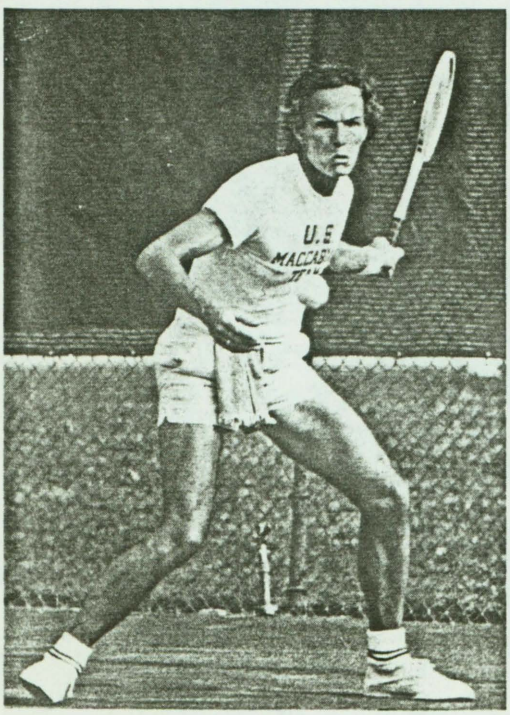
MD tennis star's sex surgery spotlights transsexualism



Dr. Richards (top) hoped to challenge women tennis pros. Before sex surgery, Dr. Raskind was a top-ranked amateur.

Chris Evert and the Women's Tennis Association she heads hold that California ophthalmologist Renee Richards, a transsexual who underwent "sex reassignment" surgery, is not a sister under the skin.

Dr. Richards, a nationally ranked amateur as a man, tried to break into the women's professional circuit after receiving hormone treatments and acquiring the external anatomy of a woman. In July, she won a small tournament in La Jolla, Calif., and in August she was accepted for play in a stronger field in New Jersey. Then she tried to enter the U.S. Open Tennis Championships at Forest Hills, and the women pros resisted.

In a statement on the case, the U.S. Tennis Association decreed, "Persons competing as women in the U.S. Open Tennis Championships will be required to undergo sex-determination tests [a Barr body test, backed up if necessary by a karyotype] as used in the Olympics. While the USTA is sensitive to and respects the rights of individuals to live as they may choose, it believes that the entry into women's events at the U.S. Open, the leading international tennis tournament, of persons not genetically female would introduce an element of inequality and unfairness into the championships."

That would presumably eliminate Dr. Richards, who was born Richard Raskind with a Y chromosome and who will die with it, regardless of surgery, hormone treatment, or any other medical intervention.

Attorneys who specialize in counseling transsexuals could recall no precedent for Dr. Richard's effort to cross this athletic barrier, no previous attempt by transsexuals, formerly men, to compete against women in sports. At a press conference in mid-August, Dr. Richards said that she did not seek the current publicity. She had changed her name, moved across the country from New York City, and started a new life with few aware of her history as a man. Then she began to play in local amateur tournaments in southern California. While she was competing in La Jolla, a sports reporter discovered that she and Dr. Richard Raskind were the same. She said she pleaded with the reporter not to break the story and even considered going "underground" again as the news spread but later chose not to because she got "thousands of letters from transsexuals." She realized that "more than tennis is at stake here. I'm a reputable physician, not a freak, and I am trying to bring to the public's attention that transsexuals are people, too."

Physicians who treat what they term gender dysphoria syndrome, sometimes leading to "sex reassignment" surgery, say that efforts are made to screen out prospects who may have self-serving publicity as a goal, even subconsciously.

Dr. Richards' surgery was performed at New York City's Physicians Hospital by Dr. Roberto C. Granato, an instructor in urology at Columbia University College of Physicians and Surgeons. As Dr. Raskind, he received female hormone therapy for many months—a necessary precursor to surgery—from Dr. Harry Benjamin Associates, an endocrinology practice in New York City. Dr. Benjamin coined the term transsexualism in 1953, a year after the sex reassignment surgery on Christine Jorgensen in Denmark.

When still Dr. Raskind, the physician, now 41, fathered a son before he was divorced. He was a prominent ophthalmologist in New York City, specializing in eye muscle surgery. A clinical professor of ophthalmology at New York Hospital-Cornell Medical Center, he held the high esteem of his peers. Dr. Charles Kelman, the noted cataract surgeon, says, "I knew him very well professionally. He was very highly thought of, very well respected. Everybody knew he had some kind of problem—whatever you want to call it—but that did not interfere with his professionalism."

Dr. Milton Edgerton of the University of Virginia School of Medicine, who formerly headed the pioneering Gender Identity Clinic at Johns Hopkins Hospital, states: "There is still dispute about whether this clinical

entity [transsexualism] should be classified as a severe variant of transvestism, as a special type of homosexuality, as a form of psychosis involving sexual identity, or as a condition separate from all of these."

Transsexuals, estimated variously at between 5,000 and 50,000 in this country, have a desire from an early age to wear clothes of the other sex but without the sexual thrill experienced by transvestites. Before sex reassignment surgery, a transsexual usually does not covet homosexual experiences but is attracted to the newly opposite sex afterward. Transsexuals have a lifelong sense of being a member of the other sex.

In the middle 1960s, when transsexualism was a popular topic in the psychiatric literature, says Dr. Ira M. Dushoff, chief of the Gender Identity Association of Jacksonville, Fla., physicians in the field who were trying to reserve surgery for transsexuals found that patients often learned to parrot the symptoms. "It took five years for everybody to catch on to the fact that we were being snowed, and patients were simply quoting us back to ourselves," says Dr. Dushoff.

The most pressing reason for care in evaluating and choosing proper recipients for sex reassignment surgery, emphasizes Dr. Dushoff, is that it is a street of no return. (The ratio of men wanting to be women and women wanting to be men runs about 1:1, but female-to-male surgery, while improving, is still less satisfactory than the reverse route.) Operating on a patient who is clearly unstable or is not prepared to handle life as a member of the other sex is equivalent to manslaughter, he says. "They are not entitled to hand me a loaded gun and say, 'Point it at me and shoot.' That's how many of us feel."

Some physicians in the field—strongly criticized by Drs. Dushoff and Edgerton and Drs. Donald R. Laub, who heads the Stanford University Medical Center team, Colin Markland of Minneapolis, and Paul J. Fink of Eastern Virginia Medical School—believe the patient is the boss if he can afford the fee, which at Stanford and Jacksonville runs about $5,000 for the hospital and surgery.

Four years ago, a New York City surgeon told colleagues at a biannual meeting on transsexualism that he had done at least 600 operations, some on an emergency basis because people threatened suicide if he didn't operate. At Stanford, operations are running about two or three a week, the highest rate of any of the university-based teams. At Jacksonville, Dr. Dushoff and his associates operate about once a month. And Dr. Granato has performed over 200 such operations in seven years.

At the Stanford and Jacksonville centers, rejection runs as high as 85% of those who make initial contact, and often years of preparation are required, including psychiatric counseling and full-time living as a member of the opposite sex.

"The unethical surgeons operate on anyone and leave us to handle the complications," says Dr. Dushoff. "And complications from this surgery can be horrendous—infection, strictures, and rectovaginal fistulas—especially with the older techniques."

Dr. Dushoff says, "Going from male to female is a one-stage operation that involves taking down the Adam's apple, making a hole between the rectum and urethra and bladder, taking the insides out of the penis, and putting the skin that represents the penis inside out into that hole. In other words, making the penis into a blind-ending vagina. Then we use the scrotum to make the labia. The urethra is shortened so it will come out at the proper place, and what you have are reasonably normal-looking external pudenda. We and other teams are now making vaginas that do not need to have forms retained in them, that are stretchable and semi-lubricated. Some teams are even leaving the penile head in to look like a uterine cervix. Because the nerve endings of the penis are still attached, most patients are capable of having orgasm."

In the female-to-male direction, Dr. Dushoff's team removes the breasts, making what looks cosmetically like a male breast, removes the uterus, ovaries, and tubes, and takes out most of the vagina—but not all because of technical problems. He said that only the teams at Stanford and Jacksonville are consistently making penises for their patients—though with different techniques.

"We started out with the idea that we wanted to connect the penis to the bladder for urination, and I believe no one else has tried this," says Dr. Dushoff. "The biggest problem we are facing is connection of skin to mucosa. Orgasm comes from pistoning the penis on the clitoris, which is left in place. It is a 1½-stage operation, the half stage is the hookup of the penis to the bladder, an outpatient operation. So far this has worked with about 30% of our patients."

While the penis fashioned at Jacksonville is permanently fairly rigid, says Dr. Dushoff, the Stanford penis obtains erection through a permanent prosthesis inside that is pumped up like a balloon. ■