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Notes From The Underground

A FREE PUBLICATION

ONE COMMUNITY - RESPECTING & BENEFITING THROUGH OUR INDIVIDUAL DIFFERENCES

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When Are We No Longer Different?

By Margo Ross

In this edition we have gathered several different and maybe difficult topics for you to look at. The reality is that this community, we so easily call transgender is in fact very diverse. It not only encompasses many different variations of gender identity, gender expression, sexual orientation and biological destiny but it also represents the most complete cross section of life - "normal living" in the most real sense.

At the last discussion group the question for discussion was "who are you?" Note it was not what are you, nor what do you want to be, but just plan and simple, how do you see you.

As you can imaging it was not an easy task for some and very clear for others. But just pause for a moment, if you do not know how you would define you, how can others easily respond to you?, how can you reach a true blend of all that you are without the destruction of many of the positive aspects of you in the name of achieving some special spot.

I would like to assert that we are distinct and unique as all groups of individuals are but that we are not really different, oh ok may be special.

EVERY CIVIL RIGHTS MOVEMENT HAS A BATHROOM ISSUE

Source Jamsion Green and Sean Cahill, Research and Policy Director NGLTF Policy Institute

It all seems to boil down to bathrooms. Every civil rights movement has a bathroom issue:

The disability rights movement - bathroom access
The black civil right movement - bathroom sharing
The Equal rights movement - requirement for unisex bathrooms
The gay and lesbian rights movement - fear of proximity and conversions

IN THE LONG RUN BATHROOMS JUST MAY BE THE ONLY UNIFORM CIVIL RIGHTS ISSUE

The Ladies Room

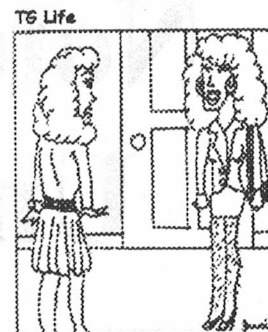
There are some things we can control, or perhaps disguise. There are some things we can do absolutely nothing about. All species of every age and gender eat, drink and eliminate. Very simple and generally of no concern. Unless one is a transgender person dressed for comfort and away from home for the first time and natural functions make their demand. The choices are few. The most simple and straight one requires the first ever visit to "The Ladies Room". All TG people probably remember their first experience of entering that forbidden space for the first time.

For myself, as for many, my first visit to the ladies room was in a large mall. There was no realistic choice. I tried to disappear, it didn't work. I approached THE DOOR took a deep breath and stepped into the forbidden space. No alarms - so far so good- there did not seem to be any other person there. This is going really well. I entered a cubical closed the door and took a breath. I just might survive this after all. The mission was successfully accomplished and I opened the cubical door. Still no-one around. I am breathing more normally. A quick wash of my hands and I am out the door to the relative safety of the mall. A piece of cake, nothing to it.

The next experience was some weeks later. I had been driving for about two hours and was approaching Brockville on the way to Ottawa. I should not have had the second cup of coffee before leaving home, nature is making demands again. Nothing to do but to drive into the service centre and head for "the Ladies Room". Not so difficult these places have been demystified for me. I enter the Room and once again there is no-one there. The gods are again smiling on me. As before the mission is successfully completed and I am about to wash my hands when the door opens and people - women - begin to stream in. There must be thirty of them. It seem like three hundred. The gods are now laughing. A tour bus has just arrived and all of the female passengers have headed to my washroom. Panic, Take a deep breath, smile, act demure , head for the door. No shouts, no screams no loud ringing bells, no police sirens. I HAVE SURVIVED. A piece of cake, no problems.

By the time I arrived in Ottawa my blood pressure and heart rate had returned to normal and I had a great weekend.

Now off to the next challenge
Isn't life fun - Kait



TRANSGENDER

OVERVIEW

Source Jamsion Green and Sean Cahill, Research and Policy Director NGLTF Policy Institute

Transgendered people are individuals of any age or sex whose appearance, personal characteristics or behaviours differ from stereotypes about how men and women are "supposed" to be.

Gender vs Sex

In everyday language as well as in the law, the terms **"gender"** and **"sex"** are used interchangeably. However, it is often important to distinguish the two terms. Social scientist, for example use the term "sex" to refer to a person's biological or anatomical identity as male or female, while reserving the term "gender" for the collection of characteristics that are culturally within maleness or femaleness.

Is She or Isn't She? (transsexual runner April Capwill)

by: Higdon, Hal

"I'm willing to talk to you," said the woman on the phone. "As long as you don't publish my name." I offered no promise. Her name was already a matter of public record. She had just placed fifth among women masters in Pittsburgh's Great Race, running the 10-K race in 38:31. Earlier in the summer, she had won that division at the Hamot 10-K/Mayor's Cup in her hometown of Erie, Pennsylvania. After that race, another woman, Mary Vasey, was so angry that she refused to accept her trophy and filed a protest.

"I'm not doing this for publicity," the woman on the phone continued. "I don't want to turn this into a media circus like Renee Richards." I told her that by winning prizes in several races--merely by participating in the races--she had brought the publicity upon herself. If she didn't want the publicity, why did she enter them? Why did she try so hard to win her division?

"I work for everything I get," she said. "If the girls doing all the complaining trained harder, they wouldn't get beat." Her comment caused me to smile. I wondered how many women road runners in the 40-44 division would appreciate being called "girls." Some might shrug. Others would consider the term demeaning, a put-down--maybe not if spoken by one woman about another, but certainly if used by a man.

And that was the point. The woman on the phone with me was a man. "Was" in the past tense. Her name is April Capwill. But if you look in the 1970 yearbook for Erie's East High School, you'll find another Capwill: Ray. This same Ray Capwill listed weight lifting and track as two of his favourite activities.

Ray and April are the same person. Ray was April's name before he had the operation 16 years ago that transformed him--physically and hormonally--into a her. April now dresses and acts like a female. No one would think twice about her if she hadn't recently turned to her old sport, running, and begun to win awards.

Capwill's hometown, Erie, Pennsylvania, is a comparatively small community of 120,000 people, where she has lived all her life. Her sx change couldn't and didn't go unnoticed. Teachers, bank tellers and coworkers saw the change. "To April's credit, she never tried to hide anything," says Patty Hoffman, an Erie-area runner who's unsympathetic to Capwill's desire to race as a female. "She never tried to move out of town and assume a different identity."

Mary Vasey's fiance, Bill Grugin, knew Capwill when she was Ray. "He used to work in the hardware department of the East Side K-Mart," recalls Grugin. "I'd talk to him when I came in to buy hardware. He seemed a normal guy. He was even involved in power lifting."

April Capwill entered one of her first road races on April 21, 1990, running 5-K in 23:48 and apparently enjoying the experience. Soon she was a regular at races in Erie. At one of her early races, she was recognized by a former teacher, Joh Peplinski. He suggested that she shouldn't be competing in the women's division. "You've got an unfair advantage," Peplinski reportedly said to Capwill.

Janet Yanosko also remembers one of those early races because Capwill finished close behind her. In conversation afterward, Capwill admitted to being a transsexual. This bothered Yanosko. "I thought it was unfair," she says. "From the back, you would swear she is a guy. Her legs, her hips, her shoulders."

Yanosko chatted with other local women runners who

agreed with her, but decided she shouldn't leap to conclusions without digging into the research. "So I sat in a medical library and read everything I could about males versus females," she says. "I discovered that you can change the outside but not the inside."

All the materials Yanosko found seemed to indicate that the biological advantages of being male for 20 years or more would give a runner a distinct edge over a lifelong female. In road running, as in other sports, women have fought long and hard for recognition. "It's not fair," says Henley Gibble, executive director of the Road Runners Club of America. "If somebody wants to change identify and become a woman, fine, but I don't think she competes equally with other women."

Despite the growing crescendo of criticism, April Capwill continued checking the "F" box on road race entry forms and entering races. By early fall of 1990, she had improved to the point where she could run 10-K in 46:29, a very respectable performance for a 39-year-old woman. "The more they complained," she said, "the harder I trained."

In 1991, as Capwill approached her 40th birthday, she increased her training, building up to 60, 70, 80 miles a week. Her times began to drop, and she became a contender to win Erie-area races not just in the masters division but in the women's open division. In one 15-K, Capwill placed second among women masters, just missing the $100 prize for the winner. "Her progress has been amazing," says Patty Hoffman.

She also began to find friends in the Erie running community. She joined the 500-runner Erie Running Club and became a willing volunteer at club activities. When some local women asked the club to make a decision about Capwill's eligibility, the topic was discussed at several meetings. "We saw no basis to take action," says club president Dan Albaugh, who adds: "From what I understand of the other women voicing their concerns, they probably have more testosterone in their systems than April."

Diane Evans, a 3:06 marathoner who competes in the 35-39 age-group, became one of Capwill's strongest supporters. "To me April's just another person," says Evans. "I knew about the objections, so I went out of my way to get to know her. I like her very much. I hope she improves. Things are difficult for April. It's unfortunate people feel the way they do about her, because there's no money involved in these races. If there was money, I could understand why they would protest."

Inevitably, in a situation as complex and emotional as this one, many people are caught in the middle. No one has questioned April Capwill's right to assume the sex and physical appearance that she believes to be her psychological home. The question is: Is it fair for a former man to compete as a woman? Even this seemingly simple question leaves many people feeling uncomfortable.

One of those people is Erie's Barbara Filutze, 45, one of the top women masters runners in the United States. As the best-known runner in Erie, Filutze is a lightning rod for questions about Capwill. "About a hundred people have asked me about her in the last month," says Filutze, "and my standard answer is, I have no opinion. I'm not giving it. I'm not taking a stand."

While Filutze and others have the right not to take a stand, someone has to, because the situation, unusual as it is, requires resolution. Particularly in a sport like running where results rest so squarely on basic physiology. Answers have been hard to find, however. When some women runners from Erie wrote The Athletics Congress (TAC) for assistance in resolving the problem, they received only an ambiguous reply. "We've taken no position yet on April," acknowledges a spokesperson at TAC's national office.

After the Hamot 10-K that Capwill won last summer, Mary Vasey wrote a letter to the sponsoring hospital to protest their award to Capwill. "I write protest letters," says Vasey, "but I never hear another word. Everybody wants to ignore the situation. They're afraid of violating April's legal rights. Well, I'm a woman, and I have rights too." A protest was also lodged after Capwill placed fifth in the Great Race in Pittsburgh. "We did receive a letter of protest," admits race director Mike Radley. "But in placing fifth, April did not win any prize money. She did not win any trophies. We had accepted her entry in good faith. We've taken the position that we're not going to upset the results for 1991. If she chooses to enter in 1992, we'll consider the issue at that time."

The protest was made by Robin Pancerev, who competes in a younger age-group and actually finished ahead of Capwill at the Great Race. "Everybody else was afraid to take a stand," says Pancerev. "But everything I've read, and everybody I've talked to, says that she does have an advantage over a biological female."

Radley did forward Pancerev's protest to William Phelps, president of TAC's Three Rivers region. Phelps admits that he had been aware of the developing situation but had not previously needed to take action because Capwill hadn't been competing in TAC-sanctioned races. Now she does. "We're going to initiate due process," Phelps said. "We'll convene a hearing panel and obtain an appropriate response." Sighing wearily, he added: "Quite frankly, I can think of better ways to spend the rest of the year."

Despite her pleas for anonymity, Capwill herself claims that she entered the Great Race to raise the issue of her sexual eligibility. "That's why I ran that race," she says. "To force TAC to make a ruling." At the highest levels of our sport, the U.S. Olympic Committee and the International Olympic Committee, answers are just as hard to come by. Wade Exum, M.D., at the USOC, says his job involves drug violations rather than sexual matters. He offers no specific information on the subject and suggests contacting the IOC.

Don Catlin, M.D., the U.S. representative on the IOC Medical Commission, is also a drug-testing expert. But he did attend a meeting in France last February where medical experts debated the merits of various gender tests. "It's a complicated subject that only affects a tiny fraction of the athletic population," says Catlin. Since 1968, Catlin explains, the test for gender verification has been the "buccal smear test" (buccal refers to the cheek). Subjects must open the mouth and stick out the tongue while a doctor rubs a swath along the saliva on the inner surface of the cheek to scoop up epithelial cells. These cells can then be examined under a microscope to identify chromosome type. Male chromosomes are typed as XY, females as XX. The result is a determination of the individual's sex at birth.

But this test procedure apparently produced anomalies. A particular problem was athletes who had the chromosomes of one sex but the physical appearance of the other. "The objections from academia," explains Catlin, "were that the buccal smear test was flawed."

A new method for performing the gender tests (called "PCR" for Polymerase Chain Reaction) has been proposed, but experts at the meeting in France debated whether this represented any improvement. Proponents of the various tests suggest that they should serve only as screening methods before a physical examination.

By physical exam, April Capwill is female. By chromosome, she is male. Which test is the fair one for athletes like Capwill (and those who must compete against her)? Reportedly, the IOC Medical Commission will reach its decision and release its findings before the Barcelona Olympics. Of course, Capwill has not attempted to hide

her previous male identity. Neither, apparently, has another transsexual Down Under. At the International Amateur Athletic Federation's (IAAF) meeting during the World Championships in Tokyo last summer, Australia asked for help in dealing with one of its athletes. The individual in question is a transsexual distance runner--male to female--in her late 20s who has surfaced as a rising star in Australia. "This person has a doctor's certificate stating she is a woman, and emotionally, psychologically and even physically she looks like a woman," said Neil King, general manager for Athletics Australia.

Put on the spot, the IAAF wiggled off, refusing to make policy. Its official stand: "National federations may currently make their own individual rulings." It hasn't happened yet--at least not to our knowledge--but unless someone makes a high-level decision soon, we may not be far from the day when a transsexual nabs a top prize in a Boston Marathon, World Championships or Olympics.

With no help from the world of officialdom, runners in Erie continue to debate the issue. "Ray Capwill made this decision to become a female and had to know the consequences of that decision," says Patty Hoffman. "He should have accepted that instead of making us accept the consequences of what he did. "I made a choice 16 years ago," counters April Capwill, "but I'm not going to crawl into a closet and die."

"I don't care what April does with her personal life," says Judy Emling, a masters runner in Erie. "I'm more concerned about her racing against biological females." "I like challenges," insists Capwill. "Unfortunately, I pick ones that cause the most controversy." "Everybody is afraid to do anything," says Robin Pancerev. "Everybody is afraid to make a move." "I feel bad about it," admits Capwill, "but most of the people in the running club have been nice to me." She adds: "It's just four or five girls making all the fuss."

The first man to sit in judgment will probably be the regional TAC president, Bill Phelps, who will rule on the protest made after the Great Race. "It's more than a legal question," says Phelps. "You can be legally a female but still have made characteristics that give you an unfair advantage in athletic competition." Regardless of TAC's ultimate decision, the controversy swirling around Capwill's desire to race as a female has split the Erie running community and inevitably must touch every woman runner. As a willing volunteer, Capwill gained social acceptance and proved a welcome addition to the local running club. Questions of fairness didn't arise until she stepped forward--a former man competing in a woman's world--to accept awards for her road race performances.

Question - what are your thoughts and how do you see this issue?

"THE CASE OF THE MISSING CAR"

by Joanne Law

I had the opportunity to march in the Montreal Pride Parade, August 6th. Cecilia and I drove down to Montreal in my car full of pride stuff. I was able to park my car near the parade set up area which was about 5 blocks away. The instructions on the information letter for the parade stated that we had to there at 10:00am. We found the parade marshals and then we found our set up site, #72 of 95 entries. Several trips back and forth to the car I was able to get all the items we needed. It was hot that day and water, fruit and sandwiches were our food source until 5:00 pm. We watched the other floats, bands and group entries collect around us, and as soon as we could we the opened the 60'x 30' rainbow flag. The parade started at 1:00pm, one hour late (GST).

It took 1 ½ hours for our entry

to get in line in the parade. Walking down Rene Leveque Blvd we passed 600,000 people waving and cheering the parade and our flag as it floated by. At the end we were exhausted we couldn't wait to get back to the car. A friend drove us back to the location of my car only to find that the space which I parked in was occupied by another car. My CAR, my beautiful 1989 Mercury Topaz was gone. was it stolen, or just towed away. I looked at the signs on the streets and it was OK to park there. Cecilia was at this time ready to stop as her legs were giving out. We found a little coffee shop on St Catherine St. to retrace my thoughts and what had just happened. I had to report this to the Montreal Police Dept and make a statement that my car was gone. Here I, am wearing all my pride colours, transgender, and worried of the police reaction in my making the report.

Well folks the police arrived, I told them of the situation on my car and what I should do. Here I am in Montreal, my car is gone and I am talking to the police like nothing was really wrong with me. The comment of the police was, Who would steel a 89 Mercury? I wasn't harassed or ignored by the two officers who made the police report. I was served professionally and with courtesy by the Montreal Police Dept. After the report to the police we took a taxi to the bus terminal, purchased 2 tickets home and with in minutes we were sitting in the bus. I wondered all the way home what had happened.

Two weeks later they found my car in Montreal, I sent Cecilia who met up with Lorne, in Montreal to get the car. They found the place and Cecilia started to drive it home, only to find that the transmission was destroyed but it did move. Lorne and Cecilia got the car to a scrap yard near by, the car was not worth repairing, too much damage.

We were able to get $75.00 for it. Now lets see, I had to pay $165 in towing fees and compound rental fee to get it out, buy the bus ticket return trip to Montreal. Not too much was left to bring home from the trunk or glove compartment. My tool box, my working supplies and vacuums, all gone, my straw hat and a few clothes items never to be seen again.

Friday the 25th. The final chapter of my stolen car. In Quebec in order to cancel your licence plates, you have to prove that your car is off the road before you are allowed to precede with the transaction. As usual there was a line up at the licence office, on St Joseph Blvd in Hull. After waiting for ever I thought, my number was called and I proceeded to the wicket and meet the gentleman who was going to serve me. I handed him my licence plates and proof of my car being off the road at the scrap yard. With the information at hand he logged into the D.O.T. computer, a pause could be seen behind the glass partition. He looked at me and then my drivers licence and then back to me and without blinking an eye he lightly circled the M on my drivers licence with a pencil. In broken english he said to me that I could change the M to an F, (like it was a mistake), if I was to send the require information to one of the Quebec offices dealing with gender placement.

Picking up a well used reference book, he showed me the correct address to do this if I needed to. I smiled thanking him in my somewhat usable french, for his courtesy and his help. He then told me that I was not the first one in that office like myself as several others had passed through the licence borough in the last couple of weeks, seeking gender identification on their licence. Folks this blew me away, I was dealing with a sensitive caring human being who helped make my day at the licence borough a memorable one. Just another day at the office for him anyway.

Yes Virginia there are people that care.

Intersex Children, What is Our Obligation as TG people?

Introduction

The birth of intersexed infants has been documented throughout recorded time. In the late 20th century scientists can determine chromosomal and hormonal gender which is typically taken to be the real, natural, biological gender, usually referred to as the 'sex' of the infant. In spite of this, such biological factors are often pre-empted by cultural factors such as the 'correct' length of the penis, when doctors determine, assign and announce the gender of an infant.

Medical teams have standard practices for managing intersexuality based ultimately on cultural or social understandings of gender, and yet in the medical literature such [cultural/social] issues as post-delivery discussions with parents, and consultations with patients in adolescence, are considered only peripherally to the central medical issues of aetiology, diagnosis and surgical procedures.

Physicians hold an incorrigible belief in, and insistence upon male and female being the only 'natural' options even in the face of incontrovertible evidence to the contrary (i.e. the birth of intersexed infants). This paradox calls into question the idea that female and male are biological givens compelling a culture of two genders.

The Study

Dr. Kessler interviewed six medical specialists (1 clinical geneticist, 3 endocrinologists, 1 psycho endocrinologist and 1 urologist) in paediatric intersexuality (three men and three women) from different teams. All the specialists agreed that the current management of intersexed cases is based on the theory of gender proposed by John Money and colleagues from Johns Hopkins Medical Centre in the USA in 1955 (and elaborated in 1972).

John Money's Recommendations

These are described (in Milton Diamond's words) as follows:

Postulate 1:

The individual is psycho sexually neutral at birth, so that, put in crude terms, if you put a baby in a pink room it will grow up like a girl; if in a blue room, like a boy [i.e. nurture is more important than nature in determining gender].

Postulate 2:

Psychosexual development is related to the appearance of the genitals [i.e. how they look]. If a child looks down and sees a vulva it will grow up like a girl; if a penis, like a boy.

Postulate 3:

Don't allow any doubt [in parents or child] as to gender assignment. Genitals must be made to match the assigned gender a.s.a.p. and gender-appropriate hormones must be administered at puberty. Then child will develop gender identity in accordance with assignment regardless of chromosomal gender and not question his/her gender or request re-assignment at later age.

Postulate 4:

Don't allow any change of sex after 2 years of age. The figure has some leeway; some people say it's as early as 15 months, some say up to 3 years, some people say up to 5 years (consensus on upper limit is 18 months to 2 years). Some say it's tied to the development of language – when the child develops language then they know what gender they are.

Kessler points out [as many others have also] that Money's theory is based on only a handful of repeatedly cited cases, but has been accepted due to prestige of the theoreticians and its resonance with the then-held ideas, i.e. that gender and children are malleable, and that psychology and medicine are the tools used to transform them. One of Kessler's interviewees says: "A gender assignment made decisively, unambiguously and irrevocably contributes, I

believe, to the general impression [my emphasis] that the infant's true, natural 'sex' has been discovered, and that something that was there all along has been found. It also serves to maintain the credibility of the medical profession, reassure the parents, and reflexively substantiate Money and Ehrhardt's theory."
Money says that any surgical 'correction' to the genitalia should be done a.s.a.p. and stresses that in cases of male-to-female reassignment any reduction in phallic tissue must not be delayed beyond the newborn period lest the infant should have traumatic memories of having been castrated.
Kessler points out that there is no corresponding concern that vaginal reconstructive surgery, often carried out much later, might be traumatic.

Kessler's interviewees felt that if diagnosis, gender assignment and genital reconstruction were postponed towards the upper limit of 18 months to 2 years (cited in Postulate 4) it would cause negative parental response to the child, i.e. the parents need to know if it's male or female.

Diagnosis
Current thinking says that a premature gender announcement by an obstetrician at delivery, prior to close examination of the genitals, can be problematic and can lead to the need for backtracking by the child's doctor in front of the parents ("I know how a mistake like that could be made, or not really a mistake but a different decision .... I know what the obstetrician meant, but the way he said it confused you ..... I think this is a better way to think about it......." etc., etc.) revealing the doctor's efforts to protect the parents from concluding that their child is neither male nor female, and also to protect other doctors' decision-making processes.
The practice in any intersexed condition is usually as follows. If the diagnostic tests show that the infant is genetically female (XX sex chromosomes), genital surgery to reduce the phallus size can proceed relatively rapidly, satisfying what the doctors believe are psychological and cultural demands. If however, the infant is determined to have at least one Y sex chromosome, then surgery may be considerably delayed due to the need for further tests to see if the infant's body can make the male hormone testosterone and whether the phallus can respond to it sufficiently to enable the phallus to develop. If neither occurs, then the Y-chromosome infant is not considered to be a male after all. If the infant's phallus responds to testosterone, the gender assignment problem is resolved, but possibly at some later cost, since the penis will not grow again at puberty. Money's case management philosophy assumes that for an adult male a much smaller than average penis may compromise his manliness, but for a young boy it may compromise his essential maleness. Although these psychological effects have not been empirically documented, Money et al advocate the avoidance of both scenarios by reassigning many such infants as female.
The above practice suggests that for Money et al chromosomes are less relevant in determining gender than penis size and that, by implication, 'male' is not defined by the genetic condition of having one Y and one X sex chromosome, or by the production of sperm, but by the aesthetic condition of having an appropriately-sized penis.

Kessler points out that although doctors are anxious not to make a premature gender assignment, their language [to colleagues and parents] whilst waiting for test results (which can be several months) suggests that it is difficult for them to take a completely neutral position and to think and speak only of 'phallic tissue that belongs to an infant whose gender has not yet been determined or decided'. They use words like "...... to see

whether he can respond to testosterone ..." and " ... this baby has an underdeveloped phallus, but we are fairly confident we can help this child look more like a boy ...". The mere fact that the word 'he' and the phrase 'underdeveloped phallus' is used rather than 'overdeveloped clitoris' suggests that the infant has been judged to be, at least provisionally, a male. In the case of the 'undersized phallus', what is ambiguous [in the minds of doctors] is not whether this is a penis, but whether it is 'good enough' to remain one. If, at the end of the treatment period the phallic tissue has not responded, what had been a potential penis (referred to in the medical literature as a 'clitoropenis') is now considered an enlarged clitoris (or 'penoclitoris') and reconstructive surgery is planned, as for the [intersexed] genetic female [referred to earlier].

Deliberating out loud on the judiciousness of making parents wait for assignment decisions, one of the interviewees asked rhetorically "Why do we do all these tests if in the end we're going to make the decision simply on the bais of the appearance of the genitalia?" This question suggests that the principles underlying doctors' decisions are cultural rather than biological, based on parental reaction and the medical team's perception of the infant's prospects for societal adjustment given the way her/his genitals look, or could be made to look. Moreover, as long as 'male' is defined as the possession of a 'good-sized' penis, more infants will be assigned as female than as male.

Dealing with Ambiguity
Kessler points out that there is Great pressure on the parents from relatives, friends etc. for a decision on the baby's 'sex' so that during the waiting period doctors have to manage the parents' anxiety. She goes on to explain some of the ways in which doctors try and steer patients through these problems:
1) Neutral first names, and use 'baby' rather than 'boy' or 'girl', write 'child of ....' on birth certificate instead of name etc.
2) Could tell friends you had twins (boy and girl) and later say that one died.
3) Evade questions by replying "Baby is having problems and we'll get back to you when resolved." (Kessler comments -- "In short, parents are asked to sidestep the infant's gender rather than admit that the gender is unknown, thereby collaborating in a web of white lies, ellipses and mystifications.")
4) Parents taught that all fetuses have potential to be male or female. Doctors may use diagrams to show that nature uses the same anlagen [neutral template] to produce the external parts of the male and female.
5) Doctors stress normality of infant in other respects, to ease the blow and re-direct attention. Terms like 'hermaphrodite' and 'abnormal' are not used.
6) Doctors imply that gender of child is not ambiguous, but only the genitals. Use words like 'undeveloped', 'maldeveloped' or 'unfinished'.
7) Reassure parents that 'true sex' will be found. Phrases like "Tests will help determine what the actual sex is" (Kessler's emphasis). "We thought originally it was a boy because baby was 'closed up down there'. We divided the closed skin and discovered that baby is in fact a girl (Kessler's emphasis).

The message in these examples is that the trouble lies in the doctor's ability to determine the gender and not in the baby's gender per se.
8) Finally, doctors tell parents that social factors are more important than biological ones (even though they are searching for biological causes). In essence, doctors teach parents Money and Ehrhardt's theory of gender development. In doing so, they shift the emphasis from the discovery of biological factors that are a sign of the

'real' gender to providing the appropriate social conditions to produce the 'real' gender (my emphasis). What remains unsaid, though, is the apparent contradiction in the notion that a 'real' or 'natural' gender can be, or needs to be produced artificially. The doctor/parent discussions make it clear to family members that gender is not a biological given (even though, of course, their own [biology-based] procedures for diagnosis assume that it is) and that gender is fluid. Doctors used words like "There is an enormous amount of clinical data to suggest that if you sex-reverse an infant, the majority of the time the alternative gender identity is commensurate with the socialization, the way they are raised, and how people view them."

The implication of these comments is that the gender identity of all children, not just those born with ambiguous genitals, is determined primarily by social factors, that the parents and society always 'construct' a child's gender; in cases of intersexed infants, the doctors merely provide the right genitals to go along with the socialization. Of course, at 'normal' births, when the infant's genitals are not ambiguous, the parents are not told that the child's gender is ultimately governed by socialization. In those cases, doctors do treat gender as a biological given.

Social Factors in Decision Making

Most of the interviewees claimed that the personal convictions of doctors ought to play no role in the decision-making process. They say things like "It's more to do with medical criteria (i.e. what is surgically and endocrinologically possible, in order that the child will grow up with genitals which will look that of the assigned gender). I don't think many social factors enter into it." However, this particular doctor then said that social factors were extremely important in the development of gender identity, operative moreover from the moment the infant leaves hospital. In fact, doctors make decisions about gender on the basis of shared cultural values that are unstated, perhaps even unconscious, and therefore considered objective rather than subjective.

Money laid down very specific guidelines. "Never assign a baby to be reared, and to surgical and hormonal therapy, as a boy, unless the phallic structure, hypospadiac or otherwise, is neonatally of at least the same caliber as that of same-aged males with small-average penises". Elsewhere, he and his colleagues provide specific measurements on what qualifies for a micro penis: "A penis is, by convention, designated as a micro penis when at birth its dimensions are three or more standard deviations [a statistical measure of scatter] below the mean [a kind of 'average']. One of Kessler's interviewees claimed that although "the [size of] phallus is not the deciding factor .... if the phallus is less than 2 cm long at birth and won't respond to androgen treatment, then it's made into a female."

These guidelines are clear, but they focus on only one physical feature, one that is distinctly imbued with cultural meaning. This becomes especially apparent in the case of an XX infant with normal female reproductive gonads [ovaries] and a perfect penis. Would the size and shape of the penis, in this case, be the deciding factor in assigning the infant as 'male', or would the perfect penis be surgically destroyed and female genitalia created? Money notes that this dilemma would be complicated by the anticipated reaction of the parents to seeing "their apparent son lose his penis." Other researchers concur that parents are likely to want to raise a child with a normal-shaped penis (regardless of size) as 'male', particularly if the scrotal area looks normal

and if the parents have had no experience with intersexuality. Elsewhere Money argues in favour of not neonatally amputating the penis of XX infants, since fetal masculinization of brain structures would predispose them "almost invariably [to] develop behaviourally as tomboys, even when reared as girls." This reasoning implies, first, that tomboyish behaviour in girls is bad and should be avoided; and, second, that it is preferable to remove the internal female organs, implant prosthetic testes, and regulate the 'boy's' hormones for his entire life rather than overlook or disregard the perfection of the penis.

The ultimate proof to these doctors that they intervened appropriately is that the reconstructed genitals look normal and function normally in adulthood. Although there is no reported data on how much emphasis the intersexed person him or her-self places upon genital appearance and functioning (my emphasis) the doctors are absolutely clear about what they believe is important. Another team of clinicians revealed their phallocentrism, arguing that the most serious mistake in gender assignment is to create an individual unable to engage in genital [heterosexual] sex. The equation of gender with genitals could only have emerged in an age when medical science can create credible-appearing and functioning genitals; and an emphasis on the good phallus above all else could only have emerged in a culture that has rigid aesthetic and performance criteria for what constitutes maleness. The formulation 'good penis equals male; absence of good penis equals female' is treated in the literature and by the doctors interviewed as an objective criterion, operative in all cases. There is a striking lack of attention to the size and shape requirements of the female genitals, other than that the vagina should be able to receive a penis.

Kessler says that while the prospect of constructing good genitals is the primary consideration in doctors' gender assignment, another extra-medical factor that was repeatedly cited by her interviewees was the specialty of the attending doctor. She then discusses the various biases. e.g. urologists (who are mostly male) liking to 'make boys'. "They are not interested in dynamic processes, they're interested in fixing and lengthening pipes, and not dealing with hormonal and certainly not psychological issues ....." Paediatric endocrinologists were said usually to opt for the easiest route – to raise the child as a female. The urologist who was interviewed mentioned the case of an adolescent who had been assigned as female at birth but who was developing some male pubertal signs and wanted to be a boy. The urologist explicitly links a cultural interpretation of masculinity to the treatment plan. "He was ill-equipped, yet we made a very respectable male out of him. He now owns a huge construction business – those big cranes that put stuff up on the building."

Post-infancy Case Management

Most interviewees claimed that the parents were equal partners in the whole process, but they gave no instances of parental participation prior to the gender assignment (my emphasis). The doctor has acted as detective (gathering the evidence), as lawyer (presenting the case) and as judge (rendering the verdict). Parents are then encouraged to establish the credibility of the assigned gender publicly, for example by giving a detailed medical explanation to a leader in their community such as a pastor or family doctor, who will explain the situation to curious acquaintances. Money argues that "medical terminology has a special magic to laymen in such a context; it is final and authoritative and closes the issue." He also recommends that the mother

"settle the argument once and for all among her woman friends by allowing some of them to see the baby's reconstructed genitals." Apparently, the powerful influence of normal-looking genitals helps overcome a history of ambiguous gender.
Kessler says that some of the same issues that arise in assigning gender can recur some years later when at adolescence the child may be referred to a doctor for counselling. The doctor then tells the adolescent many of the same things his or her parents had been told years before. Terms like 'abnormal', 'disorder', 'disease' and 'hermaphroditism' are avoided; the condition is normalized, and the child's gender treated as unproblematic. She puts forward a case reported by one of the paediatric endocrinologists interviewed, involving an adolescent patient with androgen insensitivity, as "providing an intriguing insight into the post-infancy gender-management process". The patient was told at the age of 14 that "her ovaries weren't normal and had been removed. That's why she needed pills to look normal. .... I wanted to convince her of her femininity. Then I told her she could marry and have normal sexual relations ..... [her] uterus won't develop but [she] could adopt children." The urologist interviewed was asked to comment on this handling of the counselling, and said "It sounds like a very good solution to it. He's stating the truth, and if you don't state the truth ... then you're in trouble later." This is a strange version of 'the truth', however, since the adolescent was chromosomally XY and was born with normal testes that produced normal quantities of androgen. There were no existing ovaries or uterus to be abnormal. Another paediatric endocrinologist, in commenting on the management of this case, hedged the issue by saying that he would have used a generic term like 'the gonads'. A third endocrinologist said she would say that the uterus had 'never formed'.
Technically these physicians are lying when, for example, they explain to an adolescent XY female with an intersexed history that her "ovaries ... had to be removed because they were unhealthy or were producing 'the wrong balance of hormones' ". We can presume that these lies are told in the service of what the physicians consider a greater good – keeping individual/concrete genders as clear and uncontaminated as the notions of female and male are in the abstract. The clinician suggests that with some female patients it eventually may be possible to talk to them "about their gonads having some structures and features that are testicular-like". This call for honesty might be based at least partly on the possibility of the child's discovering his or her chromosomal sex inadvertently from a buccal smear taken in a high school biology class. Today's litigious climate is possibly another encouragement.
In sum, the adolescent is typically told that certain internal organs did not form because of an endocrinological defect, and not [the truth] that those organs could never have developed in someone with her or his sex chromosomes. The topic of chromosomes is skirted. There are no published studies on how these adolescents experience their condition and their treatment by doctors (my emphasis). An endocrinologist interviewed mentioned that her adolescent patients rarely ask specifically what is wrong with them, suggesting that they are accomplices in this evasion. In spite of the 'truth' having been evaded, the clinician's impression is that "their gender identities and general senses of well-being and self-esteem appear not to have suffered".

Conclusion

(Kessler's conclusions are presented here in full)
Doctors conduct careful examinations of intersexed infants' genitals and perform intricate laboratory procedures.

They are interpreters of the body, trained and committed to uncovering the 'actual' gender obscured by ambiguous genitals. Yet they also have considerable leeway in assigning gender, and their decisions are influenced by cultural as well as medical factors. What is the relationship between the doctor as discoverer and the doctor as determiner of gender (my emphasis)? Where is the relative emphasis placed in discussions with parents and adolescents and in the consciousness of doctors? It is misleading to characterize the doctors whose words are provided here as 'presenting themselves publicly to the parents as discoverers of the infant's real gender but privately acknowledging that the infant has no real gender other than the one being determined or constructed by the medical professionals'. They are not hypocritical. It is also misleading to claim that the focus of doctors shifts from discovery to determination over the course of treatment (first the doctors regard the infant's gender as an unknown but discoverable reality; then the doctors relinquish their attempts to find the real gender and treat the infant's gender as something they must construct). They are not medically incompetent or deficient. Instead, I am arguing that the peculiar balance of discovery and determination throughout treatment permits doctors to handle very problematic cases of gender in the most unproblematic of ways.

This balance relies fundamentally on a particular conception of the 'natural'. Although the deformity of intersexed genitals would be immutable were it not for medical interference, doctors do not consider it natural. Instead they think of, and speak of, the surgical/hormonal alteration of such deformities as natural because such intervention returns the body to what it 'ought to have been' if events had taken their typical course (my emphases). The non-normative is converted into the normative, and the normative state is considered natural .The genital ambiguity is remedied to conform to a 'natural', i.e. culturally indisputable, gender dichotomy. Sherry Ortner's claim that the culture/nature distinction is itself a construction – a product of culture – is relevant here. Language and imagery help create and maintain a specific view of what is natural about the two genders and, I would argue, about the very idea of gender – that it consists of two exclusive types: female and male. The belief that gender consists of two exclusive types is maintained and perpetuated by the medical community in the face of incontrovertible physical evidence that this is not mandated by biology.

The lay conception of human anatomy and physiology assumes a concordance among clearly dimorphic gender markers – chromosomes, genitals, gonads, hormones – but physicians understand that concordance and dimorphism do not always exist. Their understanding of biology's complexity, however, does not inform their understanding of gender's complexity (my emphasis). In order for intersexuality to be managed differently than it currently is, doctors would have to take seriously Money's assertion that it is a misrepresentation of epistemology to consider any cell in the body authentically male or female. If authenticity for gender resides not in a discoverable nature but in someone's proclamation, then the power to proclaim something else is available (my emphasis). If physicians recognized that implicit in their management of gender is the notion that finally, and always, people construct gender as well as the social systems that are grounded in gender-based concepts, the possibilities for real societal transformations would be unlimited.

Unfortunately, neither in their representations to the families of the intersexed nor among themselves do the physicians interviewed for this study draw such far-reaching implications

from their work. Their 'understanding' that particular genders are medically (re)constructed in these cases does not lead them to see that gender is always constructed. Accepting genital ambiguity as a natural option would require that physicians also acknowledge that genital ambiguity is 'corrected' not because it is threatening to the infant's life but because it is threatening to the infant's culture (my emphasis).
Rather than admit to their role in perpetuating gender, physicians 'psychologize' the issue by talking about the parents' anxiety and humiliation in being confronted with an anomalous infant. The doctors talk as though they have no choice but to respond to the parents' pressure for a resolution of psychological discomfort, and as though they have no choice but to use medical technology in the service of a two-gender culture. Neither the psychology nor the technology is doubted, since both shield doctors from responsibility. Indeed, for the most part, neither doctors nor parents emerge from the experience of intersex case management with a greater understanding of the social construction of gender.
Society's accountability, like their own, is masked by the assumption that gender is a given. Thus, cases of intersexuality, instead of illustrating nature's failure to ordain gender in these isolated 'unfortunate' instances, illustrate doctors' and Western society's failure of imagination – the failure to imagine that each of these management decisions is a moment when a specific instance of biological 'sex' is transformed into a culturally constructed gender.

Milton Diamond's Alternative Recommendations

(not part of Kessler's article)
At the 1995 meeting in San Francisco (see footnote on front page) Milton Diamond, who is one of John Money's main protagonists, presented evidence from case studies (including one of Money's original patients) to indicate that there is a biologically-based bias at birth towards a particular gender identity and that many intersexed patients are unhappy as adults with their assigned gender following surgical intervention based on Money's criteria. Diamond puts forward some new recommendations for management, as follows:
Postulate 1:
An individual is psycho sexually biassed at birth.
Postulate 2:
Psychosexual development is related to, but not dependent on the appearance of the genitals. Transexuals are obviously the sine qua non of individuals whose genitals do not decide what and who they are.
Postulate 3:
Discuss openly and fully any doubt as to gender identity and orientation when doubt arises. One of the most traumatic things for intersexed people and others is the hidden secrecy that is continually fostered on them – that you can't allow any doubt because that will just prejudice the outcome.
Postulate 4:
Change of sex [should be allowed] whenever it is by informed choice.

Recommendations for Sex Assignment:

If a child is unambiguously male or female and has a traumatic (accidental) loss of the genitals, maintain the original sex assignment. [Much of Money's thesis was based on a case where a boy lost his penis during minor surgery aged 7 months and was reared as a girl. Diamond presented evidence that later this individual was severely unhappy with this and wanted to revert to being a boy.] Do not reassign, regardless of age. Do surgery as and when appropriate with minimum loss of [sexual] sensitivity. If micro penis, raise as a boy. If with clitoral hypertrophy [enlargement], raise as a girl. Do no clitoral resection. In cases of pseudohermaphroditism or

hermaphroditism [with ambiguous genitalia] do full evaluation before deciding on course of action; if the chromosomal composition is uncomplicated raise child in the genetic sex; do only that surgery required for physical health; no cosmetic surgery unless with full informed consent. And that means, since the kid's a baby, don't touch the kid! Provide in-depth and prolonged counselling to parents and child, with full disclosure of situation and possibilities; be truthful, provide support group affiliation if available; discuss sex reassignment and different sexual orientation as options. Allow and fully support sex re-assignment whenever it comes about by voluntary informed consent.

By Suzanne Kessler Ph.D. of the Divison of Natural Sciences at the State University of New York, Purchase, NY 10577 with additional material by Milton Diamond Ph.D. of the Dept. of Anatomy and Reproductive Biology at the University of Hawaii Medical School, Honolulu, HI 96822.

Question - Does this have anything to do with you , does the power of non TG or Intersex professionals over your life concern you?

TG NEWS
You provide - we share it

A friend in Quebec has advised me that a group of TS' is putting together a class action lawsuit against the Gov't for their funding of SRS (or rather the lack of appropriate funding). This is being lead by Michelle Gauthier. Any TS in Quebec who is interested and would like more information can call 1-877-421-0211.

Our Journey
by Ricky & Rita

Our Journey began 4 years ago in May, Ricky and I discussed in Length his feelings. I tried to understand, because I love him dearly, we worked on it together. Our first, outing was the Transgender Ball. Now we worked hard to have Ricky look her best. The step into the Ball was exciting and terrifying at the same time. Thanks to the transgendered people we were accepted graciously by Joanne and the member. We joined Gender Mosaic immediately. Have only missed a couple of meetings. I must give all the credit to those meetings and the members for teaching us all about our new journey. It was very exciting and we felt very much at home because that is the kind of people they are. They are there for your every need and question which is so important, or believe, we never would of made it even though we had each other.

We went along for 3 ½ years, then we has a huge bump in our journey. Ricky decided he was going back in the closet. We went his therapist and she suggested against it. I took a deep nose dive into depression because I had invested my heart and soul into this journey. We sat down and discussed it thoroughly, but this feeling didn't go away for about a month and a half which time we were devastated.

It has to be the lowest time we ever spent. But there is a bright side, thanks for the support and thoughtfulness of Margo, Suzanne, Kaitlin Barb and Linda, John for phone calls, letters we survived the ordeal.

Also, I can not leave out the members of Gender Mosaic, who are just the best. I strongly feel that we should all do our part for each other and this super club without it our journey would not have been so pleasant. Thank you all
Ricky and Rita

As the Editor I would truly like to thank Ricky and Rita for the courage to honour the journey even when it is so very difficult and for the opportunity that the have shared with this group to demonstrate what we state, that you are not alone. Margo

Did You Know?

The Gender Mosaic, PO Box 7421, Vanier Ontario. K1L 8E4 can be used by all members for their packages, delivery of books or magazines. I will pick them up and get them to you some way. Just let me know.
Thanks Your Executive

Upcoming Events

- GM Support & discussion Group fourth Thursday of each month contact Margo

- TS Support & discussion Group - Due to Lack of Consistent Participation it Is on Hold but If You Come -It Will Happen - Gwen 828.7988

- Spouse/Parnters discussion Group September 13 contact Margo **if you are coming**

UP COMING MEETINGS

September - Therapist

October - Building Community Links with local GBLT groups

November - Representative of the Crown Attorney's Office

December 9th - Christmas Party

For Member Feedback on any GM linked services talk to Lynn, Gwen or Randi

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