REPORT FROM THE HEALTH LAW PROJECT

Saturday, August 28, 1993

Second Annual International Conference on Transgender Law and Employment Policy

PROJECT DIRECTOR: Martine Aliana Rothblatt, Attorney, Health Law Project Director, ICTLEP

By Phyllis Frye:

I was handed an interesting little quote of the day. Essentially it says about civil rights, that you either have your civil rights or you don't have your civil rights. It's kind of like being pregnant. You can't just be a little pregnant. So you either have your civil rights or you don't have your civil rights. Courtesy of Mary Elizabeth.

We are now going to begin the Health Law report. When I conceived of the first conference on transgender law, I knew very little of Health Law. Actually I knew nothing of Health Law. I included Health Law, because I had a good acquaintance who taught health law, and I had hoped I might be able to get her involved. It turned out the Health Law Project is probably going to stand equal in stature to the Employment Law Project of our law conference.

The basis of our legal woes seem to stem from defacto health law and the absence of statutory health law. Therefore, it seems, we're writing on a clean slate, which is rather refreshing, sometimes.

Martine Aliana Rothblatt, Attorney, Health Law Director, ICTLEP, being introduced by Executive Director

Martine Aliana Rothblatt is a truly dear person. She volunteered to be the Health Law Director, and I was frantically searching for one. She's taught me very much. Come on up Martine. She is truly a brilliant person. I know it makes her blush, but she is. When she sent me the draft of the

second report, I was just blown away. It was so precise, and brought so much together, and was very creative.

By Martine Aliana Rothblatt:

Thanks a lot. I'm very glad to be here and have this opportunity to talk about health law and in particular to relate to everybody the outcomes of our health law committee deliberations over the last couple of days. We had a committee meeting on Thursday and Friday and at the committee meetings we said at the outset that we would break our agenda into two parts.

In the first part of the agenda which we did Thursday, we'd have a wide ranging discussion of what is transsexual and transgender health law, what they should be, what are some of the problems and communications that we're facing, what are the strategic issues in transgender health law. We were able to have some written reports to begin the discussions. Some were FAX'ed comments from people like JoAnn Roberts of Pennsylvania and Dallas Denny and some were discussions from people who came to participate in the committee meetings.

Our second agenda item, which we did on Friday, was to develop a set of health law standards of care for the medical treatment of persons involved in a transgendered or transsexual health law program. It was hoped that these standards of care would be distributed to the medical practitioners in the field, and that each year at the transgender law conference, we would review and update, amend as necessary, the standards of care so that they always were as progressive and helpful and meaningful and useful as possible. So that was our agenda for Friday. And I'm very happy to say that we really did accomplish our entire agenda.

On Thursday we had a wide-ranging discussion of health law. I'll briefly now summarize some of the different points of view that were expressed. And on Thursday, we did a line by line editing and drafting of a set of health law standards of care. We ended up with a document called the Health Law Standards of Care consists of five principles and then five standards. And we reached a complete agreement by everybody who was in the meeting on Friday. We now believe that these can be published and distributed by the International Conference on Transgender Law and Employment Policy. They can begin to, at a minimum, compliment the well known Harry Benjamin Standards of Care, and perhaps eventually, even supplant them as being the principal reference for medical practitioners dealing with transgendered patients. We accomplished our agenda so we can give all ourselves a big pat on the back.

Let's start with what we did on Thursday which was basically a wide-ranging discussion of Health Law. One point that came out quite clearly from Thursday's discussion was that transsexualism was not a mental illness even though that is a wide ranging view in the health law field today. We felt that if there was mental illness in transsexuals, then it was caused by the tremendous discrimination and unacceptance that transgendered people are faced with by society. In essence, it was society that was ill in their treatment of transsexuals. All that transsexuals were doing was reflecting that bigotry and anger and hatred, and that's going to confuse the heck out of anybody. It is much like the psychiatric community finally realizing around 1980 that homosexuals were not mentally ill, as they previously thought, but instead, in the words of the APA, American Psychiatric Association, "Homosexuals were ill in terms of the discrimination that they faced from society." So that was an important point that was developed on Thursday.

Another important point that was developed on Thursday was that it was very important to have insurance, as available as possible, to the transgendered patients in their quest for one form or another of sex modification therapy.

Following from that point of view, it was agreed that there would obviously have to be some kind of diagnostic hook, if you will, a diagnostic checklist or a diagnostic measure of some sort or another for transsexualism. If there is insurance, that means that somebody is paying, and if somebody is paying — just like

if you go to buy something at the store, you want a receipt — they want to know what it is they're paying for. No one is just going to be just giving a blank check to have some kind of surgery that you want to have. So, it was realized there would have to be some kind of diagnostic measure, although there was a very across the board unacceptance of the current diagnostic measures which are mental illness.

So, we had a very healthy discussion of different types of diagnostic measures of transsexualism as a medical condition that might be available. Let me basically just mention I think three main themes that came out. There really wasn't any resolution on this point. We will probably carry this discussion over to next year but some good views were expressed and debated.

One approach was that transsexualism could be looked at as a congenital medical condition, such like many other congenital medical conditions, whether its that your heart doesn't pump blood the way ninety-nine percent of people's hearts pump blood, or the way you speak, or the way you hear, or the way you see is not the way ninety-nine percent of the population speaks or hears or sees. Therefore you have a right to medical intelligence to bring your anatomy into conformance with how you would like that anatomy to be brought into conformance. So one way you could analogize transsexualism is as a kind of medical condition where you would go to a doctor. The doctor would say, "Yeah, you have this congenital medical condition." In a better, more humane, more insured world, these people can conceivably access health insurance to pay for either hormonal or surgical sex reassignment.

A second approach was what I would call more of a holistic health approach. This approach basically would steer away from calling any transsexualism any kind of a defective kind of condition or abnormality. It would say that a certain percentage of the human race is transgendered. This is, if you will, in the words of one of the articles quoted in the draft report, "A risk the human species is subject to without saying it's a bad risk. It's just some percentage of the population is transgendered." A person goes a doctor saying, "I'm transgendered, I would like to have my body modified in some way to conform to my self image." That should suffice as a diagnostic hook for a doctor to say that his person has a medical — medically necessary reason without saying the person is abnormal or defective or mentally ill in any way.

With regard to the concern of, "Wouldn't the whole population rush in and ask for sex reassignment surgery?" I think we all realize that the absurdity of that question answers itself and insurance would not have to worry about that. By the way that point did come up in our very international health law draft report. We don't have the time now to present all the different countries' laws that we discussed. Hopefully, in the "Proceedings", the whole report can be there.

The Netherlands passed a very progressive health law dealing with transsexuals. The Netherlands is one of the countries that does have a transsexual health law. In the Netherlands, the government funds all sex reassignment surgery and hormone surgery as the government funds all medical care. Transsexual care is medically necessary.

What's unique is that, in the other countries in Europe which have a transsexual law — there are five countries in Europe which have a transsexual health law — all those other countries limit the right to transsexual surgery to citizens of that country. The Netherlands is unique in that all you have to do is be resident in the Netherlands for one year. If you're resident there for one year and, under the Netherlands law, if two medical experts — and it does not require them to be psychologists by the way — state that this person is a transsexual, then the government in the Netherlands will pay for sex reassignment surgery.

There are a lot of jokes and serious concerns at the time this law was being debated in the Dutch legislature that the Netherlands would become a magnet. Transsexuals throughout the world would flood into the Netherlands and drain the Dutch state's coffers of all of their money. Suffice to say that has not occurred. About a quarter of the Dutch transsexuals are not Dutch born and three quarters of them are Dutch born. By the way, I have met some Dutch transsexuals that are very, very happy people because of being able to avail

themselves of surgery in Holland whereas they would not have been able to afford it in their native country. So, I think Holland has a well deserved reputation for humaneness and this is another very nice example of it.

On the third approach on the diagnostic hook for transsexualism, it was very clear in the committee reports that these diagnostic hooks should not be some kind of empirical measure of a person's brain cell structure. This is important because there is a rising view, in the field of neuro-anatomy, that perhaps by mapping a person's brain cell structure we can really decide that person's entire being, and we can explain a person's behavior based on their brain cell structure. That's basically a view.

Because transsexualism is also viewed by some people as a kind of intersexuality, where instead of being intersexed with parts of a vagina and parts of a penis on the same body, you're intersexed with parts of a quote "feminine brain structure" unquote and parts of a male quote "body structure" unquote. Perhaps a doctor would say, "We will have to measure your brain cell pattern and if we determine your brain cell pattern is a feminine brain cell pattern, then you are a transsexual."

The health law committee was very negative on this sort of thing ever occurring. That should definitely not become any kind of a diagnostic hook for saying a person is or is not a transsexual. The reason for that wasn't just a point of view. We exhaustively discussed it in the health law committee. The reason for this is that there's not a shred of evidence that you can separate all of the people in the world into people having female brains and people having male brains. Instead there's a continuum of brain types, a continuum of body types, a continuum of morphologies, a continuum of personalities across all genders and it would be absolutely ludicrous to think that you can look at a person's brain cells through some enhanced CAT scan and say that that person is one gender or another.

Two other points arose on Thursday which I'd like to mention before going into the standards of care. One, we had an incipient discussion on the causes of transsexualism. It really wasn't much in our mandate, but I would like to say that there was discussion of very divergent points of view. There was wide disagreement and a healthy discussion. I think I simply should just reflect that one point without going further into it.

We did not resolve why there are transsexuals. We did agree there have always been transsexuals. Thank God for the world that there are transsexuals, and it's a beautiful thing to be.

Lastly, point two, we noted that whatever we do in this committee with regard to standards of health care, and whatever we do with regard to health law, we have to be cognizant that the entire health law regime in this country is quite possibly going to be changed in a very significant fashion because of the Clinton Health Reform Initiative. It's very important I think. We didn't want to get too much into the Initiative because most of us know these initiatives will really be fully debated in Congress starting in the Fall, and we really don't know all the contents of what's going to be proposed. Whatever is proposed it is almost certain that transsexual health care will be affected in some way or another. So it's important that at next year's health law conference we reevaluate what we've done in light of the legislation which results from the Clinton Health Care Initiative. So that was pretty much our discussion on Thursday.

On Friday, we sat down to do sort of a line by line drafting of a set of "Health Law Standards of Care for Transsexualism." Even though these will be in the record, I think I'll more or less read some of them verbatim so that we have a flavor of it and maybe if something is not clear I'll stop and discuss it for a moment. As mentioned, we developed five principles and five standards of care. It's our goal that we would distribute these to the health care practitioners in the field. We'll publish them in a nice little, lithograph pamphlet, nothing fancy. There is an upcoming meeting of the Harry Benjamin Association in New York in October. I think it's very important for us to get these standards of care printed and published before then and to be "in their face" in October in New York.

Principle 1: Transsexualism is an ancient and persistent part of the human experience and is not in itself

a medical illness or mental disorder. Transsexualism is a desire to change the expression of one's gender identity.

Principle 2: Persons have the right to express their gender identity through changes to their physical appearance including the use of hormone and reconstructive surgery.

Principle 3: Persons denied the ability to exercise control over their own bodies in terms of gender expression through informed access to quality medical services may experience significant distress and suffer a diminished capacity to function socially, economically, and sexually. The purpose of that principle is to put the medical practitioner on notice that by denying a person, who's a transsexual, health care, they are in fact causing a harm or may be causing a harm to that individual.

Principle 4: Providers of health care including surgical services to transsexuals have a right to charge reasonable fees for their services, to be paid in advance and to require a waiver of all tort liability except negligence.

Principle 5: It is unethical to discriminate in the provision of sex reassignment services based on the sexual orientation, marital status, or physical appearance of the patient. I think this principle is a very important principle, because there is a wide ranging sexism in our society.

Many, many transsexuals suffered badly in the sixties and seventies from gender identity centers where they went in to have sex reassignment and some were told, "Well, you don't look feminine enough. Your high heels aren't high enough. You're too tall to be a woman. You're too ugly to be a woman." And vice versa for female-to-males. And it was a really terrible example of sexism at its worst. It was the kind of attitude that gave people like Janice Raymond some credence to go by. It seems like these male doctors were trying to create feminine and male stereotypes of people. We want to make it very clearly that it is very unethical to judge, by a person's appearance, their gender identity and to refuse them any kind of health care.

I'd next like to go through the five standards. Given those five principles, there are then five standards of care. The structure for these standards of care: two of the standards of care deal with hormonal sex reassignment, meaning simply prescribing hormones to a patient to affect the change to anatomy, and two of them deal with surgical sex reassignment, meaning some type of surgical alternation of the anatomy. So there's two for hormones and two for surgery and then one dealing with confidentiality. The reason there's two for each pair is one deals with what the physicians do to you as the patient and the second one deals with what the physician's obligation is. One says the conditions under which a physician should offer therapy services: the second deals with what information the surgeon should give to the patient. That's the way it's structured.

Standard 1: Physicians participating in transsexual health care shall provide hormonal sex reassignment therapy to patients requesting a change in their sexual appearance subject only to (1) the physician's reasonable belief that the therapy will not aggravate the patient's health conditions, (2) the patient's compliance with periodic blood chemistry checks to ensure continued healthy condition, and (3) the patient's signature of an informed consent and waiver of liability form. If the patient is married, the physician may not require divorce, but may also require the spouse to sign a waiver of liability form.

So that deals with the hormonal sex reassignment and the physicians duty. It's not a hormones-on-demand situation. Some people, you know, throw that in our faces as kind of a red flag. It's not a hormones-on-demand, and it's not a hormone subject-to-gate-keeper control either. It's a fair, reasonable and reciprocal relationship between the patient and doctor to allow the patient access to health care to allow that patient to achieve a greater degree of holistic health.

Standard 2: Surgeons — note the first one applied only to physicians — Surgeons and physicians participating in transsexual health care shall provide sex reassignment surgery to patients requesting a change

in their sexual appearance subject only to (1) the surgeon's reasonable belief that the surgery will not aggravate pre-existing health conditions, (2) the surgeon's reasonable determination that the patient has been under hormonal sex reassignment therapy for at least one year, and (3) the patient's signature of an informed consent and waiver of liability form. If the patient is married, the surgeon may not require divorce but may also require the spouse to sign the waiver of liability form.

Here again it's not a surgery-on-demand situation, and it's not a surgery subject-to-two-years-of-psychiatric-gate-keeping situation. It's a reasonable, reciprocal relationship. The reason for the requirement of one year hormonal therapy prior to the sex reassignment surgery is because, in all of the articles written by surgeon's performing sex reassignment surgeries, they all emphasize that it's really a part of a comprehensive therapy that begins with hormonal therapy so that the hormones make the sex reassignment more successful. Of course every surgeon wants to have a successful result as, of course, do the patients.

Also, it's very well known in the field that many patients, many transgendered patients, are fully satisfied with hormonal sex reassignment and never feel a need to go on to surgical sex reassignment. So that is kind of two birds killed with one stone built into the standard of care.

Let me now talk about the two standards dealing with the informational requirements. Again, the wording is very similar, one deals with hormone therapy and the other with standard surgery.

Standard 3: Physicians providing hormonal sex reassignment therapy shall collect and publish on an annual basis the number of hormone prescriptions they have issued and the number and general nature of any complications and complaints involved. The publication requirement of this standard shall be satisfied by providing the collective statistics, in writing, together with other current information on the potential risks and complications of sex hormone therapy, to all prospective patients inquiring into the physician's hormone therapy services.

So, basically what this says is that every time the physician issues a prescription, through a transgendered patient, they keep a record of it. Every time the patient has any kind of complaint or complication, the physician keeps a record of it. Every year the physician publishes a compilation, "I've issued this many prescriptions. I've had this many complications and this is the break down percentage wise of complications," such as elevated blood pressure, whatever might be the complications. They issue that document together with a written explanation of all the currently known risks and complications of hormone therapy to all perspective patients inquiring about this.

This information, as compiled from the different doctors and surgeons participating in transgender health, care can then be compiled by our own kind of consumer reports organizations like "Chrysalis" and "Tapestry" and be available to the community at large. I'm not going to read the one *[Standard Four]* for the surgical because it's the same wording as this one except it applies to surgical and the whole standards will be in the "Proceedings" I'm sure.

Then there is Standard Five, a confidentiality provision. Physicians and surgeons shall not divulge the name or identity of any patient requesting or receiving sex reassignment services except as explicitly directed in a notarized written request by the patient. So, I think that makes sure that it's the patient themself, since it's notarized, who's requesting information and does all we can to avoid inadvertent disclosure of confidential information regarding who did or didn't have sex reassignment surgery.

In addition to that the standards of care are included two standard form consent and waiver forms that doctors can use. These are uniform and standard throughout the country, and doctors could use these and feel confident that they would be insulated from any tort liability other than negligence. These forms have been reviewed both by other attorneys and have passed a litmus test of having academics review these forms and opining in law review articles that is highly unlikely that anybody could succeed in a final court judgment of

liability if these forms were used and executed by a sex reassignment surgeon.

In conclusion, transsexualism is a normal part of human social biological diversity stretching back thousands of years and spaning the entire globe. Modern technology has now permitted transsexuals to express our sexual identity with great effectiveness just as technology has permitted gifted artists, or engineers to express their identities with unprecedented impact. Gender creativity is our special skill. The use of biotechnology to express sexual identity is a private matter with no harmful effects on other people.

Nevertheless, a quasi legal regime has evolved over the years that unfairly impede transsexual endeavors with a mental health label and yoke. The only possible reason for this impedance is that transsexuals challenge deeply rooted sexist and heterosexist belief systems which seek to protect the integrity of these patriarchal belief systems while still dealing with the unending reality of transsexualism. Currently society tries to say the transsexual is crazy and that sex changes will be allowed only as a cure for mental disorders not as an open expression of sexual identity.

But now this is set to change. This conference is a very important part of that change. Following the lead of other oppressed minorities, transsexuals are moving from invisibility and shame to empowerment and pride. Liberated from a mind set of disability, the health law standards of care proposed at this conference will further free transsexual expression from mental health professionals. As time goes on, ever growing numbers of transsexuals will help engender a revolution in human expression. This revolution will achieve the freedom for people to navigate their entire personality not just those roles which are permitted based on a label imposed at birth. The liberal achievement of our new level of wholeness and self actualization is the ultimate goal of transsexual health law. Thank you.

NON-OPERATIVE TS: CLITORAL HYPERTROPHY

By Phyllis Frye:

I wanted to add a few things for several reasons. One reason is that we do have time to do it and two is that I told you she was brilliant. She threw it all together in just a few minutes. I want to explore a little bit more of this notion of the hormonal SRS and the surgical SRS.

We are continually evolving in our language and in our definition of ourselves. This is extremely critical because, heretofore, we, of the transgender community — be we cross dressers or what some people call transgenderists, whatever our frequency of cross dressing might have been, whether we are preoperative, postoperative, whatever — we've always been defined by people who study us, but not by anybody who is us. They don't know what we're going through. And it seems to me that back when this was still experimental and still new that the doctors — and I'm not fussing at them — didn't know who we were and they didn't know what we were going through.

There was even more sexism then than there is now. So they saw someone who appeared to be a man and who had male genitalia and they wanted to make someone who appeared to be a woman and appeared to have a women's genitalia to fit the stereotype and to keep the sexes polarized. So they came up with the fact that you either go through the surgery or you're not part of the program. You either wear your high heels or you're not part of the program. You really look femme or you're not part of the program.

Of course there's a reverse side. We should not always give it as a "reverse" side and not always as a second comment, but there is the entire other half of our community. It is surfacing. It is the female-to-male community and they still have the same stereotypes to struggle through.

I have been very privileged in that my spouse did not leave, but she stayed with me through my transition. She said that she may leave sometime; she wasn't sure, but she wasn't going to leave now. She gave me time; I didn't have to rush; I began to discover, within myself, that the hormone change was sufficient. And she still tells me that any time I feel that I absolutely have to have the surgical change that I can have it and that she will stay with me.

I don't want this to be misconstrued. I will say several times I don't want this to be misconstrued. I will stand for and I will fight for, I will storm barricades, I will do everything I can, legally, to ensure that the right of someone who wants surgery, who feels that they have to have surgical intervention, to get it.

I feel that because we were not given the choice of being a nonoperative transsexual that a lot of people have unfortunately rushed into surgery that surgery wasn't right for. This is not to detract from the people who did surgery and surgery has been right for them.

We are developing, what you've called properly and very efficiently, the hormonal SRS and the surgical SRS or what I'm calling the nonoperative transsexual and the postoperative transsexual, respectively. I want to make sure the listeners to the tape and the audio and the readers understand what I've discussed with Martine and I've heard from others. When society recognizes you as being a transsexual, at that point, you are preoperative; you're beginning to live in your preoperative role. You are going through your true life test, and you remain preoperative and on your hormones going through your voice therapy and electrolysis, etcetera, etcetera. And also for the female-to-male are the breast reduction, hysterectomy, things like that.

Until you decide you are always preoperative. When you decide that you are going to going to go for the surgery, you are postoperative once you have that surgery. Or you stop short of surgery and say, "I am nonoperative, and I'm going to stop here."

In my case, I consider myself nonoperative. I've been preoperative since 1976. I've been nonoperative, definitely nonoperative, for a couple of years. I consider myself fully and completely female. I consider myself fully female legally. I think from what we have learned in the Family Law section from what a female-to-male did in the courts and through depositions that we can be defined this way. I referred to this a couple of days ago. Connie will refer to it again, but I'm going to say it now.

This was a case of female-to-male who was married to a person who was born female. We're beginning to wonder, "What in the world is born female?" But they were married and the divorce proceeding was coming. The spouse's lawyer wanted to annul this marriage and, therefore, was attacking the sex of this female-to-male. Throughout and consistently in the depositions, this person continued to say, "I am male. I have an underdeveloped penis, but a penis nonetheless." This person, in my opinion, is a nonoperative transsexual and fully male; and right now, while the female-to-male surgery is still poor and expensive, this person should not forced into that surgery merely to be male.

I am not going to allow myself to be forced into surgery, unless I want it, just to be female.

In my deposition, if they ask me about my genitals, my answer — and I've checked it out with a doctor — my answer is, "I have clitoral hypertrophy." In other words, I have an unusually large clitoris. And in deposition or in sworn testimony if they go after the fact that I have, what they might call testicles, I will simply say, "Well I'm sorry, but that was a birth defect. Actually those are ectopic ovaries that were in the wrong place on my body." There are medical cases all through the medical literature of clitoral hypertrophy and ectopic ovaries. And if he says, "But you don't have an opening down there," that's very simple. A lot of females, what they would consider females, are born without an opening. It's called vaginal agenesis.

I'm hoping that this law conference comes up standing for the right of not only for someone who wants to have that surgical change, be it female-to-male or male-to-female, to have it — you have our blessing, we will

fight for you — but that you could be fully female or fully male, non-operatively, without having to go through expensive and dangerous — surgery is always dangerous — surgery which may or may not prove satisfactory. In the case of a female-to-male, that person would have an underdeveloped penis, and I'm sure there's a medical term for it. In the case of the male-to-female, she has clitoral hypertrophy, as I do, ectopic ovaries, as I do, and vaginal agenesis, as I do. I think we'll save a lot of people from a lot of suffering.

I charge you with updating your principles and standards annually as part of your annual law conference duty. When you come back up here to be sure to put on the record, just as I did with Sister Mary and Marian slowly, spell out the words, make sure that people can copy it down when listening to tape and video, how to get hold of you when you get ready to do your "in the face" thing for the Benjamin society. Anything else you want to say?

By Marine Aliana Rothblatt:

If people like to get a hold of me for any participation in the Health Law project of the International Conference of Transgender Law, I ask you to either call me or FAX me, and my phone number is 301-495-0172, and my FAX number is 301-495-8987.

THE HEADCOUNT: A TRANSGENDER CENSUS

By Martine Aliana Rothblatt:

I think that in the time I really have left, Phyllis, what's probably most important to me is the subject of "coming out" and how that really bears on the standards of care and on health law and on transgender law, in particular. I really feel that I came out to my family some number of years ago.

Then I came out to the professional community that I'm part of a year ago. A lot of people said to me, "Well, did you feel real good when you came out to everybody?" In a sense, the real goodness came when I came out to my family and friends some years ago, because those were the people that were important to me. Coming out to the professional community wasn't something that gave me a great sense of relief because, in fact, it was always packed with tension and pressure. Every time I came out to another person or another person called up and said, "I heard you wear women's clothes now." That would be how the whole thing would get translated. It was always kind of a tension thing, so I can't say it was exhilarating or relieving or anything like that.

The reason really that I came out professionally is I believe that coming out is really a political act and a political responsibility of any invisible minority. There are all kinds of invisible minorities. At this conference I think we're probably concerned with gays, lesbians and transgendered people as invisible minorities. But the minority can be invisible in many, many ways. The people that clean houses in South Africa are probably an invisible minority. And a lot of labor workers who work, and farm workers, are kind of like an invisible minority until they make themselves visible. So to me coming out was a political act.

I finally learned from experience, and a lot of this I learned through the March on Washington that Phyllis spoke to eloquently, that invisibility is weakness and visibility is strength and power. In a democracy, how can you count votes of the invisible? Ghosts don't vote. Therefore, everybody who doesn't come out is actually hurting everybody who has come out. The more you think about that, that's really true. By not coming out, you may be protecting yourself from some personal harm but you're also hurting every other person who already has come out because you're making them look like a smaller minority than they really are. So, I encourage everybody to come out and to get out.

You won't be thrown in jail. One thing that gave me tremendous strength and confidence was listening to Phyllis' stories last year. She told how in way after way after way she came out in the seventies. She kept saying over and over again, "If I could do it in the seventies, the you can do it in the nineties." Those words ring in my ears all the time and they give me strength all the time.

You can read Leslie Feinberg's book, Stone Butch Blues, to really feel what it's like to be a sexual minority in the seventies. It is a very graphic, stomach curdling, description of a type of physical brutality that sexual minorities regularly faced in the seventies, in the sixties, and in the fifties. I'm not saying that that doesn't happen today, hardly the case. Gays and lesbians get shot and killed from one end of the country to the other.

But your life has to be really worth living, and if, in the end even, you were to give your life to help millions of other people achieve their self expression, that's probably the most significant thing a person can do with their life. Chances are very unlikely anybody here will have to give their life to come out. Probably what will happen is it will become old news in about six months to a year and you go back to your business. But you will have, in your life, done a revolutionary personal act, something that you'll be proud of until the day you die and something that will help millions of other people throughout the world.

In the Health Law Draft Report, we make an analysis of how many transgendered people there might be in the world. I'd like to kind of end on this note. There are all types of different estimates which have been made of the number of transgendered people in the world. We note that the very most conservative estimate — the estimate which would be based on the American Psychiatric Association's current statement of the statistical incidents of transsexualism — is that there would be just over 100,000 transsexuals in the world. I'm not talking about transgendered people yet because the American Psychiatric Association doesn't even have a word, transgender. They don't use it; they don't know what it is. You either want sex change surgery or you're not in their domain. So, even the people who have been our worst oppressors can see that there are a hundred thousand transsexuals in the world living today.

On the other hand, there's been notes by several researchers. I'm going to give a quote from the leading European legal scholar on transsexualism. His name is John Doek. By the way this year he's teaching at Georgetown University School of Law, and you could contact him if you write Professor Doek, Visiting Professor, Georgetown University. He's just finished a comprehensive report on European transsexual law. He noted that there seems to be a relation between the openness, the level of acceptance by society, and the prevalence of transsexualism. So what he was saying is the more open society is, the more transsexuals there appear to be. Now, that's a very astute observation and a sensible observation. People come out of the closet; they're not afraid they'll be shot.

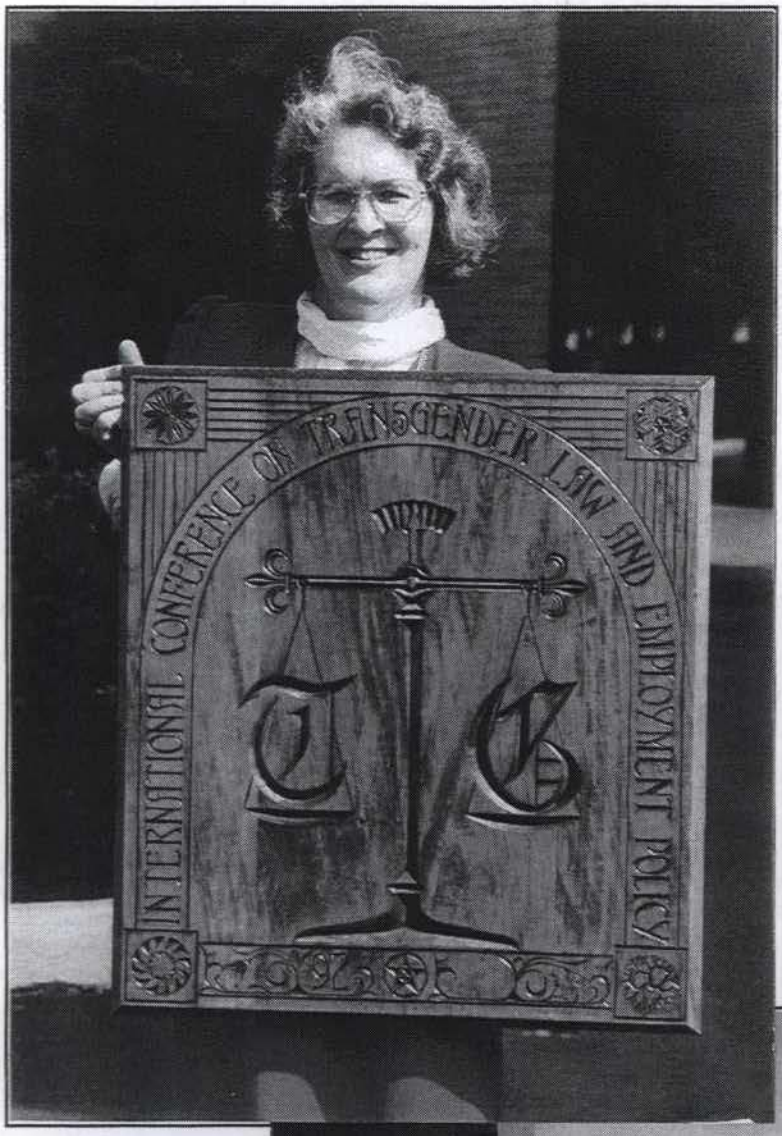
This leads to a medium range estimate for the number of transsexuals in the world. This medium range estimate is based on the incidence of transsexualism in Singapore. Singapore is known, throughout the gender and medical community, as having a very high level of acceptance for transsexuals. In Singapore, the government funds the transsexual operations. In fact, in the studies that have been done by cultural anthropologists, Singapore has the highest documented incidence of transsexuals per thousands of people. Based on the Singapore statistics, which are roughly one out of every ten thousand people are diagnosed transsexuals by psychiatrists, there would be one million transsexuals in the world today.

If one assumes, as is pretty much seems to be accepted in the community, that there are ten to one hundred times as many transsexuals that do not seek medical assistance for their sexual identities — in other words, that are more like transgendered, they're cross dressers — as do seek such treatment then there would be anywhere from ten million to one hundred million transgendered people in the world today. Ten million to a hundred million, ten million is more than the population of Sweden; a hundred million is more than the population of France.

I think if you say that even in a relatively open environment — and I see one of our audience saying

Singapore is no longer open and now arrests transsexuals — and I personally don't know if there is any open country in the world today — in fact I'll say I don't think there is any country in the world today that's, what I would call an open environment for gays, lesbians or transsexuals, because there's no country in the world today where gay people can get legally married in the church marriage sort of sense — I think the one in ten thousand incidence is a very conservative figure. Then multiply that by the number of people that don't seek anatomy changes, but are satisfied by hormones or just cross dressing, and you're looking at, I think, a minimum really of ten to one hundred million transgendered people in the world.

That's a hell of a community. That's a hell of a constituency. Get out. Come out for all of them, for all of us and for the future. Thank you.



Executive Director with the International Conference on Transgender Law and Employment Policy plaque

Dee McKellar, at the right hand of the Executive Director