I. INTRODUCTION

Most definitions of transsexuality include a medical component, often by describing hormonal and surgical treatments sought by those individuals who perceive themselves to be and seek to live as the gender other than the one assigned to them at birth. Although people had these self-perceptions prior to the development of medical treatments to alter secondary sex characteristics, their identity is now largely understood through the prism of available medical treatments. The American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV) recently consolidated transsexualism with what it classifies as other gender identity disorders and describes the experience of gender identity disorder as follows:

Adults with Gender Identity Disorder are preoccupied with their wish to live as a member of the other sex. This preoccupation may be manifested as an intense desire to adopt the social role of the other sex or to acquire the physical appearance of the other sex through hormonal or surgical manipulation.

In earlier versions of the DSM, “transsexualism” was listed separately and the diagnostic criteria included “[p]ersistent preoccupation for at least two years with getting rid of one’s primary and secondary sex characteristics and
acquiring the sex characteristics of the other sex.” Assigning diagnostic criteria and disorder status to a person’s experiences and beliefs might seem detrimental to positive identity construction. For this reason, lesbians and gay men fought hard and successfully for the exclusion of homosexuality from the DSM. Transsexualism was included in the DSM for the first time in 1980, in the same edition in which homosexuality was first removed. For transsexuals, who rely on medical authorities for diagnoses that will qualify them for the sex-reassignment treatment they desire, inclusion was the result of a successful battle.

The relationship between transsexuals and the medical establishment upon which they rely for treatment has been termed “uneasy,” however, and the victory of DSM inclusion “Pyrrhic,” because of the potential incongruity between disorder and empowerment. Nonetheless, courts have often (although not always) provided benefits to transsexuals by relying on a medical model of transsexual identity. In this Article, I explore the conflict between the potential benefits and harms of a medical model for identity construction. By relying on this model, both transsexuals and courts experience a crisis of authority, a situation in which the invocation of outside authority both bolsters and undermines the actor’s own power and authority.

In Part II, I summarize and explore the positions of theorists who oppose the role that doctors and medical rhetoric have played in the construction of transsexual identity. These theorists variously portray transsexuals as victims of or participants in this process. In Part III, I consider the role of court opinions in reinforcing the potential conflict between the harms and benefits of the medical model. This conflict is exacerbated by the inconsistent results of legal decisions on provision of medical benefits, treatment in prison, criminalization of cross-dressing, and other areas. Like transsexuals, courts experience a crisis of authority in confronting medical opinion. By unquestioningly deferring to this authority, courts often avoid difficult issues of allocating finite resources for medical treatment. In Part IV, I question the assumed association between disability and disempowerment, suggesting that for transsexuals, the medical model may offer political as well as practical benefits. Further, I suggest the

7. Such treatment normally involves hormone therapy as well as genital surgery. Together these treatments produce the primary and secondary sex characteristics transsexual patients seek. See RON LANGEVIN, SEXUAL STRANDS: UNDERSTANDING AND TREATING SEXUAL ANOMALIES IN MEN 197-200 (1983).
importance for both courts and transsexuals of considering the concept of social necessity rather than medical necessity as a basis for justifying sex-reassignment treatments. This mechanism may help courts explore some of the difficult questions the opinions often avoid.

II. MEDICAL RHETORIC AND THE CONSTRUCTION OF TRANSSEXUAL IDENTITY

A number of theorists writing about transsexuality dispute that sex-reassignment surgery is a treatment response to a pre-existing transsexual identity, but rather contend that the identity itself is created by the available treatment and the rhetoric used to justify it. For example, sociologists Dwight Billings and Thomas Urban maintain that “[t]he legitimation, rationalization, and commodification of sex-change operations have produced an identity category—transsexual—for a diverse group of sexual deviants and victims of severe gender role distress.”9 Their point is much like Michel Foucault’s—that rhetorical structures might influence and thus constrain conceivable choices in medical practice related to sexuality.10 As Janice Irvine argues, “[t]he creation of the dysfunction called transsexualism . . . . closed down more possibilities than it opened up.”11

Theorists like Billings and Urban, as well as members of the transgender community, deplore this rhetorical construction of identity because of its ill effects. They criticize medical professionals—academic writers and researchers as well as clinicians—both for establishing surgery as the ultimate desideratum for transsexual identity and for reinforcing traditional gender roles in the screening process for surgery. They believe that transsexual surgery and the stereotypes that accompany it substitute for more thoroughgoing challenges to gender norms.

Billings and Urban blame the desire for surgery on transsexuals’ unrealistic expectations that were reinforced by physicians, who, according to these authors, advertised the new body parts like commodities.12 Billings and Urban suggest that sex-reassignment surgery has generally not been as successful as reported, because the reports were disingenuously based on flawed follow-up studies.13 Further, medical professionals were able to establish a tight fit between condition and treatment by making desire for surgery a part of the

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9. Dwight B. Billings & Thomas Urban, The Socio-Medical Construction of Transsexualism: An Interpretation and Critique, 29 SOC. PROBS. 266, 266 (1982). See also HAUSMAN, supra note 2, at 137-39 (suggesting that transsexuality and its gender identity claims stabilize and hide more complex and contradictory impulses, including the desire to re-engineer the self).


11. JANICE M. IRVINE, DISORDERS OF DESIRE: SEX AND GENDER IN MODERN AMERICAN SEXOLOGY 265 (1990); see also id. at 239 (stating that “[g]ender sexologists are disinclined to hear that ‘cross-gender behavior,’ ‘gender transpositions,’ or ‘sexual deviance’ can be positive, affirming experiences for those who live them”).

12. See Billings & Urban, supra note 9, at 272.

criteria for the diagnosis of transsexualism. The arguments of Billings and
Urban and others suggest that prospective patients came to desire surgery
because they were told by the medical professionals responsible for evaluating
them (and their desire for surgery) that surgery would relieve their distress.15

In the 1970s, physicians discovered that individuals applying for surgery
frequently incorporated highlights from textbook case studies in their own
autobiographies, which they presented in interviews as part of the diagnostic
procedure.16 If candidates' life stories mirrored the textbook cases, they were
more likely to be approved for surgery: “Patients whose subjective histories are
subsumed under the unifying rhetoric of transsexualism win operations.”17 In a
similar vein, McKenzie argues that the mere availability of surgical alteration
and other practices “teach transsexuals and transgenderists to hate their body”
and thus to seek surgery.18

The medical professionals who screen transsexuals for surgery and
counsel them before and after surgery are also accused of perpetuating and
reinforcing traditional gender stereotypes. By accepting only those candidates
who are inclined to inhabit their new gender role according to stereotypes and
by training these candidates in what is perceived as the appropriate role, the
clinicians may help determine what transsexual identity means. This is one of
the means by which, Billings and Urban argue, “[s]ex-change surgery privatizes
and depoliticizes individual experiences of gender-role distress.”19 By
“reaffirm[ing] traditional male and female roles,” sex-change surgery and the
rhetoric of those who promote it hides and distorts, according to Billings and
Urban, what is in fact a great variety of potentially socially disruptive gender
expressions: “Despite the mute testimony of confused and ambivalent patients
to the range of gender experience, individuals unable or unwilling to confirm
[sic] to the sex roles ascribed to them at birth are carved up on the operating
table to gain acceptance to the opposite sex role.”20

Billings and Urban and others document many of the ways in which the
screening process, at least in the 1970s when it was most closely studied, drew
upon and promoted gender stereotypes. Most prominently cited is the apparent

14. See DSM-IV, supra note 3, at 532-33; Billings & Urban, supra note 9, at 271.
15. See GORDENE OLGA MACKENZIE, TRANSGENDER NATION 71 (1994).
16. See Billings & Urban, supra note 9, at 273; Stone, supra note 8, at 291.
17. Billings & Urban, supra note 9, at 274. Suzanne Kessler and Wendy McKenna note that in order to
be approved, the evidence needed “consists of proving, through talk, that they have always felt, as far back as they
can remember, like the gender other than the one they were assigned.” SUZANNE J. KESSLER & WENDY
MCKENNA, GENDER: AN ETHNOMETHODOLOGICAL APPROACH 117 (1978). They also note the difficulty in
assessing the validity of an individual’s assertion along such lines: “Anyone familiar with the literature on
transsexualism knows that in order to be considered a transsexual by a medical examining team, one must talk
about always having felt like a member of the ‘opposite’ gender.” Id.
18. MACKENZIE, supra note 15, at 24-25; see also KATE BORNSTEIN, GENDER OUTLAW: ON MEN,
WOMEN, AND THE REST OF US 119 (1994) (“We don’t hate any part of our bodies we weren’t taught to hate. We’re
taught to hate parts of our bodies that aren’t ‘natural’—like a penis on a woman, or a vagina on a man—and it
seems that the arbiters of nature are the doctors.”). “Transgenderists” are individuals who live as the gender other
than that associated with their anatomy, yet do not seek surgical alteration of their anatomy.
20. Id.
requirement that the successful male-to-female candidate had to be conventionally attractive in the feminine role. For example,

[a] clinician during a panel session on transsexualism at the 1974 meeting of the American Psychological Association said that he was more convinced of the femaleness of a male-to-female transsexual if she was particularly beautiful and was capable of evoking in him those feelings that beautiful women generally do.  

Successful candidates were also expected to conform to heterosexual and gender norms. They were encouraged to seek heterosexual relationships in their new gender, and preoperative candidates, living for the prerequisite time in the gender to which they sought to be assigned, were encouraged to seek employment in lines of work typical for that gender. Stone cites efforts by at least one clinic to “groom” even its accepted male-to-female candidates in the roles and mannerisms of the new gender or, as she puts it, “to produce [in the case of male-to-female transsexuals] not simply anatomically legible females, but women . . . i.e. gendered females.”

Janice Irvine and Judith Shapiro suggest that such efforts were successful, and they attribute many transsexuals’ conservative and extreme views about gender to the socialization effected by the medical screening process. Shapiro suggests that the enforcement mechanism is the treatment that will be withheld unless gender conformity is demonstrated: “The gender conservatism of

21. The term “male to female” or “female to male” is used to describe the direction of change. The first term designates the gender assigned at birth on the basis of anatomy, and the second term the gender the transsexual considers himself or herself to be.

22. KESSLER & MCKENNA, supra note 17, at 118. See also IRVINE, supra note 11, at 261 (“[P]hysicians’ evaluation of the candidate’s appearance became a critical diagnostic component.”); Judith Shapiro, Transsexualism: Reflections on the Persistence of Gender and the Mutability of Sex, in BODY GUARDS 248, 254 (Julia Epstein & Kristina Straub eds., 1991) (“Physical attractiveness seems to have provided the major basis for an optimistic prognosis in male to female sex change.”). Such evaluations partook, complexly, of racist and homophobic as well as sexist stereotypes. Billings and Urban report the comment of one physician they observed: “We’re not taking Puerto Ricans any more; they don’t look like transsexuals. They look like fags.” Billings & Urban, supra note 9, at 275. Irvine quotes another clinician similarly: “You can tell a drag queen because she looks like Diana Ross. A transvestite looks like your Aunt Mary from New Jersey.” IRVINE, supra note 11, at 261.

23. See KESSLER & MCKENNA, supra note 17, at 118. According to Stone, genital eroticism, either before or after surgery, was discouraged in male-to-female transsexuals, unless it involved heterosexual penetration. See Stone, supra note 8, at 291-92 (“‘Wringing the turkey’s neck,’ the ritual of penile masturbation just before surgery, was the most secret of secret traditions.”). In contrast, it is interesting to note the current prominence of lesbians and bisexuals among self-identified male to female transsexuals writing today. See, e.g., BORNSTEIN, supra note 18; Stone, supra note 8.

24. See Phillips v. Michigan Dep’t of Corrections, 731 F. Supp. 792, 796 (W.D. Mich. 1990) (citing criteria presented by medical expert for diagnosis of transsexual, including “work at an unambiguously female profession or one that is not associated with males or females”); RICHARD F. DOCTOR, TRANSVESTITES AND TRANSEXUALS: TOWARD A THEORY OF CROSS-GENDER BEHAVIOR 28 (1988) (noting as a “contradiction” for a diagnosis of primary transsexuality in one case study the fact that a candidate seeking transition from male to female “seems to have functioned satisfactorily in several vocational roles often held by men”).

25. Stone, supra note 8, at 290-91.

26. Id. at 291 (alteration in original).

27. See IRVINE, supra note 11, at 263; Shapiro, supra note 22, at 254.
transsexuals is encouraged and reinforced by the medical establishment on which they are dependent for therapy.\textsuperscript{28} Under this view, clinicians, as gatekeepers to transsexual identity, establish both who will be afforded that identity and what that identity will be like.

Kessler and McKenna suggest that the screening process reinforces gender in this fashion precisely because the concept of transsexuality was designed to relieve societal anxiety about gender. According to these sociologists, the diagnostic category of transsexualism was “constructed to alleviate ambiguity—to avoid the kinds of combinations (e.g., male genitals-female gender identity) that make people uncomfortable because they violate the basic rules about gender.”\textsuperscript{29} Indeed, the much-cited failure of psychotherapy as justification for surgery appears to result from a similar impulse. The psychotherapy that failed was geared toward altering the patient’s gender identity to conform to his or her genitals, rather than toward facilitating the patient’s self-acceptance as someone with a complex gender identity.\textsuperscript{30}

By contrast, others argue that transsexuals themselves have played a significant role in the development of transsexual surgical practice as well as transsexual identity. It seems unlikely that the identity-construction vector would point in only one direction. If, as Billings and Urban contend, patients at gender clinics “had routinely and systematically lied” about their own histories in order to meet the expectations of surgeons,\textsuperscript{31} then they did so not necessarily as unwitting victims, but as active seekers of treatment. Although Bernice Hausman agrees that one’s ability to assume transsexual identity “depends upon a necessary relation to the medical establishment and its discourses,” she sees the relationship as a dialectical one that includes the agency of transsexuals.\textsuperscript{32} She argues that both the technological availability of sex change surgery and transsexual demand for it played as significant a role in the complex development of transsexual identity as did the discourse and practice of the doctors who treated transsexuals:

That the demand for sex change became the key signifier for transsexualism demonstrates the centrality of technology to the

\begin{itemize}
  \item 28. Shapiro, \textit{supra} note 22, at 254.
  \item 29. \textsc{Kessler & McKenna, \textit{supra} note 17, at 120.}
  \item 30. \textit{See Mackenzie, \textit{supra} note 15, at 72 (describing the view of a pioneer sex-change surgeon on the impossibility of altering gender identity through psychotherapy); \textit{id. at 79 (ascribing psychotherapeutic failure to attempts “to mold patients into rigid stereotypes”); \textit{see also Billings & Urban, \textit{supra} note 9, at 276 (“Transsexual therapy ... pushes patients toward an alluring world of artificial vaginas and penises rather than toward self-understanding and sexual politics.”).}}}
  \item 31. Billings \& Urban, \textit{supra} note 9, at 273. Irvine, less pointedly, suggests something similar: “Soon [sexologists] began hearing a master narrative repeated by surgical candidates who had studied the literature thoroughly and were prepared to jump the therapeutic hurdles set up by gender scientists.” \textsc{Irvine, \textit{supra} note 11, at 261.}
  \item 32. \textsc{Hausman, \textit{supra} note 2, at 3. Although King notes that it is not unusual in medical discourse more generally that the available treatment influences diagnoses, and that money plays a role in the promotion of treatments, he is critical of Billings and Urban for their failure to situate medical discourse as part of a more complex cultural negotiation. \textsc{See Dave King, \textit{The Transvestite and the Transsexual: Public Categories and Private Identities} 183, 184, 186 (1993).}}}
\end{itemize}
consolidation of transsexual subjectivity—asking for technologically mediated sex change is in one and the same gesture to name oneself as transsexual and to request recognition as a transsexual from the medical institution. In addition, by making their desired treatment absolutely clear, transsexuals encouraged a therapeutic response on the part of clinicians. In this way, transsexuals were actively engaged in defining their position within medical discourses.33

Of course, the feedback loop between transsexuals and medical providers is likely to be complicated and heavily negotiated. The desire for surgery that would lead a patient to present him or herself as the ideal surgical candidate must come from somewhere. The rhetoric of doctors may be one source, but the sources may be multiple as well. Sociologist Dave King emphasizes that, significant as medical perspectives are for the construction of transsexual identity, these medical perspectives themselves are informed by other cultural constructs that similarly influence transsexuals.34 It is also plausible that the benefits presented by a transsexual identity cause individuals already uncomfortable with their own relationship to gender to reevaluate their own life histories in light of newly perceived congruities with the textbook cases.35

Despite their differences, theorists in both camps—those who see transsexuals as victims of medical rhetoric and those who see them as participants—share an either explicit or implicit belief that the surgical practices and accompanying rhetoric they criticize replace a more authentic sexuality or gender identity. Billings and Urban suggest the possibility of a utopian world beyond the constraints of both gender and physiology when they write that the medical practices they deplore have “indirectly tamed and transformed a potential wildcat strike at the gender factory.”36 Hausman, by contrast, appears to suggest that it is not possible to transcend gender in the manner suggested by Billings and Urban: “[O]ne cannot ‘escape’ gender by switching roles or performances and thereby confuse the binary logic, because that logic defines the possibility of switching in the first place.”37 Nonetheless, she also considers that there might be other ways to “truly destabilize bipolar gender schema” that involve questioning and criticism rather than transsexual surgery, or even transgender lifestyles,38 although she leaves these methods unspecified. The raising of this possibility suggests that there is a hope held out for the transcendence of gender categories outside the binary of male and female.

The critique of the medical model of transsexuality, as well as the hope for gender utopia, are shared in some instances by transsexuals themselves. By

33. HAUSMAN, supra note 2, at 129.
34. See KING, supra note 32, at 186.
35. See MACKENZIE, supra note 15, at 70 (questioning the effect of diagnostic criteria on shaping transsexuals’ and transgenderists’ own sense of identity).
36. Billings & Urban, supra note 9, at 278.
37. HAUSMAN, supra note 2, at 198.
38. See id. at 196.
definition, however, transsexuals seeking sex-reassignment surgery are beneficiaries of, or at least participants in, the medical model, because they receive the diagnosis, and with it the treatment they seek, only by seeking psychiatric intervention. The conflict created by the importance of the medical model in the lives of transsexuals and sympathy with its critique creates what can be considered a crisis of authority for transsexuals' own theorizing about their identity.

Some transsexual theorists denounce medical discourse for promoting a pathologized and possibly disempowering image of the transsexual. For example, Susan Stryker states: "I live daily with the consequences of medicine's definition of my identity as an emotional disorder. Through the filter of this official pathologization, the sounds that come out of my mouth can be summarily dismissed as the confused ranting of a diseased mind." Similarly, Sandy Stone, echoing to a certain degree Billings and Urban, is critical of the homogenization of a variety of gender experiences: "Concomitant with the dubious achievement of a diagnostic category is the inevitable blurring of boundaries as a vast heteroglossic account of difference, heretofore invisible to the 'legitimate' professions, suddenly achieves canonization and simultaneously becomes homogenized to satisfy the constraints of the category."

This medicalization of transsexual identity has gained cultural currency. The accompanying image of passivity may provide a substantial dilemma for transsexuals. For example, the author of a recent book on a transgender historical figure is so put off by the medical implications of transsexuality that he rejects the label, declaring:

The problem with pinning a psychosexual disorder on d'Eon is that it minimizes his own will and cognition in the process of his own gender transformation. Interpreting d'Eon as a transsexual renders him fundamentally passive. His gender transformation is seen as something that happened to him, the result of a genetic defect or childhood experiences, rather than a process that he freely brought upon himself as a mature adult. Instead of an active intellect, aware of his choices, and even trying to change his society, d'Eon is portrayed in this interpretation as a victim of an illness whose only fate is to suffer.

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39. See DSM-IV, supra note 3, at 533 (including a desire for surgical and hormonal intervention in the definition of Gender Identity Disorder).

40. Susan Stryker, My Words to Victor Frankenstein Above the Village of Chamounix: Performing Transgender Rage, 1 GLQ: J. LESBIAN & GAY STUD. 237, 244 (1994).

41. Stone, supra note 8, at 293.

Many transsexuals would like to see themselves as possessors of active intellects seeking to change society; thus, to the extent that medical rhetoric is perceived to be at odds with this image, medical rhetoric can be disabling. Nevertheless, a reliance on a medical model of transsexuality, despite its disempowering potential, is often deemed necessary for the provision of public and private medical insurance benefits for transsexuals, adequate treatment in prison, relief from arrest, and other benefits as well as a justification for the gender reassignment surgery sought by transsexuals.\textsuperscript{43} The term “crisis of authority” describes this conflict between the perception of the medical model’s practical importance and the countervailing perception of its disempowering effects. Kate Bornstein highlights the conflict as follows: “Transsexuals, especially middle-class, pre-operative transsexuals, are heavily invested in maintaining their status as ‘diseased’ people. The demedicalization of transsexuality would further limit surgery in this culture, as it would remove the label of ‘illness’ and so prohibit insurance companies from footing the bill.”\textsuperscript{44}

This conflict creates a crisis not just because reliance on medical authority generates both positives and negatives, but also because such reliance presents a challenge to transsexuals for an agentic image of identity. If transsexual identity is constructed through the medical model, yet the model disempowers transsexuals, there seems to be no choice (i.e., either abandoning or retaining the model) that promises a complete and empowering identity for transsexuals unless they abandon the very concept of transsexuality. Because of the role law plays in reinforcing the medical model and because of the protection it at least potentially offers transsexuals against various forms of negative societal sanction, the choice is even more complicated.

III. APPELLATE OPINIONS AND MEDICAL RHETORIC

Legal cases participate in this crisis of authority in a number of ways. Court decisions reinforce medical rhetoric and its role in determining transsexual identity by embracing a medical model. By connecting this rhetoric and concrete benefits for transsexual litigants, these cases also demonstrate the value of the medical model. However, the embrace of medical rhetoric does not produce consistently favorable results for transsexuals, in part because of the courts’ own crisis of authority.

A. The Role of Legal Opinions in Reinforcing the Benefits of Medical Rhetoric

When judges rule in favor of transsexual litigants, their opinions frequently portray transsexuals as the victims of a disorder. The most obvious area in which a finding of medical disorder leads to advantages for those deemed disordered is in the adjudication of eligibility for medical benefits, both public

\textsuperscript{43} See infra text accompanying notes 45-93.
\textsuperscript{44} BORNSTEIN, supra note 18, at 119.
and private. In addition, courts have relied on medical authorities in determining appropriate medical treatment for transsexuals in prison, in assessing the constitutionality of anti-crossdressing ordinances, and, in certain instances, in the adjudication of employment discrimination claims.

In cases where courts have held that either a private system or a public system of health insurance must cover, or may not categorically exclude, sex-reassignment surgery and other related treatments, they have demonstrated a great deal of deference to medical authority. The dichotomy offered by the court in Davidson v. Aetna Life & Casualty Insurance Co., a decision considering private insurance coverage, demonstrates the importance of the medical model to transsexuals. The court viewed the issue presented for its review as "whether the surgical treatment recommended by plaintiff's physicians is covered by defendant Aetna's employee benefit plan as a necessary medical expense, or [whether] the medical treatment rendered [is] precluded from coverage due to it being purely cosmetic in nature . . . ." Deciding that sex-reassignment surgery was indeed a "necessary medical expense," the court further elaborated the distinction: "Cosmetic surgery is surgery which is deemed optional or elective. The papers submitted herein on behalf of the plaintiff indicate that in order for the plaintiff to live a normal life, sex-reassignment surgery is imperative and necessary."

This sharp choice between serious necessity and casual indulgence as characterizations of the transsexual experience may be required by the inquiry into the appropriate use of medical benefits. However, it illustrates the significance of relying upon medical authority for a coherent and serious identity model of transsexuality. This distinction, and the negative consequences attendant with the frivolous side of it, help define the meaning of transsexual identity, a meaning associated with medical necessity.

In another example reinforcing the importance of medical necessity, the Minnesota Supreme Court held that the Minnesota State Welfare Department may not totally exclude sex-reassignment surgery from eligibility for its medical assistance program. The court relied on texts by medical experts, concluding that

transsexualism is a very complex medical and psychological problem which is generally developed by individuals early in life. By the time an individual reaches adulthood, the problem of gender role disorientation and the transsexual condition resulting

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45. These cases are few in number. The majority of private and public health plans do not cover sex-reassignment surgery and related treatment. See Maggard v. Hanks, 131 F.3d 670, 672 (7th Cir. 1997). However, few of these exclusions have been challenged.
47. Id. at 451 (emphasis added).
48. Id. at 453.
therefrom are so severe that the only successful treatment known to medical science is sex conversion surgery.\textsuperscript{49}

The plaintiff was eligible for medical assistance benefits in the first place because she had earlier been "certified," presumably by officials within the program itself, "as totally disabled for psychological reasons resulting from his [sic] transsexual condition."\textsuperscript{50} In \textit{Pinneke v. Priesser},\textsuperscript{51} the Eighth Circuit overturned a similar categorical denial by the Iowa Medicaid program, showing deference to medical authorities. The court characterized the plaintiff as someone who "suffers from transsexualism" and characterized surgery as "the only procedure available for treatment of the condition from which Pinneke suffers."\textsuperscript{52} The court emphasized its reliance on the viewpoints of doctors, holding that Iowa's "approach reflects inadequate solicitude for the applicant's diagnosed condition, the treatment prescribed by the applicant's physicians, and the accumulated knowledge of the medical community."\textsuperscript{53} Transsexuals have won similar victories with respect to private insurance.\textsuperscript{54}

A similar reliance on medical rhetoric is apparent in cases concerning the treatment of transsexual prisoners. These prisoners, who are usually preoperative in the reported cases,\textsuperscript{55} often request interventions ranging from hormone regimens to sex-reassignment surgery itself. In order to prove cruel and unusual punishment that violates the Eighth Amendment, a prisoner must demonstrate that prison officials have shown deliberate indifference to a "serious medical need."\textsuperscript{56} Typically, the courts find that transsexualism is a "serious medical need," an "affliction,"\textsuperscript{57} or a "serious psychiatric disorder."\textsuperscript{59}

\textsuperscript{49} Doe v. Minnesota Dep't of Pub. Welfare, 257 N.W.2d 816, 819 (Minn. 1977). The court went on to hold that "[i]n future cases involving an application for [medical assistance] benefits to fund transsexual surgery, a thorough, complete, and unbiased medical evaluation should be made by the individual agencies to determine whether the requested surgery is 'medically necessary.'" Id. at 820.

\textsuperscript{50} Id. at 817-18. Of course, whether or not one agrees that transsexuality itself is a disorder, it is easy to imagine that a person who is a transsexual may experience considerable psychological distress in seeking comfort and acceptance in society.

\textsuperscript{51} 623 F.2d 546 (8th Cir. 1980).

\textsuperscript{52} Id. at 548; see also id. at 549 (suggesting that Iowa had excluded "the only available treatment known at this stage of the art"); id. at 550 ("Pinneke proved a real need for the only medical service available to alleviate her condition.").

\textsuperscript{53} Id. at 549.

\textsuperscript{54} See Davidson v. Aetna Life & Cas. Ins. Co., 420 N.Y.S.2d 450, 453 (N.Y. Sup. Ct. 1979) (finding that "in order for the plaintiff to live a normal life, sex-reassignment surgery is imperative and necessary").

\textsuperscript{55} Transsexuals are defined as preoperative when they are planning or preparing for sex-reassignment surgery but have not yet undergone it. See \textit{John Money}, \textit{Venuses Penuses: Sexology, Sexosophy, and Exigency Theory} 377-79 (1986).

\textsuperscript{56} White v. Farrier, 849 F.2d 322, 325 (8th Cir. 1988); see also Estelle v. Gamble, 429 U.S. 97, 104 (1976).

\textsuperscript{57} Meriwether v. Faulkner, 821 F.2d 408, 413 (7th Cir. 1987); \textit{accord White}, 849 F.2d at 325; see also Phillips v. Michigan Dep't of Corrections, 731 F. Supp. 792, 800 (W.D. Mich. 1990) (finding both transsexualism and related condition—gender identity disorder of adolescence or adulthood, nontranssexual type, or "GIDAANT"—present serious medical needs).


\textsuperscript{59} Maggert v. Hanks, 131 F.3d 670, 671 (7th Cir. 1997); \textit{accord Meriwether}, 821 F.2d at 411.
from which a transsexual prisoner can be said to suffer. Finding that "[t]here is no reason to treat transsexualism differently than any other psychiatric disorder," the court in Meriwether, as in the health insurance case of Davidson, disapproved of the characterization made by the prison officials and the lower court that the hormone treatment requested by the prisoner was "elective medication." However, courts, prison officials, and doctors have disagreed about the kind and degree of care to which transsexuals are entitled under the Eighth Amendment.

Another set of cases in which the reliance on medical authority is particularly pronounced, and in which this reliance by courts advantages transsexuals, involves the consideration of the constitutionality of ordinances forbidding public cross-dressing. In City of Chicago v. Wilson, the court held unconstitutional an ordinance imposing a fine on "[a]ny person who shall appear in a public place . . . in a dress not belonging to his or her sex, with intent to conceal his or her sex" as it applied to two preoperative transsexuals who had been arrested under the ordinance. The court relied on the defendants' status as medical patients undergoing therapeutic preparation for sex-reassignment surgery, concluding that "[i]ndividuals contemplating such surgery should, in consultation with their doctors, be entitled to pursue the therapy necessary to insure the correctness of their decision." In Doe v. McConn, a federal court striking down a similar Houston ordinance held that "the Ordinance, as applied to individuals undergoing psychiatric therapy in preparation for sex-reassignment surgery, is unconstitutional." The court, which described transsexualism as a "rare syndrome," found particularly relevant the effect of the ordinance on the medical practices of a psychiatrist, an additional plaintiff in the case: "His prescribed treatment, required for adequate sexual integration, is thwarted by the Ordinance in direct contravention of medical and psychological indications."

Just as Hausman argued that the medical model was in some respects a response to transsexual demands rather than an imposition upon them, the judicial use of medical rhetoric is also often a response to the manner in which transsexual litigants frame their claims. Of course, the process is likely to be a negotiated one, for litigants frame their arguments in the manner they perceive to be most likely to win them concrete benefits. Courts then respond with similar rhetoric, and, if the results are positive, reinforce the initial perception.

60. See Phillips, 731 F. Supp. at 800.
61. Meriwether, 821 F.2d at 413.
62. Id. at 411.
63. See infra text accompanying notes 98-115.
64. 389 N.E.2d 522 (Ill. 1978).
65. Id. at 523 (quoting CHICAGO, ILL., MUNICIPAL CODE § 192-8 (1978)) (alteration in original).
66. Id. at 525.
68. Id. at 79-80.
69. Id. at 77.
70. Id. at 79.
For example, even in cases unrelated to medical benefits, transsexuals often present their situation as one involving serious medical issues. In *J.L.S. v. D.K.S.*, 71 two parents, one a male-to-female transsexual who had completed sex-reassignment surgery, argued over custody of their two sons. To counter the mother’s argument that the father had “adopted a lifestyle” potentially harmful to their children, the transsexual father responded “that he had been diagnosed ‘gender dysphoric’ and had pursued treatment and rehabilitation medically indicated by this condition,” and that “the change in his lifestyle was medically necessary for his health.” 72 Although not directly related to the issues in contention, the claim of medical necessity was likely perceived to add legitimacy and to aid acceptance of the choices made by the father. Similarly, the dissent in *Daly v. Daly*, 73 a case in which the transsexual father’s parental rights were terminated, relied heavily on testimony regarding the medical foundation for transsexuality and emphasized the therapeutic aspects of the father’s experience in recounting the facts of the case. 74

Yet another example is provided by the opinion in *In re Eck*, 75 in which the court approved a transsexual’s petition for a name change. The court ultimately determined that, in the absence of fraud “or other improper purpose,” courts should respect most name changes adults choose. 76 Nonetheless, the court still found it important to emphasize the petitioner’s previous status as a patient and her doctor’s conclusion that her sex-reassignment surgery had been “medically and psychiatrically indicated.” 77

When the legislature has allowed it, the medical model has also been deployed to battle employment discrimination against transsexuals. For example, after transsexuality had been firmly denied protection under federal employment discrimination law, 78 some litigants attempted to seek protection under provisions prohibiting discrimination against the disabled by adhering to a medical model. In *Doe v. United States Postal Service*, 79 a male-to-female transsexual, who was denied employment with the U.S. Postal Service on account of her transsexuality, argued “that she was handicapped by reason of her medically and psychologically established need for gender reassignment surgery,” and therefore entitled to the protection afforded disabled federal employees under the Rehabilitation Act. 80 In denying the defendant’s motion to dismiss, the court found that because of the broad language of the Act, a non-traditional disability such as the plaintiff’s might be covered: “For purposes of

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71. 943 S.W.2d 766 (Mo. Ct. App. 1997).
72. Id. at 770.
73. 715 P.2d 56 (Nev. 1986).
74. See id. at 61 (Gunderson, J., dissenting). However, the primary basis for the dissent’s position was the impropriety of grounding a decision to terminate parental rights on the harms of visitation when visitation was not being sought. See id. at 60.
76. Id. at 860.
77. Id.
78. See, e.g., Ulane v. Eastern Airlines, 742 F.2d 1081 (7th Cir. 1984); Holloway v. Arthur Andersen & Co., 566 F.2d 659 (9th Cir. 1977).
80. See id. at 1869 (internal quotations omitted).
After Doe was decided, however, the Rehabilitation Act was amended to conform to the various provisions and limitations of the Americans with Disabilities Act (ADA), which extended protection to disabled individuals in private employment, as well as in many other settings. One such change narrowed the broad language in a very specific way: the ADA and the Rehabilitation Act explicitly exclude transsexualism as a covered disability. Thus, the court in Dobre v. National Railroad Passenger Corp. ("Amtrak"), an employment discrimination case against a private employer, rejected the plaintiff's attempt to apply the analysis used in Doe to the Pennsylvania Human Relations Act's provisions prohibiting private employers from discriminating against the disabled. Although the Pennsylvania law had been modeled on the language of the Rehabilitation Act that applied at the time Doe was decided, the court did not find this congruence dispositive. The court explained that the "amendment did not effectuate a substantive change in the law, but rather, merely 'clarifie[d] the original intent of Congress as to the parameters of the definition of disabled individual . . . ." " The court in Dobre held that Doe was no longer good law.

Because of such federal legislation, in more recent years transsexuals have relied on the specific protections offered disabled employees by state law in order to claim discriminatory treatment when they have been fired or otherwise treated differently because of their transsexual status. In Doe v. Boeing Co., the court found it to be "uncontested that gender dysphoria is an abnormal, medically cognizable condition with a prescribed course of treatment." However, the Washington statute prohibiting discrimination against the disabled "requires a factual finding of discrimination because of the condition in order to determine whether the condition is a 'handicap' in the first place." The court found that no such discrimination had taken place where the employee violated a "unisex" dress code adopted by the employer for its

81. Id. (internal quotations omitted).
83. See 42 U.S.C. 12211(b)(1) ("Under this chapter, the term 'disability' shall not include . . . transvestitism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, or other sexual behavior disorders . . . .")
85. See id. at 289. In Dobre, plaintiff argued that her transsexualism was "recognized as a disorder by the American Psychiatric Association." Id. at 288.
86. Id. at 289 (alterations in original) (quoting Winston v. Maine Technical College Sys., 631 A.2d 70, 74 (Me. 1993)). In Dobre, the court also found against plaintiff on her claim that she was discriminated against on the basis of a perceived disability, holding that such a claim could not be maintained in Pennsylvania unless an actual impairment were also proven. See Dobre, 850 F. Supp. at 290; see also Holt v. Northwest Training Partnership Consortium, Inc., 164 A.2d 1134, 1139 (Pa. 1997) (relying on Dobre's interpretation to reject similar claim by transsexual plaintiff).
88. Id. at 536.
89. Id. at 535.
transsexual employees. It further found that the company had adequately accommodated the plaintiff's condition.

In Conway v. City of Hartford, the female-to-male transsexual plaintiff fared better, at least at the very early stages of the trial. The court denied the defendant's motion to strike the count in the plaintiff's complaint claiming discrimination on the basis of a "past mental disorder" by finding that transsexualism is a covered "mental disorder" under the Connecticut statute prohibiting such discrimination. The court was able to so find because of the inclusion within the DSM-IV of gender dysphoria and the statute's incorporation of the DSM-IV's definitions of mental disorder.

B. The Pitfalls of Judicial Reliance on Medical Authority

Typically, when the courts rely on medical authorities, they do so with intense deference. The court in Davidson v. Aetna Life & Casualty Insurance Co. demonstrates the deferral that medical opinion commands: "For this court to suggest alternative remedies or treatment for this procedure would interfere with the professional judgment of medical experts, and would be beyond the scope of this court's expertise or jurisdiction." However, such deferral can compel courts to follow medical opinion away from, as well as towards, the needs expressed by transsexual litigants.

The court in Rush v. Johnson refused to compel the state of Georgia to offer Medicaid reimbursement for sex-reassignment surgery, holding that the surgery was experimental. It reached this conclusion by relying on "[s]ubstantial evidence" that "presents a picture of growing concern in the medical literature over the long-term effectiveness of sex-reassignment surgery as a generally accepted form of treatment." Further, the DSM in 1980 stated, according to the court, that the "long-term course of the treatment of transsexualism with surgical reassignment is unknown." On this basis, the court concluded that the surgery was experimental.

In the prison context, courts show extreme deference to the treatment choices made by prison medical personnel, even when these choices conflict markedly with the expressed interests of the transsexual prisoners. Courts have held that prison officials violate the Eighth Amendment if they demonstrate

90. Id. at 536. The real reason, the court found, was her refusal to follow the requirements the company had imposed on her attire, even though this refusal was in fact connected to her transsexual status. See id. at 533-34 (detailing the dispute).
91. See id. at 534. It did so by allowing her to wear unisex clothing while on the job. See id. at 537.
93. See id. at *5.
94. Id.
97. Id. at 868.
"deliberate indifference to serious medical needs." 99 Because of the high hurdle the "deliberate indifference" standard presents, 100 transsexual prisoners generally do not prevail unless they are able to show that prison officials offered no treatment whatsoever. 101 For example, the Federal Bureau of Prisons's policy "to maintain a transsexual inmate at the level of change existing upon admission" to the prison system has been found to be constitutional on its face. 102 A court also found the mere housing of the prisoner at a prison hospital sufficient to rebut the claim of deliberate indifference. From the hospital confinement, the court inferred that the prisoner "is presently undergoing some type of mental treatment." 103 Similarly viewed as conforming to the standard was the decision by prison doctors to offer testosterone replacement therapy to a prisoner who had engaged in self-castration after repeated requests for estrogen were denied. 104 In each of these decisions and others, the medical expertise of the individual prison physicians was treated with great deference.

In Supre, for example, the court portrayed the choice of testosterone or estrogen following the plaintiff's self-castration as one reflecting controversy within the relevant medical community, because one expert and the Colorado Department of Corrections medical staff disagreed with two other experts. 105 The court stated:

It is apparent from the record that there were a variety of options available for the treatment of plaintiff's psychological and physical medical conditions . . . . While the medical community may disagree among themselves as to the best form of treatment for plaintiff's condition, the Department of Corrections made an informed judgment as to the appropriate form of treatment . . . . 106

100. See, e.g., Helling v. McKinney, 509 U.S. 25, 32 (describing the standard as designed to prevent "the unnecessary and wanton infliction of pain contrary to contemporary standards of decency").
101. See, e.g., Farmer v. Hawk, 991 F. Supp. 19, 28 (D.D.C. 1998) (denying motion for summary judgment by Federal Bureau of Prisons Medical Director because his sanctioning of the withholding of all treatment from transsexual prisoner could, if true, constitute deliberate indifference to a serious medical need); Farmer v. Haas, 1991 WL 26456, at *5 (7th Cir. Mar. 1, 1991) (overturning district court's grant of summary judgment to prison officials because "the record supports Farmer's position that she consistently requested, but was denied, any type of treatment for her transsexualism"); Phillips v. Mich. Dep't of Corrections, 731 F. Supp. 800, 801 (1990) (finding that "defendant has failed to provide plaintiff with treatment of any kind" and issuing a preliminary injunction); Meriwether v. Faulkner, 821 F.2d 408, 414 (1987) (stating that the case is the type "where there had been a total failure to provide any kind of medical attention at all" and finding that plaintiff's case survived summary judgment motion).
102. Farmer, 991 F. Supp. at 22 (internal quotations omitted).
104. Supre v. Ricketts, 792 F.2d 958, 963 (10th Cir. 1986). The dissent suggests that the majority did not need to reach this issue in determining whether Supre, whose formal case became moot when she was released from prison, was entitled as a prevailing party to attorney's fees. See id. at 966 (Seymour, J., dissenting). The majority's determination on this issue, however, is treated by subsequent cases as a holding. See, e.g., Brown v. Zavara, 63 F.3d 967, 970 (10th Cir. 1995); Meriwether, 821 F.2d at 413.
105. See Supre, 792 F.2d at 963.
106. Id.
In so deferring, the court ignored both the prisoner/patient’s expressed choice of treatment as well as the prison’s delay in providing any response to her requests for estrogen.\textsuperscript{107}

The Eighth Circuit Court of Appeals has twice deferred to the determination of Dr. Paul W. Loeffelholz, an Iowa Department of Corrections psychiatrist, that in both instances an inmate claiming to be a transsexual was not.\textsuperscript{108} In \textit{White}, the court held that prison officials could be found not to be deliberately indifferent to a serious medical need because they were justified in relying on the doctor’s opinion that no such need existed.\textsuperscript{109} Furthermore, the court failed to find that the record established Dr. Loeffelholz’s own deliberate indifference: “Although White’s experts diagnosed White’s condition differently than Dr. Loeffelholz did, this does not establish deliberate indifference. Physicians are entitled to exercise their medical judgment.”\textsuperscript{109}

In \textit{Long}, the court gave Dr. Loeffelholz’s medical judgment similar weight, citing with approval the District Court’s assessment that his refusal to prescribe tranquilizers, along with other treatment options recommended by plaintiff’s expert witness, “was based on a difference in professional judgment,” and that prison officials were “justified in relying on the opinions of medical staff.”\textsuperscript{111} These cases demonstrate the court’s unwillingness to question the medical authority of the doctor in charge of the prisoner’s case, even when that authority’s opinions are disputed by other medical experts.

The unwillingness to look behind the veil of stated medical opinion in these cases also creates a crisis of authority for the courts. As with transsexuals, the absolute reliance on medical rhetoric buys the courts benefits, but also potentially costs them agency and power. Judge Posner of the Seventh Circuit, writing for the court, highlights what is problematic about case-by-case deferral to medical authorities in his review of the application of the deliberate indifference standard to requests by transsexual prisoners for hormone treatments:

Does it follow that prisons have a duty to administer (if the prisoner requests it) the standard cure to a prisoner who . . . is diagnosed as a genuine transsexual? The cases do not answer “yes,” but they make the question easier than it really is by saying that the choice of treatment is up to the prison. The implication is that less drastic (and, not incidentally, less costly) treatments are available for this

\textsuperscript{107} See id. at 965 (Seymour, J., dissenting) (highlighting the prison’s delay in responding to prisoner’s request for treatment).

\textsuperscript{108} See \textit{Long v. Nix}, 86 F.3d 761, 764 (8th Cir. 1996); \textit{White v. Farrier}, 849 F.2d 322, 326 (8th Cir. 1988).

\textsuperscript{109} See \textit{White}, 849 F.2d at 327. This case reviewed a summary judgment for the plaintiff. Contrary to the lower court, the Court of Appeals found that a jury could find in favor of the prison officials on this issue. See \textit{id.} at 328.

\textsuperscript{110} Id. at 327.

\textsuperscript{111} \textit{Long}, 86 F.3d at 764 (quoting \textit{Long v. Nix}, 877 F. Supp. 1358, 1366 (S.D. Iowa 1995)).
condition. However, we have found only one report of successful nonradical treatment of gender dysphoria.\textsuperscript{112}

Judge Posner's comments suggest that medical authority commands such respect that it normally causes courts to abandon their critical ability to evaluate the medical authority offered. However, the deferral to medical authority may serve the courts' own interests. If, as in \textit{Long}, they do not question the authority or acknowledge the conflict, they avoid difficult issues of cost and allocation. When such authority is questioned, or, as Posner demonstrates, shown to be in conflict with other medical sources, courts must then engage with the difficulties of allocating finite resources.

Judge Posner examines the difficulty of this allocation, pointing out that the procedures requested by transsexual prisoners are "protracted and expensive."\textsuperscript{113} However, he addresses this expense in a manner that ultimately displaces elsewhere the decision about coverage. He justifies his determination that the Eighth Amendment does not require "curative treatment" for gender dysphoria primarily on the basis that most public and private medical plans have decided not to cover such treatment.\textsuperscript{114} Estimating at $100,000 the cost of hormone treatment and sex-reassignment surgery in the absence of insurance or public assistance, Posner concludes:

Withholding from a prisoner an esoteric medical treatment that only the wealthy can afford does not strike us as a form of cruel and unusual punishment. It is not unusual; and we cannot see what is cruel about refusing a benefit to a person who could not have obtained the benefit if he had refrained from committing crimes.\textsuperscript{115}

The factual basis for this conclusion could change if more Medicaid and private plans were challenged. Nonetheless, Posner offers some guidance for the difficult decisions that might need to be made if such challenges occur. He states for the court: "Gender dysphoria is not, at least not yet, generally considered a severe enough condition to warrant expensive treatment at the expense of others than the person suffering from it."\textsuperscript{116} Whether most courts would ultimately agree or not, assessing this sort of tradeoff is a difficult question that is avoided by most courts through their rhetoric of deferral to medical expertise. The crisis for judges, as for transsexuals, is exacerbated by the starkness of the choice they often set up, and that Posner's analysis examines more carefully, between medical necessity and cosmetic or elective procedure.

\begin{flushleft} \textsuperscript{112} Mappert, 131 F.3d at 671 (citations omitted). \textsuperscript{113} Id. \textsuperscript{114} Id. at 672. \textsuperscript{115} Id. \textsuperscript{116} Id. \end{flushleft}
Like judges, transsexuals are faced with choices more difficult than they appear. It may seem as if the choice transsexuals face is simply whether to rely on a medical rhetoric that brings positive practical benefits, as the cases demonstrate, but negative consequences for identity, as some have argued. However, the choice is actually more complicated. First, because medical authorities do not always reach conclusions beneficial to transsexuals, and because the courts rely on these authorities when deciding whether to provide positive practical benefits, the positive side of the equation is not reliably constant. Second, as I hope to suggest in this Part, the medical model may hold positive as well as negative consequences for transsexual identity. More precisely, the inclusion of transsexuality as a diagnostic category in medical texts such as the DSM may have very different meaning for transsexual identity construction than the inclusion of homosexuality had for lesbian and gay identity construction. The differences arise from the connection transsexuals have experienced between pathology and acceptance and from the different historical context in which the fight for acceptance by transsexuals has occurred. In addition, the options made available to transsexuals by the medical model may answer social needs specific to their situation.

A. Disability as Enabling

Janice Irvine, although critical of the medicalization of transsexuals, notes that the medical model can present some psychic benefits: "For individual transsexuals, it presents the possibility that they suffer from a disease rather than a moral failing or sexual deviation." According to Ronald Bayer, gay and lesbian activists abandoned a similar attitude toward the medical establishment by the 1960s. However, the circumstances for transsexuals, as opposed to gays and lesbians, have been different. The decision by the American Psychiatric Association to remove homosexuality from the DSM was the result of intense activism by gay and lesbian advocates. A strong motivation for this activism was indeed the negative association of identity with pathology. But it is also clear from accounts of the series of political actions and meetings leading to the removal that for lesbians and gay men, inclusion of their status in the DSM offered no positive benefits whatsoever to counterbalance the negative impact. Because inclusion of homosexuality led to treatment protocols that sought to undermine or alter sexual orientation, such inclusion was seen as both a denial of the identity claims of those who sought

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117. IRVINE, supra note 11, at 265.
118. See BAYER, supra note 5, at 9.
119. See generally BAYER, supra note 5.
120. See id. at 119 ("We are told that we are emotional cripples forever condemned to an emotional status below that of the 'whole' people who run the world.").
121. See id. at 105-07 (describing the role of the official diagnosis in the oppression of lesbians and gay men).
no treatment and also the justification for numerous discriminatory practices in
the world at large.\footnote{See id.} For transsexuals, by contrast, inclusion of their condition
in the DSM provides a basis for treatment protocols, such as sex-reassignment
surgery, that bolster their identity claims.

In addition, the concept of disability in the 1990s carries different
connotations than in earlier eras. In contrast to the stigma associated with
pathology, Dave King suggests that a concept of disability helps rescue the
transsexual from stigma.\footnote{See K\textcopyright{}NG, sup\textsuperscript{ra} note 32, at 16-17 (presenting the view that analogizing transsexuality to a disability like blindness or deafness can be seen as empowering).} He distinguishes the concept of disability, with its
implication of reduction and management, from the less empowering concept of
a disease, for which “cure” is needed.\footnote{See id.} That this distinction is meaningful in
the nineties may be a reflection of the advances made by the disabled in
creating a more empowered social vision of disability.\footnote{See Adrienne L. Hiegel, Sexual Exclusions: The Americans with Disabilities Act as a Moral Code, 94 COLUM. L. REV. 1451, 1452 (1994) (describing the role of the Americans with Disabilities Act in achieving this new attitude).}

The exclusion of transsexuals from coverage in the landmark Americans
with Disabilities Act (ADA) may illustrate the empowering aspect of
association with disability by negative example. In supporting the exclusion,
Senator Jesse Helms specifically sought to denounce a medical model for
transsexuality and the other conditions excluded, suggesting that they were
better classified not as “medically treatable diseases” but as “moral
problems.”\footnote{Id. at 1481. In its definition of protected disability, the ADA excludes “transvestitism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, or other sexual behavior disorders.” 42 U.S.C.A. § 12211(b)(1). As Hiegel points out, all of these conditions, as opposed to homosexuality and bisexuality which are also excluded, are listed in the DSM-IV, otherwise used as a guide to ADA coverage. See Hiegel, supra note 125, at 1452 n.9.} Adrienne Hiegel suggests that under the ADA, disease and
disability are actually unpathologized. The purpose of the ADA, she argues “is
to transform the notion of what constitutes an ‘able’ body or a ‘qualified’
worker and to change the social consequences of a disability by integrating
disabled workers into, rather than excluding them from, the workplace.”\footnote{Hiegel, supra note 125, at 1452.} She
contrasts this attitude of “welcome” toward the disabled generally with the
exclusion that “carves out a new class of untouchables defined by sexuality and
sex behaviors,”\footnote{Id. at 1452-53.} a move that “reifies the moral grid that lies beneath the notion
of a disability.”\footnote{Id.} In other words, it might be argued that the ADA actually
provides accessible transport away from a pathologized view of disability for
most disabled individuals, while pathologizing and disempowering the identity
claims of those whom it excludes. Thus, in the era of the ADA, an attempt,
despite these exclusions, to associate one’s identity with disability may have
very different political meaning than in earlier eras. With any doubt of the
application of the ADA to state prisons removed, were it not for the explicit exclusion of transsexuality, the statute would provide a powerful means for transsexual prisoners to challenge many of the most distressful conditions of their confinement.

From this historical nexus, one might conclude that a relationship to a medical model of identity may not be altogether negative and disempowering for transsexuals. Although Bernice Hausman traces the history of transsexual surgery to determine that transsexuals were themselves active and instrumental in the development of these procedures, she does not view this agency, and the resultant relationship between transsexual identity and medical rhetoric, as in any way positive. One reason may be that she, like Billings and Urban, fails to see how an identity model fashioned at least in part from diagnostic criteria and current understandings of gender differentiation can ever be affirming for its holders or transformative for society.

Transsexual theorists, however, have begun to articulate a vision of their own identity that relies on pushing at these criteria and understandings without necessarily transcending them. Although Sandy Stone contemplates a "posttranssexual" future, for the time being, she recognizes a relationship of tension between medicine and transsexuals themselves. She hopes to use this tension to complicate and expose some of the questionable assumptions about gender in society: "I am suggesting that in the transsexual's erased history we can find a story disruptive to the accepted discourses of gender, which originates from within the gender minority itself and which can make common cause with other oppositional discourses."

Similarly, Susan Stryker maintains that a medical agenda potentially at odds with the interests of transsexuals does not "preclude medically constructed transsexual bodies from being viable sites of subjectivity. Nor does it guarantee the compliance of subjects thus embodied with the agenda that resulted in a transsexual means of embodiment."

Obviously, so long as transsexuality is defined in relationship to surgery and hormones, a relationship to medical specialists will be necessary for those who assume that identity. It is possible that this relationship will open up possibilities for some while it restricts possibilities for others. How that relationship evolves, what is gained and lost, is to a certain degree in the hands of transsexuals and to a certain degree in the hands of the courts.

B. Social Necessity


131. It has been so used by prisoners to challenge conditions relating to covered disabilities. See, e.g., id. at 1954 (describing prisoner with hypertension who challenged rejection from "Motivational Boot Camp" program that would have entitled him to early parole).

132. See HAUSMAN, supra note 2, at 129-40.

133. See Stone, supra note 8, at 292 (describing "an uneasy adversarial relationship" between doctors and transsexuals that has eased somewhat through time and increased dialogue).

134. Id. at 295.

135. Stryker, supra note 40, at 242.
Just as it is possible for transsexuals to maintain agency while also relying on medical authority, courts can empower themselves to confront hard questions while also consulting medical authority. "Medical necessity" is a standard that forms the basis for a number of the decisions that provide transsexuals with benefits or that withhold them if the standard is not met. Whereas medical necessity considers the importance of a particular treatment to an individual's bodily or psychiatric well-being, a concept of social necessity might instead consider the importance of a treatment to an individual's ability to function and survive in society, given current biases and beliefs. Although Judge Posner offers a number of variables for courts to weigh in adjudicating claims of medical necessity, his assessment of the costs and benefits involved does not take into account additional important variables. It is important, for instance, to take into account not only the severity of the distress experienced by individual transsexuals seeking treatment, but also the social consequences of not receiving treatment. Although transsexuals have been accused of fetishizing the anatomy of gender, theirs may instead be a response to the importance society places in anatomical congruence. Kate Bornstein insists: "We don't hate any part of our bodies we weren't taught to hate. We're taught to hate parts of our bodies that aren't 'natural'—like a penis on a woman, or a vagina on a man . . . ."

If social necessity were to replace medical necessity as a basis for decisionmaking, courts would be forced to consider the imperative society places on gender conformity. This societal importance is reflected in the adverse consequences routinely experienced by those who seek to express themselves and live as a gender that does not conform to their anatomy. Cases challenging discrimination toward transsexuals in employment reflect the degree of discomfort pre-operative transsexuals generate among their colleagues and employers. Furthermore, the discriminatory behavior that

136. See supra text accompanying notes 45-74.
137. See supra text accompanying notes 108-12.
138. See Shapiro, supra note 22, at 260.
139. BORNSTEIN, supra note 18, at 19.
140. See, e.g., Sommers v. Budget Marketing, 667 F.2d 748, 748-49 (8th Cir. 1982) (stating that employees threatened to quit if transsexual female with anatomical body of male was allowed to use the same restroom facility as female employees); Kirkpatrick v. Seligman & Latz, Inc., 636 F.2d 1047, 1048 (5th Cir. 1982) (stating that transsexual was fired when she started wearing female garb while undergoing male to female sex reassignment); Holloway v. Arthur Anderson & Co., 566 F.2d 659, 661 (9th Cir. 1977) (stating that transsexual's dress, appearance and manner was disruptive and embarrassing); Underwood v. Archer Management Servs., 857 F. Supp. 96, 97 (D.D.C. 1994) (stating that transsexual alleged that she was discharged on the basis of "personal appearance" while she was undergoing sex change); Dobre v. National R.R. Passenger Corp. (AMTRAK), 850 F. Supp. 284, 286 (E.D. Pa. 1993) (stating that transsexual undergoing male to female sex reassignment was not allowed to dress as a female and not permitted to use the women's restroom, that supervisors would only refer to her by her male name, and that her desk was moved out of view of the public); Powell v. Read's, Inc., 436 F. Supp. 369, 370 (Md. 1977) (stating that transsexual living as a female was fired allegedly because recognized by someone who knew her as a man); Ashlie v. Chester-Upland Sch. Dist., No. 78-4037 (1979 U.S. Dist. LEXIS 12516, at *2) (E.D. Pa. May 9, 1979) (stating that teacher undergoing male-to-female surgery was dismissed for "incompetency, immorality, and other conduct or improper conduct which is potentially psychologically damaging to students"); Holt v. Northwest Pa. Training Partnership Consortium, 694 A.2d 1134, 1136 (Pa. 1997) (stating that transsexual was dismissed from employment for allegedly violating employer dress code after she began dressing in a unisex fashion); Maffei v. Kolaeton Indus., 164 Misc. 2d 547, 546 (N.Y. 1995) (stating that
arises out of this discomfort is rarely compensated, and thus rarely deterred. Additionally, preoperative transsexuals in prison who, if they have penises, are housed with men, are subject to harassment, rape, or segregation to prevent such assaults. Finally, there have been an increasing number of news accounts of assaults and murders committed against preoperative transsexuals. In one case that received a considerable amount of press, emergency treatment was temporarily withheld from a male-to-female crossdresser badly injured in an automobile accident when the emergency worker discovered the incongruity between the victim’s dress and anatomy. The victim later died.

In light of these consequences for those whose gender identity and anatomy do not conform, it is not surprising that conforming anatomy to gender identity may become an imperative for self-identified transsexuals, although the motivation, of course, extends beyond these concerns to matters of self image and emotional comfort. The world may not yet be a safe place for the diverse gender expression that Billings and Urban or MacKenzie envision. And

president of company degraded and humiliated transsexual undergoing sex-reassignment surgery, called him names, stripped him of his duties, and ostracized him from the rest of the employees); Terry v. EEOC, 25 Fair Empl. Prac. Cas. (BNA) (1980) (stating that restaurant refused to hire physical male who wanted to become a female as a waitress/hostess).

141. See, e.g., Sommers, 667 F.2d at 750 (holding that Title VII ban on discrimination based on sex does not encompass discrimination based on transsexualism); Kirkpatrick, 636 F.2d at 1050-51 (holding that employer did not discriminate when it discharged transsexual undergoing sex reassignment for wearing female garb); Holloway, 566 F.2d at 664 (holding that Title VII does not prohibit the discharge of an employee for initiating the process of sex transformation); Dobre, 850 F. Supp. at 287 (holding that Title VII does not protect employees from discrimination on basis of transsexualism; transsexualism is not a physical or mental impairment under Pennsylvania Human Rights Act); Powell, 436 F. Supp. at 371 (holding that Title VII does not include discrimination against transsexuals); Grossman, 11 Fair Empl. Prac. Cas. (BNA) at 1197 (holding that Title VII does not protect teacher who was discharged after assuming sexual characteristics of female gender); Holt, 694 A.2d at 1139 (holding that transsexuality is not a disability under Pennsylvania Human Relations Act). But see Maffei, 164 Misc. 2d at 555-56; 626 N.Y.S.2d (holding that discrimination against transsexual was cause of action based on creation of a hostile work environment); Underwood, 857 F. Supp. at 98 (holding that transsexual stated a claim by alleging that she was discharged on the basis of "personal appearance").

142. See Maggett v. Hanks, 131 F.3d 670, 672 (7th Cir. 1997) (holding that transsexual prisoner was entitled to protection "from harassment by prisoners who wish to use him as a sexual plaything... ."); Luceria v. Samples, 1995 WL 630016, at *2 (N.D. Cal. 1995) (explaining that transsexual’s request to be treated as a woman was denied because her pre-sentence report identified her as male); Lamb v. Maschner, 633 F. Supp. 351, 352-53 (D. Kan. 1986) (explaining that transsexual requested transfer to women’s facility from men’s facility to be protected from harassment and molestation).

143. See, e.g., John D. Cramer, Transvestite Prostitutes Fly Streets in Fear, L.A. TIMES, Sept. 22, 1990, at B1 (reporting that transsexual prostitutes are murdered because customers are enraged to find they have picked a man); Four to Face Trial in Lengthy Attack on Transvestite, EVENING NEWS (Harrisburg), Oct. 20, 1993 (describing attack on transsexual who became engaged to her boyfriend); Davina Anne Gabriel, Background of the Murder of Brandon Teena, FTM INT’L, May 19, 1995, <http://www.ftm-intl.org/News/Brn/brn.bkor.html> (describing slaying of transsexual after murderers discovered that he was anatomically female but living as a man); Ben L. Kaufman, Transsexual Sues over Prison Threats, Beating; Officials Did Nothing to Stop It, She Says, CINCINNATI ENQUIRER, July 8, 1998, at B5 (describing death threats and assault on preoperative transsexual in prison); Man Who Beat Transsexual Gets 2 Years, BOSTON GLOBE, May 17, 1997, at B2 (stating that defendant went into a rage and attacked and killed male-to-female preoperative transsexual when he discovered she had male anatomy).


145. See supra text accompanying notes 9-20.
because recognition of transsexual status as a protected class for private employment discrimination, for the purpose of identifying hate crimes, and for other purposes has been withheld, courts and lawmakers are complicit in this hazard. One way for both courts and transsexuals to recognize the reality of these dangers, while also breaking away from what is negative about the medical model, is to begin to articulate a concept of social necessity as opposed to medical necessity. A concept of social necessity would involve letting go of the absolute dichotomy between medical necessity and cosmetic or elective choice. A concept of social necessity, moreover, both requires and allows transsexuals and judges to assert their own agency.

V. CONCLUSION

For both judges and transsexuals, medical authority carries the promise of assistance, but potentially threatens the decisionmaking power and agency of each. Both groups, however, may nonetheless gain power from a medical model, particularly if it is employed in a manner that is strategic rather than beholden to medical opinion.

The cases suggest, however, and Posner’s cost benefit calculation underlines, that the strategies of courts and those of transsexuals are not fully synchronous. For instance, judges may seek to contain costs that transsexuals would like government agencies to bear. Nevertheless, the legal opinions that rely in a seemingly unstrategic manner on the medical model do not consistently provide benefits for transsexuals. The adoption of a concept of social necessity may produce similarly inconsistent results, as courts sometimes agree and sometimes disagree with the interpretation of social necessity put forward by the transsexual litigant. Despite this uncertainty, such decisions would at least be more likely to raise and confront the difficult questions of allocation while also recognizing the negative social consequences to which transsexuals are subject.

Weighing the issues of cost and distress will both require from judges and provide them with a greater sense of their own independence from other authority, just as the concept of social necessity provides more power for the transsexual litigant advancing it. This power is one they have always each had, as Hausman’s account underlines in the case of transsexuals, to forge a more complicated and questioning relationship with medical authority.