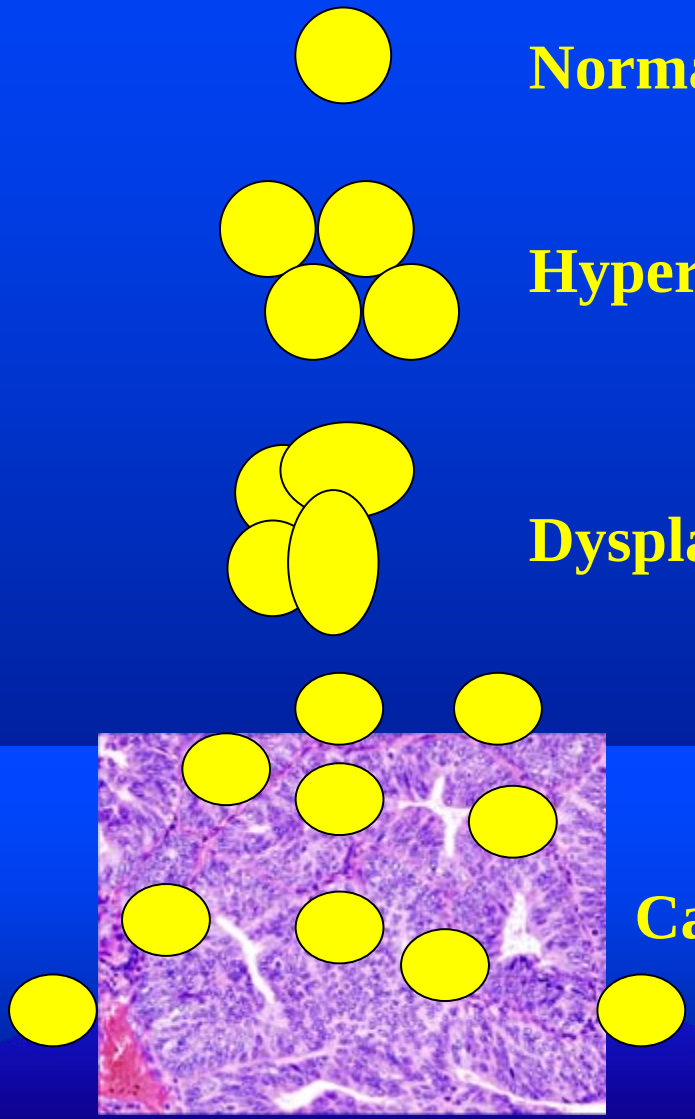


Gynecologic Cancer risks in FTMs

$$\frac{5 + ???}{???}$$



Gynecologic Cancer risks in FTMs



Normal

Hyperplasia

Dysplasia

Cancer

FTM

???

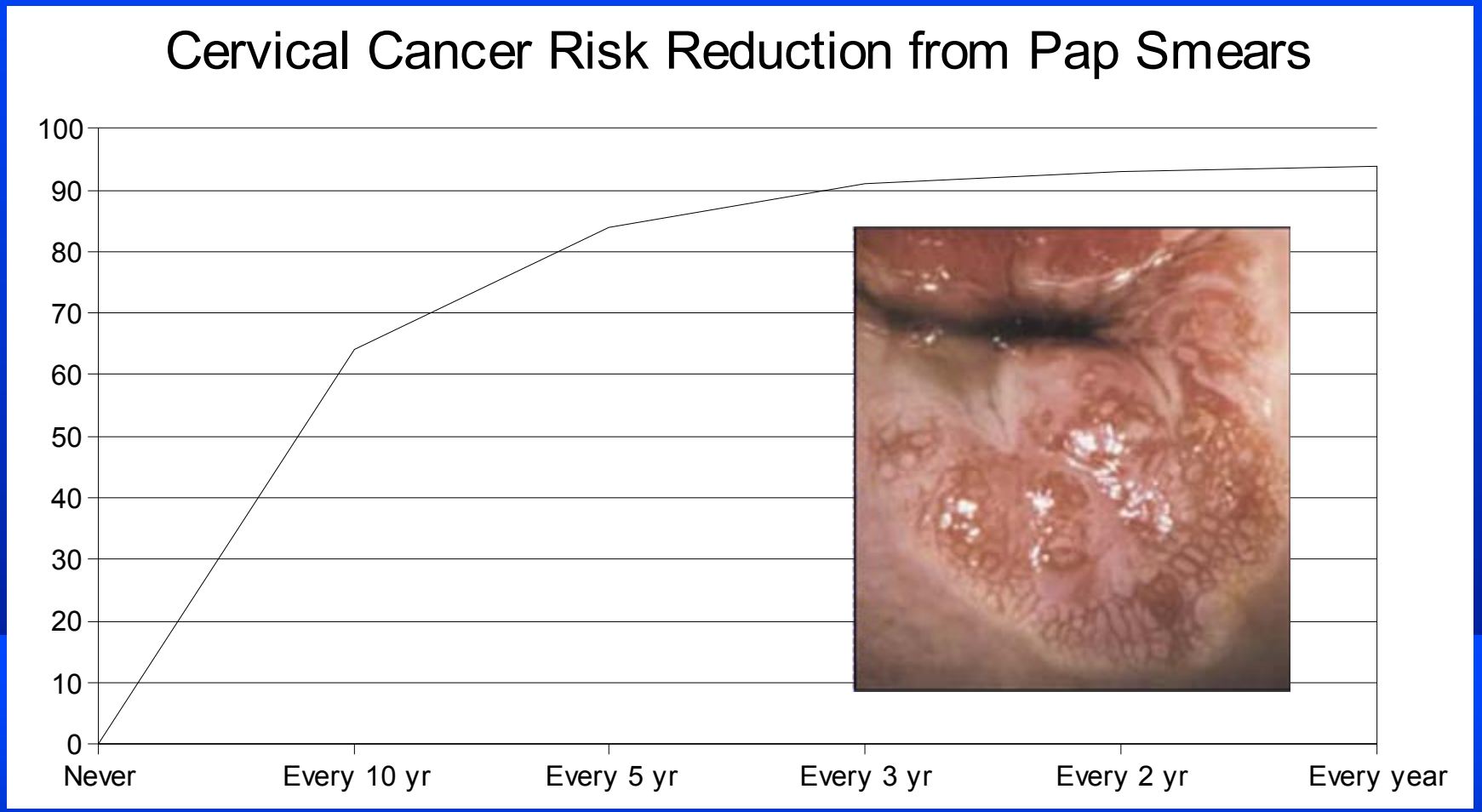
PCOS

If infrequent periods

ENDOMETRIAL CANCER (slight)

Gynecologic Cancer risks in FTMs

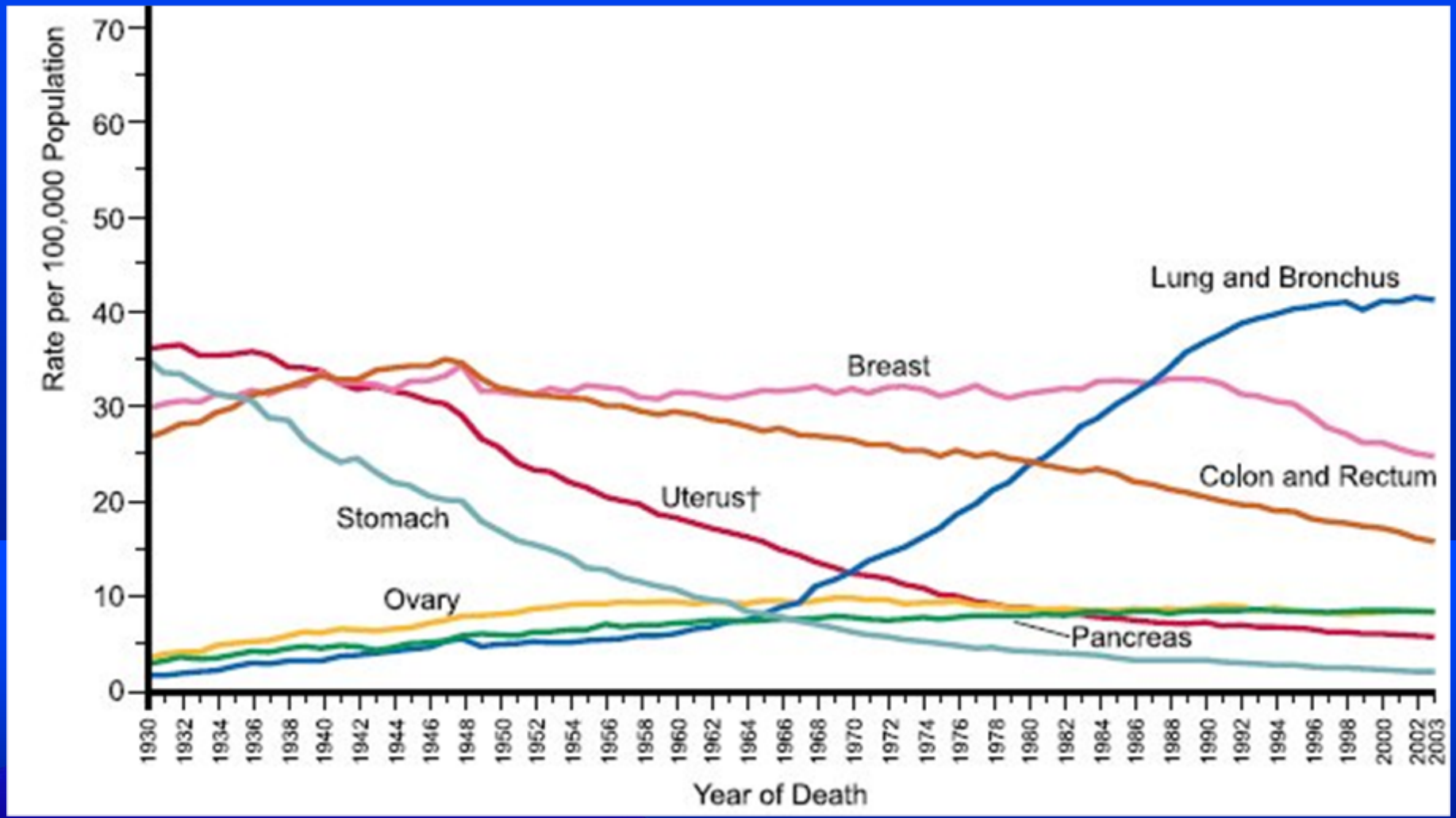
Gynecologic Cancer risks in FTMs



IARC Working Group on Evaluation of Cervical Cancer Screening Programmes. Screening for squamous cervical cancer: duration of low risk after negative results of cervical cytology and its implication for screening policies. Br Med J. 1986;293:659-664.

Gynecologic Cancer risks in FTMs

Gynecologic Cancer risks in FTMs



Is it effective?

- Suicidality decreased from 20-30% pre-treatment to 3% post treatment
- Decreased depressive symptoms, improved social functioning, regrets rare

The Hard Stuff: Advocacy

Insurance: Denial of Care

- Exclusions
  - Individual and small group
  - Larger groups
- De facto exclusions - Medicaid
  - Title XIX: Medicaid agencies "may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition" (§440.230(c))

Insurance: Denial of Care

- Medicaid Denials
  - Not medically necessary
  - Experimental
- AMA Policy Statement

2008 AMA Res 122

- Whereas, Gender Identity Disorder (GID) is a serious medical condition recognized as such in both the DSM-IV-TR and ICD-10
- Whereas, GID, if left untreated, can result in clinically significant psychological distress, dysfunction, debilitating depression and, for some people without access to appropriate medical care and treatment, suicidality and death
- Whereas, An established body of medical research demonstrates the effectiveness and medical necessity of mental health care, hormone therapy and sex reassignment surgery as forms of therapeutic treatment for many people diagnosed with GID
- RESOLVED, That the AMA support public and private health insurance coverage for treatment of gender identity disorder; and be it further
- RESOLVED, That the AMA oppose categorical exclusions of coverage for treatment of gender identity disorder when prescribed by a physician

Insurance: National Health Care??

- Medicaid???
- Exclusions like the Stupid Stupak Amendment?

504 261 8379
nick@lyon-martin.org

Identity Documents

- Identity documentation change is one part of the medical treatment for GID
- Lack of appropriate ID
  - Vulnerability to interpersonal violence
  - Inability to
    - Get a job
    - Make a purchase with a credit card
    - Board a plane
    - Enter a federal building
  - Voluntary withdrawal from activities

Supportive Letters

- There are no gender cops
- Its not your job to enforce bad policy
- Your job
  - Advocate for your patients needs
  - Don't lie
  - Give your true medical opinion
  - Don't write something if you don't have experience

Supportive Letters: a thought experiment

- You are a doctor in NC in 1950. An 18 year old young man who is your patient asks you for help. He is white, but his great grandfather was African American. He was accepted to attend UNC-CH, but an anonymous letter to the school revealed his heritage. He was told he must provide a letter from a teacher, doctor, or minister verifying he is white to be allowed to enter UNC.

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- You're pretty advanced for the 50's and understand race as a social construct and believe he really is white.... but know that UNCs policies and understanding of race would exclude him.

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- You're pretty advanced for the 50's and understand race as a social construct and believe he really is white.... but know that UNCs policies and understanding of race would exclude him.
- Do you write the letter?

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  - **Don't write something if you don't have experience**

Supportive Letters

- I am a physician licensed to practice medicine and surgery in the state of California.
- John Smith is a patient in my care at LMHS
- In my medical opinion Mr Smith is a transsexual man.
- I have determined that his male gender predominates and have provided him with appropriate and irreversible sex reassignment treatments.
- (In addition, he has undergone irreversible sex reassignment surgery that I have verified by my own examination.)

Supportive Letters

- As a result Mr Smith has completed all necessary medical (and surgical) procedures to fully transition from female to male.
- He should be considered male for all legal and documentation purposes – including drivers license, birth certificate, passport, and social security records.
- Indicating his gender as male is accurate and will eliminate the considerable confusion and bias Mr Smith encounters when using identification that does not reflect his current true gender.

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