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Abstract

In this paper, I argue that in cases in which competent adult patients have been suffering from long-term gender identity disorders which interfere with their everyday life functions, gender reassignment surgery is a morally permissible treatment option. Though many argue that it is morally impermissible to allow the use of surgery for such non-medical things as reassigning gender, I argue that the use of surgery for reassigning gender is morally permissible on the basis of Kantian autonomy and Utilitarian reasoning. In this paper, I will further discuss my argument, as well as the primary objections to the argument and my replies to those objections.

Sex, Lies, and Surgery: The Ethics of Gender Reassignment Surgery

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Abstract

In this paper, I argue that in cases in which competent adult patients have been suffering from long-term gender identity disorders which interfere with their everyday life functions, gender reassignment surgery is a morally permissible treatment option. Though many argue that it is morally impermissible to allow the use of surgery for such non-medical things as reassigning gender, I argue that the use of surgery for reassigning gender is morally permissible on the basis of Kantian autonomy and Utilitarian reasoning. In this paper, I will further discuss my argument, as well as the primary objections to the argument and my replies to those objections.

Introduction

“Before I knew I was transsexual, I went through years of pain... It’s only now that I’m living as a woman that I finally feel comfortable with myself” (“Real Lives – Three Transsexuals”). This quote, from a male-to-female transsexual individual who was living as a woman while waiting to qualify for gender re-assignment surgery (GRoS), demonstrates the agony that those who struggle with gender identity disorders (GIDs) undergo while ‘trapped’ in the physical and social conventions of their biological gender, as well as the relief that comes with living as a member of their “true” gender. Though some may argue that use of surgery for purposes of treating GIDs is morally unacceptable since transsexuality does not belong within the domain of medicine, GRoS is morally permissible. In cases in which adult patients have been suffering from a severe gender-related mind-body imbalance which interferes with their everyday life functions, gender reassignment surgery is a morally permissible treatment option, provided that the patients requesting it are competent and are able to pay for the surgery out-of-pocket as an elective surgery without any serious financial detriment to their dependent family members. Since the inner struggle that goes with transsexuality is something that can be fixed by changing the body through surgery, surgery is a viable treatment option. If someone has the money to achieve a desired image that he or she feels ‘matches what’s on the inside,’ along with enough competence to fully understand

the risks and benefits of undergoing surgery, then he or she, as an autonomous agent, has the right to do so.

Background

Gender identity disorder has been classified as a psychiatric disorder in the DSM-IV, the handbook for psychiatric disorders, since 1980 (Draper and Evans, 97). According to the DSM-IV, gender identity disorder, or transsexuality, involves: a strong, long-standing identification with another gender, a long-standing disquiet about the sex assigned biologically, and clinically significant discomfort or impairment at work, in social situations, or other important areas of life (American Psychological Association, 302.85). Furthermore, someone is not classified by the DSM-IV as having a transsexual disorder if there is a physical intersex condition (American Psychological Association, 302.85).

In contrast to the American Psychological Association, many transgender reform advocates argue that transsexuality is *not* a mental disorder, but rather a physical problem which can be alleviated by means of a combination of physical therapies designed to change the body. Whether transsexuality is viewed as a mental disorder or whether it is viewed as simply another category of gender that should be accepted by society as legitimate, the moral tension on the issue of GReS remains strong since GReS is an invasive surgery or group of surgeries which requires lots of medical resources that may, at times, be scarce. The two conceptions of transsexuality, (a) that it is a primarily psychiatric disorder and (b) that it is a primarily physical disorder, vary widely in their arguments regarding GReS. These conceptions of transsexuality and their opinions regarding the moral permissibility of GReS will be discussed briefly below.

For those who accept the idea that transsexuality is a psychiatric disorder, there is moral tension regarding whether it is the duty of surgery to solve problems that could possibly be dealt with by means of a psychosocial approach or whether surgery is ever a morally acceptable, medically appropriate solution to the mind-body incongruity that exists in transsexual individuals. One must consider how to go about defining who should provide treatment, as well as what kind of treatment is medically appropriate. Some definitions of health, such as Daniel Callahan's, include physical well-being as a criterion for health while rejecting social and psychological well-being as legitimate criteria (Callahan, 77-87). However, other definitions, such as that of the World Health Organization, include psychological and social well-being in the criteria for health (Callahan, 78-79). The difference between these two conceptions of what it means to be healthy leads to moral tension on the issue of surgery's role in treating GID, since GIDs are classified under the realm of psychiatry rather than the realm of surgery. People

who maintain that all psychiatric disorders should be treated solely by psychologists and psychiatrists hold that GReS is not an acceptable solution to transsexualism. To accept GReS as a solution to transsexuality would be to medicalize the issue of transsexualism, according to people like Daniel Callahan. Additionally, some may argue that surgeries which limit the function of healthy organs or produce significant health risk, as GReS does, should not be performed. If harm can be done to the patient with an elective surgery such as GReS, some may say, it should not be performed since surgery should only be done if it benefits a patient medically. The moral tension of this issue primarily lies in whether it is the duty of surgery to solve problems that could possibly be dealt with by means of a psychosocial approach, and whether surgery is ever a morally acceptable, medically appropriate solution to achieving a new identity as a transsexual. Those who accept GID as a true psychiatric disorder and use the WHO's definition of health would argue that GReS may be morally permissible in some cases, whereas those who accept GID as a psychiatric disorder and use Callahan's definition of health would argue that using GReS to treat GID would never be morally permissible.

Those who believe that transsexualism is a physical problem, on the other hand, maintain that for some transsexuals, surgery is a medically appropriate treatment that has the potential to emotionally heal and provide a source of inner peace for those who feel their biological gender is incompatible with their inner gender identity (Girshick, 143-146; Winters, GIDReform). Since the primary cause of discomfort is physical, physical solutions are the key, according to this group of people. Furthermore, this group argues, transsexuality should not be classified as a psychiatric disorder since it is a biological problem rather than a mental illness. The stigmatization of transsexuality resulting from its classification in the DSM-IV as a 'gender identity disorder' has been very harmful for transgendered people since it has led to an increase in violence, medical neglect, and discrimination towards transgendered individuals (Girshick, 145). As Girshick puts it, "...application of these diagnostic labels unnecessarily pathologizes transgender and gender-variant people" (Girshick, 145). To call transgenderism an identity disorder, Girshick argues, is to suggest that having a transsexual gender identity is not legitimate (Girshick, 145). Treating gender identity that varies from the norm as a disease is simply wrong, people like Girshick argue. If society – as well as the medical profession – were to accept transsexuals as another category of gender, this would most likely lead to the elimination of GID as a psychiatric disorder, impacting patients' ability to obtain GReS. It is important to note, however, that though many advocates for gender-variant individuals are pushing for acceptance of genders outside of the gender binary, they also worry that the elimination of GID as a disorder might even more severely restrict access to GReS (GID Reform Advocates; Girshick, 145-146; Green 91-93; Lev, 177-181). GReS is already quite difficult to obtain. With the elimination of GID as an "admission ticket" to therapy, it might become even more difficult to obtain surgery (Lev, 177). In most places, gender-variant people must be

diagnosed with GID and have lived in the opposite gender for approximately a year, in order to be eligible for the surgery and, in some cases, even for hormone therapy (Lev, 207-210, 261-263). Additionally, it is already very difficult to obtain funding for GReS (Green, 91-92). Eliminating GID as a psychiatric classification may lead to increased restrictions on the surgery, as well as more difficulty in obtaining insurance reimbursement for medical treatments (Lev, 177-181).

Considerations regarding the status of GID as a disorder and its relation to access to GReS are important since many people who identify as transsexual strongly desire body modification as the last step of their identity achievement (Lev, 258-269). Serious incongruity between body and soul can, understandably, be very disquieting for an individual. Some transsexuals can achieve an adequate sense of body-soul congruency through hormonal therapies and cross-dressing, but for some, body modification is perceived as an integral part of achieving an identity as a member of the opposite gender (Lev, 258). In order to achieve full body modification, surgery is often required for patient satisfaction (Lev, 207-210). Hormone therapies can only do so much for patients; they can give MtF transsexuals breasts, but they can never give them a vagina. Cross-dressing and hormone therapies can give an FtM transsexual some sense of being male, but when he looks in the mirror, it is still a woman's soft face which looks back at him.

Arguments for the Moral Permissibility of GReS

Though some claim that surgery has no place as a morally acceptable possibility in the treatment of GIDs or in alleviating the disequilibrium that exists between body and soul in transsexual individuals, looking to bioethical principles leads to the conclusion that it is indeed morally permissible under certain conditions. The primary reason that GReS is morally permissible has its basis in the notion of patient autonomy, an idea that comes directly from Kantian reasoning. If someone is a rational person, he or she is free. Thus, he or she possesses autonomy and is entitled to make proactive decisions about his or her own healthcare. Competent adults who have identified themselves as transsexual have the right to self-determination. Those who have the right to self-determination have the right to decide what to do with their bodies. Therefore, competent, adult individuals have the right to request and receive GReS.

Competence is key when it comes who should be able to obtain access to GReS. The decision to undergo GReS is not one lightly undertaken or hastily made; rather, it is often the final step towards completion of a long, arduous journey of identity realization as a member of the opposite sex (Lev, 259). According to Arlene Istar Lev, a clinical social worker and family therapist, most gender-variant people go through stages in achieving their desired gender identity (Lev, 229-270). Some people stop at

cross-dressing and hormone therapy, while others continue on to request GReS. All human beings go through different stages in realizing their identities, but for people who are gender-variant this can be much more difficult since society is generally quite intolerant of gender categories outside of the gender binary.

Lori Girshick, author of *Transgender Voices* has proposed that gender is not something that can be broken up into discrete categories, but rather that gender identity is a continuum and that people at all points on the gender continuum should be accepted by society (Girshick, 180-183). But unfortunately, society currently does not follow the gender continuum model. Most people in society are quite hesitant to reject the gender binary. Many, though not all, people who identify as transsexual or gender dysphoric have, at some point in their lives, experienced discrimination, harassment, violence, or medical neglect (Girshick, 139-143). Thus, those who request GReS understand the social risks they would be undertaking in undergoing GReS and becoming a member of the opposite gender. Though they may have, over the years, been criticized, ridiculed, or even harassed for their unconventional gender and lifestyles, the achievement of a fully realized identity is more important to them than social acceptance. If someone feels so strongly about something as to take risks like those, one must conclude that it is something of utmost important to them. Autonomy should, as always, be highly respected, but it should be especially respected for those making decisions which have such profound social risks.

It is important, however, to note that there is an additional stipulation regarding the right to request and receive GReS: competent adults only have the right to request GReS so long as it does not infringe upon their dependents'¹ qualities of life in any major financial way. The idea that one must take others' needs into account comes directly from Kantian moral theory. Since we possess autonomy, Kant argues, we also possess human dignity and are therefore obligated to accept responsibility for our actions (Rachels, 127-129). Thus, as John Hardwig argues, one must consider the needs of those close to him or her when making serious medical decisions (Hardwig, 5-10). This would especially apply to cases such as GReS, which, in addition to causing emotional distress to those close to the patient, is usually not covered by health insurance and must be paid for as an out-of-pocket expense. The possibility for impact on family members – especially financial impact – is great. Thus, Kantian philosophers would conclude that though patient autonomy must be respected, the needs and interests of others are also important.

Feminist moral theory also would advocate considering relationships, though perhaps to a greater degree than Kantian moral theory since it is much more concerned with relationships. There is, however, a limit to the consideration that others may receive when one is making such a profound decision about his or her body. Since the gender-

¹ Please note that 'dependents' may include children, parents, or spouses.

questioning individual is the one most affected by his or her gender, his or her interests must be considered as being the most important.

Utilitarian philosophers would argue that if one strongly identifies as transsexual and wishes to receive GReS against the wishes of parents, siblings, spouses, or children, he or she should be able to do so on the basis that the amount of happiness that stands to be gained by the person wishing to undergo GReS is, in most cases, much greater than the happiness that stands to be gained should family members continue to live with the anguish that comes with being close to someone attempting to suppress an identity that is trying to claw its way out.

That being said, one must also look at the practical side of the issue. GReS costs quite a bit of money, and currently is not paid for by most health insurance (Girshick, 144-146). Thus, under the current system in which insurance does not generally pay for GReS procedures, only the financial considerations of individuals dependent on the prospective candidate for surgery may be considered to be more important than the concerns of the candidate requesting surgery. Though feminist theory would say that all concerns of other family members must be considered, only the financial considerations of dependents may be considered to be as important as the transsexual patient's desire to undergo surgery since the application of Utilitarian moral philosophy yields the conclusion that the amount of pleasure that stands to be gained from most prospective patients is far greater than the amount of pleasure that stands to be gained by family members in maintaining the status quo. Provided that financial means are adequate and that those dependent on the transsexual in question will not be negatively financially affected by their loved one undergoing GReS, then it is morally permissible for said transsexual to undergo GReS. Familial support is not necessary for GReS to be morally permissible, but it should be noted that many who do not have adequate positive familial support are seen as poor candidates for the surgery, possibly because support is, quite understandably, often needed for such a radical lifestyle transition (Lev, 43). Nevertheless, it is morally permissible for a transsexual individual to undergo GReS so long as the patient is competent and can pay for the surgery without any significant financial detriment to dependents.

Arguments against the Moral Permissibility of GReS

There are several possible objections to the argument that GReS is morally permissible. Three of them will be discussed here. The first possible objection is that it is morally wrong for a physician to remove healthy, functioning organs from a patient under any circumstances, on the basis that such actions are incongruous with the goals of medicine. Those who make this objection against GReS argue that removing healthy organs for non-prophylactic reasons is an action diametrically opposed to the primary

duty of physicians: “First, do no harm” (*Oath of Hippocrates*). It does not make any sense, medically speaking, to remove healthy organs. Therefore, proponents of this idea argue, undergoing GReS is unnatural, medically inappropriate, and morally impermissible. Destroying breasts, ovaries, and uteri that are full of diseased, cancerous cells is entirely different from removing the same organs from a healthy person. Resolving psychiatric issues such as GID should not involve surgery that removes perfectly healthy organs, some may argue.

Another reason for objection to the argument that GReS is morally permissible can be found using Daniel Callahan’s definition of health, which defines health as having to do solely with physical states. Currently, transsexuality is classified as a psychiatric disorder by those in the psychiatric and medical community. Thus, some may object to the argument for GReS on the grounds that surgery should not be used for disorders that are primarily psychiatric or psychosocial, such as transsexuality. Daniel Callahan would certainly agree with this assessment; in his essay on the WHO definition of health, Callahan warns against the ‘medicalization of the human condition’ (Callahan, 77-87). To consider surgery as a possible treatment option for GID would be to medicalize gender variance. Having a medical solution to a non-medical problem, it can be argued, is not only wasteful of precious medical resources, but also entirely illogical.

The third argument against allowing GReS as a treatment option has to do with whether a doctor/psychiatrist/team of doctors should treat the physical symptoms of a psychiatric disorder on the basis of what would make a patient ‘feel’ better or whether the psychiatric causes of disorder should be treated. For example, one could argue that a doctor could not justifiably encourage, nor condone, that a patient suffering from severe anorexia nervosa – also classified as a psychiatric disorder by the DSM-IV-TR – continue to starve himself or herself on the basis that being thinner would make the patient feel more comfortable with him or herself in the context of the psychiatric disorder; to do so would be utterly negligent and medically inappropriate (Wilson, G., “Anorexia Nervosa”). In the same vein of argument, a doctor could not justifiably encourage, nor condone, that a patient suffering from transsexuality undergo dramatic, life-altering surgery in order to make the patient feel more comfortable in the context of his or her disorder. Thus, it can be argued that just as starving oneself is not the appropriate way in which an anorexic can come to terms with his or her body, surgery is not the antidote for transsexuality as both solutions only address the physical symptoms of the real problems. One can claim that in the two examples outlined above, superficial solutions only serve to mask the underlying disorder.

Replies to Arguments against the Moral Permissibility of GReS:

The first objection to the argument that GReS should be considered morally permissible makes good points, but ultimately falls short since it fails to consider all possible situations in which one might want to have a healthy organ removed or incapacitated. For example, both Kantianism and Utilitarianism would consider it morally permissible for men and women who are certain that they do not want to bear any more children to undergo vasectomies and tubal ligations that will almost guarantee no more offspring will result from sexual intercourse. These procedures essentially incapacitate the sexual reproductive organs in males and females. One cannot make the claim that there is a qualitative moral difference between such procedures and the procedures that remove sex organs in transsexuals during GReS. In the case of transsexual patients, the sex organs can be removed and replaced by reconstructed sex organs of the desired gender. Changing gender may mean trading functioning organs for ‘organs’ that are largely nonfunctional, in addition to creating medical risks for patients.

Medical risks for FtM transsexuals include: risk of infection, excessive scarring, or loss of function at the tissue donor site (Green, 109). The function and appearance of genitalia for FtM transsexuals may be less satisfactory than for MtF transsexuals (Brown). Though the surgery for MtF transsexuals is different in that it uses skin closer to the actual site of surgery, medical risks for MtF transsexuals are quite similar. The sex organs are as functional as the surgeon makes them; sometimes the MtF transwoman will have a clitoris which ‘functions’ in that she may be aroused sexually and the FtM transman will have a penis which allows him to become aroused sexually (Green, 109). But transwomen and transmen no longer have reproductive capabilities after surgery. There are risks involved, and the ‘sex organs’ of transwomen and transmen are nonfunctional in that they cannot produce offspring in the same way that the sex organs of a biologically female or male can. However, this does not mean that they have no importance for the patient. Having the ‘proper’ genitalia may serve as the final step for many transsexuals in their journey toward a new gender identity. As Jamison Green, a well-known transsexual activist and writer, puts it: “There are a lot of reasons to have lower surgery, not the least of which is the desire to have one’s body match one’s gender identity—to feel whole, as some describe it” (Green, 107). Thus, the replacement of biological sex organs with non-functional sex organs can have a significant impact on the psychological well-being of the patient and should, therefore, be considered as having positive moral weight when one is evaluating the moral permissibility of removing healthy organs such as the mammary glands.

Though it is true that the goals of medicine are diametrically opposed to the intentional, non-prophylactic removal of healthy organs, it is also true that in some cases, organs are not needed for certain goals of patients. Here, the role of patient autonomy is important. If a competent patient has determined that an organ is unnecessary to his or

her goals for personal well-being and that, furthermore, said organ is causing him or her some type of discomfort, it can be considered morally permissible for a doctor to remove said organ so long as removing said organ will not profoundly negatively affect other people. Possible negative effects on other people that must be considered include possible detrimental financial effects on dependents such as children or parents. Though the views regarding GReS of others to whom a transsexual is close are important, they do not outweigh the preferences of the patient requesting GReS. Both of aforementioned criteria – that the patient is competent and that undergoing surgery will not detrimentally financially affect the patient’s dependents – must be met in order for removal of a healthy organ to be considered morally permissible.

The second argument against the moral permissibility of GReS – that transsexualism is a psychiatric disorder and that psychiatric disorders do not merit surgical treatments – is faulty since transsexuality cannot be ‘cured’ using psychiatric therapies. All that psychiatric treatments could achieve would be to change a person’s perception of himself or herself so that it matches what the gender binary society expects. Psychiatric therapies could not change a person’s physical gender, but only distort his or her perception of his or her gender. Additionally, therapies which attempt to change a person’s gender are, thus far, largely ineffective. According to *The Merck Manual for Healthcare Professionals*, “Treatment [of transsexuals] is aimed at helping patients adapt rather than trying to dissuade them from their identity; in any case, the latter approach is ineffective” (Brown). Often, in order to alleviate the distress that comes with body-soul incongruity, outward appearances must be changed. Surgery, when combined with hormone therapy, is the only way to actually change a patient’s outward appearance to make it look like that of the opposite gender. Only surgery has the power to change someone’s physical sex. Thus, it cannot be argued that surgery has no place in the treatment of GIDs.

The third argument against the moral permissibility of GReS – that surgical treatment would only serve to superficially treat the physical aspects of disorders that are primarily psychiatric – is also faulty. Whereas anorexia truly is a mental disorder, transsexuality is not. Though it is classified by the American Psychological Association as a psychiatric disorder, many are pushing for change (GIDReform.org). According to many experts on the subject, transsexuality actually is a physical problem rather than a psychiatric disorder. As such, it deserves a physical treatment. Since transsexuality is a physical problem that deserves physical treatment, surgical treatments are morally permissible. Psychiatry cannot change physical appearances, and it cannot cure physical problems. As such, transsexuality does not belong within the realm of psychiatry. Rather, surgery is a morally permissible treatment for alleviating the distress of being trapped in the ‘wrong’ body.

Conclusion

As much as some may try to separate mental well-being from overall health, the fact remains that there is an inseparable connection between mind and body. No one field can conquer the mysteries of body and mind. Medicine and psychiatry must work in tandem to produce results that are beneficial to patients. The body is servant to the power of the mind. Though appearances are not everything, what one feels is right on the inside should be reflected on the outside. On the basis of individual patient autonomy, it is morally permissible for adult patients who have been suffering from long-term gender identity disequilibrium which interfere with their everyday life functions to receive gender re-assignment surgery, as long as a few conditions are met. The conditions are: (a) the surgery will not cause undue financial stress to family members, such that dependents would be put in a bad situation, (b) the person receiving the surgery is able to pay for it, and (c) the choice is made entirely autonomously by the patient. The primary reason that gender re-assignment surgery should be available as a morally permissible option is due to the Kantian notion of autonomy and the Utilitarian principle of the greatest pleasure for the greatest number; each competent person is an autonomous agent and can decide for himself or herself what is both in his or her best interest and in the best interest of those around him or her. This argument stands up to opposing arguments that removing healthy organs is always morally wrong, that transsexuality should not be treated with surgery, and that surgery is a superficial treatment to a deeper problem, primarily due to the fact that transsexuality is a physical problem rather than a psychiatric problem. It has been established that GReS is morally permissible. The next question is, as always, where we can go from here in providing adequate options for persons seeking help in realizing their gender identities. For society to move forward, the definition of gender must change from the binary to a continuum. Human beings cannot be categorized discretely. The full realization of an individual's identity can only be achieved peacefully if society is to become more accepting and tolerant of diversity in gender, race, religion, and all other discrete categories which divide people. We must come together, united in the midst of difference, in order to move forward toward a better, more peaceful world filled with justice, diversity, and acceptance.

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