**Association of Medical Humanities**

**National Conference 2016:**
**Body Talk: whose language?**

**Keynote Address:**

# Monsters, Modernity and Medical Humanities

**Zoë Playdon**

**Emeritus Professor of Medical Humanities**
**University of London**

*To situate myself in this paper, I am a former co-Chair of the Gay and Lesbian Association of Doctors and Dentists [GLADD] and in 1995 co-founded, with Dr Lynne Jones MP, the Parliamentary Forum on trans matters, as a location where trans community leaders, doctors, and lawyers may meet to discuss key issues with government departments and interested parliamentarians, with the intention of working mutually to achieve equality for trans people. The Forum is currently chaired by the Baroness Barker.*

If you walk along the Thames footpath westwards towards the city, just beyond London Bridge you will find a replica of Sir Francis Drake's ship, *The Golden Hinde*. It is a memorial to the Elizabethan military and commercial colonial project, and a unique monument to capitalism. Drake's project to circumnavigate the globe was a prototype Limited Liability Company, funded by investors whose risk was effectively covered by the Crown.

Cartography was essential to Drake's enterprise, which both depended on existing maps and was undertaken to map the world further. In 1569, Mercator mapped the spherical globe onto a flat plane, showing the world as it was known then, with proto-anthropological annotations locating variously the Land of the Dwarfs; people who devour each other; and men who unearth the gold of ants. What was unknown was invented in line with cultural fantasy and prejudice, beginning the process of mapping the monstrous.

The blank screen on which colonial conquest projected its desires and fantasies was 'Terra Nullius', an empty space, an objectified location which European subjects could 'discover', define, and own. Classification formed an important part of that project, providing 'a rationalizing, extractive, dissociative understanding which overlaid functional, experiential relations among people, plants, and animals'[1]. As the Elizabethans gave way to the Enlightenment, medicine and natural history 'conceived of the world out of which the scientist *produced* an order',[2] a *systemae naturae* in which 'the naming, the representing, and the claiming are all one; the naming brings the reality of order into being'.[3] This included the ordering of peoples,

reified and ranked by Linnaeus's authoritative twelfth edition of his *Systemae Naturae* which provided six categories for *homo sapiens*, with the sixth being 'monster', and the 'monster' category already including 'androgyni or hermaphrodites . . . and also people who have changed their sex'.[4] In this lay the beginning of what Foucault terms 'scientia sexualis', 'the difference between the physiology of reproduction and the medical theories of sexuality.'[5] From this point onwards, while biological science followed the same rational, empirical methods as other sciences, medical theories of sex and sexuality fostered irrational fears and bizarre solutions to them. As Foucault put it, 'the one would partake of that immense will to knowledge which has sustained the establishment of scientific discourse in the West, whereas the other would derive from a stubborn will to non-knowledge.'[6]

So, I am taking Drake's *Golden Hinde* as a touchstone for the colonial project, which depended on the ideas of a Terra Nullius and a systemae naturae, inherent in which were ideas about the monstrous. These cultural concepts bled over into early European medicine's attempts to map the body, making a stark division between so-called sexology and the rest of medicine. Such division became especially evident by the late Victorian period. Then, anxiety about the loss of Empire,[7] combined with domestic unrest,[8] produced a ferocious Purity Campaign, an 'outburst of neurotic puritanism' resulting in 'a repressive new sex code' which 'directly linked sexual pollution with the threat of social chaos and the fall of the Empire'.[9] The Imperial eye had turned inwards, seeking another location where it could more confidently assert its regulation. It found expression in the 1885 Criminal Law Amendment Act which added to existing categories of the monstrous – unmarried mothers and intellectual women for example – masturbation, homosexuality, and nude bathing.

Medicine had to carry the burden of containing and hygienicising citizens who were culturally inappropriate, a category that included intersexed people, called 'hermaphrodites' by the Victorians, who 'were criminals, or crime's offspring, since their anatomical disposition, their very being, confounded the law that distinguished sexes and prescribed their union'.[10] Consequently, the subjects of scientia sexualis were criminalised or psychopathologised or both. By contrast, the study of embryology, morphology, physiology, genetics, and neurology carried no such moral charge or legal consequences for its patients.

The violently hierarchical, binary language system of British Imperial colonialism contrasted savage, ignorant, cruel, immoral, black indigenous people with civilised, educated, kind, moral, white settlers, whose conquest was framed as generous enlightenment. Colonial conquest abroad was typified by a concurrent repudiation of indigenous cultures and appropriation of their resources. Victorian sexology paralleled this by a dual movement of concealment and disclosure, borrowed from Victorian pornography in which the purported concealment of monstrous sexed and sexual minorities operated to draw the eye towards them. The more they were repudiated, the more they could be appropriated as commodities for exchange, without voice or agency. Pornography provided a parallel taxonomy for the classification of British people as degenerate, immoral, perverted, and depraved,

placing them in a sub-species similar to that already occupied by indigenous peoples. Both groups could be used to construct titillating discourses that could be commodified and sold as 'educational', or 'in the public interest', or simply as part of the scientific project, as geography, anthropology, biology. Both groups supported missionary activities. Christian foundations of every denomination literally sent missionaries and built residential schools in the colonies, while at home, the task of normalising inverts supported the early growth of psychological therapies. Scientia sexualis replaced 'Terra Nullius' with 'Homo Nullius', objectifying, mapping, and ordering sexed, sexual, and gendered minorities for the profit, pleasure, and promotion of a European élite.

So, in 1886, a year after the criminalisation of male homosexuality, Richard von Krafft-Ebing produced his landmark psychiatric taxonomy, *Psychopathia Sexualis*, its publication coinciding with the last volume of Henry Spencer Ashbee's less well-known *Index Librorum Prohibitorum*. A cotton magnate, who travelled abroad extensively to further his business, Ashbee was also an extraordinary bibliographer, producing under the pseudonym 'Pisanus Fraxi' three large codifications of pornography, which he bequeathed to the British Library, together with 15,900 volumes of pornography.[11] Ashbee personifies the intimate connection between Empire and sex, materially and ideologically. Pornography was as much an export as cotton clothes, steel goods, or other material culture, while 'without the easy range of sexual opportunities which imperial systems provided, the long-term administration and exploitation of tropical territories, in nineteenth century conditions, might well have been impossible.'[12] The categorisation of sexual fantasy allowed it to be commodified and sold more easily, since then, as now, purchasers could readily identify the category of fantasy literature or 'sex tourism' they preferred.

Krafft-Ebing's categorisation of sexual practices was 'above all a framework for discussing sexual crimes in court', [13] that is to say, it reflected contemporary fears and fantasises about the monstrous. Unsurprisingly, then, Ashbee's and Krafft-Ebing's taxonomies were similar in style and content. They share the same subject matter of minority sexual practices, and use the same petrifying gaze, to map and classify. They are stylistically similar, both anonymising their informants. Both writers are dismissive of items that do not interest them, both are self-indulgent in providing long, detailed accounts of favourite items, and they speak with an identical authorial voice: forceful, judgemental, and final. Latin is used by both writers to euphemise or otherwise disguise matters they believe too salacious for the English language, infusing both of their works with prurience posing as prudence. Neither works are empirically scientific, even in a nineteenth century sense: they are haphazard collections of whatever came the collector's way, organised by whim and personal preference, without critical purchase or analytical framework beyond that supplied by conventional propriety. Both authors, too, were writing 'forbidden books', Ashbee's title making that explicit, while the Publisher's Preface to the English translation of Krafft-Ebing's work prohibited its sale to 'the general public'.[14] Ironically, while Ashbee's promotion of salacious stories was little known – its initial printing was limited to 250 copies[15] - Krafft-Ebing kept 'thousands of readers, fascinated and

horrified'.[16] *Psychopathia Sexualis* went to twelve editions, was widely translated and hugely influential, and was still current in the 1950s.

Crucially, both Krafft-Ebing and Ashbee made the same fundamental philosophical mistake, known as a 'category error', in which items of one category are positioned as belonging to another.[17] They both collapsed together sex, sexuality, and gender into a single category, a violent binary, so that three different items were assumed to be congruent with each other. To be male was to be heterosexual and masculine; to be female was to be heterosexual and feminine. In fact, at the level of definition, sex is a matter of biology (female, male, intersex), and sexuality one of love (gay, straight, bisexual), while gender is a matter of cultural norms that categorize activities and artefacts as masculine, feminine, or transgressive. But the restrictive binary mindset of sexology placed all third terms – intersex, bisexual, transgressive – into the category of bizarre and degenerate, together with homosexuality.

Inevitably, then, Krafft-Ebing's categories included 'individuals who we would today call transsexuals' (sic),[18] categorised by Krafft-Ebing as 'Metamorphosis Sexualis Paranoia', 'a sexual neurasthenia that has developed into *neurasthenia universalis*, resulting in a mental disease – *paranoia*'.[19] Clearly fascinated by it, Krafft-Ebing gives twenty pages to Case 129. An anonymous letter from a physician, describes in detail the writer's experience of metamorphosis sexualis, noting in particular a physical culminating episode (an attack of gout) after which 'then, to the patient's horror, he felt bodily like a woman . . . His physical and psychical feelings were absolutely those of a woman; but his intellectual powers were intact, and he was thus saved from *paranoia*'.[20] Unlike his contemporaries, Karl Ulrichs, Edward Carpenter, and Magnus Hirschfeld, Krafft-Ebing did not generally regard homosexuality as an acceptable diversity but as an acquired psychopathology. However, as an exception, Case 129 was regarded by Krafft-Ebing as a congenital condition, without psychopathology, metamorphosis sexualis without paranoia, effectively removing trans people from criminalisation and classifying them as examples of congenital intersex, since their metapmorphosis was biologically based. This meant that trans women who wished to take advantage of the new reconstructive surgery that became available in the 1930s could do so, provided their case history matched that of Case 129.

The first detailed account of these new possibilities being used is that of a Danish woman, Lili Elbe. Krafft-Ebing's Case 129 established a typical patient narrative with fourteen key points, all of which Lili's account of her life had to match, if she were to fall into the rare category of metamorphosis sexualis without paranoia. She ensured that it did, as her biography by Niels Hoyer, published in 1933 as *Man Into Woman*,[21] records. Lili's childhood appearance, deportment, socialisation, preferences, personal identity and social identity were female; in adolescence, she was strongly artistic (a metonym for feminine) and in adulthood, she had an extended real life experience of living in the female role, before a culminating physiological episode altered her morphology to that of a woman, producing a 'strange alteration in the contours of my body'. She was disgusted by male homosexuality (crucial if she was not to be psychopathologised) although when approached by men as a woman, she

enjoyed their attention. She had a desire for genital surgery, maintained a consistent female appearance over time, and was content to accept the social limits of the female role. What's more, playing into the predilections of contemporary psychological therapies, Lili added to her history parenting by an effeminate father and a dominant mother; playing into the new discipline of endocrinology, she reported that she might have rudimentary ovaries; and playing into the biological determinism already established by colonial racism, she recorded that post-operatively, she had a soprano voice and different handwriting - orthography, as well as phrenology, was a predilection of early psychiatry.

Lili's account was in 1933. The memoir combines multiple narrative voices, and falls into the genre of sexual confessional, a format popularised by the magazine *True Story*, first published in the USA in 1919. The format, still hugely popular today, operates to formulaic, highly repetitive, heteronormative conventions, and is popular because readers believe their contents are 'stories that actually happened to people. They are true life experiences'.[22] *Man Into Woman* uses these conventions in a dazzling display of what de Certeau calls 'tactics', 'the clandestine forms taken by the dispersed, tactical, and make-shift creativity of groups or individuals already caught in the nets of "discipline".'[23] Tactics are a location of resistance, a way of bringing power to the powerless, necessary because 'The weak must continually turn to their own ends forces alien to them. This is achieved in the propitious moments when they are able to combine heterogeneous elements'.[24] In her narrative, Lili foregrounded endocrinology and surgery and backgrounded psychiatry, by utilising Krafft-Ebing's script. Hers was the first successful trans activism, and her remarkable achievement was to demonstrate practically how trans people could be freed from scientia sexualis and how their care could be relocated in medical science: it was a practical demonstration that trans people were congenitally different, rather than experiencing an acquired mental illness. As asymptomatically intersexed people, contemporary culture might still position them as monstrous, as it did so-called 'hermaphrodites', but they were monsters over which psychiatry had no jurisdiction.

It is clear that Lili and her physicians were working together to establish the tactics that freed her and subsequent trans people from psychopathologisation. There was no evidence that Lili did, in fact, have vestigial ovaries, but the possibility was admitted as a working hypothesis, on the basis that since she had no psychiatric pathology, an endocrinological diversity provided the most logical explanation of her condition. Subsequent clinicians applied the same tactics and principles, and the period until the 1960s was one in which trans people and their clinicians worked collaboratively to find the best available route to health for them. In the UK, the surgeon Sir Harold Gillies was the most notable trans activist amongst clinicians, recording patients as being treated for more recognisable symptomatic intersex conditions – hypospadias, congenital absence of vagina – rather than their asymptomatic intersex condition, to enable them easily to correct their birth certificates, and to gain full civil liberties in their real sex. When psychiatry was chosen by trans people, it was not to diagnose them or to control their healthcare but to help them to adjust to heteronormativity, a task that was hard for many women in

the period of what Betty Friedan called 'the feminine mystique',[25] the cultural view that women were most fulfilled by childbirth and housework.

The climate changed in the 1960s, however, and scientia sexualis reasserted its stubborn will to non-knowledge, in one of the dark places in medicine's history. In 1962 the first Gender Identity Clinic [GIC] was founded at the University of California, Los Angeles, specifically to 'cure' homosexuality, transvestism, and transsexualism. By 1964, the term 'gender identity' had been coined, to justify the use of aversion therapy, leucotomy, and electro-convulsive therapy on trans people. A taxonomical 'turf-war' broke out between endocrinology and psychiatry, which endocrinology lost after the publication in the USA of two pieces of falsified research. First, in the notorious 'John/Joan' case, an accidentally penectomized baby boy was given reconstructive surgery and raised as a girl: longitudinal research published in 1972 by John Money, professor of paediatrics and medical psychology at Johns Hopkins University, claimed that 'gender reassignment' had been successful, and that so-called 'gender identity' was a matter of nurture not nature.[26] Trans people were therefore the results of poor nurture that psychiatry could cure. It was not until 1997 that Dr Milton Diamond, professor of anatomy and reproductive biology at the University of Hawaii, discovered that Money's experiment in sex reassignment had failed, that the boy, David Reimer, had been deeply unhappy, forced by his parents to feign 'female' behaviour when Money visited,[27] and that when he finally learned his medical history, he immediately returned to his male sex. The stresses of Reimer's medical abuse were so great that in 2004 he committed suicide.[28] Second, in 1979, a survey by Meyer and Reter showed that after reconstructive surgery, many trans people did not enter heteronormativerelationships and their job opportunities were not improved.[29] Accordingly, they concluded, reconstructive surgery 'confers no objective advantage in terms of social rehabilitation',[30] in spite of its startlingly high levels of patient satisfaction.

It was triumph for scientia sexualis and a defeat for scientific medicine. A new systemae naturae dismissed thirty years functional experience of successful pharmaceutical and surgical medicine for trans people and replaced it with a dissociative cultural antipathy, a stubborn will to non-knowledge. In the UK, newly psychopathologised trans people were subjected to enforced, compulsory sterilisation as a part of their care pathway, while records of their treatment were not collected in the public record, and their basic human rights were removed. Trans people could no longer have their birth certificates corrected, could not marry or adopt, had no employment rights whatsoever, and if they were unable to pay their parking fines, could be sent to the wrong sex prison where they would be raped by inmates and warders alike. Epistemological hostages to diagnosis as an independent entity, trans people became monsters once again, morally degenerate, sexually perverted, and socially deviant. What has all the features of a eugenic project - biological genocide, cultural genocide, and social disenfranchisement - took place without parliamentary debate, without new legislation, and without protest or support from other minority groups. By 1980, 'transsexualism' appeared as a mental illness in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* [DSM].[31]

In a replay of colonial anxiety UK trans people were segregated from all other citizens, as though they were footing a cultural bill for other people's liberalisation – the Race Relations Act in 1965, adult male homosexuality decriminalised in 1967, elective termination of pregnancy decriminalised in 1967, the Equal Pay Act passed in 1970, divorce by mutual consent introduced in 1973, the Sex Discrimination Act passed in 1975. Paralleling racist anxiety about black people who 'passed' as white – the 'tragic mulatto' motif of popular film and fiction – media anxiety focussed on trans people's ability to 'pass' in their real sex. Either their inability to 'pass' made them monstrous and freakishly obvious, or their ability to 'pass' made them monstrous and dangerously threatening. Because 'gender identity' is not and has never been a medical specialty in the UK, psychiatrists tasked with containing this new monstrosity simply did as they pleased, without training, standards, protocols, or regulation.[32] So-called 'Gender Identity Specialists' became gatekeepers to essential medicines, surgeries, and therapies, providing access solely on their individual or collective whim. Even though trans people clearly did not lack the capacity to consent, they nevertheless lost their right to informed consent and instead were forcibly conscripted into years of psychological therapy, which many experienced as useless and abusive. What is worse, this breach of the *Mental Health Act (2007)* takes place outside the operation of the *Deprivation of Liberty Safeguards (2009)* that provide protection from psychiatric abuse to all other UK citizens. It is sobering to know that this abuse is still current in most of the UK's Gender Identity Clinics today. It is, of course, a basic principle of psychological therapies that clients and patients should not be coerced into attendance, and that the therapeutic relationship must not be compromised by the therapist becoming a gatekeeper. The coercion and control exerted by psychiatry on trans people necessarily precluded the formation of a therapeutic relationship, and replaced it by a lengthy process of traumatic bonding, in what was essentially a grooming process for social degradation.

Change did not come until 1 May 1996, when the European Court of Justice ruled that Cornwall County Council had discriminated against its employee, P, by dismissing her when she told her manager, S, that she was trans.[33] It marked a turning point in trans activism, as 'the first piece of case law to come into existence, anywhere in the world, that prevents discrimination because someone is a transsexual'.[34] The decision was supported by new medical evidence and now, twenty years later, it is generally accepted that trans people experience a congenital neuroendocrinological condition, and that 'the attribution of psychopathology, deficient parenting, or childhood trauma as the "cause" of gender dysphoria must be forever relegated to the status of myth'. [35]

Now, a range of international bodies – Amnesty International, the European Commission,[36] and the European Union[37] have called for the depsychopathologisation of trans people, and the World Health Organisation is preparing to move the care of trans people out of the mental and behavioural disorders section of its *International Classification of Disorders*, ICD-11.[38] Trans communities are increasingly reclaiming their voice. The term 'transsexual' has been

reclaimed and reworked as ‘trans’, a wide umbrella for those experiencing biological difference as well as those experiencing cultural diversity. Terms such as ‘gender identity’ and ‘gender dysphoria’ are increasing rejected as denoting historical medical abuse and justifying contemporary unequal citizenship. Following patient narratives at #TransDocFail which related scores of trans people's experiences of both verbal abuse and abuse of their informed consent at so-called gender identity clinics, a major inquiry was carried out by the Women and Equalities Committee, which reported earlier this year. Government has recognised that the Equality Act (2010) must be modified to meet the needs of trans people, including non-binary people, and at last attention is beginning to be paid to the needs of so-called ‘intersexed people’, ‘individuals whose anatomy or physiology differ from contemporary cultural stereotypes of what constitutes typical male and female’.[39] There, too, strong objections have been raised to surgery on neonates, to their difference as being a defect to be corrected, and to the term ‘disorders of sex development’, which is regarded as ‘cruelly – and completely unnecessarily - pathologising and stigmatising’ natural variations in human development.[40] Just as the GMC has published new guidance on the treatment of trans people, so the NHS is preparing new National Service Specifications for their care, which it is expected will ‘transfer the management of services for trans people from mental health services to endocrinologists and restore equal consent to trans people, not least to ensure the proper use of scarce NHS resources’.[41]

We are at a moment when treatment of trans people may, once again, meet Marx’s idea of modernity, in which their ‘real conditions of life’ [42] may be restored. The exposure of a colonial mindset which benefits financially by defining some people as always automatically less worthy than everyone else, thereby creating a systemae naturae, and then subjects them to fantasy science, scientia sexualis, in stubborn disregard of empirical science, is crucial to that restoration. Simply telling the story, even as briefly as I have done here, exposes a narrative which all ethically-minded people must find abhorrent, a eugenic body-politics of which most scholars, in the humanities and in medicine, are unaware. One might ask how the enormity of such historical events and present inequities could be overlooked, but perhaps the real question is the reverse: how could it be seen, given the historical divide between medicine and the humanities? The two disciplines grew up in isolation from each other, so that ‘even today most medical schools seem to be hosted by, rather than incorporated into, their universities’.[43] Bridging this divide, surely, is the role of practice-based Medical Humanities, which sets out to provide new perspectives on everyday complex, messy, real-life clinical settings – new ways of understanding the narratives, politics, literatures, ethnographies, and dramas, that is, the world of values, that surrounds and permeates the work of all clinicians. In this particular case, understanding more about language and society allows us to see the category error that conflated sex, sexuality, and gender, encourages us to be more precise in clinical distinctions, and obliges us to recognise that gender is a philosophical idea, not a biological characteristic, and certainly not a medical diagnosis. This recognition is liberating for medicine, which can dispense with scientia sexualis and restore scientific medicine, it expands the understandings of humanistic scholarship, which

can support medicine in working towards a more equal society, and it helps to restore equity for all people who occupy that third space, between male and female.

---

[1] Mary Louise Pratt, *Imperial Eyes: Travel Writing and Transculturalism*, 2nd edition (London: Routledge, 2008), p. 37.
[2] Pratt (2008), p. 30.
[3] Pratt (2008), p. 32.
[4] Thomas Bendyshe, "The History of Anthropology", *Memoirs of the Anthropological Society of London*, I (1863-4), p. 397.
[5] Michel Foucault *The History of Sexuality* Volume 1, translated by Robert Hurley (London: Penguin, 1978), p. 55.
[6] Foucault (1978), p. 55.
[7] Canada, New Zealand and Australia having been granted responsible government from the 1840s onwards. The Boer Wars in South Africa, the Anglo-Afghan Wars, and demands for Home Rule in Ireland provided a backdrop of additional military and cultural anxiety.
[8] For example, the Match-Girls' Strike in 1888 had won considerable public sympathy, epitomising the spirit of movements such as trades unionism, socialism, fabianism, suffragism, and the new Independent Labour Party, founded by Keir Hardy in 1893.
[9] Ronald Hyam, *Empire and Sexuality: the British Experience* (Manchester: Manchester University Press, 1990), p. 65.
[10] Foucault (1978), p. 38.
[11] Steven Marcus, *The Other Victorians: A Study of Sexuality and Pornography in Mid-Nineteenth Century England* (London: Weidenfeld and Nicholson, 1966), pp. 34-76.
[12] Hyam (1990), p. 1.
[13] Renate Irene Hauser, *Sexuality, Neurasthenia, and the Law: Richard von Krafft-Ebing, 1840 -1902*, PhD thesis (University College, London: 1992), p. 21.
[14] Richard von Krafft-Ebing, *Psychopathia Sexualis*, translator unknown (New York: Pioneer Publications, 1947), p. x.
[15] Marcus (1968), p. 34.
[16] Victor Robinson, 'Introduction", Richard von Krafft-Ebing (1947), pp. iv-ix, p. v.
[17] Gordon Ryle, *The Concept of Mind* (London: Hutchinson, 1949).
[18] *The Transgender Studies Reader*, edited by Susan Stryker and Stephen Whittle (London: Routledge, 2006), p. 21.
[19] Krafft-Ebing (1947), p. 328.
[20] Krafft-Ebing (1947), pp. 323-4.
[21] *Man Into Woman: An Authentic Record of a Change of Sex*, edited by Niels Hoyer, translated by H. J. Stenning (London: Jarrolds, 1933).
[22] Maureen Honey, *Creating Rosie the Riveter* (Amherst: University of Massachusetts Press, 1984), p. 140.
[23] Michel de Certeau, *The Practice of Everyday Life*, translated by Steven F. Rendall (Berkeley: University of California Press, 1984), p. xiv.
[24] de Certeau (1984), p. xix.
[25] Betty Friedan, *The Feminine Mystique* (London: Gollancz, 1963).
[26] John Money and Anke A. Ehrhardt, *Man and Woman, Boy and Girl: The Differentiation and Dimorphism of Gender Identity from Conception to Maturity* (Baltimore: Johns Hopkins Press, 1972).
[27] M Diamond and H K Sigmundson, 'Sex reassignment at birth. Long term review and clinical implications', *Archives of Pediatrics and Adolescent Medicine*, 1997 151: 298-304.
[28] J. Colapinto. As Nature Made Him: The Boy Who Was Raised as a Girl. Harper Perennial. 2000).
[29] Jon K. Meyer and Donna J. Reter, 'Sex Reassignment: Follow-up', *Archives of General Psychiatry* 36 (August 1979), 1013-1015.
[30] Joanne Meyerowitz, *How Sex Changed: A History of Transsexuality in the United States* (Cambridge, Massachusetts: Harvard University Press, 2002), p. 267-8.
[31] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (Washington: APA, 1980).

[32] Dr John Dean, Women and Equalities Committee Oral Evidence: Transgender Equality Inquiry, HC390, Tuesday 8 September 2015 (London: House of Commons, 2016): 'I have to say there is quite considerable diversity of opinion between different clinicians and different clinics. All seven gender clinics in England arose out of the special interest of an individual a long time in the past. There has not been a lot of planning of their development, and there certainly is no training pathway for medical practitioners or others who work in this field. It is very much learning by apprenticeship, working with other people and observing. People working in this field generally in the past have come primarily from psychiatry, but more recently genitourinary medicine and family medicine as well. As there is not a standard approach or a standard training in how the guidelines are interpreted, there is certainly room for variation in interpretation'.
[33] P v (1) S and (2) Cornwall County Council (1996 IRLR 347)(ECJ).
[34] Stephen Whittle, Respect and Equality: transsexual and transgender rights (London: Cavendish, 2002), p. 110.
[35] Randi Ettner, 'Etiopathogenetic Hypotheses of Transsexualism', *Management of Gender Dysphoria: A Multidisciplinary Approach* edited by C Trombetta, G Liguori and M Bertolotto (Springer-Verlag Italia, 2015) pp. 47-53, p. 51.
[36] Silvan Agius and Christa Tobler, *Trans and intersex people: Discrimination on the grounds of sex, gender identity and gender expression* (Luxembourg: European Union, 2012), para. 3.2.
[37] For example, FRA: European Union Agency for Fundamental Rights, *Being Trans in the European Union: Comparative analysis of EU LGBT survey data* (Luxembourg: Publications Office of the European Union, 2014).
[38] http://tgeu.org/who-publishes-icd-11-beta/ accessed 10 July 2015.
[39] http://www.ukia.co.uk/about.html accessed 1 July 2016.
[40] http://www.ukia.co.uk/ukia/dsd.html accessed 1 July 2016.
[41] *BMJ* 2016;353:i2329.
[42] Karl Marx and Friedrich Engels, *The Communist Manifesto* [1840] (London: Penguin, 2015), p. 6.
[43] Zoë Playdon and Abdol Tavabie, 'The uncertain future of medical education', *BMJ Careers*, 16 February 2011.