NEW YORK COUNTY FAMILY COURT INDEX NO. K1154/96

Supreme Court of the State of New York

Appellate Division—First Department

In Re BRIAN (a/k/a MARIAH) L.,

Petitioner-Respondent,

– against –

ADMINISTRATION FOR CHILDREN'S SERVICES,

Respondent-Appellant.

BRIEF OF *AMICI CURIAE*
THE ASSOCIATION OF GAY AND LESBIAN PSYCHIATRISTS, GEORGE BROWN, M.D., MICHAEL BROWNSTEIN, M.D., CALLEN-LORDE COMMUNITY HEALTH CENTER, ANN DANOFF, M.D., LAURA ELLIS, M.D., FENWAY COMMUNITY HEALTH, JAMES FRANICEVICH, N.P., R. NICK GORTON, M.D., HISPANIC AIDS FORUM, HOUSING WORKS, INC., LYON-MARTIN WOMEN'S HEALTH SERVICES, LINETTE MARTINEZ, M.D., CHARLES MOSER, PH.D., M.D., GARY REMAFEDI, M.D., M.P.H., EUGENE SCHRANG, M.D., JOELLEN VORMOHR, M.D., AND THE WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH, INC.

Dated: May 22, 2007

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I. STATEMENT OF INTEREST OF *AMICI CURIÆ*

Amici curiæ are physicians, psychologists, surgeons, and health clinics with expertise in the treatment and care of individuals with Gender Identity Disorder.[1] *Amici* include the organization that publishes the Standards of Care for Gender Identity Disorders ("Standards of Care") as well as many professionals with expertise in applying the Standards of Care. *Amici* have a vital interest in addressing the proper interpretation of the Standards of Care and their application to people with Gender Identity Disorder ("GID"), and are concerned by certain

[1] *Amici* recognize that unnecessary amicus briefs are a burden and therefore submit a single brief to avoid duplicative filings. The particular expertise of each *amicus* is more fully described in the "Description of *Amici Curiæ*."

inaccurate assertions ACS has made in this case. In particular, *amici* vigorously disagree with ACS's assertions that the Standards of Care bar the provision of surgical treatment to people with GID who lack stable housing or employment, and that an ACS administrator could apply the Standards of Care more appropriately than qualified GID experts who have performed thorough patient evaluations.

Amici invite the Court's attention to the information presented herein—which is not addressed in the parties' submissions and which could otherwise escape the Court's attention—because *amici* have expertise regarding the type of procedures and treatment contemplated in the present appeal. As *amici* explain herein, medical treatment must be tailored to individual circumstances, and a patient's health care professionals are generally most competent to address the appropriate course of treatment for that particular patient. Accordingly, *amici* limit their submission to discussion of the Standards of Care and general considerations relating to GID treatment, and do not opine on the particular facts or circumstances of the treatment prescribed for respondent Mariah L. in this case.

In the earlier appeal of the instant matter previously before this Court, many *amici* addressed ACS's inaccurate arguments concerning the necessity and legitimacy of sex reassignment treatment for GID. For that reason, *amici* will provide only minimal information about the effectiveness and benefits of these

treatments, and respectfully refer the Court to the brief previously submitted by *amici* for additional information on this subject.

A. Identity and Description of Amici Curiæ

The Association of Gay and Lesbian Psychiatrists ("AGLP") is a community of psychiatrists that advocates for lesbian, gay, bisexual and transgender ("LGBT") mental health issues. As an affiliate of the American Psychiatric Association, AGLP seeks to foster a greater understanding of LGBT mental health issues. AGLP educates and advocates for the best mental health care for the LGBT community. AGLP develops resources to promote LGBT mental health.

George R. Brown, M.D., is Professor of Psychiatry and Associate Chairman of Psychiatry at the East Tennessee State University School of Medicine. He is also on the Board of Directors of the World Professional Association for Transgender Health, and a coauthor of Version 5, Standards of Care, and contributor to Version 6, Standards of Care.

Michael Brownstein, M.D., is a member of the Board of Directors and Chairman of the Ethics Committee of the World Professional Association for Transgender Health. Dr. Brownstein is a Board Certified plastic surgeon and a member of the American Society of Plastic Surgeons, specializing in plastic, reconstructive, and gender-related surgery. Dr. Brownstein has performed gender-

related surgery since the late 1970s, when, with the advice and support of Paul Walker, co-founder of the World Professional Association for Transgender Health, he received the first of many referrals for bilateral breast reconstruction for transgender patients.

Callen-Lorde Community Health Center ("Callen-Lorde") is New York City's only primary health care center dedicated to meeting the health care needs of the lesbian, gay, bisexual and transgender ("LGBT") communities and people living with HIV/AIDS - regardless of any patient's ability to pay. All are welcome, regardless of sexual orientation or insurance coverage. Callen-Lorde is a New York State-licensed Diagnostic and Treatment Center and provides approximately 45,000 patient care visits per year to over 11,000 patients. Services include primary and episodic medical care; sexual health services; gynecologic services; HIV counseling and testing; case management/care coordination; dental care; and mental health services, including psychiatry. Callen-Lorde serves over 800 patients of transgender experience.

Ann Danoff, M.D., is Director of the Division of Endocrinology and Associate Professor of Medicine at New York University School of Medicine. She is also a member of the Ethics Advisory Committee of the Endocrine Society and former Chair of the Institutional Review Board at Bronx-Lebanon Hospital Center.

Laura Ellis, M.D., has been Board Certified in Family Medicine for twenty-five years. She is currently the second in command staff physician at Dothan Veterans Administration Outpatient Clinic in Dothan, Alabama. Dr. Ellis is a representative to the American Academy of Family Physicians ("AAFP") National Congress for Special Constituencies, and has recently been elected to serve on the AAFP's policy-making body, the National Congress of Delegates. Dr. Ellis also lectures at conventions on transgender issues across the United States.

Fenway Community Health ("Fenway") has been working to improve the physical and mental health of those who are traditionally underserved, including lesbian, gay, bisexual and transgender people, women, those living with HIV/AIDS, and people from communities of color, for more than thirty years. Fenway operates the Transgender Health Program, which offers comprehensive medical and mental health care to transgender clients. Fenway also provides training and education on transgender health issues to other health care organizations.

James Franicevich, N.P., a nurse practitioner at San Francisco's Tom Waddell Health Clinic ("TWHC"), regularly treats transgender patients during TWHC's weekly transgender clinic. He is a member of the Transgender Health Team and contributed to TWHC's Protocols for Hormonal Gender Reassignment.

R. Nick Gorton, M.D., is a transgender physician. He graduated from UNC School of Medicine and completed residency and chief residency in Emergency Medicine at Kings County Hospital, Brooklyn, NY. In addition to his Emergency Medicine practice, Dr. Gorton volunteers at Lyon-Martin Women's Health Services in San Francisco where he has a weekly clinic that focuses on transgender patients. He is a co-author of the book "Medical Therapy and Health Maintenance for Transgender Men: A Guide For Health Care Providers." He consults regarding transgender issues for legal organizations including Lambda Legal, the Transgender Law Center, and the Sylvia Rivera Law Project. He is on the National Center for Transgender Equality's Advisory Board. In 2005, he and two other physicians proposed a successful amendment to include gender identity/expression in the non-discrimination clause of the American College of Emergency Physicians Code of Ethics. Dr. Gorton lectures on transgender medical care to medical schools, community organizations, and professional associations.

Hispanic AIDS Forum ("HAF") is New York City's largest Latino-run HIV/AIDS organization offering treatment, education and innovative prevention services to the city's Latino population. HAF's mission is to reduce HIV transmission and secure timely, quality support services for Latinos affected by HIV/AIDS. HAF's services include health clinics, support groups, HIV counseling

and testing, and health promotion workshops, including services focused on the transgender Latina community.

Housing Works is New York's largest provider of social services to people living with HIV and AIDS. Housing Works is a provider and partial owner of Vidacare, a Medicaid Managed Care program designed to serve the designated HIV special needs population. In addition to providing an array of adult day treatment and mental health services, Housing Works is also a New York State licensed provider of primary care services, currently operating three Diagnostic and Treatment Clinics on the Lower East Side, in Greenwich Village, and in East New York, Brooklyn; a fourth clinic is planned to open in Downtown Brooklyn within the year. Housing Works serves a significant number of transgender clients at these sites, providing both health care services and case management services to transgender clients.

Lyon-Martin Women's Health Services ("Lyon-Martin") provides personalized health care and support services, regardless of ability to pay, to women and transgender people who lack access to quality care because of their sexual or gender identity. Founded in 1979, Lyon-Martin provides critical primary care for over 1500 women and transgender people each year. Many of those clients come to Lyon-Martin in crisis and in need of other forms of care, and in response to these needs, Lyon-Martin provides health education, counseling, and

referral services to aid in maintaining the overall health and well-being of all women and transgender people.

Linette Martinez, M.D., is a physician at San Francisco's Tom Waddell Health Clinic ("TWHC") where she provides transition-related and primary care to hundreds of transgender people during TWHC's weekly transgender clinic. Dr. Martinez contributed to the 2001 and 2006 TWHC Protocols for Hormonal Reassignment of Gender and is a member of the Transgender Health Team. Dr. Martinez lectures on transgender health care delivery at national conferences.

Charles Moser, Ph.D., M.D., received his Ph.D. in 1979 in Human Sexuality from the Institute for Advanced Study of Human Sexuality in San Francisco, and he received his M.D. from Hahnemann University in 1991. He is also a Licensed Clinical Social Worker and maintained a private psychotherapy practice specializing in the treatment of sexual concerns prior to his medical career. He is certified in Internal Medicine by the American Board of Internal Medicine and was recently elected to fellowship of the American College of Physicians. Currently, Dr. Moser is a Professor of Sexology and Chair of the Department of Sexual Medicine at the Institute for Advanced Study of Human Sexuality. He also maintains an Internal Medicine private practice focused on the sexual aspects of medical concerns and the medical aspects of sexual concerns. He has authored or co-authored over 40 scientific papers and books.

Gary Remafedi, M.D., M.P.H., is the Director of the Youth and AIDS Projects and a Professor of Pediatrics at the University of Minnesota. Dr. Remafedi received his baccalaureate degree from Yale University and medical degree from the University of Illinois. He completed his pediatric residency training at Cook County Hospital, Chicago, and a Master's Degree in Public Health and fellowship in Adolescent Medicine at the University of Minnesota. Dr. Remafedi is a Fellow of the American Academy of Pediatrics and a member of the editorial review boards of the Journal of the American Medical Association, American Journal of Public Health, Pediatrics, and other distinguished scientific publications. He has published and lectured widely on the topics of adolescent sexuality, HIV/AIDS, and other sexually transmitted diseases. His regular professional activities include caring for pediatric and adolescent patients, research in adolescent medicine, and teaching physicians and graduate students at the University of Minnesota.

Eugene Schrang, M.D., is an experienced surgeon in all male-to-female transsexual operations including breast and genitalia procedures. Dr. Schrang also has expertise in female-to-male chest work and some genitalia operations. He has performed approximately 1,400 genital reassignment procedures and more than 3,000 breast augmentation mammoplasties, in addition to other procedures.

Joellen Vormohr, M.D., is a physician at San Francisco's Tom Waddell Health Clinic ("TWHC") where she provides transition-related and primary care to hundreds of transgender people during TWHC's weekly transgender clinic. Dr. Vormohr contributed to the 2001 and 2006 TWHC Protocols for Hormonal Reassignment of Gender and is a member of the Transgender Health Team.

The **World Professional Association for Transgender Health, Inc.** (formerly known as The Harry Benjamin International Gender Dysphoria Association, Inc.) (hereinafter "WPATH") is a professional organization devoted to the understanding and treatment of gender identity disorders, and is actively involved in supporting, educating, and advocating on behalf of individuals diagnosed, or undiagnosed, with Gender Identity Disorder. The organization's membership includes approximately 400 licensed professionals in the disciplines of medicine, internal medicine, endocrinology, plastic and reconstructive surgery, urology, gynecology, psychiatry, nursing, psychology, neuropsychology, sociology, social work, counseling, sexology, and law, from twenty countries, including the United States. WPATH develops and publishes the Standards of Care for the treatment of gender identity disorders. The Standards of Care are internationally-accepted guidelines, designed to promote the health and welfare of persons with gender identity disorders.

II. STATEMENT OF THE CASE

Mariah L. is a young transgender woman who has been diagnosed with GID. *Brian L. a.k.a. Mariah L. v. Admin. Children's Serv.*, K-1154/96 at 5 (N.Y. Fam. Ct. Feb. 21, 2007). Mariah has lived as a woman for years, and receives feminizing hormone therapy as part of her GID treatment. *Id.* at 6. In 2004, ACS sent Mariah to be evaluated by four health care experts to determine the next step in her GID treatment. *Id.* at 5-6. Those experts were Katherine Rachlin, Ph.D., a clinical psychologist, WPATH member, and certified sex therapist specializing in the treatment of transgender people; C. Christine Wheeler, Ph.D., a psychotherapist with over thirty years of experience in GID treatment, a WPATH member, and a drafter of the Sixth Edition of the Standards of Care; board-certified psychiatrist David Kreditor, M.D., Ph.D.; and Michael K. Bartolos, M.D., a physician trained in internal medicine and medical genetics whose practice includes the treatment of transgender people and who is also a WPATH member. *Id.* All four of these professionals evaluated Mariah and agreed that sex reassignment surgery was necessary medical treatment for her in accordance with the Standards of Care. *Id.* at 4. Subsequent to and despite those unanimous professional opinions, the ACS Commissioner unilaterally stated that the four providers had incorrectly applied the Standards of Care, opining that Mariah acted in an "unstable" manner and thus was not eligible or ready for sex reassignment surgery. *Id.* at 6. The Family Court cites

no evidence that the Commissioner is a qualified health care provider. Based on his determination, and in contravention to the considered recommendations of the medical professionals who assessed Mariah, the Commissioner refused to pay for sex reassignment surgery. *Id.* ACS has continued to make this assertion to the Family Court and on appeal to the First Department.

III. SUMMARY OF ARGUMENT

The World Professional Association for Transgender Health ("WPATH") Standards of Care[2] are internationally-accepted protocols rooted in medical research showing that GID is a serious health condition and that sex reassignment effectively relieves the associated suffering and distress. (See Sections A and D *infra.*) The overarching purpose of the Standards of Care's eligibility and readiness criteria for genital sex reassignment surgery[3] ("SRS") is to ensure that the gender identity of a patient with GID is consistent, enduring, and consolidated. (See Section B *infra.*) While a professional may consider life stability in assessing surgical eligibility and readiness, the Standards of Care are ultimately intended to

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[2] The World Professional Association for Transgender Health, which has established the internationally-accepted Standards of Care for treatment of individuals with Gender Identity Disorder, is formerly known as the Harry Benjamin International Gender Dysphoria Association. *See* http://www.wpath.org/about_wpath.cfm.

[3] The term "sex reassignment surgery" can mean one or more of several different procedures, depending on the individual patient's medical needs. *Amici's* comments are directed toward genital reconstructive surgery, specifically, because it is the type of procedure that Mariah L.'s doctors have found medically necessary and that the Family Court has ordered ACS to provide. The information in this brief, particularly with regard to eligibility and readiness criteria, should not be assumed to apply equally to other types of sex reassignment surgery.

facilitate "lasting personal comfort with the gendered self." The Standards of Care are not intended to bar medically necessary treatment that would greatly benefit the patient. Other health conditions and life challenges often stem from inadequately treated GID, and GID treatment may diminish or resolve them. The Standards of Care accord with a burgeoning field of medical research confirming the therapeutic effectiveness of sex reassignment as treatment for GID. (See Section D *infra*). Ultimately, only qualified providers can ascertain the appropriate treatment for their patients with GID after thorough assessment. (See Section C *infra*.)

IV. ARGUMENT

The Standards of Care outline the recognized therapeutic treatment protocols for people diagnosed with GID, and guide health care providers and clinicians who work with such patients.[4] Qualified medical professionals make individualized treatment recommendations for their patients based upon the criteria listed in the Standards of Care, and are informed by a growing body of studies demonstrating that sex reassignment is generally the only effective treatment for GID.

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[4]World Professional Association for Transgender Health, STANDARDS OF CARE FOR GENDER IDENTITY DISORDERS (6th Ed., 2001) at 1, *available at* http://www.wpath.org/publications_standards.cfm (hereinafter "STANDARDS OF CARE") ("The major purpose of the Standards of Care (SOC) is to articulate this international organization's professional consensus about the psychiatric, psychological, medical, and surgical management of gender identity disorders. Professionals may use this document to understand the parameters within which they may offer assistance to those with these conditions.").

A. The Internationally-Accepted Protocols for Therapeutic Treatment of Gender Identity Disorder are Set Forth in the Standards of Care Published by the World Professional Association for Transgender Health.

For more than twenty-seven years, transgender health care providers have followed a set of internationally-recognized clinical protocols for the treatment of GID. In 1979, WPATH published the first Standards of Care for Gender Identity Disorders ("Standards of Care"). Today the Standards of Care are in their sixth edition.[5]

WPATH, a professional organization devoted to the understanding and treatment of gender identity disorders, includes licensed professionals from twenty countries in the disciplines of medicine, endocrinology, surgery, psychiatry, psychology, neuropsychology, and others. WPATH "has always played a major role in the research and treatment of transsexualism,"[6] hosting biennial symposia where GID experts discuss important developments in the field and publishing an international journal to educate providers on therapeutic treatment for GID.

Most responsible professionals who diagnose and treat patients with GID follow the Standards of Care because they "provide a valuable guide for evaluation

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[5] *See* STANDARDS OF CARE, *supra* note 4.

[6] G. Selvaggi, et al. *Gender Identity Disorder: General Overview and Surgical Treatment for Vaginoplasty in Male-to-Female Transsexuals*, 116 PLASTIC & RECONSTRUCTIVE SURGERY 135e, 137e (Nov. 2005).

and treatment."[7] Many medical and health service providers and clinics have developed their own detailed protocols for treating clients with GID that build on the Standards of Care.[8] The Standards of Care recognize a single overarching treatment goal: the patient's achievement of "lasting personal comfort with the gendered self in order to maximize overall psychological well-being and self-fulfillment."[9] The Standards of Care recommend SRS when determined after thorough assessment to be necessary for a patient's well-being:

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[7] George R. Brown, *Transvestism and Gender Identity Disorder in Adults*, in TREATMENTS OF PSYCHIATRIC DISORDERS 2030 (Glen O. Gabbard ed., 2001). *See also* Dasari Harish & B.R. Sharma, *Medical Advances in Transsexualism and the Legal Implications*, 24 AM. J. FORENSIC MEDICINE & PATHOLOGY 100, 102 (2003) (noting that the Standards of Care have been accepted worldwide); P. Cohen-Kettenis & L.J.G. Gooren, *Transsexualism: A Review of Etiology, Diagnosis and Treatment*, 46 JOURNAL OF PSYCHOSOMATIC RESEARCH 315, 315 (1999) ("In many countries, transsexuals are now treated according to the Standards of Care of the Harry Benjamin International Gender Dysphoria Association..."); Kevan Wylie, *Gender Related Disorders*, 329 BRITISH MEDICAL JOURNAL 615, 616 (2004) (noting that the Harry Benjamin International Gender Dysphoria Association publishes internationally agreed-upon standards of care for transgender patients).

[8] *See, e.g.*, The Transgender Health Project, Vancouver, B.C., *Guidelines for Transgender Health Care*, *available at* http://www.vch.ca/transhealth/resources/tcp.html#guidelines (last visited May 17, 2007) ("The protocols are consistent with . . . the World Professional Association for Transgender Health's Standards of Care."); Memorandum from Tom Waddell Health Center Transgender Team, *Protocols for Hormonal Reassignment of Gender* (Dec. 12, 2006), *available at* http://www.dph.sf.ca.us/chn/HlthCtrs/HlthCtrDocs/TransGendprotocols122006.pdf (last visited May 16, 2007); THE REED CENTRE FOR GENITAL SURGERY, ELIGIBILITY, *available at* http://www.srsmiami.com/SRS_Eligiblity.htm (last visited May 16, 2007) ("The Reed Centre conforms to 'Standards of Care of the Harry Benjamin International Gender Dysphoria Association.'").

[9] *See* STANDARDS OF CARE, *supra* note 4, at 1 (discussing overarching goal of psychotherapeutic, endocrine, or surgical therapy for persons with gender identity disorders).

> In persons diagnosed with transsexualism or profound GID, sex reassignment surgery, along with hormone therapy and real-life experience, is a treatment that has proven to be effective. Such a therapeutic regimen, when prescribed or recommended by qualified practitioners, is medically indicated and medically necessary. Sex reassignment is not "experimental", "investigational", "elective", "cosmetic", or optional in any meaningful sense. It constitutes very effective and appropriate treatment for transsexualism or profound GID.[10]

B. The Eligibility and Readiness Criteria in the Standards of Care Guide Clinicians in Determining Whether to Recommend SRS for a Patient with GID.

The Standards of Care provide criteria to assist medical professionals in providing individualized therapeutic treatment for their patients with GID and to ascertain their patients' eligibility and readiness for hormone therapy and surgical treatments. The Standards of Care list six eligibility criteria for SRS:

> 1. Legal age of majority in the patient's nation;
> 2. Usually 12 months of continuous hormonal therapy for those without a medical contraindication;
> 3. 12 months of successful continuous full time real-life experience. Periods of returning to the original gender may indicate ambivalence about proceeding and generally should not be used to fulfill this criterion;
> 4. If required by the mental health professional, regular responsible participation in psychotherapy throughout the real-life experience at a frequency determined jointly by the patient and the mental health professional. Psychotherapy per se is not an absolute eligibility criterion for surgery;

[10] *Id.* at 18.

5. Demonstrable knowledge of the cost, required lengths of hospitalizations, likely complications, and post surgical rehabilitation requirements of various surgical approaches; [11]
6. Awareness of different competent surgeons.[12]

In addition to these eligibility requirements, a person seeking SRS must also be deemed ready for surgery by his or her provider. The Standards of Care state that determining readiness for SRS "rests on the clinician's and patient's judgment."[13] Determining whether someone meets the readiness criteria "is more complicated" than making an eligibility determination, and requires close assessment of an individual as a whole.[14] Before recommending surgery, clinicians must assess whether the patient demonstrates "further consolidation of the evolving gender identity or improving mental health in the new or confirmed gender role."[15] Rather than listing what the criteria "are," as with eligibility, the

[11] On the fifth and sixth point, it is worthwhile to note that individuals are not expected to garner independently all of the relevant knowledge to share with a mental health professional, physician, or surgeon. Expecting an individual to learn this medical information entirely independently of his or her providers would be illogical; in fact, it could border on irresponsible. Rather, it is part of the role of the evaluating and treating professionals to share this information with the individual being evaluated for treatment. See STANDARDS OF CARE, *supra* note 4, at 6 (listing one of the tasks of the mental health professional as counseling the individual about "the range of treatment options and their implications"); Tom Waddell Health Center, *supra* note 8, at 19 (describing assistance to patients that includes "offering education about the procedures and their effects, providing a directory of different surgical groups within the country and abroad, and facilitating pre-op requirements.").

[12] STANDARDS OF CARE, *supra* note 4, at 20.

[13] *Id.* at 7.

[14] *Id.*

[15] *Id.* at 20.

Standards of Care instead state that the readiness criteria "include" two subjective criteria.[16]

The readiness criteria ask providers to assess whether, in their opinion, a patient has shown:

> 1. Demonstrable progress in consolidating one's gender identity;
> 2. Demonstrable progress in dealing with work, family, and interpersonal issues resulting in a significantly better state of mental health; this implies satisfactory control of problems such as sociopathy, substance abuse, psychosis, suicidality, for instance)[sic].[17]

The patient's progress in gender identity consolidation is thus a primary consideration. Simply living and getting along well over a long period of time as a member of the gender congruent with one's identity demonstrates progress in dealing with work, family, and interpersonal issues, as "it requires a not inconsiderable amount of mental stability."[18]

1. The Standards of Care Require an Individualized Approach and Consideration of the Transgender Individual as a Whole in Order to Assess Surgical Eligibility and Readiness.

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[16] *Id.*

[17] *Id.*

[18] FRIEDMANN PFÄFFLIN & ASTRID JUNGE, SEX REASSIGNMENT. THIRTY YEARS OF INTERNATIONAL FOLLOW-UP STUDIES AFTER SEX REASSIGNMENT SURGERY: A COMPREHENSIVE REVIEW, 1961-1991 Chapter Six (Roberta B. Jacobson & Alf B. Meier trans., Symposion Publishing Dusseldorf 1997), *available at* http://www.symposion.com/ijt/pfaefflin/6003.htm (last visited May 17, 2007).

In assessing a transgender person's eligibility and readiness for SRS under the Standards of Care, medical professionals must consider the patient as a whole. In order to appreciate fully how surgery can alleviate the psychological discomfort of patients diagnosed with GID, clinicians "need to listen to these patients discuss their life histories and dilemmas."[19] Thus, clinicians applying the Standards of Care's eligibility and readiness criteria do not arrive at a surgery recommendation without having first taken a broad view of the client's life and having considered the totality of that person's experience living as a member of the gender congruent with his or her identity.

Inherent in the accepted medical approach for GID treatment is the understanding that the extent of medically necessary treatment varies depending on each person's individual circumstances and needs. The Standards of Care expressly state that they are intended to provide flexible guidelines and that treatment recommendations ultimately must be based on an individualized assessment of each patient's unique circumstances and needs.[20] The Standards of Care remind medical providers that "clinical departures from these guidelines may come about because of a patient's unique anatomic, social or psychological

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[19] STANDARDS OF CARE, *supra* note 4, at 19.

[20] *See e.g.* STANDARDS OF CARE, *supra* note 4, at 1-2 ("The [Standards of Care] are intended to provide flexible directions for the treatment of persons with gender identity disorders."); *id.* at 20-21 ("The [Standards of Care] provide for an individual approach for every patient ... there is no inherent reason that [a transgender patient] must take hormones prior to genital surgery.").

situation, an experienced professional's evolving method of handling a common situation, or a research protocol."[21] A rigid, formulaic approach to determining surgical readiness contradicts the letter and spirit of the Standards of Care and undermines accepted transgender health care protocols.

The relevant medical literature underscores this flexibility, noting that the Standards of Care "offer guidance to physicians, rather than any clear criteria for treating any particular individual . . . . Treatment in every case must be individualized and responsive."[22] Because all people have their own life experiences and circumstances, health professionals are encouraged to "take into account the needs of the individual patient rather than enforcing a rigid package of care."[23] The provider must consider multiple factors in an evaluation, including the risks associated with not providing SRS to the individual.[24]

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[21] STANDARDS OF CARE, *supra* note 4, at 2.

[22] Hazel Beh & Milton Diamond, *Ethical Concerns Related to Treating Gender Nonconformity in Childhood and Adolescence: Lessons from the Family Court of Australia*, 15 HEALTH MATRIX 239, 270-71 (Summer 2005) (reviewing current treatment practices and emphasizing need for individualized clinical assessment).

[23] Kevan Wylie, *Gender Related Disorders*, 329 BRITISH MEDICAL JOURNAL 615, 616 (2004).

[24] Brown, *supra* note 7, at 2039 (explaining that therapist must examine the risks of not treating the patient's gender dysphoria, including possible "disastrous consequences").

The individualized nature of transgender health care outlined in the Standards of Care is a "client-centered approach."[25] Such an approach necessitates flexibility on the part of the provider:

> While evaluation of hormone/surgery eligibility and readiness does not involve a fully collaborative process (i.e., the client does not typically have latitude to negotiate the eligibility/readiness criteria), it is important to be flexible enough in hormone/surgery assessment to consider areas that may be open to negotiation (e.g., interpretation of what constitutes "real life experience" or "mental stability"), and to discuss these with the client.[26]

Thus, while the Standards of Care provide a protocol for the provision of medically accepted forms of treatment, they do not mandate a cookie-cutter approach. Rather, "the length and kind of treatment provided will depend on the individual needs of the patient and will be subject to negotiation between the [mental health care professionals] involved, the patient's general practitioner and the patient."[27] Applying the Standards of Care to a given person must be left to her

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[25] *See* WALTER O. BOCKTING ET AL., COUNSELLING AND MENTAL HEALTH CARE OF TRANSGENDER ADULTS AND LOVED ONES at 18 (2006), *available at* http://www.vch.ca/transhealth/resources/library/tcpdocs/guidelines-mentalhealth.pdf (last visited May 17, 2007). *See also* L. KOPALA, RECOMMENDATIONS FOR A TRANSGENDER HEALTH PROGRAM (Apr. 26, 2003), *available at* http://www.vch.ca/transhealth/resources/library/thpdocs/0304kopalareport.pdf (last visited May 16, 2007) (recommending client-directed approach).

[26] Bockting, *supra* note 25, at 18.

[27] R. REID ET AL., TRANSSEXUALISM: THE CURRENT MEDICAL VIEWPOINT 4.3 (1996), *available at* http://www.pfc.org.uk/node/614 (last visited May 16, 2007).

health care providers, whose medical judgment, qualifications and expertise allow them to ascertain the best course of treatment for her.

2. The Standards of Care Do Not Require a Person with GID to Be Free of Other Health Conditions or Life Challenges in Order for That Person to Be Both Eligible and Ready for SRS.

The Standards of Care's readiness criteria direct a clinician to assess whether a patient has shown demonstrable progress and improved mental health, and has satisfactory control of her problems, before recommending SRS.[28] The Standards of Care do not require that the patient demonstrate a complete absence of mental distress or instability in all aspects of life. Rather, clinicians need only assess whether the patient with GID has made recognizable progress or improvement around any existing life and health challenges after beginning treatment for GID.

Although a range of considerations might affect the appropriateness of SRS for a patient, the Standards of Care and the clinicians who follow them recognize that other health conditions and life challenges often stem from inadequately-treated GID and are reasons to provide treatment, not deny it.[29] "Other mental

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[28] STANDARDS OF CARE, *supra* note 4, at 20.

[29] *See, e.g.*, Collier M. Cole et al., *Comorbidity of Gender Dysphoria and Other Major Psychiatric Diagnoses,* 26 ARCHIVES OF SEXUAL BEHAVIOR 13, 19 (1997) (finding risk of suicidality in patients with "intense frustration and exasperation over the gender dysphoric condition" and noting significant decrease in symptoms after beginning treatment for GID); CAMERON BOWMAN & JOSHUA GOLDBERG, CARE OF THE PATIENT UNDERGOING SEX REASSIGNMENT SURGERY (2006) at 3 ("Readiness does not imply that the client must no longer have any mental health concerns; rather, sufficient stability needs to be in place to both make an informed decision and to be adequately prepared to deal with the physical, emotional, and social

health concerns, psychosocial concerns, or substance use issues are not absolute contraindications to SRS. Sometimes these issues are a direct result of the gender dysphoria or suppressed transgender feelings and alleviate or remit entirely as the gender conflicts are addressed."[30] Clinicians must be cognizant of the difficulties patients may encounter in navigating their lives when beginning gender transition as "gender distress often intensifies relationship, work, and educational dilemmas."[31] Clinicians will need to incorporate this understanding in their overall assessment of a patient.

Emotional distress stemming from GID often increases or becomes aggravated around the time of puberty.[32] Some transgender people develop secondary diagnoses to GID such as depressive or anxiety disorders.[33] These

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consequences of the decision.") (*available at* http://www.vch.ca/transhealth/resources/library/tcpdocs/guidelines-surgery.pdf); Cohen-Kettenis, *supra* note 7, at 323 (1999) (noting that mental health problems should not serve as a barrier to sex reassignment treatment but need to be taken into account by clinician in determining proper course of treatment for patient).

[30] Bockting, *supra* note 25, at 22.

[31] STANDARDS OF CARE, *supra* note 4, at 12.

[32] *See* P. Cohen-Kettenis & S. Van Goozen, *Sex Reassignment of Adolescent Transsexuals: A Follow-Up Study*, 36 AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY 263, 264 (1997) (explaining that transgender adolescents may experience feelings of hopelessness that can slow down their social, psychological, and intellectual development); STANDARDS OF CARE, *supra* note 4, at 8 ("Intense distress is often experienced, particularly in adolescence, and there are frequently associated emotional and behavioral difficulties.").

[33] See Brown, *supra* note 7, at 2035. *See also* OLIVIA ASHBEE ET AL., TRANS CARE- GENDER TRANSITION: GETTING SEX REASSIGNMENT SURGERY 10 (Vancouver Coastal Health, Transcend Transgender Support & Education Society and Canadian Rainbow Health Coalition Feb. 2006),

disorders are often defense mechanisms protecting the person from the frustration, psychological pain, anxiety, and discrimination that results from their inability to live safely and comfortably in society as the gender they understand themselves to be.[34] Due to the intense distress that many transgender people experience, some may "make unrealistic and damaging life decisions; cling to their feelings of worthlessness and internal misery; chronically apologize for themselves; feel victimized; display an intense discomfort with intimacy; sabotage employment opportunities; [or] deny themselves a family environment"[35] during adolescence and beyond. These issues may indicate the seriousness of the patient's need for appropriate treatment in the form of SRS.[36]

The clinician's goal in applying the Standards of Care is thus not to ensure the absence or resolution of all co-existing conditions, but rather to determine that, within the context of a given patient's life, she or he is prepared for the changes

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available at http://www.vch.ca/transhealth/resources/library/tcpdocs/consumer/getting_surgery.pdf (last visited May 16, 2007) ("Trans[gender] people experience many stresses living in a transphobic society, and these stresses can cause depression, anxiety, or other mental health issues.").

[34] See Brown, *supra* note 7, at 2035.

[35] *Id.* at 2039.

[36] One study noted "a marked decrease of suicide attempts, criminal activity, and drug use in our postoperative population. This might indicate that there is marked improvement in antisocial and self-destructive behavior that was evident prior to sex reassignment surgery." Jamil Rehman et al., *The Reported Sex and Surgery Satisfaction of 28 Postoperative Male-to-Female Transsexual Patients,* 28 ARCHIVES OF SEXUAL BEHAVIOR 71, 83 (1999).

that will accompany SRS and is capable of handling stress related to these changes.[37] As one transgender health program explains to patients:

> Mental readiness doesn't mean you have no mental health problems or life stresses, it means you have:
> 1. A solid sense of your gender identity ....
> 2. Enough mental stability to make an informed decision about your medical care ....
> 3. Enough coping skills and supports to withstand the typical stresses of SRS.[38]

Far from being contingent on the absence of other health conditions or life challenges, sex reassignment often leads to improved mental health and life stability.[39] (See discussion in Section D, *infra.*)

3. The Standards of Care Do Not Require Psychotherapy Prior to Surgical Treatment for GID.

Psychotherapy before SRS is not a requirement for all patients.[40] The decision of whether psychotherapy should be recommended for a particular person

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[37] Bockting, *supra* note 25, at 22 ("[T]he clinician should be confident that supports are adequate and that any co-existing conditions are under control to the degree that (i) the introduction of a new stressor will not seriously destabilize the client, and (ii) the client has sufficiently clear thinking to be competent to consent to treatment.").

[38] A. J. SIMPSON AND JOSHUA GOLDBERG, TRANS CARE- GENDER TRANSITION- SURGERY: A GUIDE FOR MTFS 28-29 (2006), *available at* http://www.vch.ca/transhealth/resources/library/tcpdocs/consumer/surgery-MTF.pdf (last visited May 16, 2007). See also Bowman & Goldberg, *supra* note 29, at 3 ("Readiness does not imply that the client must no longer have any mental health concerns; rather, sufficient stability needs to be in place to both make an informed decision and to be adequately prepared to deal with the physical, emotional, and social consequences of the decision.").

[39] *See, e.g.*, Pfäfflin & Junge, *supra* note 18.

with GID is best made by an appropriately-qualified evaluating mental health professional, considering the individualized needs and experiences of the person. The goals of psychotherapy for patients with GID are "to help the person to live more comfortably within a gender identity and to deal effectively with non-gender issues."[41] Psychotherapy may also educate those who receive it about different options for their treatment and help them to set realistic life goals for life and relationships.[42]

Recent outcome studies support the position of the Standards of Care that psychotherapy need not be mandatory. In her 2000 study of sex reassignment surgery in 232 women with GID, Dr. Anne Lawrence examines the impact of a number of preoperative variables, including duration of preoperative therapy, on the outcomes of surgery. Dr. Lawrence measured outcomes based on improved quality of life, absence of regret, and happiness with the result of the treatment. Neither absence of regret nor happiness with the result of surgical treatment could

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[40] STANDARDS OF CARE, *supra* note 4, at 11, 20; Bockting, *supra* note 25, at 21. *See also* Bockting, *supra* note 25, at 5 ("As a heterogeneous population, there is great diversity among transgender individuals and their needs relating to mental health services. In a recent BC-wide survey of individuals requiring transgender health services (n=179), 53% of respondents reported a current need for counseling relating to gender issues . . . .").

[41] STANDARDS OF CARE, *supra* note 4, at 12.

[42] STANDARDS OF CARE, *supra* note 4, at 11; Brown, *supra* note 7, at 2038.

be correlated with duration of psychotherapy prior to surgery.[43] Improved quality of life, however, was significantly and *negatively* correlated with amount of preoperative therapy.[44] This study indicates that uniform treatment requirements do not necessarily advance the goals of treatment for GID.

C. Only Qualified Professionals, in Consultation with Their Patients, May Determine Appropriate Treatments for GID.

Because therapeutic treatment for GID must be individualized, and because eligibility and readiness criteria must be weighed by qualified professionals based on a holistic understanding of each patient's history and circumstances, the Standards of Care provide guidance on minimum credentials for individuals who diagnose and assess transgender people. The Standards of Care establish that mental health professionals are responsible for diagnosing GID and ascertaining eligibility and readiness for hormone and surgical therapy.[45] In addition to the general clinical training and competence in diagnosis and treatment these professionals must have, in order to develop the skills to apply the Standards of Care effectively and appropriately, professionals need to have specialized knowledge of gender identity disorders. The Standards of Care recommend the

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[43] Anne Lawrence, *Factors Associated with Satisfaction or Regret Following Male-to-Female Sex Reassignment Surgery*, 32 ARCHIVES OF SEXUAL BEHAVIOR 299, 307-308 (2003).

[44] *Id.* at 309.

[45] STANDARDS OF CARE, *supra* note 4, at 6.

following credentials[46] as a minimum for professionals diagnosing and treating GID:

> 1. A master's degree or its equivalent in a clinical behavioral science field. This or a more advanced degree should be granted by an institution accredited by a recognized national or regional accrediting board. The mental health professional should have written credentials from a proper training facility and a licensing board.
> 2. Specialized training and competence in the assessment of the DSM-IV/ICD-10 Sexual Disorders (not simply gender identity disorders).
> 3. Documented supervised training and competence in psychotherapy.
> 4. Continuing education in the treatment of gender identity disorders which may include attendance at professional meetings, workshops, or seminars or participating in research related to gender identity issues.[47]

Mental health professionals assessing what medical or surgical treatment is necessary and appropriate for a person with GID must be familiar with the Standards of Care, must have some experience with GID treatment or an association with another provider who has such experience, and must know the current research and treatment protocols. The readiness criteria in particular are more complicated for clinicians to assess and depend heavily on the clinician's and patient's judgment.[48] Thus, it is never acceptable or responsible for a layperson, a

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[46] For special competence in gender identity disorders in children or early adolescents, the professional should also have been trained in childhood and adolescent developmental psychopathology and should be competent in diagnosing and treating the ordinary problems of children and adolescents. *Id.* at 7.

[47] *Id.* at 6-7.

[48] *Id.*

professional without GID competence, or a professional who has not personally evaluated the individual to attempt to substitute their judgment for the considered recommendation of a qualified professional who has conducted a personal evaluation.

Therefore, while *amici* do not opine on the issue of necessity of SRS for Mariah L., *amici* do submit that ACS's decision to override the considered opinion of four highly qualified medical professionals with the opinion of an administrator who has not demonstrated any of the necessary competencies for applying the Standards of Care is inappropriate and in no way consistent with those Standards of Care. Indeed, it is irresponsible and inconsistent with professional standards to suggest that someone who has never personally evaluated an individual and who does not have the relevant minimum credentials for such an evaluation could better determine whether a person with GID is eligible and ready for SRS according to the Standards of Care. This is especially true where, as here, the evaluating professionals appear to have demonstrated competence and experience in treating GID, are in consensus with regard to their conclusions, and have among them one of the professionals who co-authored the Standards of Care.[49]

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[49] *See* STANDARDS OF CARE, *supra* note 4, at 1 (listing Connie Christine Wheeler among the Committee members that drafted the Standards of Care). Even in the more restrictive context of prison inmates, courts have held that administrators must follow the medical advice of treating physicians rather than exercising their own judgment. *See, e.g., Martinez v. Mancusi,* 443 F.2d 921, 924 (2d Cir. 1970), *cert. denied,* 401 U.S. 983 (1971); *Gill v. Mooney,* 824 F.2d 192, 196 (2d Cir. 1987) ("Prison officials are more than merely negligent if they deliberately defy the

D. Abundant Medical Literature Supports the Benefits of SRS as Treatment for GID, and the Concomitant Risks of Failure to Treat.

A growing number of research studies demonstrate what the Standards of Care have affirmed for decades: SRS is remarkably successful in relieving the suffering and distress associated with GID. Clinicians who recommend SRS for their patients thus do so in the context of burgeoning evidence supporting the unparalleled effectiveness of that treatment for certain individuals with GID. Surgical treatment alleviates the feelings of shame, self-hatred, depression and anxiety that many people with GID experience.[50] One study found that, after SRS, people with GID had more self-confidence, better interpersonal communication, less difficulty in finding romantic partners, and overall improvement in social functioning.[51] Untreated, GID can lead to serious negative health consequences for

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express instructions of a prisoner's doctors"); *Zentmyer v. Kendall County*, 220 F.3d 805, 812 (7th Cir. 2000) (prison officials may not "substitute their judgments for a medical professional's prescription"); *Woods v. Goord*, No. 01 CIV. 3255(SAS), 2002 WL 731691, at *4-*5 (S.D.N.Y. Apr. 23, 2002) (finding that inmate stated claim for deliberate indifference where he alleged that prison doctors failed to comply with the directives of specialists).

[50] *See, e.g.,* B. Levi, et al, *Endocrine Intervention for Transsexuals,* 59 CLINICAL ENDOCRINOLOGY 409 (2003); Z. Rakic et al., *The Outcome of Sex Reassignment Surgery in Belgrade: 32 Patients of Both Sexes,* 25 ARCHIVES OF SEXUAL BEHAVIOR 515 (1996).

[51] The study also reported a threefold increase in the number of patients who pursued further university-level education after surgery. The patients reported greater motivation to study, improved sleep, fewer symptoms of anxiety and depression, as well as greater understanding from their families. Rakic, *supra* note 50. *See also* Cohen-Kettenis & Van Goozen, *supra* note 32; Pfäfflin & Junge, *supra* note 18 (reviewing thirty years of research and finding evidence of lessened suffering, increased subjective satisfaction, and improved partnership and sexual experience, mental stability, and socio-economic functioning among patients with GID who received sex reassignment treatment).

those individuals who live with the condition. Social isolation and problems with relationships, school, and work are common results.[52] Sex reassignment has been shown to be effective treatment in adolescents,[53] and to reduce or even eliminate the need for psychotropic medications.[54]

V. CONCLUSION

Only qualified health care professionals who conduct a thorough, individualized assessment of a patient with GID can ascertain the appropriate therapeutic treatment for that patient and determine whether sex reassignment surgery is medically necessary. An unlicensed, unqualified and untrained individual cannot make this determination. The Court should respect the time-tested medical standards of care that are solidly rooted in an evidence-based understanding of what constitutes effective treatment for people with GID.

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[52] See, e.g., AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 577 (4th ed. text revision 2000).

[53] SRS in adolescents was "therapeutic and beneficial...resolved the patients' gender identity problem and enabled them to live in the new gender role in quite an inconspicuous way. Socially and psychologically these adolescents do not seem to function very differently from nontranssexual peers...." Cohen-Kettenis & Van Goozen, *supra* note 32, at 269.

[54] "A transgender[] individual who has not had hormonal therapy or surgery may require psychopharmacologic medications, but after a patient receives medical and/or surgical treatment, psychotropic medicines are often unnecessary." Norman Spack, *Transgenderism,* LAHEY CLINIC MEDICAL ETHICS JOURNAL (Fall 2005), *available at* http://www.lahey.org/NewsPubs/Publications/Ethics/JournalFall2005/Journal_Fall2005_Feature.asp (last visited May 16, 2007).

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CERTIFICATE OF COMPLIANCE
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