

Resisting Medicine, Re/modeling Gender

Dean Spade[†]

INTRODUCTION

“How do you know you want rhinoplasty, a nose job?” he inquires, fixing me with a penetrating stare.

“Because,” I reply, suddenly unable to raise my eyes above his brown wingtips, “I’ve always felt like a small-nosed woman trapped in a large-nosed body.”

“And how long have you felt this way?” He leans forward, sounding as if he knows the answer and needs only to hear the words.

“Oh, since I was five or six, doctor, practically all my life.”

“Then you have rhino-identity disorder,” the shoetops state flatly. My body sags in relief. “But first,” he goes on, “we want you to get letters from two psychiatrists and live as a small-nosed woman for three years . . . just to be sure.”¹

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1. RIKI ANNE WILCHINS, READ MY LIPS: SEXUAL SUBVERSION AND THE END OF GENDER 63 (1997).

Everywhere that trans² people appear in the law, a heavy reliance on medical evidence to establish gender identity is noticeable. Try to get your birth certificate amended to change your sex designation, and you will be asked to show evidence of the surgical procedures you have undergone to change your sex.³ Try to change your name to a name typically associated with the “other gender,” and in many places you will be told to resubmit your petition with

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2. Like many communities resisting oppression, the trans community uses ever-evolving terms to describe our articulation of non-normative identities and our struggles against a coercive binary gender system. In this article, I use several terms to name the set of people my work aims to assist. I use the words “trans” and “gender transgressive” frequently. I use “trans” to indicate people who identify as transgender, transsexual, or within the transgender spectrum. Transgender and trans are both political terms that have emerged in recent years to indicate a wide variety of people whose gender identity or expression transgress the rules of binary gender. I also use the word “gender transgressive,” though, because I find in my work that there are many people who are not trans-identified who experience persistent gender identity discrimination and who have a large stake in work to end this kind of oppression. Feminine men and masculine women, for example, though not trans-identified, frequently experience gender identity discrimination. I use “gender transgressive” in an attempt to capture this broad set of experiences of discrimination stemming from the continued insistence that every person in our culture conform their bodies and expressions to narrow understandings of “maleness” and “femaleness” according to the gender assigned to them at birth. When I use the word “transsexual” in this article, it is usually because I am referring to a medical expectation or requirement for membership in this category, as defined by doctors for the purposes of evaluating who is eligible for gender reassignment, or because I am referring to a person who identifies himself with this word.
 3. See ALA. CODE § 22-9A-19 (2002) (order of court of competent jurisdiction and surgery required); ARIZ. REV. STAT. § 36-326 (2001) (change may be made based on sworn statement from licensed physician attesting to either surgical operation or chromosomal count, although registrar may require further evidence); ARK. CODE ANN. § 20-18-307 (2002) (order of court of competent jurisdiction and surgery required); CAL. HEALTH & SAFETY CODE § 103425, 103430 (2002 Supp.) (court order and surgery apparently required); COL. REV. STAT. ANN. § 25-2-115 (2002) (same); D.C. CODE ANN. § 7-217 (2002) (same); GA. CODE ANN. § 31-10-23 (2002) (same); HAW. REV. STAT. § 338-17.7 (2002) (physician affidavit and surgery required; registrar can require additional information); 410 Ill. Comp. Stat. 535/17 (2002) (same); IOWA CODE § 144.23 (2002) (physician affidavit and surgery “or other treatment”); LA. REV. STAT. ANN. § 40:62 (2002) (order of court of competent jurisdiction and surgery required); MASS. ANN. LAWS ch. 46, § 13 (2002) (same); MICH. COMP. LAWS § 333.2831 (2002) (affidavit of physician certifying sex reassignment surgery); MISS. CODE ANN. § 41-57- 21 (2001) (registrar may correct certificate that contains incorrect sex on affidavit of two persons having personal knowledge of facts; not clear whether restricted to initial error in certificate or includes gender change); MO. REV. STAT § 193.215 (2001) (order of court of competent jurisdiction and surgery required); NEB. REV. STAT. § 71-604.1 (2002) (affidavit of physician as to sex reassignment surgery and order of court of competent jurisdiction changing name required); N.J. STAT. ANN. 26:8-40.12 (2002) (certificate from physician attesting to surgery and order of court of competent jurisdiction changing name); N.M. STAT. ANN. § 24-14-25 (2002) (same); N.C. GEN. STAT. 130A-118 (2001) (affidavit of physician attesting to sex reassignment surgery); OR. REV. STAT. § 432.235 (2001) (order of court of competent jurisdiction and surgery required); UTAH CODE ANN. § 26-2-11 (2002) (order of Utah District Court or court of competent jurisdiction of another State required; no specific requirement of surgery); VA. CODE ANN. § 32.1-269 (2002) (order of court of competent jurisdiction indicating sex has been changed by “medical procedure”); WIS. STAT. § 69.15 (2001) (order of court or administrative order) *cited in* Matter of Heilig, 2003 WL 282856 at *15 n.8 (Md. 2003). See also LAMBDA LEGAL DEFENSE AND EDUCATION FUND, RESOURCES: TRANSGENDER ISSUES, at <http://www.lambdalegal.org/cgi-bin/iowa/docu-ments/record?record= 1162> (Nov. 12, 2002) (last visited Mar. 30, 2003).

evidence of the medical procedures you have completed.⁴ Try to get your drivers' license sex designation changed, and again you will be required to present medical evidence. If you are trans or gender transgressive, even your ability to use a gendered bathroom without getting harassed or arrested⁵ may be dependent on your ability to produce identification of your gender, which will only indicate your new gender if you have successfully submitted medical evidence to the right authorities.

In almost every trans-related case, whether it be about the legitimacy of a trans person's marriage,⁶ the custody of hir⁷ children,⁸ hir right not to be

4. In New York City, name changes are frequently rejected by judges when they notice that the new name is one associated with the other gender. Some judges have seen fit to require that medical documentation of transition be attached, such as affidavits from healthcare providers, while others have even rejected applications with such documentation attached. One client I work with had her name change rejected despite attached medical documentation, and the judge's order stated that in order to get her name changed she would need to return with proof that she had undergone sex reassignment surgery and gotten a divorce from her wife. These rulings are particularly noteworthy because *Rivera* established that changing your name in New York does not and cannot change your legal gender. *Matter of Rivera*, 627 N.Y.S.2d 241, 244 (City Civ. Ct. 1995). Because it is only a name change, the assumption should be that it will be approved according to the common law doctrine, as long as you are not doing it to defraud your creditors. The result of these rulings is that currently you can change your name to virtually anything, but if you are changing your name outside of the norms associated with your birth gender, you are held to a higher evidentiary standard and still may never be able to successfully complete the process. I am currently working to find suitable test cases to clarify the law in this area, hopefully resolving the issue as it was resolved in New Jersey and Pennsylvania. *See Matter of McIntyre*, 715 A.2d 400 (Pa. 1998) (holding that absent fraud or other improper purpose a person has a right to a name change); *Matter of Eck*, 584 A.2d 859 (N.J. Super. Ct. App. Div. 1991) (holding that the fact that the applicant had chosen an obviously "female" name did not warrant denial of the application, absent fraud or other improper purpose).
5. Gender transgressive and trans people have faced violence and harassment in bathrooms since the emergence of gender-segregated bathrooms. I experienced the gravity of this problem, myself, when I was arrested in February of 2002 for using a men's room in Grand Central Station. I spent 23 hours in jail on a false trespassing charge, catching a glimpse of what more vulnerable trans people (homeless, youth, people of color, disabled) face daily. *See DEAN SPADE, 2 LEGIT 2 QUIT, PISS & VINEGAR, at* <http://www.makezine.org/2legit.html> (last visited March 14, 2003). Dylan Vade, working in conjunction with the San Francisco Human Rights Commission, surveyed over 400 gender transgressive people about the problems we face in gender-segregated bathrooms. *See JODIE MARKSAMER & DYLAN VADE, GENDER NEUTRAL BATHROOM SURVEY, at* http://www.transgenderlawcenter.org/documents/safe_WC_survey_results.html (2001) (last visited Mar. 30, 2003).
6. *See Littleton v. Prange*, 9 S.W.3d 223, 224 (Tex. App. 1999); *M.T. v. J.T.*, 355 A.2d 204, 205 (N.J. Super. Ct. App. Div. 1976); *Anonymous v. Anonymous*, 325 N.Y.S.2d 499, 500 (Sup. Ct. 1971); *In re Ladrach*, 13 N.E.2d 828 (Ohio Misc. 1987). *But see In re Estate of Gardiner*, 42 P.3d 120, 136 (Kan. 2002) (declining to consider expert medical testimony because Congress contemplated "sex" under its common and traditional meaning).
7. I use the gender-neutral pronouns "sie" (pronounced "see") and "hir" (pronounced "here") to promote the recognition of such pronouns, which resist the need to categorize all subjects neatly into male and female categories, at the suggestion of Leslie Feinberg. I use these pronouns when discussing a hypothetical person, but when I am referring to people who have articulated a self-identification in a particular gender, I respect that choice by using pronouns which reflect it. *LESLIE FEINBERG, TRANS LIBERATION: BEYOND PINK OR BLUE 1* (1998).
8. *See Matter of Welfare of V.H.*, 412 N.W. 2d 389, 393 (Minn. Ct. App. 1987); *In re D.F.D. and D.G.D.*, 261 Mont. 186, 192 (Mont. 1993); *Kantaras v. Kantaras*, No. 98-5375CA (Fla.

discriminated against in employment,⁹ hir right to wear gender appropriate clothing in school or foster care,¹⁰ hir rights in prison,¹¹ or whatever other context brings hir to court, medical evidence will be the cornerstone of the determination of hir rights. As a transgender person, and a lawyer working for trans equality, I must continually negotiate how to use medical evidence responsibly. This negotiation is complicated by my awareness of the contentious and oppressive relationship between the medical establishment and gender transgressive people. In a context in which medical care remains inaccessible to most—and particularly to low-income—gender transgressive people, where medical care associated with sex reassignment is still doled out through gender-regulating processes that reinforce oppressive and sexist gender binaries, and where, because of these circumstances and others, many gender transgressive people will choose not to or be unable to access medical care associated with their gender identity, I must proceed with extreme caution when approaching the interwoven governance mechanisms of legal and medical realms that continue to determine the fates of gender transgressive people. Similarly, because the reliance on medical evidence and the medical assessment of gender identity is so deeply entrenched, no legal strategist can avoid working within requirements of medical documentation at least sometimes when seeking to expand trans rights.

This essay will highlight my concerns about reliance on medical evaluation of gender identity in legal work toward trans equality. I will rely, in part, on excerpts (italicized) from writing I did while I was seeking sex reassignment surgery.¹² These excerpts focus on the ways that sex reassignment-related procedures are regulated through a mental health model which promotes regulatory, binary gender expression and denies access to medical procedures to

Cir. Ct. Feb. 21, 2003), *available at* <http://www.nclrights.org/cases/pdf/kantarasopinion.pdf>; *Christian v. Randal*, 516 P.2d 132 (Colo. Ct. App. 1973).

9. *See, e.g., Goins v. West Group*, 635 N.W.2d 717, 720-21 (Minn. 1999); *Oiler v. Winn-Dixie Louisiana, Inc.*, 2002 WL 31098541 at *1 (Sept. 16, 2002).
10. *See Doe v. Bell*, 2003 WL 355603 at *1-2 (N.Y. Sup. Ct. 2003); *Doe ex rel. Doe v. Yunits*, 2001 WL 664947 at *5 (Mass. Supp.) (2001).
11. *See Farmer v. Brennan*, 511 U.S. 825, 829 (1994); *Lucrecia v. Samples*, 1995 WL 630016 at *6 (N.D. Cal. Oct. 16, 1995); *Powell v. Schriver*, 175 F.3d 107, 111 (2nd Cir. 1999); *Maggert v. Hanks*, 131 F.3d 670, 670-71 (7th Cir. 1997); *Long v. Nix*, 86 F.3d 761, 764 (8th Cir. 1996); *Brown v. Zavaras*, 63 F.3d 967, 969 (10th Cir. 1995); *White v. Farrier*, 849 F.2d 322, 324 (8th Cir. 1988); *Meriwether v. Faulkner*, 821 F.2d 408, 410 (7th Cir. 1987); *Jones v. Flannigan*, 1991 WL 260880 at *1 (7th Cir. 1991); *Supre v. Ricketts*, 792 F.2d 958, 959 (10th Cir. 1986); *Lamb v. Maschner*, 633 F. Supp. 351, 353-54 (D. Kansas 1986). *See also* SHANNON MINTER, REPRESENTING TRANSSEXUAL CLIENTS, *available at* <http://www.nclrights.org/publications/tgclients.htm> (2000) (last visited Mar. 30, 2003).
12. I use this term because the double mastectomy and construction of a male chest that I was seeking is considered by doctors to be “sex reassignment surgery” and is, therefore, regulated through the understandings of gender dysphoria that this article explores. However, even when adopting this term to discuss the practices it indicates, I also want to suggest a critical approach to the labeling of certain surgeries, such as mastectomy for people assigned “female” at birth or breast enlargement for people assigned “male” at birth, as surgery that changes gender expression or performance while other surgeries such as breast enlargement for people assigned “female” at birth or pectoral implants for people assigned “male” at birth are understood as innocuous “cosmetic” surgery.

those who fail to perform normative binary gender for their health care providers. I will also explore the other barriers to medical care that trans people face, including economic issues. Finally, I will look at the recent developments in disability law as a mechanism for trans rights, and examine how a reliance on medical evidence is both dangerous and appealingly effective in these cases.

I. GOVERNANCE: PASSING AS A TRANSSEXUAL

*[Psychiatrists and therapists] . . . use you, suck you dry, and tell you their pitiful opinions, and my response is: What right do you have to determine whether I live or die? Ultimately the person you have to answer to is yourself and I think I'm too important to leave my fate up to anyone else. I'll lie my ass off to get what I have to.*¹³

*Here's what I'm after: a surgically constructed male-appearing chest, no hormones (for now, maybe forever), no first-name change, any pronouns (except "it") are okay, although when it comes to gendered generics I happen to really like "Uncle" better than "Aunt," and definitely "Mr. Spade."*¹⁴ Hausman writes, "transsexuals must seek and obtain medical treatment in order to be recognized as "transsexuals." Their subject position depends upon a necessary relation to the medical establishment and its discourses."¹⁵ I've quickly learned that the converse is also true: in order to obtain the medical intervention I am seeking, I need to prove my membership in the category "transsexual" to prove to the proper authorities that I have Gender Identity Disorder.¹⁶ Unfortunately, stating my true objectives is not convincing them.

"When did you first know you were different?"¹⁷ the counselor at the L.A. Free Clinic asked. "Well," I said, "I knew I was poor and on welfare, and that was different from lots of kids at school, and I had a single mom, which was really uncommon there, and we weren't Christian, which is terribly noticeable in the South. Then later I knew I was a foster child, and in high school, I knew I

13. CLAUDINE GRIGGS, S/HE: CHANGING SEX AND CHANGING CLOTHES 32 (1998).

14. My position on these questions has changed since I wrote these words three years ago. At the time, I chose to use female pronouns and go by my given, more feminine first name. Those particular aspects of my gender presentation at the time, and the fact that they did not conform to the expectations of the medical providers I visited regarding what a female-to-male trans person should express, were integral to my experience of not being able to find the healthcare I sought.

15. BERNICE L. HAUSMAN, CHANGING SEX: TRANSSEXUALISM, TECHNOLOGY, AND THE IDEA OF GENDER 3 (1995) (emphasis in original).

16. AMERICAN PSYCHOLOGICAL ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL 532 (4th ed. 1994) [hereinafter APA].

17. Feinberg answers the question about the origin of gender nonconformity thus: "Who cares! As long as my right to explore the full measure of my own potential is being trampled by discriminatory laws, as long as I am being socially and economically marginalized, as long as I am being scapegoated for the crimes committed by this economic system, my right to exist needs no explanation or justification of any kind." FEINBERG, *supra* note 7, at 32.

was a feminist and that caused me all kinds of trouble, so I guess I always knew I was different.” His facial expression tells me this isn’t what he wanted to hear, but why should I engage a narrative in which my gender performance has been my most important difference in my life? It hasn’t, and I can’t separate it from the class, race, and parentage variables through which it was mediated. Does this mean I’m not real enough for surgery?

I’ve worked hard to not engage the gay childhood narrative—I never talk about tomboyish behavior as an antecedent to my lesbian identity, I don’t tell stories about cross-dressing or crushes on girls, and I intentionally fuck with the assumption of it by telling people how I used to be straight and have sex with boys like any sweet trashy rural girl. I see these narratives as strategic, and I’ve always rejected the strategy that adopts some theory of innate sexuality and forecloses the possibility that anyone, gender troubled childhood or not, could transgress sexual and gender norms at any time. I don’t want to participate in an idea that only some people have to struggle to learn gender norms in childhood. So now, faced with these questions, how do I decide whether to look back on my life through the tranny childhood lens, tell the stories about being a boy for Halloween, about not playing with dolls? What are the costs of participation in this selective recitation? What are the costs of not participating?

Rachel Pollack writes,

What sense does it make to label some people as true transsexuals, and others as secondary, or confused, or imitation? Whom does such an attitude serve? I can think of no one but the gatekeepers, those who would seize the power of life and death by demanding that transsexuals satisfy an arbitrary standard. To accept such standards, to rank ourselves and others according to a hierarchy of true transsexuality, to try to recast our own histories to make sure they fit the approved model, can only tear us down, all of us, even the ones lucky enough to match that model.¹⁸

It’s always been fun to reject the gay childhood story, to tell people I “chose” lesbianism, or to over-articulate a straight childhood narrative to suggest that lesbianism could happen to anyone. But not engaging a trans childhood narrative is terrifying. What if it means I’m not “real”? Even though I don’t believe in real, it matters if other people see me as real. If not, I’m a mutilator, an imitator, and worst of all, I can’t access surgery.

Transsexual writer Claudine Griggs’ book takes for granted that transsexuality is an illness, an unfortunate predicament, something fortunate, normal people don’t have to go through. She writes: “Fortunately, most people, though they strive to become a certain kind of woman or man, never question

18. Rachel Pollack, *The Varieties of Transsexual Experience*, 7 *TRANSSEXUAL NEWS TELEGRAPH* 18, 20 (1997).

their foundational gender. . . . A person with gender dysphoria is crippled emotionally and socially, which accounts for part of the transsexual compulsion for body alteration."¹⁹ On the first page of the preface she writes,

*I am not an advocate of sex change procedures. I know that sex reassignment is necessary for some individuals with gender dysphoria in much the same way as a radical mastectomy is necessary for some individuals with breast cancer, but I hope that such treatment is undertaken only when no other effective prescription exists. The best recommendation, though pointless, is don't get cancer and don't be a transsexual.*²⁰

This is precisely the approach I want to avoid as I reject the narrative of a gender troubled childhood. My project would be to promote sex reassignment, gender alteration, temporary gender adventure, and the mutilation of gender categories, via surgery, hormones, clothing, political lobbying, civil disobedience, or any other means available. But that political commitment itself, if revealed to the gatekeepers of my surgery, disqualifies me. One therapist said to me, "You're really intellectualizing this, we need to get to the root of why you feel you should get your breasts removed. How long have you felt this way?" Does realness reside in the length of time a desire exists? Are women who seek breast enhancement required to answer these questions? Am I supposed to be able to separate my political convictions about gender and my knowledge of the violence of gender rigidity (which has been a part of my life and the lives of everyone I care about) from my real "feelings" about what it means to occupy my gendered body?

From what I've gathered in my various counseling sessions, in order to be deemed real I need to want to pass as male all the time, and not feel ambivalent about this. I need to be willing to make the commitment to "full-time" maleness, or they can't be sure that I won't regret my surgery. The fact that I don't want to change my first name, that I haven't sought out the use of the pronoun "he," that I don't think that "lesbian" is the wrong word for me, or, worse yet, that I recognize that the use of any word for myself—lesbian, transperson, transgender

19. GRIGGS, *supra* note 13, at 10-13.

20. *Id.* at ix. Hausman posits a similarly helpless and afflicted view of transsexuals. "Ostensibly, the demand for sex change represents the desperation of the transsexual condition: after all, who but a suffering individual would voluntarily request such severe physical transformation?" HAUSMAN, *supra* note 15, at 110. This presumption is a fundamental part of the medical approach to transsexualism. The therapists I've seen have wanted to hear that I hate my breasts, that the desire for surgery comes from desperation. What would it mean to suggest that such desire for surgery is a joyful affirmation of gender self-determination—that a SRS candidate would not wish to get comfortable in a stable gender category, but instead be delighted to be transforming—to choose it over residing safely in "man" or "woman"?

Griggs writes that there is no "perceptual middle ground between male and female" and that "transsexuals cannot fade gently" between genders. GRIGGS, *supra* note 13, at 1. To this I would respond with a proverb that Feinberg quotes: "The person who says it cannot be done should not interrupt the person doing it." FEINBERG, *supra* note 7, at 61.

butch, boy, mister, FTM fag, butch—has always been/will always be strategic, is my undoing in their eyes. They are waiting for a better justification of my desire for surgery, something less intellectual, more real.

I'm supposed to be wholly joyous when I get called "sir" or "boy." How could I ever have such an uncomplicated relationship to that moment? Each time I'm sirred I know both that my look is doing what I want it to do, and that the reason people can assign male gender to me easily is because they don't believe women have short hair, and because, as Garber has asserted, the existence of maleness as the generic means that fewer visual clues of maleness are required to achieve male gender attribution.²¹ This "therapeutic" process demands of me that I toss out all my feminist misgivings about the ways that gender rigidity informs people's perception of me.

The counselor at the L.A. Free Clinic decided I wasn't transsexual during the first (and only) session. When I told him what I wanted, and how I was starting counseling because I was trying to get some letters that I could give to a surgeon so that they would alter my chest, he said, "You should just go get breast reduction." Of course, he didn't know that most cosmetic surgeons won't reduce breasts below a C-cup (I wouldn't even qualify for reduction), and that breast reduction is a different procedure than the construction of a male-looking chest. I also suppose that he wasn't thinking about what happens to gender transgressive people when they end up in the hands of medical professionals who don't have experience with trans people.

Some surgeons have strong reactions to transsexual patients, and often, if the surgery is done in a teaching hospital, the surgeon turns out to be a resident or staff member who is offended by the procedure. "In one case, with which I am familiar," writes a doctor, "the patient's massive scars were probably the result of the surgeon's unconscious sadism and wish to scar the patient for 'going against nature.'"²²

To this counselor, my failure to conform to the transsexuality he was expecting required my immediate expulsion from that world of meaning at any cost. My desire couldn't be for SRS because I wasn't a transsexual, so it must be for cosmetic surgery, something normal people get.

All my attempts at counseling, and all those experiences of being eyed suspiciously when I suggested that I was trans, or of being told outright I was not trans by non-trans counselors, made me expect that I would get a similar reception from trans people in activist or support contexts. This has not been the case. I've found that in trans contexts, a much broader conception of trans experience exists. The trans people I've met have, shockingly, believed what I say about my gender. Some have a self-narrative resembling the medical model of transsexuality, some do not. However, the people I've met share with me what

21. MARJORIE GARBER, VESTED INTERESTS: CROSS DRESSING AND CULTURAL ANXIETY 102 (1992).

22. *Id.* at 103.

my counselors do not: a commitment to gender self-determination and respect for all expressions of gender. Certainly not all trans people would identify with this principle, but I think it makes better sense as a basis for identity than the ability to pass “full-time” or the amount of cross-dressing one did as a child. Wilchins posits an idea of identity as “an effect of political activism instead of a cause.”²³ I see this notion reflected in trans activism, writing, and discussion, despite its absence in the medical institutions through which trans people must negotiate our identities.

Feinberg writes:

Once I figured out that “transgendered” was someone who transcended traditional stereotypes of “man” and “woman,” I saw that I was such a person. I then began a quest for finding words that described myself, and discovered that while psychiatric jargon dominated the discourse, there were many other words, both older and newer, that addressed these issues. While I accepted the label of “transsexual” in order to obtain access to the hormones and chest surgery necessary to manifest my spirit in the material world, I have always had a profound disagreement with the definition of transsexualism as a psychiatric condition and transsexuals as disordered people.²⁴

After attending only three discussion group meetings with other trans people, I am struck by the naiveté with which I approached the search for counseling to get my surgery-authorizing letters. No one at these groups seems to see therapy as the place where they voice their doubts about their transitions, where they wrestle with the political implications of their changes, where they speak about fears of losing membership in various communities or in their families. No one trusts the doctors as the place to work things out. When I mention the places I’ve gone for help, places that are supposed to support queer and trans people, everyone nods knowingly, having heard countless stories like mine about these very places before. Some have suggestions of therapists who are better, but none cost less than \$50/hr. Mostly, though, people suggest different ways to get around the requirements. I get names of surgeons who do not always ask for the letters. I have these great, sad, conversations with these people who know all about what it means to lie and cheat their way through the medical roadblocks to get the opportunity to occupy their bodies in the way they want. I understand, now, that the place that is safe to talk about this is in here, with other people who understand the slipperiness of gender and the politics of transition, and who believe me without question when I say what I am and how that needs to look.

23. WILCHINS, *supra* note 1, at 60.

24. FEINBERG, *supra* note 7, at 63.

II. PRACTICING MEDICINE, POLICING GENDER

When I wrote those words, I was experiencing acutely the gulf between trans community understandings of our bodies, our experiences, and our liberation, and the medical interpretations of our lives. The medical model, ultimately, was what I had to contend with in order to achieve the embodiment I was seeking. I learned quickly that to achieve that embodiment, I needed to perform a desire for gender normativity, to convince the doctors that I suffered from GID and wanted to “be” a “man” in a narrow sense of both words. My quest for body alteration had to be legitimized by a medical reference to, and pretended belief in, a binary gender system that I had been working to dismantle since adolescence. Later, as I contended with my own legal gender status and that of my clients, I would learn that not only medical treatment, but also legal rights and social services for trans people are dependent upon successful navigation of that medical system.

Symptoms of GID in the Diagnostic and Statistical Manual (DSM-IV)²⁵ describe at length the symptom of childhood participation in stereotypically gender inappropriate behavior. Boys with GID “particularly enjoy playing house, drawing pictures of beautiful girls and princesses, and watching television or videos of their favorite female characters. . . . They avoid rough-and-tumble play and competitive sports and have little interest in cars and trucks.”²⁶ Girls with GID do not want to wear dresses, “prefer boys’ clothing and short hair,” are interested in “contact sports, [and] rough-and-tumble play.”²⁷ Despite the disclaimer in the diagnosis description that this is not to be confused with normal gender non-conformity found in tomboys and sissies, no real line is drawn between “normal” gender non-conformity and gender non-conformity which constitutes GID.²⁸ The effect is two-fold. First, normative childhood gender is produced by creating and pathologizing a category of deviants: normal kids are simply those who do the opposite of what kids with GID are doing. Non-GID kids can be expected to: play with children of their own sex, play with gender appropriate toys (trucks for boys, dolls for girls), enjoy fictional characters of their own sex (girls, specifically, might have GID if they like Batman or Superman), play gender appropriate characters in games of “house,” etc.

25. APA, *supra* note 16, at 532.

26. *Id.* at 533.

27. *Id.*

28. *Id.* at 536. The difference is, apparently, that GID gender trouble “represents a profound disturbance of the individual’s sense of identity with regard to maleness or femaleness.” *Id.* Personally, I never knew a tomboy or sissy who might not qualify as profoundly disturbed about their gender, especially in the eyes of their parents and teachers. The differential diagnosis of these kids from kids with GID seems like an afterthought in the writing—a quick way to try and make it not appear that all gender nonconformity is being pathologized by the generalized diagnosis which relies on an impossible norm—a child with no cross gender play habits or transgressive gender explorations. Since almost no child will state “I’m profoundly disturbed about my gender,” this determination will always be left for parents, doctors, and teachers—the surveillance system kicks in.

Secondly, a regulatory mechanism is put into place. Because gender nonconformity is established as a basis for illness, parents now have a “mill of speech,”²⁹ speculation, and diagnosis to feed their children’s gender through should it cross the line. As Foucault describes, the invention of a category of deviation, the description of the “ill” behavior that need be resisted or cured, creates not a prohibitive silence about such behavior but an opportunity for increased surveillance and speculation,³⁰ what he would call “informal-governance.”³¹

Another immediate error and danger of the medical model of transsexuality is its separation of gender from cultural forces. The Diagnostic Criteria for Gender Identity Disorder names, as a general category of symptom, “[a] strong and persistent cross-gender identification (*not merely a desire for any perceived cultural advantages of being the other sex*).”³² This criterion suggests the possibility of a gender categorization not read through the cultural gender hierarchy. This requires one to imagine a child wanting to be a gender transgressive from the one assigned to hir without having that desire stem from a cultural understanding of gender difference defined by the “advantaging” of certain gender behaviors and identities over others. But gender behavior is learned, and children are not born with some innate sense that girls should wear dresses and boys shouldn’t like anything pink. So how can a desire to transgress an assigned gender category be read outside of cultural meaning? Such a standard naturalizes and depoliticizes gender and gender role distress. It creates a fictional transsexual who just knows in hir gut what man is and what woman is, and knows that sie is trapped in the wrong body.

The diagnostic criteria for GID produces a fiction of natural gender in which normal, non-transsexual people grow up with minimal to no gender trouble or exploration, do not crossdress as children, do not play with the wrong-gendered kids, and do not like the wrong kinds of toys or characters. This story is not believable. Yet, it survives because medicine produces it not through a description of the norm, but through a generalized account of the norm’s transgression by gender deviants. By instructing the doctor/parent/teacher to focus on the transgressive behavior, the diagnostic criteria for GID establishes surveillance and regulation effective for keeping both non-transsexuals and

29. MICHEL FOUCAULT, *THE HISTORY OF SEXUALITY, VOL. 1: AN INTRODUCTION* 21 (1978).

30. Foucault uses the example of sexual discourse in the secondary schools of the 18th century. While the general impression may be that the sexuality of children was hardly spoken of at these institutions, in reality an elaborate discourse about the danger of the sexuality of the schoolboy dominated. Every aspect of education was designed to contain the imagined danger. As Foucault describes, “the internal discourse of the institution – the one it employed to address itself” was consumed with concern, speculation, and attempted regulation of schoolboy sexuality. *Id.* at 28.

31. ALAN HUNT & GARY WICKHAM, *FOUCAULT AND LAW: TOWARDS A SOCIOLOGY OF LAW AS GOVERNANCE* 27 (1994).

32. APA, *supra* note 16, at 537 (emphasis added).

transsexuals in adherence to their roles.³³ In order to get authorization for body alteration, the scripted transsexual childhood narrative must be performed, and the GID diagnosis accepted, maintaining an idea of two discrete gender categories that normally contain everyone but occasionally are wrongly assigned, requiring correction to reestablish the norm.

In addition to performing a certain narrative of a gender troubled childhood, the most overt requirement for GID diagnosis is the ability to inhabit and perform the new gender category “successfully.”³⁴ Through my own interactions with medical professionals, accounts of other trans people, and medical scholarship on transsexuality, I have gathered that the favored indication of such “success” seems to be the intelligibility of one’s new gender in the eyes of non-trans people. Because the ability to be perceived by non-trans people as a non-trans person is valorized, normative expressions of gender within a singular category are mandated.

For Claudine Griggs, her project of changing genders fundamentally concerns non-trans people’s perception that she is a born woman. She writes:

I have always had a feminine gender, yet I became a woman not because I changed my driver’s license, took estrogens, applied makeup, grew long hair, or had genital surgery, but because on 1 July 1974, a man

33. In her remarks at the Queer Disability Conference in San Francisco in 2002, Susan Aranoff, staff attorney for Connecticut Legal Rights Project, described her dismay that attorneys were using the GID diagnosis in legal briefs in cases for trans rights. She discussed her experience as an advocate of people diagnosed with mental illness and stated that many people, often children, are still being institutionalized for gender difference on the basis of a GID diagnosis. Based on this I worry about what it means for trans rights advocates and attorneys to bolster the legitimacy of this diagnosis in court when it is still being used to institutionalize people on the basis of gender transgressive expression. *See also* DAPHNE SCHOLINSKI, *THE LAST TIME I WORE A DRESS* (1997) (detailing the punishments—including physical assault, sexual abuse and institutionalization at 15 years of age—visited upon the author when she failed to live up to prevailing definitions of femininity and was diagnosed with GID).

34. Schaefer and Wheeler, chroniclers of Harry Benjamin’s work, describe a “successful” transsexual:

With Benjamin’s encouragement and the inspiration of Jorgensen’s story, Janet took a more scientific and intelligent path toward fulfilling her dream. As with Inez, despite her generally masculine appearance and the late age at which she completed her surgery (in her late 50s), Janet’s is a genuine success story. Freed from her lifelong gender struggle, her brilliant talent emerged. Janet and a business partner developed an invention sufficiently valuable to be sold eventually for millions of dollars.

Except for her closest and most intimate friends, no one in Janet’s life knew that this loved and wonderful woman was not a genetic female. Although she died at 72 of lung cancer, Janet lived her last 25 years in great wealth and contentment.

Leah Cahan Schaefer and Connie Christine Wheeler, *Harry Benjamin’s First Ten Cases (1938-1953): A Clinical Historical Note*, 24 *ARCHIVES OF SEXUAL BEHAV.* 73 (1995) (individual pagination not available). The story illustrates the mediation of proper gender performance through capitalist values. I would assume that a patient who went on to have a career in sex work or food service would not be considered equally “successful.”

opened the door for me as I entered my 8:00 a.m. class. . . . Society must see a woman; otherwise, sex-change surgery or not, one cannot be a woman.³⁵

Griggs uncritically engages and accepts the entirety of the subject position “woman.” The performance of coherent oppositional gender norms, including the rules of chivalry whose underlying premises are questionable at best, secures Griggs’ own self-perception of femaleness. Griggs also tells a story about meeting a man at a bar who assumed her to be a man during a long conversation, and then discovered that she was a woman after the bartender addressed her. She describes that the rest of their interaction included him buying her drinks and saying things like,

Gee, I’m sorry . . . I feel terrible. Now that I see you, I don’t know how I could possibly have thought . . . But maybe you shouldn’t sit so rough, like. You have a beautiful figure. . . . And if you didn’t put your elbows on the bar, a guy could see . . . And maybe, . . . a little makeup would soften you up . . . You could fix your hair.³⁶

In response to this overt policing of her performance of femininity, Griggs writes, “After a while, even I began to wonder if I had carried the ‘butch’ thing too far.”³⁷ Just like many medical practitioners, Griggs accepts that a successful transition hinges upon full participation in the normative, sexist, narrowly defined performance of “woman.”

Judith Halberstam points out a similar operation in the desire of some female-to-male transsexuals (FTMs) and, I would add, of professionals “treating” FTMs, to distinguish FTMs from butch lesbians at any cost.³⁸ Demonstrating how hyper-normative gender normativity becomes for gender transgressive people, Halberstam describes that butch and FTM bodies are always read against and through each other, commonly through a continuum model that seeks to find a defining difference between the two.³⁹ She asserts that such a construction stabilizes butch lesbians as “women” and erases the disruptive work that butch identity engages on dichotomous gender categorization. She points to the lists of “passing tips” that are commonly shared between FTMs on the internet and at conferences.⁴⁰ Many such tips focus on an adherence to traditional aesthetics of masculinity, warning FTMs to avoid “punk” hair cuts, black leather jackets and other trappings associated with butch lesbians. A preppy, clean-cut look is often suggested as the best aesthetic for

35. GRIGGS, *supra* note 13, at 17.

36. *Id.* at 21-22.

37. *Id.* at 22.

38. Judith Halberstam, *Transgender Butch: Butch/FTM Border Wars and the Masculine Continuum*, 4 GAY AND LESBIAN Q. 287 (1998).

39. *Id.* at 292.

40. *Id.* at 298. “[M]any of the tips focus almost obsessively on the care that must be taken not to look like a butch lesbian.” *Id.*

passing. Again, this establishes the requirement that gender transgressive people be even more “normal” than “normal people” when it comes to gender presentation, thereby discouraging gender disruptive behavior. The resulting image, with the most “successful” FTMs resembling khaki-clad frat boy clones, leave feminist gender-queer trannies with the question, why bother? The “passing” imperative begins from the moment a SRS-seeker enters a medical office and is sized up by a professional who will decide hir “realness” and seriousness about surgery. The fact that the professional makes this assessment at least in part based on the success of the SRS-seeker’s presentation of a gender norm makes this process an essential regulating aspect of the process of “transsexual” (and “non-transsexual”) production.

What if the propriety of SRS was not determined by trans patients’ deviations from (non-trans) normative definitions of femininity and masculinity? What if the “success” of transition was not measured by trans people’s adherence to (non-trans) normative definitions of femininity and masculinity? I imagine that, like me, some people have a multitude of goals when they seek gender-related body alteration, such as access to different sexual practices, ability to look different in clothing, enhancement of a self-understanding about one’s gender that is not entirely reliant on public recognition, public disruption of female and male codes, or any number of other things.⁴¹ Some birth-assigned “men” might want to embody “woman” as butch lesbians in a way that meant they enjoyed occasionally being “sirred” and only sometimes “corrected” the speaker. Some birth-assigned “women” might want to take hormones and become sexy “bearded ladies” who are interpreted a variety of ways but feel great about how they look. When the gatekeepers employ dichotomous gender standards, they foreclose such norm-resistant possibilities.

Many of the trans people I have talked to do not imagine themselves entering a realm of “real manness” or “real womanness,” even if they pass as non-trans all the time. Rather, they recognize the absence of meaning in such terms. They regard their transformations as freeing them to express more of themselves, and enabling more comfortable and exciting self understandings and images. While some do rely on passing as non-trans women or men in various aspects of their lives, and some embrace non-trans male or female identity, I think that all are disserved by the requirement that trans people exhibit hyper-masculine or hyper-feminine characteristics to get through medical gatekeeping.

For most of us, negotiating medical standards—whether we are seeking to change our bodies or identity documents, or seeking to enforce our rights—is

41. In some ways these goals are similar to those of people who seek other kinds of cosmetic surgery. Perhaps the most notable difference between some instances of SRS and, say, breast enhancement, pectoral implants, or laser vaginal reconstruction is the ferociousness with which medical practitioners guard technologies which aid in enhancement of the femininity of birth-assigned men and the masculinity of birth-assigned women, and the easy pleasure with which they perform procedures to enhance the femininity of birth-assigned women and the masculinity of birth-assigned men. See Peter M. Warren, *A Cap and Gown—and New Breasts*, L.A. TIMES, May 21, 1999, at E1.

fraught with difficulty. The medical approach to our gender identities forces us to rigidly conform ourselves to medical providers' opinions about what "real masculinity" and "real femininity" mean, and to produce narratives of struggle around those identities that mirror the diagnostic criteria of GID. For those of us seeking to disrupt the very definitions and categories upon which the medical model of transsexuality relies, the gender-regulating processes of this medical treatment can be dehumanizing, traumatic, or impossible to complete.

III. NEGOTIATING A TRANSGENDER PRAXIS

Informed by my own experiences navigating the medical model of transsexuality, and those of my friends and clients, my goal for trans law and policy remains demedicalization and an end to practices that coerce people into expressing gender identity through a narrowly defined binary. I would like to see the end of gender designation on government documents, the end of gender segregation of bathroom and locker room facilities, and the end of involuntary "corrective" surgeries for babies with intersex conditions.⁴² I would like people to have the freedom to determine their own gender identity and expression and not be forced to declare such an identity involuntarily or pick between a narrow set of choices. And I would want no person to be required to show medical or psychiatric evidence to document that they are who and what they say they are. I would like self identification to be the determining factor for a person's membership in a gender category to the extent that knowledge of the person's membership in such a category is necessary.⁴³

I certainly believe that we can move toward de-regulating gender and still engage in important corrective practices like gender-based affirmative action. I am not arguing for a gender-blind society in which all people are similarly androgynous, but instead for a world in which diverse gender expressions and identities occur, but none are punished and membership in these categories is

42. For information on such surgeries, *see generally* INTERSEX SOCIETY OF NORTH AMERICA, *available at* <http://www.isna.org>.

43. San Francisco's Human Rights Commission is currently drafting changes to its Compliance Guidelines for the anti-gender identity discrimination portion of its Human Rights Law. Committee members have suggested that the drafting body is hoping to move away from the standards that currently determine gender identity for trans people seeking use of gender-segregated facilities (which rely on body modification) and toward self-identification as the determination of gender identity. *See generally* TRANSGENDER LAW AND POLICY INSTITUTE, PROHIBITING DISCRIMINATION BASED ON GENDER IDENTITY, *at* <http://www.transgenderlaw.org/resources/sfpolicy.htm>. There is hope that if San Francisco makes these changes other cities will follow suit in their compliance guidelines. Fifty-three jurisdictions in the United States now have anti-discrimination protection that includes gender identity: two states, eight counties, and forty-three cities. The total number of people now living in a jurisdiction with a transgender-inclusive anti-discrimination law in the United States is 36.8 million people, 13 percent of the U.S. population. *See* NATIONAL GAY AND LESBIAN TASK FORCE, POPULATIONS OF JURISDICTIONS WITH TRANSGENDER EXPLICIT ANTI-DISCRIMINATION LAWS, *at* <http://www.ngltf.org/downloads/transinclusivelaws.pdf>.

used less and less to distribute rights and privileges.

Similarly, I would want various groups of similarly-identified people to be able to seek spaces to meet together and for the inevitable conflicts that emerge regarding the identity borders erected by those groups to be determined by negotiation and cultural work, not by legal or medical determinations of gender category membership.⁴⁴ These are my goals for gender and law, but in my work as an advocate for low-income gender transgressive people I am often forced to recognize how far we are from attaining those goals. Consequently, I engage in compromises that I hope will be steps toward the deregulation of gender, compromises which provide access to vitally needed services and entitlements for gender transgressive people who are in crisis now.

These compromises, moreover, are necessitated by the fact that most of the successful legal claims for trans equality have come through strategic use of the medical model of transsexuality. The history of legal struggles for trans rights, of course, has been dominated by judicial decisions which would not recognize gender transition at all, and would not allow gender change no matter what medical evidence was presented. Through extensive effort by activists and lawyers, however, an increasing number of legal and policy victories have emerged. Most of these have made trans access to discrimination protection, identity document change, or other legal remedies entirely reliant on documentation of medical procedures, usually genital surgery.⁴⁵ The mostly unexplored territory remains in the realm of de-medicalization, where trans rights are recognized but will not hinge upon surgical status or medical evidence.⁴⁶ As an attorney working to improve the conditions of people living in crisis, I have to accept that my job cannot just be demanding that all laws I am working to reform immediately relinquish any reliance on medical evidence.

44. At the *Transecting the Academy Symposium* at Brown University in February 2003, Andrea Thompson discussed the controversies that have erupted about "women's space" and whether or not trans people should be permitted in such spaces. Thompson talked about how useful the people of color-only events on her campus had been to students of color and herself, and her frustration with white students who opposed the existence of such spaces. She went on to warn against trans people failing to respect "women-only" spaces that exclude us. While I agree with her that there is a vital importance to the existence of spaces where people who share marginalized identities can gather, I disagree with her defense of the Michigan Women's Music Festival policy which singles out trans women and invests deeply in a narrowly defined birth-gender based conception of "womanhood." I believe this policy reifies binary gender norms and violates the basic feminist principles that biology is not destiny and one is not born a woman. However, these debates about space are an important part of our community work, and I would like to see them continue. We need opportunities for people to think about the meaning of gender categories that are generally taken for granted.

45. See generally LAMBDA LEGAL DEFENSE AND EDUCATION FUND, *supra* note 3.

46. A few examples of this kind of analysis do exist. In a ruling on a discovery motion in a case involving transgender women's use of women's restrooms, Judge Shafer stated that "the status of a transgendered individual is not dependent up on their physical anatomy. . . information about the anatomical sex of [plaintiff's] clients . . . is immaterial." No. 112428-01, slip op. at 6 (N.Y. Sup. Ct. Jan. 10, 2003). See also the San Francisco Human Rights Commission's Compliance Guidelines for the anti-gender identity discrimination portion of its Human Rights Law, *supra* note 43.

Instead, I end up doing a lot of work to get things moving in that direction, but often without even the option of invoking where I am headed.

A good example is my recent work with the Department of Vital Statistics in New York City. The current Vital Statistics policy for changing sex designation on birth certificates, derived from the recommendations of a 1965 committee appointed by the New York Board of Health, requires a person to prove that sie has undergone genital surgery in order to change hir sex designation. Even upon showing of such proof, hir designation will only be changed from its current marking to a blank—not to the letter reflecting hir new gender identity. The policy creates an enormous barrier for people seeking to change their birth certificate so that they can apply for educational or economic opportunities, or prove membership in a gender category for purposes of a sex-segregated facility.

I have been working with attorneys, medical and mental health professionals, and civil rights organizations to encourage Vital Statistics to change its policy not only with regard to leaving sex designation blank, which is certainly unusual and uncommon amongst jurisdictions issuing birth certificates, but also with regard to requiring genital surgery as a precursor to sex designation change. We have led this negotiation, of course, with our most conservative and non-threatening arguments. We have argued that many people cannot undergo surgery because of pre-existing medical conditions. Additionally, we have demonstrated that medical treatment and understanding of transsexuality has changed since 1965. The medical emphasis is now on determining a course of treatment appropriate to individual patients, rather than on a single surgical procedure as the culmination of all patients' treatment. We have emphasized that ninety percent of trans men do not seek phalloplasty because an effective procedure has not been developed. We have asked that a new policy more suited to the current state of medical treatment of transsexuality be applied, one in which medical documentation that the transition is complete and all necessary medical procedures have been undergone be accepted as sufficient evidence. This standard, which no doubt will still be difficult for many trans people to meet, would be an enormous improvement for trans people born in New York City. It would also be the best birth certificate policy in the country because it would possess the fewest medical requirements. However, getting a new policy in place requires me to make strong arguments based on the medical governance of transsexuality to the Vital Statistics staff, who are deeply concerned about people "changing back" if they lower their requirements. These arguments involve my detailing how wonderfully rigid the medical processes of transition are, and how no one passes through without making a permanent decision to live in their new gender. Of course, I am at the same time continually working to loosen the medical grip on trans people and to challenge this fear of "changing," even as I argue to these policymakers about how legitimate that tight grip is and how they do not need to police trans identity because the doctors will do it for them.

This negotiation demonstrates the position that trans attorneys and advocates are placed in when wrestling with the fact that, to some extent, the medicalization of trans identity was at one time a progressive step toward dignity and equality because it was preferable to total illegitimacy and criminality. However, even as we rely on it to argue that trans people should be protected from discrimination and allowed to legally change our genders, we proceed with caution and work to reduce the gatekeeping powers of medical experts over us.

The most pressing and controversial area in trans law bringing up these issues currently is the question of whether and when disability discrimination claims should be used to address instances of gender identity discrimination. In an ideal world, many trans advocates, including myself, would like to see gender identity discrimination dealt with through gender discrimination claims. In my view, gender identity discrimination is fundamentally an aspect of gender discrimination. Sexist oppression requires that all people adhere to two narrowly defined gender categories; that all people work, dress, reproduce, and generally behave according to the standards set out as appropriate for members of their respective categories; and that all people be afforded or denied rights and privileges based on their membership in, and performance of, these categories. Those who violate these norms by trying to work in a field not designated for their gender, or by refusing to dress according to the expectations of the gender category they have been assigned, need protection from discrimination based on such narrow expectations of how people of each gender should live and behave. Anti-gender-based discrimination law, then, is the logical place to find protection for people being discriminated against for, say, wearing a dress when they are considered "male" by the discriminator, or requesting to be called by male pronouns when they are considered "female" by the discriminator.⁴⁷

However, as much as I prefer those claims, there are serious obstacles to pursuing gender discrimination claims when seeking trans rights. For one, most courts have found that Title VII does not protect against discrimination for trans people, because the statute's intent was solely to eradicate barriers to "women's" equality.⁴⁸ With similar rationales, many state courts have refused to extend protection under state gender discrimination law to trans people.⁴⁹ Because

47. This rationale would place gender identity discrimination under the precedent against sex stereotyping elaborated in *Price-Waterhouse v. Hopkins*, 490 U.S. 228 (1989).

48. See *Ulane v. Eastern Airlines, Inc.*, 742 F.2d 1081 (7th Cir. 1984) (holding that "the words of Title VII do not outlaw discrimination against a person who has a sexual identity disorder, i.e., . . . a person born with a female body who believes herself to be a male"). See also *Somers v. Budget Marketing*, 667 F.2d 748 (8th Cir. 1982); *Holloway v. Arthur Andersen & Co.*, 566 F.2d 659 (9th Cir. 1977); *James v. Ranch Mart Hardware, Inc.*, 881 F. Supp. 478 (D. Kan. 1995); *Powell v. Read's, Inc.*, 436 F. Supp. 369 (D. Md. 1977); *Voyles v. Ralph K. Davies Med. Ctr.*, 403 F. Supp. 456 (N.D. Calif. 1975).

49. See *Conway v. City of Hartford*, 1997 Conn. Super. Ct. LEXIS 282 (Feb. 4, 1997) (dismissing a sex discrimination claim alleging violations of Connecticut Fair Employment Practice Act); *Underwood v. Archer Mgmt. Serv., Inc.*, 857 F. Supp. 96 (D.D.C. 1994) (dismissing a sex discrimination claim alleging violations of the D.C. Human Rights Act); *Dobre v. National R.R. Passenger Corp. (AMTRAK)*, 850 F. Supp. 284 (E.D. Pa. 1993)

gender discrimination claims have often been a dead end or a risky venture, disability discrimination claims have become an important alternative.

The federal disability statutes—the Americans with Disabilities Act and the Rehabilitation Act—both explicitly bar coverage of transsexuals.⁵⁰ However, trans plaintiffs have had some success with disability discrimination claims under state disability discrimination statutes.⁵¹

In my own practice, my greatest struggle with the issue of whether to use disability discrimination claims came when I was working with a team of attorneys on the *Jean Doe v. Bell* case.⁵² That case involved a young trans woman in foster care who was moved to a group home facility where she was not allowed to wear skirts or dresses. We sued the Administration for Children's Services seeking a change in policy, and brought claims based on gender discrimination, the First Amendment, and disability discrimination.

I worked with a team of attorneys from a large firm, in addition to two attorneys at my hosting agency on the case. I was the only trans person, besides the plaintiff, involved in the litigation. I was also the youngest attorney and the person who had been practicing for the shortest amount of time. My colleagues wanted to pursue the most winnable claims in the most direct ways possible. Even with my continued discussion of the controversial nature of disability law claims for trans plaintiffs, they generally seemed unconcerned about the broader implications of relying on GID in our lawsuit.

I was deeply concerned about the disability discrimination claim for a number of reasons. First, claiming disability discrimination required pleading “a physical, mental or medical impairment resulting from anatomical, physiological, genetic, or neurological condition which prevents the exercise of a normal bodily function or is demonstrable by medically accepted clinical or laboratory diagnostic techniques.”⁵³ I was concerned about relying on GID to meet this requirement, both because of my own misgivings about the description and treatment of that diagnosis, and because I knew that many trans youth in foster care will never be able to access such a diagnosis because they lack access to any medical care, let alone care that is trans-friendly. As I worked with the other attorneys on the case, I continually ran up against their lesser interest in thinking about the broader implications of the case for other trans youth, and their narrow focus on winning the single case for the single plaintiff.

(dismissing claim brought under sex discrimination provision of Pennsylvania Human Rights Act); *Kirkpatrick v. Seligman*, 636 F.2d 1047 (5th Cir. 1981) (holding there is no violation under the 14th Amendment or under state law prohibiting sex discrimination where employer fired plaintiff when plaintiff notified employer of her intent to undergo sex reassignment, began living and dressing as a female, and refused to comply with employer's requirement that she must wear male clothing to work).

50. See Rehabilitation Act, 29 U.S.C. § 706(8)(F)(i) (1997); ADA, 42 U.S.C. § 12211(b)(1) (1997).

51. See, e.g., *Doe v. Bell*, 2003 WL 355603 (Jan. 9, 2003); *Doe ex rel. Doe v. Yunits*, 15 Mass.L.Rptr. 278 (Mass. 2001).

52. 2003 WL 355603 (Jan. 9, 2003).

53. N.Y. EXEC. LAW § 292 (21) (2003).

There were some aspects of our New York disability claim that eased my misgivings a little. The positive aspect of the “impairment” requirement was that, unlike the federal disability statutes and some state statutes, we did not need to plead that Jean was “substantially limited in a major life activity.”⁵⁴ New York’s disability discrimination coverage is broader, allowing individuals with diagnosable impairments, even if they cannot prove limitation in a specific major life activity, to be considered “disabled” for purposes of the statute. This meant simply demonstrating that Jean had been diagnosed with GID was enough to get her covered under the law and to force the court to look at whether she was being discriminated against by the dress code policy. Nonetheless, I was very concerned about relying on GID in our claim.

We won the case, and the court chose disability discrimination as the claim upon which we would prevail.⁵⁵ The court’s decision establishes a basis for challenging discriminatory treatment of trans youth in foster care in New York, a pervasive problem, and also strengthens claims about discrimination against trans people in other contexts. However, its reliance on disability law claims highlights some important questions in the trans community.

The first response that always comes up, which does not get to the heart of my concerns about these claims, is the argument that trans people do not want to be seen as “disabled.” There is a gut reaction that occurs, where people feel that using disability law claims means we are arguing that we are somehow flawed people. What is at play in this response is ableism, and this reaction is usually resolved by pointing out that the theory of disability law is not about going into court and arguing for rights based on an idea that people with disabilities are flawed. Instead, the disability rights movement, and the legal claims developed by the tireless activism of people in that movement, is about pointing out that disabled people are capable of equal participation, but are currently barred from participating equally by artificial conditions that privilege one type of body or mind and exclude others.

Similarly, trans people could use the disability rights framework to argue that we are fully capable of participating equally, but for artificial conditions that bar our participation. Examples of such conditions include gender-segregated facilities or dress codes administered according to birth gender. Like others in the disability rights movement, trans people are fighting against entrenched notions about what “normal” and “healthy” minds and bodies are, and fighting to become equal participants with equal access and equal protection from bias and discrimination.

This part of the overlap between disability rights and trans rights is not what concerns me. What does concern me is the process I have to go through to plead a disability discrimination claim for a trans plaintiff. Specifically, if I have

54. 29 C.F.R. § 1630.2(j)(1) (2003).

55. “Because the Court finds that Doe is entitled to relief on her disability discrimination claim, the Court need not reach her alternative bases for relief.” 2003 WL 355603, at *17 (Jan. 9, 2003).

to find a “diagnosable condition,” I have to rely on GID to make my claims. I do not want to make trans rights dependent upon GID diagnoses, because such diagnoses are not accessible to many low income people; because I believe that the diagnostic and treatment processes for GID are regulatory and promote a regime of coercive binary gender; and because I believe that GID is still being misused by some mental health practitioners as a basis for involuntary psychiatric treatment for gender transgressive people. I do not want to legitimize those practices through my reliance on the medical approach to gender nonconformity.

One part of me believes that real harm will not come from using disability discrimination claims. I understand many attorneys’ argument that we have an ethical obligation to our clients to plead all winnable claims. Additionally, because we can plead multiple claims and judges can pick and choose on what basis to rule, perhaps it is best to plead all possible bases for victory. However, another part of me recognizes the ease with which non-trans people might approach a medicalized and pathologizing approach to gender difference, and that this may cause judges to continually choose disability law claims and thus ignore more appropriate claims of gender discrimination.

Consequently, I use these claims with extreme caution. We must strike a balance between wanting to avoid over-reliance on medical evidence while contending with the fact that many trans people’s lives are entangled with medical establishments, and for those people, it would be beneficial to prove that sex reassignment related treatments are “medically necessary” and should be covered by Medicaid and private health insurance.

Attorneys and advocates working for trans equality have to skate this delicate line, de-medicalizing legal approaches to gender identity where we can, educating medical providers on how to provide medical services to gender transgressive people in ways that respect and encourage individual expression rather than conformity to binary gender, and also fighting for increased access to medical care for all people. Moreover, because of the compromised and potentially dangerous character of successful litigation on behalf of trans clients, our advocacy must also address the systemic problems inherent in the institutions that entangle our disproportionately low-income clients. In my work, in particular, I understand that the institutions which dominate my clients’ lives—prisons, foster care, public benefits programs, juvenile justice, and the like—are often mobilized to do harm by racist and anti-poor sentiment. These same institutions more often than not are gender-segregated and operated through violence, harassment and intimidation that particularly impacts people whose bodies and expressions violate binary gender norms. The more I work in law, the more invested I become in the non-legal activism I engage in, because I realize increasingly that the role of law in creating the fundamental shifts that we are demanding is limited. I am excited about using legal skills to help trans people in crisis, and engaging in creative use of medical evidence when necessary to assist my clients, but I also recognize that legal cases are always

about single plaintiffs or classes of similarly situated plaintiffs, and cannot always do the work necessary to create remedies and protections for the diversity of gender-different people. Sometimes it is possible to use victories for single plaintiffs to expand rights for a broad group, but it is always important to be careful that the fight for a single plaintiff's rights does not curtail rights for a broader group. For example, I do not want to plead cases for clients who have undergone medical procedures in ways that will lead to a victory where the rights of trans people hinge on undergoing those procedures.

For this reason, I think it is important that trans people be a part of conversations about how legal claims are pursued by attorneys, and that attorneys working on such claims understand themselves to be determining not just the rights of a single plaintiff, but impacting a broad set of gender transgressive people who may differ from the plaintiff in question in essential ways. Additionally, I think that now, more than ever, trans activists should be thinking about how we can work in coalition with other activists—particularly those working to combat racism and end poverty—to increase awareness of what role trans and gender transgressive people have in anti-racist and anti-poverty movements. Trans people remain disproportionately low-income, struggling against gender segregation in regulatory government facilities and services where we are still usually placed based on genital status. As we struggle with medicalization in these contexts, we have valuable opportunities to ally ourselves with other communities that are fighting against the violence and dehumanization of these systems. Too often, legal rights organizations in the LGB movement have been focused on gains that predominately benefit upper class people and have failed to prioritize welfare rights, affordable housing, police brutality, and other policy areas central to the lives of low-income people and people of color. Trans people have also been marginalized by this mainstream movement and our issues ignored or put on the backburner.⁵⁶ As we emerge struggling for our own equality, and demanding accountability from community organizations that have failed to include us in their struggles, we must keep our attention on this history of racism and classism in the LGB movement and discover new ways to ally ourselves with movements that are addressing the institutions in which we too remain entangled.

In this way, the negotiation of medical knowledge in trans people's

56. Our history is laden with these examples. Most recently, the Sexual Orientation Non-Discrimination Act passed the New York State Legislature. N.Y. EXEC. LAW § 291. This bill does not include any protection against gender identity discrimination despite years of trans activism fighting for inclusion. The organization sponsoring the bill, the Empire State Pride Agenda, made the decision that it was more politically expedient to exclude us from coverage. *See generally* EMPIRE STATE PRIDE AGENDA, at <http://www.espany.org>. Similarly, the federal Employment Non-Discrimination Act, as drafted, does not include language to protect trans people. Again and again, mainstream LGB groups have chosen to excise trans issues from their agendas, despite the fact that the efforts and bravery of trans and gender transgressive people have been an integral part of the struggle for queer and trans liberation throughout our history.

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personal and legal struggles makes clear that a multi-strategy approach is always necessary for political action. Legal reform will not be the forefront of bringing the fundamental changes to gender oppression that I desire. I believe in the necessity of litigation and policy work to alleviate immediate crises in the lives of trans people, but I also know that organizing and cultural work have been central to this movement since its inception. Even if we see increasing legal victories, we need to remember that it is that work which will lead to the kinds of change we want to see: change unmitigated by entanglement with the regulatory medical constructs that we are striving to escape.