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TRANS FORMATION

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TRANSFORMATION

Three myths regarding transgender identity have led to conflicting laws and policies that adversely affect transgender people

IN RECENT YEARS transgender legal issues have gained increasing visibility. Legislatures of several states, cities, and counties have passed laws forbidding discrimination on the basis of gender identity and enhancing punishments for violent crimes motivated by bias based on gender identity. At the same time, courts have struggled with cases involving transgender litigants that include questions of parental rights, marriage recognition, immigration issues, employment discrimination, prisoners' rights, juvenile justice, foster care, identity documentation, and more. Many of the legal battles that are being fought address transgender identities and focus on determinations by courts of a transgender litigant's legal gender, rights to access transgender healthcare, or fitness as a parent.

Three key myths of transgender identity

are producing many problematic and sometimes controversial laws, policies, and decisions. As a result of these myths, laws affecting transgender populations are inconsistent and conflicting, resulting in the devastating marginalization of transgender people from employment and social services. These issues cannot adequately be addressed through a traditional antidiscrimination framework. Reducing the legal and policy barriers to transgender survival will require not just the addition of laws prohibiting discrimination on the basis of gender identity and expression but also significant changes in the law regarding the regulation and administration of gender categories.

While these issues have been addressed for decades in the administrative systems of many jurisdictions, the resulting policies often con-

tradict one another and lead to irremediable conflicts for individuals who are subject to divergent policies and laws simultaneously. In part, the reforms of the last four decades that produced new rules recognizing transgender identities relied on new myths and misunderstandings that offered only limited relief to the legal marginalization of transgender people. For that reason, engaging in legal reform work that is primarily focused on inclusion and recognition may not be enough. Building a larger vision of the administration of gender categories is necessary for increasing the life chances of trans people. Understanding that injustice faced by trans

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people stems not only from bias and discrimination but also from structural exclusions based on how gender is regulated by law reveals the significant transformative potential of this area of law.

There are likely innumerable myths, stereotypes, and misunderstandings about transgender people that contribute to discrimination, marginalization, and violence. However, in addressing the obstacles arising from laws and policies, three key myths stand out as regularly generating exclusions and difficulties for trans populations. These myths are not consistent with one another and with many others to which they are related. Still, the burden of these inconsistencies fall on those who are oppressed rather than on those enforcing damaging regulatory frameworks.

Myth #1: Transgender people do not exist.

Behind laws, policies, and administrative practices that deny basic recognition to trans people in a variety of contexts lies the myth that transgender people do not exist. One of these areas is identity documentation. When ID-issuing agencies refuse to change the gender marker on an ID, they are operating on the idea that birth-assigned gender should be permanent and no accommodation is necessary for those for whom such an assignment does not match their lived experience of gender. An example of these policies includes the Tennessee statute prohibiting the change of gender markers on birth certificates for people born in that state.¹ An example of jurisprudence that relies on this myth is *Littleton v. Prange*,² in which the judge, despite the fact that Christie Lee Littleton had changed the gender on her birth certificate, determined that she would not be considered female for purposes of marriage, and thus her marriage was not valid. The phrasing of the judge's opening paragraphs was a giveaway of what authority he planned to use to deny the validity of the marriage. He asked, "[I]s a person's gender immutably fixed by our Creator at birth?" and answered the question at the end of the opinion, writing, "Christie was created and born a male....There are some things we cannot will into being. They just are."

This myth is also visible in the policies of many institutions that use sex segregation to organize their residential programs. The common policy in U.S. prisons of placing people in sex-segregated facilities based on birth-assigned gender, which is one factor leading to the high rates of sexual assault of transgender prisoners,³ refuses recognition of transgender existence by insisting that birth-assigned gender is the only relevant criteria for placement. Similarly, the majority of homeless shelter systems in the United States have

no written policies regarding the placement of trans residents and therefore enforce this myth in their daily operations by placing people according to birth-assigned gender. Some jurisdictions—such as New York City, San Francisco, Washington, D.C., and Boston—have adopted policies explicitly stating that transgender people should be able to access homeless shelters based on current gender. These jurisdictions are still in the minority.⁴ For many transgender people, this means that seeking shelter means becoming a target for harassment and assault in a large facility. This results in chronic homelessness for many who are afraid to face such conditions.⁵

Sex segregation in youth services is similarly reliant on a model of birth-assigned gender that refuses recognition of transgender youth. When foster care group homes consistently place transgender youth according to birth-assigned gender rather than current gender identity, high rates of running away occur. This is a major contributor to the high incidence of homelessness among transgender youth, which in turn creates barriers to education, healthcare, and employment.⁶ Homelessness among youth also contributes to their involvement in criminal activities to survive, such as sex work, drug sales, theft, and other crimes of poverty, such as trespassing, loitering, and sleeping outside. These activities by homeless youth can result in their placement in juvenile justice systems. Like foster care systems, juvenile justice systems regularly place youth based on birth-assigned gender, which makes transgender youth highly vulnerable to harassment and assault and concomitant mental and physical health problems.⁷ These placement issues are also prevalent in schools, where trans youth face problems because schools will not allow them to wear clothing associated with their current gender⁸ or use bathrooms or locker rooms associated with their current gender.⁹ The obstacles create a hostile environment in the school for transgender youth, in which their identities are denied by those in authority. This leads to high levels of harassment and attrition.¹⁰

The myth that birth-assigned gender is the only gender identity that can be recognized also motivates judicial decisions in which courts deny legal name changes to transgender people based on the assertion that such a name change may allow the petitioner to engage in fraud.¹¹ Changing one's name is a broad right in the United States, with restrictions generally limited to preventing people from using name changes to defraud creditors or escape criminal prosecution, marital obligations, or child support. However, some judges still deny transgender people's name-change petitions based on the belief that

allowing a person to change from a traditionally feminine name to a traditionally masculine name or vice versa is somehow facilitating fraud. This belief that transgender people's gender identities are fraudulent or false and that legal obstacles to articulating such an identity publicly should be upheld by judges is based in a fundamental notion that birth-assigned gender is the only "true" gender an individual can have and that transgender identity is not recognizable or legitimate.

Such thinking is also visible in some parental rights cases, in which judges invalidate the parental rights of transgender parents who are not the genetic parent of the children in question. In *Kantaras v. Kantaras*, the Florida Court of Appeals reversed a circuit court ruling that the father, Michael Kantaras, a transgender man, was the legal parent of the children. Michael's former wife knew he was transgender when they married, but when Michael filed for divorce, she attacked the validity of their 10-year marriage—and Michael's history as a legal parent to the couple's two children—based solely on Michael's transgender history. The circuit court issued a lengthy opinion finding that the marriage was valid and Michael was legally male, but the court of appeals reversed.¹² Thus, despite the fact that the children had been conceived during marriage using a sperm donor—a technique that any couple who could not conceive might use—and despite the fact that several states have explicit case law recognizing heterosexual marriages involving transgender people,¹³ the Florida court articulated the belief that birth-assigned gender is controlling and transgender identity did not merit legal recognition. In the case of Michael Kantaras, this meant that no number of agreements he had made with his wife and the sperm donor, or anything else, could protect his parental rights.

The myth that transgender people's identities are fraudulent, false, or legally insignificant, and that all people should be regarded solely through the lens of their birth gender, arises in all of these contexts with harsh consequences. These can include, at a minimum, prison rape, homelessness, lack of access to education, the termination of parental rights, and myriad forms of harassment and violence. Opposition to this myth, and the assertion that transgender people exist and should be recognized in their current gender identities, has been articulated in cultural, medical, and legal arenas with increasing frequency in the past 60 years.

The growing discourse in the United States about this topic and the attendant controversy about trans recognition gained visibility during the 1950s, when Christine Jorgenson became a celebrity based on the media cov-

erage of her gender transition.¹⁴ An argument contrary to the myth that transgender people do not exist emerged in the mainstream media and was reflected in law. This argument asserted that transgender people have a rare medical disorder that can be diagnosed and treated by medical professionals. Further, those who sought out and obtained treatment should be recognized in their identities. This competing argument was and is very much promoted by people who, based on compassion for trans experiences of discrimination, marginalization, and violence,

that people often are classified as male in some settings and female in others. These inconsistencies in documentation and classification lead to obstacles for transgender people in employment, health care, interactions with police, and in commercial activities. When identity documents are required, these inconsistencies can lead to “outing” transgender people and making them vulnerable to discrimination, harassment, and violence.

Moreover, this myth is also highly problematic because it is based on a misunderstanding of transgender healthcare. The cul-

tus, which is usually only known to one’s closest intimates. Additionally, genital surgeries are not recommended medical treatment for all transgender people. Many do not want to undergo such procedures or may be ineligible because of other medical issues.

Finally, genital surgeries are more expensive procedures than other options and are still not covered by a majority of private insurance or Medicaid programs in the United States. For that reason, they remain inaccessible to most transgender people.¹⁹ This means that the myth that surgery is determinative of a

The most obvious example of the codification of medical evidentiary requirements for recognition of transgender people’s current identities are the gender reclassification rules used by ID-issuing agencies and institutions.

seek to win recognition of transgender people’s identities and show that those identities are “real” through medical verification. Unfortunately, this line of thinking produced a new myth that has created its own obstacles for transgender people.

Myth #2: Trans people can only be understood or recognized through medical authority.

Medical narratives have been a key tool in the legitimization and recognition of trans identities in the last half century. They also have produced hundreds of laws and policies and countless incidences of individual exercises of authority by government workers, employers, and others that make recognition for trans people conditioned on the production of medical evidence. Some of these policies and laws are formal and explicit, with particular medical evidence, such as proof of having undergone a particular treatment, required by an agency or institution for a gender marker to be changed in their records. Other instances of the enforcement of this myth occur on a case-by-case basis, because the basic idea that transgender people need to have undergone some kind of surgery in order to “really” be the new gender is so widely believed that employers, government employees, coworkers, social contacts, media, and others use it as an inconsistent and arbitrary standard in a wide variety of circumstances.

This myth is problematic for several reasons. First, its enforcement is very inconsistent, with different medical evidence being required in different contexts. The result is

tural belief that transgender people are defined by undergoing certain treatments, particularly surgical treatments, and cannot be considered to have become the new gender until having undergone such treatment, is incorrect. In fact, gender-confirming healthcare constitutes individualized treatment that differs according to the medical needs and preexisting conditions of individual transgender people.¹⁵ Some transgender people undergo no medical care related to their expression of a gender identity that differs from their birth-assigned sex.¹⁶ Others undergo only hormone therapy treatment or any of a number of surgical procedures.

There are several reasons that the majority of transgender people do not undergo surgeries. Most obviously, people have different aims and desires for their bodies and express gendered characteristics in the ways that make the most sense to those needs and desires.¹⁷ For those who wish to enhance the masculinization or feminization of their appearance, changing external gender expressions such as hairstyle, clothing, and accessories is often an effective, affordable, and noninvasive way to alter how they are perceived in day-to-day life. For those who seek medical treatment, the most common medical treatment is not surgery but masculinizing or feminizing hormone therapy, which is an effective step for enhancing feminine or masculine secondary sex characteristics (voice, facial hair, breast tissue, muscle mass).¹⁸ For surviving daily life—work, school, street interactions—these external markers of gender are far more important than genital sta-

transgender person’s gender has an income-based impact, causing greater obstacles for middle- and low-income people who cannot afford to pay out of pocket for the procedure, if they even want or need it. Statistical information about the transgender population, while scant, reveals economic marginalization. One study found a 70 percent unemployment rate in the transgender population nationwide.²⁰ Another study found that only 58 percent of transgender residents of Washington, D.C., were employed in paid positions, 29 percent reported no source of income, and another 31 percent reported annual incomes under \$10,000.²¹ Considering the economic hardships of trans people overall due to discrimination, this means that a vast majority of transgender people do not have surgery and cannot meet surgery requirements for gender recognition under certain laws and policies.

The most obvious example of the codification of medical evidentiary requirements for recognition of transgender people’s current identities are the gender reclassification rules used by ID-issuing agencies and institutions. These include departments of health issuing birth certificates, departments of motor vehicles issuing drivers’ licenses and nondriver IDs, the Social Security Administration (SSA) maintaining its records, the Department of State issuing passports, agencies issuing immigration-related documents, welfare and Medicaid authorities issuing benefits cards, transportation authorities issuing various bus and train passes, and public schools and universities issuing ID cards and maintaining

records. All have policies and practices for addressing gender reclassification in their systems. In the last 40 years, many of these agencies and institutions formulated written policies that include medical evidence requirements. Interestingly, these policies are wildly inconsistent in their requirements, not only between the states but even between different agencies within the same state, city, or county.

For example, California's gender change policy for birth certificates requires the applicant to show that he or she has undergone any of a variety of gender confirmation surgeries,²² which could include chest surgery (breast enhancement for trans women or mastectomy and reconstruction for trans men), tracheal shave ("Adam's Apple" reduction), penectomy (removal of the penis), orchiectomy (removal of the testicles), vaginoplasty (creation of a vagina), phalloplasty (creation of a penis), hysterectomy (removal of internal pelvic organs), or any one of a range of other gender-related surgeries. When addressing birth certificate gender reclassification, New York City and New York State each require genital surgery. However, their genital surgery requirements differ entirely. People born in New York City are required to provide evidence that they have undergone phalloplasty or vaginoplasty, while people born in New York State must provide evidence that they have undergone penectomy or hysterectomy and mastectomy.²³ The fact that two jurisdictions issuing birth certificates in the same state have come up with entirely different requirements for recognition of gender change alone attests to the inconsistency in this area.

Gender reclassification policies also often tie recognition to the ability to show that other identity documents have already been changed. Massachusetts, for example, will only change DMV ID when an applicant shows both proof of surgery (unspecified) and a birth certificate indicating the new gender. For people born in Tennessee, which does not change birth records, and living in Massachusetts, this would be an impossibility.²⁴ Further, gender reclassification policies often include requirements of recognition by other agencies or institutions.

The SSA's policy requires genital surgery but is nonspecific regarding which surgeries will be accepted.²⁵ Some DMV gender reclassification policies—such as those of Colorado, New York, and the District of Columbia—do not require evidence of surgery but still require medical documentation in the form of a doctor's letter attesting that the person is transgender and is living in the new gender.²⁶

The results of these varying medical evidentiary requirements by ID-issuing organizations are several. Many transgender people, depending on which state they live in and

which state they were born in, cannot get any ID that matches their current gender or can only get some pieces of ID that match current gender, meaning that when an employer or someone else needs to see multiple pieces of ID they will be outed as having a prior gender marker. Not being able to obtain corrected ID can lead to unemployment, difficulty in interactions with the police (including discrimination and violence),²⁷ problems entering age-barred venues or purchasing age-barred products, accusations of fraud in a variety of situations, traveling difficulties, and other complications.

Additionally, recent law and policy changes at the federal level have focused on making increasing comparisons between databases of different ID-issuing agencies such as the SSA and the various DMVs, or using SSA records to confirm employment eligibility. These policies seek to find people with mismatching information on various types of records. Many transgender people have gotten caught up in these "no match" problems due to having mismatching gender markers on different IDs due to ID-issuing agencies having different rules regarding gender marker correction.²⁸

The belief that the recognition of trans people's gender identities requires medical verification is also reflected in case law. Cases in which courts have recognized a transgender person's heterosexual marriage frequently focus on the person's successful completion of various surgical interventions.²⁹ Cases in which courts have affirmed that transgender people are covered by antidiscrimination laws often rely on a medical component for trans identity,³⁰ although cases in which courts have found transgender people outside the ambit of antidiscrimination laws have also, at times, relied on a medical framework.³¹

In general, the association between transgender identity and medical care, especially surgery, is so common that judges frequently use it as the primary paradigm for thinking about trans people's identities regardless of whether they decide in favor of a transgender litigant or not. The codification of this myth into law means that even the well-intentioned work that some lawmakers, judges, and advocates do to increase transgender recognition and overcome Myth #1 has no beneficial impact on the majority of trans people who do not or cannot have surgery, or not the particular surgery a given rule is based upon, as part of their gender expression.

Myth #3: Trans people's gender-confirming healthcare is not legitimate medicine.

The third myth that causes major obstacles in law and policy for transgender people claims that gender-confirming healthcare for trans-

gender people is not legitimate medicine. This myth can be seen in the policies and practices of a variety of private and public entities that provide or insure healthcare.³² State Medicaid programs and private insurers often have explicit exclusions of this care in their policies. If they do not, they reject individual claims on a case-by-case basis.³³ Additionally, state and federal programs that are responsible for providing healthcare for people in their custody, such as foster care programs, juvenile justice programs,³⁴ and prisons,³⁵ frequently deny gender-confirming care either in a written policy or in an unwritten blanket practice.

The denial of gender-confirming healthcare, along with the incorrect assumption that most transgender people undergo surgery, results in several negative consequences. First, the inability to receive this care has severe health consequences for those who need it. Depression, anxiety, and suicide are commonly linked to the unmet need for gender-confirming medical care.³⁶ According to the few studies that have been done on the issue, HIV rates are also extremely high among transgender people.³⁷ One study found seroprevalence in 63 percent of African American trans women.³⁸ A contributing factor to this may be that many people seek treatments on the black market and receive care without medical supervision because it is not available through more legitimate means. This avenue to care may result in inappropriate dosage, nerve damage, and HIV and hepatitis infection resulting from injections without medical supervision or clean needles.³⁹

Additionally, research has shown that the inability to receive appropriate healthcare may be a contributing factor to the high rates of incarceration of transgender youth and adults.⁴⁰ Indeed, overrepresentation in the juvenile and adult criminal justice systems is an ongoing issue for the transgender population. Factors contributing to this overrepresentation include participation in black market transgender healthcare and, more broadly, participation in criminalized activity such as sex work to survive.⁴¹ This occurs for several reasons. Most centrally, many transgender people turn to informal or illegal economies to get by due to high levels of unemployment, homelessness, and poverty stemming from discrimination and economic marginalization. Transgender imprisonment may also be elevated because of a widespread trend of police profiling that has been documented in the United States.⁴²

Finally, transgender imprisonment is also bolstered by lack of access to alternatives to incarceration. For example, many nonprofit drug treatment programs refuse transgender applicants, sometimes based on an assertion that they lack the experience or expertise to

serve transgender people.⁴³ In most states, such policies of exclusion are not forbidden by antidiscrimination law.⁴⁴ Even those programs that admit transgender defendants typically are segregated by sex and use gender reclassification policies that prevent transgender people from being placed in gender-appropriate settings. Transgender people are at a disadvantage for succeeding in such therapeutic programs when their gender identities are denied and birth-assigned, gender-based rules such as dress codes are applied to them.⁴⁵ The result is that these alternative programs are less accessible to the transgender population.

These three myths operate across the spectrum of law and policy and through daily enforcement by individuals often acting on a belief, correct or incorrect, that the law supports their actions⁴⁶ to marginalize transgender people. The obstacles to income, housing, social services, public spaces and facilities, educational opportunity, and emergency services created by the simultaneous operation of these myths impede the opportunities and ultimately shorten the life spans of transgender people. In every context in which the myths are at play, clear and straightforward solutions exist that require changing rules about how gender categories are enforced by laws, policies, and practices to reduce the impact on trans people.⁴⁷

Antidiscrimination laws, unfortunately, do not sufficiently address these issues. Discrimination certainly describes some of the conditions faced by transgender people, such as the denial of employment or housing based on bias and stereotype. Still, the framework of discrimination does not adequately address all the concerns. Questions of whether and when gender should be used in government recordkeeping, on IDs, and to segregate people in various facilities, and what criteria should institutions use to determine who qualifies for membership in a given gender category, remain untouched even when a jurisdiction passes an antidiscrimination law. The existence of trans people raises these questions and has resulted in extensive, though inconsistent, policy reform that has brought some relief as well as some increased hurdles to those navigating gender reclassification issues. Similarly, questions of whether the gender-confirming healthcare regularly provided to nontransgender people will be provided to transgender people under various private insurance and state healthcare coverage programs are not addressed by antidiscrimination laws.

These questions remain hotly contested, especially when healthcare is paid for by public funds. They raise fundamental issues about how trans identities are seen and to what degree gender is a matter of personal deter-

mination or expression rather than regulation. Moreover, they involve the types of gender expectations that employers, government programs, and schools are permitted to have and enforce. Trans law reform projects must of necessity go beyond celebrating the passage of antidiscrimination laws to focus on a range of controversies that disrupt the law's most basic acceptance of and reliance upon traditional categories of maleness and femaleness. Individuals misidentified by these categorizations, those who contest their assigned categories, or those who experience multiple and conflicting assignments bring into stark relief the instability of the system of gender classification itself.

With a half-century of attempts to modify the rules of gender classification, it appears that the time has come for a deeper level of change. Tinkering with the rules of classification to allow some people permission to be reclassified has not resolved the many injustices still experienced by transgender people. It may be necessary to inquire whether gender performs the labor it is assumed to perform in various regulatory systems. To resolve these issues, reliance on gender as a method of identity classification and verification must be reduced or eliminated. ■

¹ TENN. CODE ANN. §68-3-203(d) (2006).

² Littleton v. Prange, 9 S.W. 3d 223 (Tex. Civ. App.

1999), cert. denied, 531 U.S. 872 (2000).

³ See Bassichis, "It's War in Here": A Report on the Treatment of Transgender & Intersex People in New York State Men's Prisons, available at <http://www.srlp.org>.

⁴ For a detailed discussion and review of these policies, see Dean Spade, *Documenting Gender*, 58 HASTINGS L.J. 731 (2008).

⁵ LISA MOTTET & JOHN M. OHLE, *TRANSITIONING OUR SHELTERS: A GUIDE TO MAKING HOMELESS SHELTERS SAFE FOR TRANSGENDER PEOPLE* (2003); Dean Spade, *Compliance Is Gendered: Struggling for Gender Self-Determination in a Hostile Economy*, in *TRANSGENDER RIGHTS* 217, 229 (Paaisley Currah et al. eds., 2006).

⁶ Jody Marksamer & Dean Spade, *Meeting the Needs of Transgender Youth in Congregate Care Facilities* (2008) (forthcoming from the National Center for Lesbian Rights) (on file with author).

⁷ *Id.*

⁸ *Doe v. Yunits*, 2001 WL 664947 (Mass. Super. Ct. 2001).

⁹ *Toilet Training* (DVD, Sylvia Rivera Law Project 2003).

¹⁰ See Marksamer & Spade, *supra* note 6, at 14.

¹¹ See, e.g., *In re Guido*, 771 N.Y.S. 2d 789 (N.Y. City Civ. Ct. 2003); Press Release, Sylvia Rivera Law Project, *Manhattan Judge Obstructs the Right of Four Transgender Women to Change Their Names* (2006), available at <http://www.srlp.org/index.php?sec=03H&page=namechange.obstruction.release>.


¹² *Kantaras v. Kantaras*, 884 So. 2d 155 (2005). See also National Center for Lesbian Rights, *Case Docket: Kantaras vs. Kantaras*, available at http://www.nclrights.org/site/PageServer?pagename=issue_caseDocket_kantaraskantaras.

¹³ See *M.T. v. J.T.*, 355 A. 2d 204 (N.J. App. Div. 1976). See also Stuart Pfeifer, *Transsexual Can Sue for Custody*, ORANGE COUNTY REGISTER, Nov. 26, 1997, at B1 (discussing *Vecchione v. Vecchione*, an unreported

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California case recognizing a marriage between a trans man and his female spouse).

¹⁴ See generally SUSAN STRYKER, *TRANSGENER HISTORY* (2008).

¹⁵ Sylvia Rivera Law Project, *The Fight for Fair Access to Birth Certificates Continues*, available at http://srjp.org/index.php?sec=03H&page=nycbc_newpolicy (last visited Mar. 17, 2008).

¹⁶ See Dylan Vade, *Expanding Gender and Expanding the Law: Toward a Social and Legal Conceptualization of Gender That Is More Inclusive of Transgender People*, 11 MICH. J. GENDER & L. 253, 260–61 (2005).

¹⁷ See Dean Spade, *Resisting Medicine, Remodeling Gender*, 18 BERKELEY WOMEN'S L.J. 15, 25–26 (2003), reprinted in *SEXUALITY, GENDER, AND THE LAW* (William N. Eskridge & Nan D. Hunter eds., 2003).

¹⁸ See Sylvia Rivera Law Project, *supra* note 15 (discussing overreliance on medical authority in legal determinations of the gender of transgender people).

¹⁹ R. Nick Gorton, *Transgender Health Benefits: Collateral Damage in the Resolution of the National Health Care Financing Dilemma*, 4 SEXUALITY RES. & SOC. POL'Y: J. NSRC 81, 85–89 (2007); WORKPLACE TRANSITIONS: EFFECTIVE ADVOCACY FOR TRANSGENDER-INCLUSIVE EMPLOYEE HEALTH BENEFIT PLANS (Kay Whitlock ed., 2005), available at <http://www.afsc.org/lgbt/trans-health-care.htm>.

²⁰ PATRICK LETELLIER & YOSEFIO V. LEWIS, *ECONOMIC EMPOWERMENT FOR THE LESBIAN GAY BISEXUAL TRANSGENDER COMMUNITIES: A REPORT BY THE HUMAN RIGHTS COMMISSION CITY AND COUNTY OF SAN FRANCISCO* 10 (2000), available at <http://www.sfgov.org/site/uploadedfiles/sfhumanrights/docs/econ.pdf>. In another study based in San Francisco, 64 percent of participants reported annual incomes in the range of \$0 to \$25,000. SHANNON MINTER & CHRISTOPHER DALEY, *TRANS REALITIES: A LEGAL NEEDS ASSESSMENT OF SAN FRANCISCO'S TRANSGENDER COMMUNITIES* (2003), available at <http://www.transgenderlawcenter.org/tranny/pdfs/Trans%20Realities%20Final%20Final.pdf>. Minter and Daley also found that nearly one in every two transgender respondents reported having experienced employment discrimination based on gender identity. Lack of ID that matches a person's current gender is a significant factor contributing to employment discrimination. MOTTET & OHLE, *supra* note 5, at 18; Spade, *supra* note 5.

²¹ Jessica M. Xavier, *The Washington Transgender Needs Assessment Survey*, *Glaa.org* (2000), available at <http://www.glaa.org/archive/2000/tgneedassessment1112.shtml>.

²² See *Documenting Gender*, *supra* note 4, at 832.

²³ *Id.* at 838.

²⁴ *Id.* at 825.

²⁵ *Id.* at 762.

²⁶ *Id.* at 822–830.

²⁷ CHRIS DALEY, ELLY KUGLER, & JO HIRSHMAN, *WALKING WHILE TRANSGENDER: LAW ENFORCEMENT HARASSMENT OF SAN FRANCISCO'S TRANSGENDER/TRANSSEXUAL COMMUNITY* (2000); AMNESTY INTERNATIONAL, *STONEWALLED: POLICE ABUSE AND MISCONDUCT AGAINST LESBIAN, GAY AND TRANSGENDER PEOPLE IN THE U.S.* 12–19 (2005), available at http://www.amnestyus.org/LGBT_Human_Rights/Stonewalled_A_Report/page.do?id=1106610&n1=3&n2=36&n3=1121.

²⁸ For a detailed description of these emerging issues, see *Documenting Gender*, *supra* note 4.

²⁹ See *M.T. v. J.T.* 355 A. 2d 204 (N.J. App. Div. 1976); *Kantaras v. Kantaras*, Case No: 98-5375CA (Circuit Court of the Sixth Judicial Circuit, Pasco County, Fla., Feb. 19, 2003) (full text of the decision available at <http://www.transgenderlaw.org>).

³⁰ *Doe v. Bell*, 754 N.Y.S. 2d 846 (Sup. Ct. N.Y. County 2003).

³¹ *Oiler v. Winn Dixie*, No. 00-3114, 2002 U.S. Dist.

LEXIS 17417 (2002).

³² In recent years, several major public systems have added coverage of this care to their employee benefits packages. This includes the city of San Francisco, the University of California, and the University of Michigan. At the same time, these benefits have come under attack in certain states that have included them in Medicaid coverage, such as Washington and Minnesota, and benefits have been reduced as a result. The medical necessity of this type of care, and questions about whether excluding it constitutes discrimination, are being actively debated with regard to private and public insurance. R. Nick Gorton, *supra* note 19; WORKPLACE TRANSITIONS, *supra* note 19.

³³ Twenty-two states explicitly exclude coverage for gender-confirming healthcare for transgender people. See *Documenting Gender*, *supra* note 4.

³⁴ No foster care or juvenile justice system in the United States has a written policy providing for transgender healthcare for youth in their custody. Some jurisdictions currently work to provide transgender healthcare for eligible transgender youth on an individual basis, but denial of such care is the norm. Interview with Jody Marksamer, National Center for Lesbian Rights (Feb. 28, 2007). For more information on the variety of proposed policies in this area, relevant lawsuits, and social science research, see *Documenting Gender*, *supra* note 4, and Marksamer & Spade, *supra* note 6.

³⁵ Seven states have explicit, written policies about transgender people in their corrections systems. See Sydney Tarzwell, Note: *The Gender Lines Are Marked with Razor Wire: Addressing State Prison Policies and Practices for the Management of Transgender Prisoners*, 38 COLUM. HUM. RTS. L. REV. 167 (2006). All seven policies indicate that they provide hormones to transgender prisoners. Six of them explicitly state, however,

that hormone therapy will be provided only to prisoners who can prove that they were already receiving this type of care before incarceration. This provision denies hormones to transgender people who cannot document their care prior to imprisonment because the care was obtained without medical supervision. At least one court has found that requiring pre-incarceration verified treatment only in the case of gender-confirming healthcare is unreasonable. Brooks v. Berg, 289 F. Supp. 2d 286, 289 (N.D. N.Y. 2003). No prison system in the United States provides surgical treatment to transgender prisoners. Interestingly, Canadian law differs from U.S. law in this regard. In 2001, a Canadian judge ordered a federal prison to pay for the gender confirmation-related surgery of a prisoner. Kavanagh v. Attorney Gen. of Canada, Tribunal File No. T505/2298 (Can. Human Rights Trib. 2001), at http://www.chrt-tcdp.gc.ca/search/view_html.asp?doid=264&lg=_e&cisruling=0, *aff'd* Canada (Att'y General) v. Canada (Human Rights Comm'n), F.C. 89 (Fed. Ct. 2003). See also Life Site, *Canadian Court Orders Prisons to Pay for Sex Change Operations*, Feb. 7, 2003, at <http://www.lifesite.net/ldn/2003/feb/03020707.html>; Janice Tibbetts, *Canada: Federal Prisons Ordered to Pay for Sex Changes*, NATIONAL POST, Feb. 7, 2003, available at <http://www.freerepublic.com/focus/f-news/838017/posts>.

³⁶ See Pooja S. Gehi & Gabriel Arkles, *Unraveling Injustice: Race and Class Impact of Medicaid Exclusions of Transition-Related Health Care*, 4 SEXUALITY RES. & SOC. POL'Y: J. NSRC 7, 11 (2007).

³⁷ *Id.*

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ Marksamer & Spade, *supra* note 6; Gehi & Arkles, *supra* note 36; Alexander L. Lee, *Nowhere to Go but*

Out: The Collision between Transgender and Gender-Variant Prisoners and the Gender Binary in America's Prisons (Spring 2003), at 4 (unpublished note), available at http://www.srlp.org/documents/alex_lee_paper2.pdf; Franklin H. Romeo, *Beyond a Medical Model: Advocating for a New Conception of Gender Identity in the Law*, 36 COLUM. HUM. RTS. L. REV. 713 (2005).

⁴¹ Gehi & Arkles, *supra* note 36, at 13; Spade, *supra* note 5, at 226.

⁴² Lee, *supra* note 40, at 4; STONEWALLED, *supra* note 27; WALKING WHILE TRANSGENDER, *supra* note 27.

⁴³ Interview with Gabriel Arkles, Sylvia Rivera Law Project (Jan. 10, 2007); Interview with Alexander Lee (Apr. 3, 2007).

⁴⁴ See *Documenting Gender*, *supra* note 4.

⁴⁵ Interview with Gabriel Arkles, *supra* note 43; Interviews with Carrie Davis (May 15, 2004 & June 10, 2004); Interview with Alexander Lee (Apr. 3, 2007).

⁴⁶ For example, during my time providing legal services I had several clients who were asked by their employers to verify that they had undergone surgery in order to be allowed to use a restroom that matched their current gender, based on the employer's belief that surgery would verify their "legal gender." I have also been asked to verify surgical status for clients seeking access to a shelter, drug treatment program, youth program, or other resource that segregates people by sex.

⁴⁷ See the Sylvia Rivera Law Project (www.srlp.org), the TGI Justice Project (www.tgijp.org), FIERCE! (www.fiercencyc.org), the Audre Lorde Project (www.alp.org), the National Center for Lesbian Rights (www.nclrights.org), the National Center for Transgender Equality (www.nctequality.org), the National Gay and Lesbian Taskforce (www.thetaskforce.org), Lambda Legal Defense and Education Fund (www.lambdalegal.org).

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