
Facial Feminization Surgery and The Standards of Care



by

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Re: The status of Facial Feminization Surgery (FFS) within the Standards of Care

Introduction

Facial Feminization Surgery (FFS) has been a rapidly developing specialization in transgender health care over the last 2 decades. Its impact upon the transgender community was limited however until the Internet became widely available and images depicting the results of FFS reached a wide audience. In the late 1990's "**before and after**" photographs of extensive FFS first began to penetrate the collective consciousness of the transgender community. The effect upon the transgender community has been profound. Many transsexual individuals have finally begun to hope that with the aid of FFS they could truly assimilate in society at large as a member of their target gender.

The purpose of this letter is to prompt a reevaluation of the current coverage of FFS related surgeries within the Standards of Care. Facial feminization surgery is a complex suite of interrelated surgical procedures that can profoundly affect the day-to-day life of an individual diagnosed with *Gender Identity Disorder in Adolescents or Adults (302.85)*². It is the writer's contention that HBI-GDA and the current version of the Standards of Care have not devoted sufficient attention to FFS and its place within the field of transgender health care. For example, only a single talk addressing this issue was presented at the **XIX Biennial Symposium of the Harry Benjamin International Gender Dysphoria Association (i.e. Facial Feminizing Surgery: feminization of the Face in Male-to-Female Transsexuals A. Morellini (Italy) (2005))** compared to 19 talks dedicated to different aspects of genital reassignment surgery (both MtoF and FtoM). This concern for the manner in which FFS is discussed in the Standards of Care is prompted by new developments in insurance coverage for transgender surgeries. Insurance companies are looking to the Standards of Care to determine what surgical procedures should be considered appropriate for the treatment of *Gender Identity Disorder in Adolescents or Adults*². The current rather minimal discussion of FFS procedures in the Standards of Care may lead insurance companies to reject claims for FFS surgeries using the same arguments previously used to reject coverage for genital reassignment surgery (i.e. that they are purely "cosmetic").

Andrea James has graciously provided a detailed commentary on facial feminization surgery in an accompanying letter (see attached). Andrea is uniquely qualified to comment on the effect of FFS and GRS (genital reassignment surgery) on the life and social relationships of a transsexual individual. As a transgender patient that has undergone both FFS and GRS she is in a better position to describe the true significance of these procedures than the author. As one of the first individuals to

publish “*before and after*” photographs of herself on the Internet she has also been profoundly important in the dissemination of information concerning FFS to the transgender community.

As a member of the Harry Benjamin International Gender Dysphoria Association (HBIGDA, now known as WPATH) I have taken it upon myself to bring this issue before the officers of the organization. I hope to prompt the organization (HBIGDA) to seriously consider this request and to accommodate discussion of this issue at the conference in Chicago next year (September 2007). I currently plan to attend the conference and look forward to participating in the discussion.

Legislative developments and the University of California

Last year, the State of California passed legislation making it illegal to discriminate against transgender individuals with respect to health insurance (**AB 1586, Appendix F**). Based on this legislation the University of California began providing a “*Transgender Surgery Benefit*” to faculty and staff of the University and its affiliated laboratories. California Bill AB 1586 specifically bans discrimination in health insurance based on gender identity (**Appendix F**). Although AB 1586 does not mandate that any particular benefits be provided, the University of California Office of the President (UCOP) negotiated a “*Transgender Surgery Benefit*” with each of the health plans that contract with the University (**Appendix E**)³. The decision to provide health insurance benefits for transgender surgery was guided in part by the program instituted by the City and County of San Francisco in 2001 for city and county employees (**Appendix E**). Many of the initial fears that the program would be excessively expensive proved groundless (San Francisco City and County Transgender Health Benefit letter) and the program has continued to expand and decrease in price.

The need for a reevaluation of Facial Feminization Surgery

This letter is first and foremost a plea for a considered examination of facial feminization surgery (FFS) within the context of transgender health care and its codification within the Standards of Care. It is also a personal plea for support from the organization and the individual members of the committee in presenting my case to Blue Cross of California. Developments in transgender health care always seem to begin with the treatment of a single individual; someone always seems to become the focal point of the discussion. Due to an accident of timing and circumstances I appear to be such an individual for the discussion of facial feminization surgery and health insurance. As a scientist employed by the University of California I have become one of the first individuals to take advantage of new health insurance benefits specifically designed to provide for transgender surgery. The importance of facial feminization surgery in my own transition has led me to build a case for inclusion of FFS within the current benefits. For this reason, this letter is addressed to the Committee of the Harry Benjamin International Gender Dysphoria Association responsible for maintaining the Standards of Care.

A proper and detailed discussion of facial feminization surgery within an updated version of the Standards of Care would be a persuasive argument for convincing Blue Cross of California to include FFS under the current benefits. But changing the Standards of Care will take time, careful discussion and considerable thought. Given the time constraints of my own transition a simple response from HBIGDA discussing

this issue must take the part of the updated version of the Standards of Care. I hope to include a response from the Harry Benjamin International Gender Dysphoria Association in support of my request that facial feminization surgery be considered an essential “gender conformation surgery” and included as part of the “Transgender Surgery Benefit” provided by the University of California and administered by Blue Cross of California.

The diversity of opinion concerning Facial Feminization Surgery in the Transgender Community

Every advance in transgender surgery has been subject to considerable debate and any consideration of facial feminization surgery will spark discourse. I recently opened up a discussion on an Internet forum dedicated to facial feminization surgery and I got a wide range of responses. Many participants were concerned that bringing up the issue with HBGDA would result in restrictions and requirements for authorization letters (i.e. the don’t ask don’t tell response). Most responses were highly supportive but still concerned that bringing up the issue might make it harder for people to have the surgery without jumping through hoops. A few individuals even seem to be afraid that trying to cover FFS would in some way harm their chances to have GRS. Most people within the transgender community consider FFS to be an essential part of transition but for those that transitioned without it the issue is still contentious. If an individual transitioned without FFS there is a tendency to feel that others should be able to do likewise. Some don’t feel like FFS is really a “need” but a “want” particularly if they pass well without surgery and want cosmetic surgery for same reasons a genetic woman does. But the consensus of opinion is clearly towards integrating FFS as an essential part of any transition timetable.

Facial Feminization Surgery as part of a transition timetable

Facial feminization surgery (FFS) has become a critical step in everyone’s transition, at least within the portion of the transgender community I am most familiar with. Typically an individual begins with extensive psychotherapy (both individual and group) for a considerable period before and after starting hormones. After an individual has been on hormones for a prolonged period and has decided to go “full-time” and begin their “real-life experience” it is common to undergo FFS to ease the transition and increase acceptance of their new gender. Having FFS has become the hallmark of truly beginning transition and making an irreversible commitment to living in a new gender role. In my own case I started my “real-life experience” without FFS for a wide variety of reasons including an inability to pay for the surgery without insurance coverage. In the end I’m glad I’ve had some experience living in my new gender role without surgery but it has undoubtedly been more difficult as a result. But I still face significant challenges in my daily life primarily due to the effect my facial features have on my gender gestalt.

The importance of “passing” and the role of facial features

The therapeutic goal of ALL transgender surgeries and the medical, psychological and psychiatric treatments is to allow (as much as possible) a transgender individual to successfully function socially as a member of their desired gender. Although some may argue the point, the ability to “pass” in normal social situations as a member of the desired gender is of great therapeutic significance and anyone that thinks it isn’t is

denying reality. We all deal with our ability to “pass” in different ways but we all deeply desire to appear female (or male) in each and every way. Some of us, by the grace of genetics, can easily “pass” with only the help of hormone therapy and genital reassignment surgery becomes the primary goal during transition. On the other extreme are those of us unlucky enough to be unable to “pass” due to prominent facial features that invariably identify our genetic gender despite our skill and efforts to appear female.

One of the most important components of the gender gestalt is the face and it is difficult to overstate its importance. Andrea James has eloquently discussed the importance of facial feminization surgery on her website: ***The TS Roadmap (excerpt below)***.

Andrea James –TS Roadmap

<http://www.tsroadmap.com/physical/face/facesurgidx.html>

*“If being accepted as female is your goal, one of the most important things to consider is facial feminization surgery. I feel that it can have a major impact in the quality of your day-to-day life, far more so than other aspects of transition. It's not enough by itself to make you be accepted as female, but for some, it's a necessity. I feel **the key to being accepted as female is from the neck up**. That means hair removal, voice and face are vital.*

Arianne van der Ven writes:

*You put the most relevant questions out there in a clear and succinct manner, and you dare crack the hardest nut of all in the TG community: **IT IS NICE TO PASS**. I think it is part of being a TS, that is that we cannot change mentally without also changing physically. Every step that I have done on this road has been lighter with every bit of progress towards passing. **Passing is not a mental thing for someone with adequate reality testing skills.***

The reason I do not post this on the newsgroup is that these are such hard words to hear for those who cannot afford expensive surgery. Those of us that do not pass may be the darlings of the queer theorists for whom all gender is performative, just another fun activity. But to a large extent our most deeply human experiences do not come from performing but from being, and being (that man or that woman) in a relationship, in a job or alone. And being a man or a woman makes a hell of a lot of a difference.

Facial Feminization Surgery and the Internet

The increasing importance and popularity of facial feminization surgery is due largely to the distribution, via the Internet, of “**before and after**” photographs illustrating its effects. The highly distributed and isolated nature of the transgender community limited the spread of information about FFS until the late 1990's. But with the turn of the new century, increasing availability of personal computers combined with the courage and dedication of a few individual brave enough to publish “**before and after**” photographs of themselves on the Web led to an explosion of new information.

Appendix A contains a brief summary of the more widely used Internet resources dedicated to FFS and a selection of “**before and after**” photographs culled from sites dedicated to individual surgeons and personal pages published by recipients.

Several years ago it also became possible to have “virtual FFS” images prepared to help guide individuals in their personal quests for FFS. The artist responsible for this valuable service has tremendous experience in projecting the likely effects of FFS surgical procedures on a given individual. The projected effects of FFS on the writer

are presented in **Appendix B** along with a short statement concerning the experience and qualification of the artist.

Facial surgery for MtoF and FtoM transsexuals

Facial surgery is used almost exclusively in the treatment of MtoF transsexuals primarily due to the profound effect of testosterone on facial bone structure. While the importance of facial gender features is equally true for FtoM transsexuals they generally do not require facial surgery to appear male primarily because testosterone has a profound effect on both the bony structure of the skull and the promotion of facial hair. The male gender gestalt is more influenced by the presence of certain features (brow bossing, square chin, Adam's Apple, etc.) than their absence. In a sense the basic human face is female and is transformed to male by adding the gender cues created by testosterone. Simply adding facial hair to a "female" face significantly affects the gender gestalt. Testosterone can frequently promote changes in the bony structure of the face and often produces a male gestalt without surgery. Unfortunately, even the combined effects of estrogen, progesterone and anti-androgens do not produce the same changes in facial features for MtoF transsexuals. Long-term use of female hormones does promote soft tissue changes to a female norm but they have an extremely limited effect upon the underlying bone.

Fortunately, adolescent transgender patients can avoid the need for FFS by starting hormone therapy before their facial features are heavily influenced by testosterone. Unfortunately, fully adult phenotypic male patients with GID often require surgical modification of their facial features to appear female. The degree of need varies from individual to individual however and may be radically different for different racial groups due to differences in sexual dimorphism. As the average age of patients beginning transition appears to be decreasing the need for FFS may eventually decrease as well. If adolescent patients are given access to hormones before the physical effects of testosterone become disfiguring the need for such extensive surgery might eventually disappear. Vast changes in the acceptance and understanding of gender dysphoria within society at large would have to occur first however.

The "Real Life Experience" requirement and the need for FFS

Although it is clearly possible to transition from male to female without facial feminization surgery it can be extremely difficult for many individuals if their facial features are distinctly masculine. Even individuals that develop extremely feminine bodies as a result of hormones often find it extremely difficult to gain acceptance if their facial features are extremely masculine. The degree of acceptance individuals attain is often directly correlated with how "congruent" their gender presentation is (particularly at the beginning of transition). As a result, facial feminization surgery (FFS) is critical to many MtoF transsexuals. In fact it is often difficult (or even impossible) for some individuals to fulfill the "real life experience" requirement for obtaining a recommendation for genital reassignment surgery (GRS) without it. FFS is especially important to patients that follow the second developmental course (see **DSM IV excerpt²**) of the condition since fully developed masculine facial features are combined with male aging patterns to make "passing" almost impossible. Although many factors affect how difficult transitioning to "full time" status becomes; it is

generally true that the more “congruent” and “passable” an individual is the better the quality of life and the lower the stress involved.

It is somewhat ironic that the patients the current University of California benefits have been designed to serve is characterized by those most in need of facial feminization surgery. The “**Transgender Surgery Benefit**” is only available for faculty and staff of the University of California (and their dependents). Since most faculty and staff are older, having already established careers and credentials as a qualification for employment, they are more likely to have followed the second developmental course² of Gender Identity Disorder. A majority of the patients that follow the second developmental course require FFS before beginning the “real life experience” stage of their transition. In reality, it may be effectively impossible for many of the patients in the covered population to ever take advantage of the new benefits without the availability of FFS.

The types of facial feminization surgery

The effect of testosterone on facial features varies widely from individual to individual and more broadly by racial and ethnic heritage. The characteristics and degree of sexual dimorphism are quite variable and the facial gender characteristics stereotypical of northern Europeans may not translate widely beyond that group. In general however, the differences between male and female skulls are a reflection of the evolutionary need for more robust and resilient structures on male faces. Male skulls are generally larger and characterized as “robust” with bony ridges above the eyes and more massive mandibles and chins. Female skulls on the other hand, are smaller and more “gracile”, lacking the thickened bones evolved to protect males. Every facial element (e.g. brow, nose, chin, etc.) plays a part in constructing the gender gestalt but the dominate players are always the increased size and thickness of the bones associated with the forehead, jaw and nose.

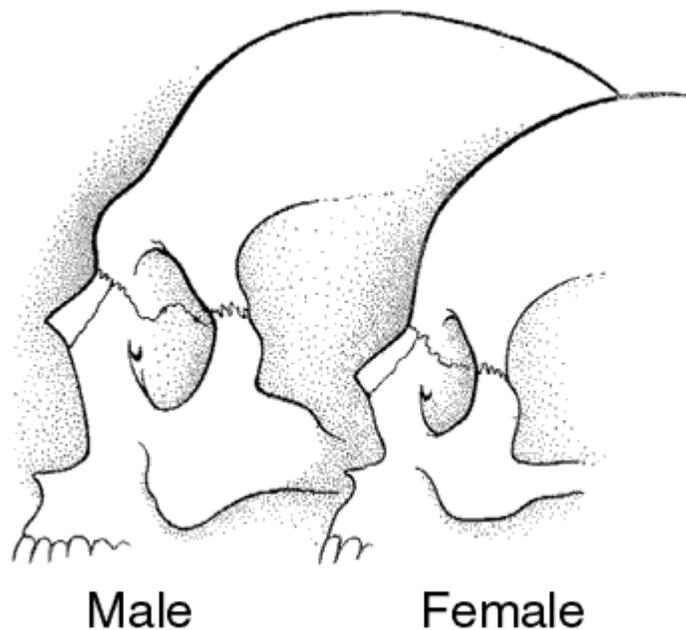


Figure 1: Differences in the structure of male and female facial bones.
(*Feminization of the Transsexual (Except SRS) Appendix D, Ousterhout*)

Many of the procedures used to modify facial features (FFS) in the context of Gender Identity Disorder (GID) are coded as so-called “cosmetic” procedures. The surgical procedures that, taken together, constitute FFS are broadly categorized into modification of “bony structure” and “soft tissue”. The “soft tissue” procedures are very commonly employed for purely cosmetic purposes to alleviate aging patterns (i.e. face-lift) in other contexts. However, the modification of “bony structures” such as brow shaving or chin and jaw restructuring are almost never done except in the treatment of GID or to repair catastrophic injuries. Many of the major “bony structure” modifications are by their very origin and design treatments specifically for Gender Identity Disorder (GID).

Partial List of Facial Feminization Surgical Procedures

<i>Facial Bone Modification Surgeries</i>	CPT Code
<i>Feminization of the brow (Forehead Reconstruction)</i>	
<i>Types 1,2,3 and 4</i>	21139
<i>Chin Feminization (genioplasty)</i>	21122
<i>Mandibular angle bone reduction</i>	21209
<i>Feminizing rhinoplasty/septoplasty</i>	30420
<i>Thyroid cartilage (tracheal shave)</i>	31599
<i>"Soft" Tissue Modification Surgeries</i>	
<i>Scalp Advancement</i>	14041
<i>Forehead Lift</i>	
<i>Upper and Lower Eyelid Blepharoplasty</i>	
<i>Face and neck lift</i>	
<i>Vertical lip lift</i>	40799
<i>Masseter Muscle Shaving</i>	
<i>Alarplasty</i>	
<i>Ancillary Surgical Procedures</i>	
<i>Cheek Implants</i>	
<i>Fat grafting to the lips and nasolabial folds</i>	

In the context of GID some of the procedures normally employed for purely aesthetic purposes (e.g. blepharoplasty) are necessary as a direct result of the application of bony structure modifications (e.g. forehead re-contouring) for a patient. For example, rhinoplasty is commonly done for purely cosmetic purposes but is made medically necessary when done in concert with a Type III forehead re-contouring procedure (***Feminization of the Transsexual (Except SRS) Appendix D***). The frontal sinus is heavily modified in the course of the re-contouring of the forehead and the rhinoplasty must be done to maintain proper biological function. In a similar fashion a “face and neck lift” would normally be done for purely cosmetic purposes but it becomes functionally necessary when the jaw and chin are restructured to female proportions and shape. The greater size of the male jaw leaves substantial excess skin after it has been restructured to female proportions. Failure to perform the soft tissue work made necessary by extensive bony modifications to the face is to functionally treat

only the first part of the problem. Most “soft tissue” surgery is only “medically necessary” due to the need to adjust the soft tissues in response changes in the underlying bone. Many so-called “cosmetic” procedures are routinely performed to correct problems created by surgical interventions focused on non-aesthetic issues in other fields of medicine (e.g. removal of cancerous lesions or tumors).

The most common objective raised when considering facial feminization surgery, as a part of gender conformation is where to draw the line between modifications required to effect gender perception and those that are simply aesthetic. Although this distinction may at first be difficult to approach, a case can be made for making such a distinction after careful thought. Careful consideration of:

- (1) A procedure’s ability to influence the gender gestalt,
- (2) The availability of satisfactory non-surgical alternatives,
- (3) An individuals ability to compensate through diet and exercise and
- (4) The demand for the procedure in the non-transgender population.

Each of these characteristics must all be carefully weighed when determining if a given surgical procedure is being performed for aesthetic consideration or as part of gender conformation. The following is a partial list of some of the issues the writer feels should be examined in this discussion.

- (1) Modifications to the underlying bony structure of the skull (e.g. brow ridges, mandibular angle, chin height) are essential gender conformation surgeries. The influence of these modifications on the gender gestalt is profound and the same effects cannot be obtained through any acceptable prosthesis or through diet and exercise. In addition, the demand for these procedures is extremely rare outside the transgender community.
- (2) Soft tissue modifications (e.g. blepharoplasty, face and neck lifts) are not necessarily essential gender conformation surgeries when done in isolation. However, if they are performed in concert with any of the essential gender conformation procedures just described, to compensate for modifications to the size and position of the underlying bone, they may be practically necessary.
- (3) Procedures that are commonly employed by the general public to enhance appearance (e.g. breast augmentation) or change ethnic identity (e.g. rhinoplasty) may greatly augment gender presentation but may not be essential gender conformation procedures if done in isolation. Such surgeries could be considered necessary if they can make a substantial impact upon the gender gestalt however.
- (4) Some procedures that are not considered essential for gender conformation may become functionally necessary in conjunction with primary structural modifications (e.g. rhinoplasty in conjunction with brow and forehead re-contouring, face and neck lift in conjunction with mandible re-contouring).
- (5) Soft tissue modifications that can be influenced by behavior and/or diet (in conjunction with hormone therapy) might not be considered essential gender conformation surgery although they may be extremely helpful in generating the correct gender gestalt (e.g. liposuction of the chin or abdomen).
- (6) Procedures for which no acceptable means of mitigation exist without surgery (i.e. no prosthesis are available) must be considered critical and medically

necessary in the context of gender dysphoria. For example, thinning hair can be covered with wigs and insufficient breast augmentation can be treated with prosthesis but nothing can change facial bone structure except surgical intervention.

Changes to the underlying bones of the face (e.g. brow, chin, etc.) are typically essential gender conformation surgeries while soft tissue modifications are not. A case can be made however for including soft tissue modifications if they are made necessary by procedures intended to modify the structure of the underlying bone. Even some modifications of the bone directly may not necessarily be essential gender conformation surgeries (e.g. rhinoplasty) although they may greatly assist in generating a female gender gestalt. Almost all of the procedures developed for “cosmetic” purposes in other contexts however may come into play particularly when major structural changes are made to the underlying shape of the skull. An example of this is the need for a face and neck lift in concert with extensive modification of the mandible.

Another impediment to insurance coverage for the “cosmetic” procedures employed in transgender medicine is the natural reluctance of the companies to cover procedures for one group while denying them to others. A perfect example of this is the obvious need for hair transplants by transgender patients that have developed extensive male pattern baldness. Although hair transplants can be tremendously valuable to individuals with this condition the insurance companies would be extremely reluctant (possibly with good reason) to cover them only for transgender individuals. Many genetic women also develop thinning hair with age and the writer can understand the rationale that covering a procedure for one group and not another is ultimately untenable. *(The writer must confess however that this isn't one of her issues so she may lack the proper perspective)*

In general, when a procedure is commonly employed for aesthetic purposes in the general population (e.g. breast augmentation) it reflects a general desire in the public for features that are not always created by nature. Many women are unsatisfied with their breast size and a large market exists for breast augmentation services for purely aesthetic reasons. Having large breasts is not an automatic requirement for being perceived as female however particularly when the face and the rest of the body are in agreement. This fact argues against including breast augmentation as a critical gender conformation surgery. Exceptions do exist however particularly in the case where an individual cannot tolerate hormones that would allow natural breast development. In such cases an argument could be made for considering breast augmentation as a critical gender conformation surgery in the same fashion that breast augmentation is considered “medically necessary” following a mastectomy.

Liposuction is another example of a “cosmetic” procedure that can greatly benefit transgender individuals that may not be defensible as a critical gender conformation surgery. Many transgender individuals develop fat distributions that are characteristic of their natal gender and interfere with presenting the “correct” gender gestalt. But if liposuction is covered for one group shouldn't it be covered for everyone? Fat deposits (particularly under the chin and around the abdomen) can seriously interfere with presenting as “female” and certainly effect how attractive an individual is perceived to be. Men and women store fat differently and only very long-term exposure to cross-gender hormones can significantly influence their distribution.

Despite long term exposure to such hormones there will always be a tendency for transgender individuals to exhibit fat in portions of their bodies reflecting their natal gender. The simple presence of fat cells in a particular part of the body (e.g. abdomen for phenotypic men and thighs for phenotypic women) means that fat will be stored there instead of in new locations more congruent with an individual's desired gender. This unfortunately means that diet and exercise are even more important for transgender individuals than the general population. The over-riding fact is that fat distribution can normally (barring chronic physiological obesity) be effected by diet and exercise (and by hormones after long exposure) and is therefore at least potentially within the control of the individual. This example illustrates another important principle: characteristics that can be affected by behavior might not be considered inherently critical gender conformation surgeries. *The writer must again state that she is may be biased because she is generally thought to be thin as a rail (too little rather than too much curvature) As a result, liposuction is not of great significance (she still struggles with fat deposits characteristic of her natal gender however).*

The attitude of the surgeons towards the distinctions made in the previous section may well be ambivalent. The surgeons that specialize in feminizing the facial features of members of the transgender community are primarily concerned with creating positive results and naturally wish to apply all their artistry and skill towards that end. Characterizing some procedures as “medically necessary” gender conformation surgeries, while others that help to create a positive result are not, will undoubtedly seem artificial to the surgeons involved. However, without some means of addressing the issues raised by critics it will be effectively impossible to have any of the necessary procedures covered by insurance in the future. This may have little influence on the practices of surgeons that work primarily with patients without insurance coverage for their work. For patients depending upon insurance coverage to complete their transition it has tremendous significance however.

The Standards of Care and FFS now

“Other Surgery for the Male-to-Female Patient. *Other surgeries that may be performed to assist feminization include reduction thyroid chondroplasty, suction-assisted lipoplasty of the waist, rhinoplasty, facial bone reduction, face-lift, and blepharoplasty. These do not require letters of recommendation from mental health professionals. There are concerns about the safety and effectiveness of voice modification surgery and more follow-up research should be done prior to widespread use of this procedure. In order to protect their vocal cords, patients who elect this procedure should do so after all other surgeries requiring general anesthesia with intubation are completed.*”¹ (The Harry Benjamin International Gender Dysphoria Association's Standards Of Care For Gender Identity Disorders, Sixth Version February, 2001)

The Standards of Care don't specify any requirements (e.g. letters of documentation) for patients seeking facial feminization surgery. The rationale for not requiring authorization for facial feminization surgery appears to be the totally reasonable reluctance to place more requirements on patients in transition. Since psychiatrists and therapists are not called upon to play a “gatekeeper” role for FFS (as they do for GRS) there has been no economic incentive to codify FFS within transgender health care. Patients with GID have had no incentive to change this state of affairs and health professionals have had no economic incentive to consider the issue in detail. But not explicitly addressing facial feminization surgery (FFS) in greater detail in the Standards of Care has had an unexpected side effect. Lack of proper

coverage in the Standards of Care means that anyone unfamiliar with transgender medicine will consider FFS to be ancillary and unimportant. The current silent agreement to simply not discuss the issue is no longer tenable with the advent of health insurance coverage for transgender health care.

The only mention of facial feminization surgery in the current version of the Standards of Care is so minimal and lumped in with clearly optional procedures that it is frankly almost insulting to those of us that require it. The cursory mention of “facial bone reduction” in the same sentence with lipoplasty naturally leads those unfamiliar with facial feminization surgery to assume that such procedures aren’t really necessary.

Trying to take advantage of the new benefits

I have the somewhat dubious pleasure of being one of the first transgender individuals to try and take advantage of this new benefit provided by the University of California. I began my transition in October of 2005 without knowledge of the benefits that had recently been negotiated (July 2005). I only became aware of the full scope of the new benefits in January 2006 (several months after I began my own transition) when the Evidence of Coverage documents became available from the health plans.

Although the language describing the new benefits is extremely broad, Blue Cross is attempting to interpret the term “Transgender Surgery” as synonymous with genital reassignment surgery (GRS). Historically all types of transgender surgery have been excluded by health insurance companies as purely “cosmetic” in nature. Now that the health insurance industry is being forced to cover transgender health care it is trying to adopt a very restrictive definition of “gender conformation surgery” (“Transgender Surgery Benefit”) and has only provided limited coverage for genital reassignment surgery (GRS). Although official requests for FFS have yet to be formally made, Blue Cross is inclined to defend exclusion of the procedures using the same basis that was previously used to exclude GRS (i.e. cosmetic). The failure of the Standards of Care to properly discuss FFS within the context of MtoF health care is lending credence to their interpretation. The health insurance companies are claiming to follow the Standards of Care so proper discussion of FFS within them is critical to having these procedures included within the new insurance programs.

Implementation of the “Transgender Surgery Benefit”

Implementation of the new “Transgender Surgery Benefit” has been extremely difficult for a variety of reasons. Perhaps the fundamental problem is the structural assumptions built into the administration of the benefits that the diagnosis of *Gender Identity Disorder in Adults and Adolescents (DSM IV 302.85)* is in a fundamental way a mental rather than a physical (i.e. medical) disorder. Any claim submitted to Blue Cross of California with an illness or diagnosis coded as 302.85 has been automatically denied and referred to United Behavioral Health for payment. Blue Cross has made no attempt to accommodate the new benefits within their internal accounting and payment protocols and nearly every claim is contested and often several grievances must be filed before full payment is received.

Although the science is not yet definitive, it is strongly supportive of the interpretation of a neonatal origin for the roots of Gender Identity Disorder in Adults and Adolescents (“*Atypical Gender Development – A Review*”, *GIRES, International Journal of Transgenderism, Vol 9(1) 2006*). Surgical intervention is a well-established treatment for

patients suffered from this condition. Ascribing the surgical interventions necessary to treat this condition to the realm of purely “cosmetic” procedures is a failure to understand why these procedures are necessary in the first place. In a similar fashion, treating Gender Identity Disorder as a purely psychiatric condition without a profound biological origin is to ignore everything we have come to understand about the condition in the last half century.

The underlying fear appears to be that if any so called “cosmetic” procedures are paid for in this context it will automatically lead to abuses where people try to obtain purely cosmetic procedures simply by claiming to be suffering from GID. Appropriate psychological screening for anyone accessing these benefits would effectively eliminate this concern. A formal diagnosis of GID might be required by the health plans to access benefits under this program but similar requirements would not be necessary outside of the context of the health plan. Being diagnosed with GID is a profound and frightening experience in many ways. Believe me when I say that no one would ever risk the stigma associated with this condition simply to pay for a face-lift.

The City and County of San Francisco recently released usage statistics concerning their transgender health program (*see Appendix E*) and the balance of payments has been incredibly in the favor of the health insurance companies. In a single year the plan paid out only 3.6% (\$156,000.00) of the total \$4.3 million dollars it collected from the City and County of San Francisco as a premium during the same period. The following year (2005) the total premiums actually increased (although the rate decreased) as the program was expanded to include the HMOs (\$5.6 million dollars) but only 3.3% of that amount was paid out on 11 claims. Clearly the fear that there would be a flood of requests for surgery and that the insurance companies would suffer economic losses was a figment. If FFS were to become a standard expense for those using the insurance benefits the companies might experience a drop from a 96.7% profit to a profit of only 93.4%; in the unlikely event that the costs more than double.

What is the definition of “Transgender Surgery”?

We are not arguing about whether surgical treatment is appropriate for those suffering from Gender Identity Disorder. We are not arguing about whether gender conformation surgery should be paid for by insurance. Both these questions have already been answered. We are also not discussing the conditions under which different non-reversible surgical procedures should be employed for the treatment of GID. Extremely stringent criteria are already in place (HBIGDA Standards of Care) for determining the conditions under which surgical treatment is appropriate for patients with this condition. We are arguing about what constitutes gender conformation surgery. The insurance companies have entered into a contract to provide a **“Transgender Surgery Benefit”** and it is my contention that gender conformation surgery (i.e. Transgender Surgery) is a complex suite of surgical procedures including both FFS and GRS and dependent upon the needs of the individual patient.

It is not appropriate for Blue Cross of California to determine what is and is not appropriate treatment for Gender Identity Disorder; that is the responsibility and prerogative of professional organizations like the Harry Benjamin International Gender Dysphoria Association (HBIGDA). Any attempt to usurp such authority is an

unwarranted intrusion into the established relationship between doctors and the patients seeking care. The term “**Transgender Surgery Benefit**” cannot be interpreted by Blue Cross of California to mean whatever they wish it to mean.

The Harry Benjamin International Gender Dysphoria Association is the only organization that can legitimately define what constitutes “Transgender Surgery”. At present the insurance companies providing services to the University of California are taking it upon themselves to define what “Transgender Surgery” means and how such care is provided. The insurance companies are determining what procedures to cover based on an extremely naïve assessment of what a “sex change” surgery entails.

It is my contention that “Transgender Surgery” is a suite of surgical procedures including GRS, FFS, electrolysis, and a host of others depending upon the needs of individual patients. Appropriate surgical intervention should be geared to the needs of individual patients and not dictated by bureaucrats with no knowledge of transgender medicine. The therapeutic goal of ALL transgender surgeries is to allow (as much as possible) a transgender individual to function successfully as a member of their desired gender in both a social and sexual sense. The definition of what constitutes “Transgender Surgery” must be guided by the overarching treatment goal as defined in the Standards of Care (SOC Version 6, February 2001, page 1)

The Overarching Treatment Goal. *The general goal of psychotherapeutic, endocrine, or surgical therapy for persons with gender identity disorders is lasting personal comfort with the gendered self in order to maximize overall psychological well-being and self-fulfillment. (SOC Version 6, February 2001, page 1)*

Facial feminization surgery can have significant therapeutic impact on the life of individuals suffering from gender identity disorder and contributes substantially to the goal of treatment stated above.

Determination of Medical Necessity and the Standards of Care

All health insurance contracts contain multiple exclusions to reject claims on the basis that they were not “medically necessary”. Medical doctors and surgeons are extremely reluctant to state that ANY of the surgical procedures used in transgender medicine and covered by the Standards of Care are “medically necessary”. This is true for both GRS and FFS in the insurance context. Surgeons typically feel ill equipped to evaluate whether an individual truly suffers from gender dysphoria and leave such determinations to psychiatrists and psychologists. But even psychiatrists rarely use the term “medically necessary” when preparing documentation letters for genital reassignment surgery authorization. Using the term “medical necessity” carries considerable semantic significance and can open the physician to charges of malpractice and they usually avoid the term. Surgeons working with the transgender community to provide genital reassignment surgery use the documentation letters required by the Standards of Care as a de facto determination of medical necessity. Presentation of documentation letters prior to surgery effectively absolves surgeons from the need to personally determine medical necessity. In a similar fashion, psychiatrists and psychologists follow the Standards of Care in order to facilitate surgery for those meeting the eligibility and readiness requirements and use them essentially as a means of demonstrating “medical necessity”.

Now that health insurance is starting to become available for transgender health care it is essential that some mechanism be created to determine “medical necessity”.

The Harry Benjamin International Gender Dysphoria Association and the Standards of Care that it publishes are often resented by members of the transgender community as an impediment to obtaining the services of physicians and surgeons (i.e. the “gatekeeper” role). HBIGDA could do much to alleviate this resentment by acting to advocate for the “medical necessity” of the surgical procedures sought by members of the community.

It is the writer’s contention that fulfilling the eligibility and readiness requirements (defined in the Standards of Care) and undergoing the associated psychological and psychiatrist reviews (accompanied by the required documentation) constitute a de facto demonstration of “medical necessity”. The Standards of Care are currently being used by everyone involved in the process as a substitute for a clear statement of “medical necessity” on the part of any individual. If this situation is not clarified then any insurance company can reject requests for surgical intervention without cause. Now that transgender surgeries are no longer being excluded on the basis that they are “cosmetic” in nature they may continue to be excluded because there is no way to demonstrate “medical necessity”. All an insurance company needs to do to reject a claim (for clearly covered procedures) is to have one of their Peer Clinical Reviewers state that the procedure is “not medically necessary”. Since there is currently no way to demonstrate “medical necessity” for any of the surgical procedures that constitute transgender medicine the insurance companies can choose to pay at their own discretion. Following the guidelines defined in the Standards of Care to determine “medical necessity” is the only possible way that this dilemma can be rectified. A clear statement of this fact should be included in the next revision of the Standards of Care.

My own approach to FFS eligibility and readiness

In my own case, I have approached this surgery with the same degree of care normally given only to GRS (*see excerpt from the Standards of Care, Version 6¹*). I have obtained written evaluations from my primary psychotherapist (Casey Weitzman) concerning the appropriateness of FFS in my case. I have also obtained a written evaluation of my case from a psychiatrist (Thomas A. Cotsen) acting in the evaluative role required for a second GRS documentation letter but specifically addressing my desire for FFS. Both Weitzman and Cotsen are extremely experienced gender therapists who prepare similar documentation for GRS surgical recommendations (*Appendix C*). I have also obtained surgical evaluations from Dr. Douglas Ousterhout (San Francisco), Dr. Zukowski (Chicago), Dr. Chettawut (Thailand), and Dr. Suporn (Thailand) all of whom are recognized authorities in the field of facial feminization surgery (*Appendix D*). While I am not recommending that such documentation be required for all patients seeking FFS it seemed highly advisable in my case. The absence of a defined procedure for FFS authorization in the Standards of Care might lead my insurance company to assume that such surgery is not an intimate and essential part of my transition. I have not yet made a formal written request for facial feminization surgery to Blue Cross of California. Coverage of FFS under the current contract language is clearly possible and guidance and commentary from HBIGDA is critical before making such a formal request. I hope that by approaching FFS using exactly the same authorization procedures reserved for GRS will lend credence to my position.

The surgical evaluations

All of the facial feminization surgical evaluations I have obtained generally agree with only minor exceptions (*Appendix D*). I originally sought to have the recommendations broken down into “medically necessary” and optional procedures for aesthetic purposes. I would gladly agree to personally pay for procedures that are of a purely aesthetic nature. I feel strongly however that the changing the bony structures are medically necessary gender conformation surgery and should be paid for under the “*Transgender Surgery Benefit*”. Unfortunately, none of the surgeons felt that they could make the distinction. Each of the surgeons felt that changing individual facial features in isolation would not create a positive outcome.

The facial features most responsible for generating a male gestalt in my case are

- (1) The presence of prominent brow bossing,**
- (2) The height of the forehead (despite the absence of male pattern balding),**
- (3) The shape and vertical height of the chin,**
- (4) The distance between the base of the nose and the upper lip,**
- (5) The presence of prominent thyroid cartilage (Adam’s apple) and**
- (6) The sharpness of the mandibular angle (to a much lesser extent).**

Photographs illustrating the proposed surgical modifications and artistic representations of the expected results are presented in (*Appendix B*)

All of the surgeons recommended rhinoplasty, which is medically necessary when a Type III (Ousterhout terminology) forehead reconstruction is performed. Rhinoplasty was also indicated to correct a deviated septum and repair the damage from a broken nose that I suffered due to an assault in February 2006 shortly after I began my transition. All of the surgeons also recommended a full-face lift and blepharoplasty primarily to adjust the soft tissue in response to the forehead and mandible restructuring. Ordinarily I would not consider blepharoplasty and a face-lift to be necessary. However, I’ve been counseled that due to my age, the skin will not be able to adjust to decreased size of my forehead and jaw and will make me look deformed if they are not performed. Some of the surgeons recommend that the soft tissue work be done in a separate surgery 4 to 6 months after the bone modifications while others think the procedures can be performed in a single surgery. Only one surgeon (Zukowski) recommended cheek implants, and I’m inclined to treat this as a purely aesthetic procedure that I wouldn’t seek insurance coverage for if I choose to pursue it.

Why is FFS so important to me?

I consider FFS surgery to be absolutely essential in my own case. FFS is not a magic charm and I do not have any intention of seeking “stealth” after transition. But FFS will affect the quality of my day-to-day life far more than any other therapeutic procedure. Although I am in excellent health and considered to be generally quite attractive, my facial features are distinctly masculine and no matter what I do in terms of makeup or physical fitness I will always appear “male” without surgery. Genital reassignment surgery only affects one’s ability to engage in intimate relationships and does not affect one’s ability to function socially as female (except in the legal sense). In some cases the gender “gestalt” can be successfully changed only by surgical

intervention. Unfortunately, this is true in my case. But undertaking a course of treatment for gender dysphoria that includes facial feminization surgery is not something that can be taken lightly. It is possible (though not desirable) to revert to a male gender presentation after genital reassignment surgery (male to female). However, undergoing facial feminization surgery makes it forever difficult if not impossible to present as male. Facial feminization surgery may have a far more profound effect on the quality of life of a transgender individual than genital reassignment surgery. GRS will allow me to function in intimate relationships as fully female but it will have little effect on my non-intimate relationships (except in the legal sense). Most relationships are by their fundamental nature social rather than sexual so FFS will have a far more profound effect than GRS on the quality of my life.

My own attitudes towards plastic surgery

My own attitudes towards cosmetic surgery for purely aesthetic purposes may be of some relevance here. I recently described the procedures that I am planning to have done to a casual acquaintance and she said, “My God! You must really hate the way you look!” My response was that I don’t consider myself unattractive and I don’t “hate the way I look” in the traditional sense. I doubt I would ever seek plastic surgery for purely aesthetic reasons. But despite considering myself to be fairly attractive I am never perceived as female due to fairly subtle facial features that invariably generate a male gestalt. If I could truly function socially as female without surgery I would. Unfortunately I can’t and surgical intervention is the only possible solution to this dilemma. My desire for surgery is not to be more attractive but simply to be female. My dearest wish is that I could be perceived as female without surgery. But I have excellent reality testing skills and I refuse to fool myself into believing a delusion.

I have been living full time as a woman for a considerable period at this point and I cannot conceive of ever trying to function socially as male again. However, I will continue to live my life in a sort of limbo until I can undergo the required surgeries. It is quite likely that I may be forced to retire early to afford the surgeries if they are not covered under the current benefits.

What does HBGDA need to do?

It is my contention that a clear statement from HBGDA concerning the definition of the term “gender conformation surgery” (i.e. “Transgender Surgery”) is desperately needed. A statement from the Committee responsible for updating the Standards of Care placing FFS in perspective within the surgical procedures appropriate for the treatment of GID is clearly warranted and would be tremendously useful in my own case. FFS clearly belongs to the group of surgical procedures classified as irreversible interventions. Other surgical treatments that are irreversible are discussed in great detail but no statement is made within the SOC concerning when FFS should be considered an appropriate treatment. I am not suggesting that FFS be placed under the same “gatekeeper” status as GRS however (other member of the community would object strongly if I did).

A mechanism for demonstrating the “medical necessity” of ALL the procedures employed as part of transgender medicine is also essential. A simple statement that fulfilling the eligibility and readiness requirements constitutes such a proof may well be sufficient. Only HBGDA is in a position to make such a determination on behalf of the transgender community.

I am formally requesting a statement from HBIGDA supporting my case for inclusion of FFS as a "Transgender Surgery" in my case. I am presenting mental health evaluations and documentation similar to the documentation normally supplied for genital reassignment surgery. I am writing this to solicit such a statement from the Standards of Care Committee of HBIGDA concerning FFS and to sincerely request letters of support for my individual case from the members of the Committee and the Officers of the organization as well. Any statement provided by HBIGDA as an organization or by individual members will be included in the packet of documentation that will be provided to Blue Cross of California by the surgeon I choose to perform my FFS.

Documentation provided

A set of supporting documents accompanies this letter including letters from my psychotherapist, psychiatrist, and surgical evaluations from four specialists in facial feminization surgery. I have also included a commentary from Andrea James who is a well-known proponent of facial feminization surgery as an important facet of transition. I have included the legislative history of California Bill AB 1586 that led the University of California to provide the "Transgender Surgery Benefit". The relevant portions of the Evidence of Coverage documents describing the "Transgender Surgery Benefit" provided by the Blue Cross of California Plus and PPO health plans are also included. I have requested a legal analysis of the case for including FFS within the existing benefits from Chris Daly at the Transgender Law Project and it will be based on the response provided by your organization to this request. I have also included several photographs showing my current appearance and the projected effects of the planned facial feminization procedures. Although my projected appearance cannot be considered truly definitive the artist is extremely familiar with facial feminization surgery and has done hundreds of similar renderings.

I look forward to a response from your organization and I would appreciate any comments you care to make concerning this issue. I would like a response from HBIGDA as an organization and hopefully letters from individual officers and members if they wish to contribute them. I will gladly provide any additional documentation that reviewers may find significant and I would be happy to discuss the issues involved at your convenience. I look forward to participating in discussions of this issue as a member of HBIGDA in the future.

Sincerely,

Jennifer Milburn
August 15,2006

**Standards of Care Version 6 – Eligibility and Readiness Criteria for GRS
Diagnostics and Statistics Manual IV – 302.85 Gender Identity Disorder in Adolescents or Adults**

**¹The Harry Benjamin International Gender Dysphoria Association's
Standards Of Care For Gender Identity Disorders, Sixth Version
February, 2001**

Relevant Excerpts from the most recent Standards of Care

Two Letters are Generally Required for Genital Surgery. Genital surgery for biologic males may include orchiectomy, penectomy, clitoroplasty, labiaplasty or creation of a neovagina; for biologic females it may include hysterectomy, salpingo-oophorectomy, vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular prostheses, or creation of a neophallus. It is ideal if mental health professionals conduct their tasks and periodically report on these processes as part of a team of other mental health professionals and nonpsychiatric physicians. One letter to the physician performing genital surgery will generally suffice as long as two mental health professionals sign it. More commonly, however, letters of recommendation are from mental health professionals who work alone without colleagues experienced with gender identity disorders. Because professionals working independently may not have the benefit of ongoing professional consultation on gender cases, two letters of recommendation are required prior to initiating genital surgery. If the first letter is from a person with a master's degree, the second letter should be from a psychiatrist or a Ph.D. clinical psychologist, who can be expected to adequately evaluate co-morbid psychiatric conditions. If the first letter is from the patient's psychotherapist, the second letter should be from a person who has only played an evaluative role for the patient. Each letter, however, is expected to cover the same topics. At least one of the letters should be an extensive report. The second letter writer, having read the first letter, may choose to offer a briefer summary and an agreement with the recommendation.

(page 8 – SOC Version 6)

Physical interventions fall into three categories or stages:

1. Fully reversible interventions. These involve the use of LHRH agonists or medroxyprogesterone to suppress estrogen or testosterone production, and consequently to delay the physical changes of puberty.
2. Partially reversible interventions. These include hormonal interventions that masculinize or feminize the body, such as administration of testosterone to biologic females and estrogen to biologic males. Reversal may involve surgical intervention.
3. Irreversible interventions. These are surgical procedures.

(page 9 – SOC Version 6)

Eligibility Criteria. These minimum eligibility criteria for various genital surgeries equally apply to biologic males and females seeking genital surgery. They are:

1. Legal age of majority in the patient's nation;
2. Usually 12 months of continuous hormonal therapy for those without a medical contraindication (see below, "Can Surgery Be Performed Without Hormones and the Real-life Experience");
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;
5. Demonstrable knowledge of the cost, required lengths of hospitalizations, likely complications, and post surgical rehabilitation requirements of various surgical approaches;
6. Awareness of different competent surgeons.

Readiness Criteria. The readiness criteria include:

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).

(page 20 – SOC Version 6)

Genital surgeries for individuals diagnosed as having GID are to be undertaken only after a comprehensive evaluation by a qualified mental health professional. Genital surgery may be performed once written documentation that a comprehensive evaluation has occurred and that the person has met the eligibility and readiness criteria. By following this procedure, the mental health professional, the surgeon and the patient share responsibility of the decision to make irreversible changes to the body.

Genital Surgery for the Male-to-Female Patient. Genital surgical procedures may include orchiectomy, penectomy, vaginoplasty, clitoroplasty, and labiaplasty. These procedures require skilled surgery and postoperative care. Techniques include penile skin inversion, pedicled rectosigmoid transplant, or free skin graft to line the neovagina. Sexual sensation is an important objective in vaginoplasty, along with creation of a functional vagina and acceptable cosmesis.

Other Surgery for the Male-to-Female Patient. Other surgeries that may be performed to assist feminization include reduction thyroid chondroplasty, suction-assisted lipoplasty of the waist, rhinoplasty, facial bone reduction, face-lift, and blepharoplasty. These do not require letters of recommendation from mental health professionals.

There are concerns about the safety and effectiveness of voice modification surgery and more follow-up research should be done prior to widespread use of this procedure. In order to protect their vocal cords, patients who elect this procedure should do so after all other surgeries requiring general anesthesia with intubation are completed.

(page 21 – SOC Version 6)

²DSM IV Definition of Gender Identity Disorder

302.85 Gender Identity Disorder in Adolescents or Adults

In adult males, there are two different courses for the development of Gender Identity Disorder. The first is a continuation of Gender Identity Disorder that had an onset in childhood or early adolescence. These individuals typically present in late adolescence or adulthood. In the other course, the more overt signs of cross-gender identification appear later and more gradually, with a clinical presentation in early to mid-adulthood usually following, but sometimes concurrent with, Transvestic Fetishism. The later-onset group may be more fluctuating in the degree of cross-gender identification, more ambivalent about sex-reassignment surgery, more likely to be sexually attracted to women, and less likely to be satisfied after sex-reassignment surgery. Males with Gender Identity disorder who are sexually attracted to males tend to present in adolescence or early childhood with a lifelong history of gender dysphoria. In contrast, those who are sexually attracted to females, to both males and females, or to neither sex tend to present later and typically have a history of Transvestic Fetishism. If Gender Identity Disorder is present in adulthood, it tends to have a chronic course, but spontaneous remission has been reported.

³ ***The person largely responsible for negotiating the benefits was Shane Snowdon who worked for UCOP at the time. Andre Wilson at University of Minnesota was also involved in an advisory capacity during the negotiations through contact with Shane Snowdon. The primary administrative contact for the program within the university has been Joan Manning at the University of California Office of the President (UCOP).***

Letter of Documentation for Facial Feminization Surgery and Supporting Information

Supporting statements concerning the importance of FFS during transition

Andrea James – well known transgender advocate and former recipient of FFS

Commentary on the efficacy of facial feminization surgery and its place in transgender medicine

Internet Resources on Facial Feminization Surgery – *Selected “Before and After” Photographs*

Summary of Recommended FFS Surgical Procedures – Jennifer Milburn August 2006

Photographs showing projected before and after surgery appearance

Mental Health Professional Documentation Letters

Casey Weitzman M.A., M.F.T. – primary psychotherapist

Recommendation for Hormone Therapy Letter to Richard Horowitz

Recommendation for Facial Feminization Surgery

Thomas A. Cotsen MD – psychiatrist in the evaluative role

Confirmation of GID Diagnosis and recommendation for FFS

Facial Feminization Surgical Evaluation Letters

Douglas K. Ousterhout, M.D., D.D.S. – Surgeon for Facial Feminization Surgery

Recommendations of specific surgical procedure for facial feminization

Feminization of the Transsexual (Except for SRS) Douglas K. Ousterhout, M.D.,D.D.S.

Mark L. Zukowski, M.D. – Surgeon for Facial Feminization Surgery

Recommendations of specific surgical procedure for facial feminization

Dr.Chettawut Tulayaphanich M.D. – Surgeon for Facial Feminization Surgery

Recommendations of specific surgical procedure for facial feminization

Dr Suporn Watanyusakul M.D. – Surgeon for Facial Feminization Surgery

Recommendations of specific surgical procedure for facial feminization

Chris Daly – Transgender Law Center (in preparation)

Legal analysis of the Evidence of Coverage from Blue Cross

City and County of San Francisco Transgender Health Benefit – Human Rights Commission

Blue Cross of California, PPO – Evidence of Coverage Documentation

Blue Cross of California, Plus – Evidence of Coverage Documentation

California AB 1586 – Analysis and Legislative History



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June 16, 2006

Harry Benjamin International Gender Dysphoria Association
1300 South Second Street, Suite 180
Minneapolis, MN 55454

To whom it may concern:

I am writing in support of including more specific and supportive language about Facial Feminization Surgery (FFS) in future revisions of HBGDA Standards of Care. I believe it is medically necessary for male-to-female transitioners.

When I transitioned last century, the conventional wisdom among trans health service providers focused largely on the so-called “triadic therapy” of hormones, genital surgery and therapy as part of a “real-life test.”

However, it was clear to me that the more important procedures for male-to-female trans people, in terms of daily social interaction with others, were feminization of the voice and face. I have been a strong advocate of focusing on these areas for those who wish to assimilate in their target gender. Vocal and facial cues are far more likely to be factors in how others respond to a trans woman and are in my opinion the key to being accepted more easily in one’s target gender. These cues affect everything from one’s personal and professional relationships to one’s ability to move through the world safely. While complete assimilation is not every trans person’s goal, I would argue that a transsexual person is defined as someone who successfully incorporates all available techniques to present in their target gender. My aphorism “passing is from the neck up” holds true in all but the most intimate situations. Those who focus on the so-called “triadic therapies” while neglecting these steps typically have a much harder time being accepted as women.

To that end, there are three key elements a trans woman can focus on to feminize her face:

1. facial hair
2. scalp hair
3. facial feminization procedures

All three should be considered medically necessary for those who seek feminization.

(continued)

Facial hair removal

Halting and eliminating androgen-induced facial hair is critical. In my own case, permanent facial hair removal was enough to allow me to “pass” in many situations. This costly and painful first step should be emphasized as a bottom-line necessity. There’s a reason many female-to-male transitioners wear facial hair—it is an instant gender cue.

Scalp hair

Halting and correcting androgen-induced hair loss is also critical. In the way that women undergoing chemotherapy often find hair loss to be emotionally devastating, trans women dealing with male-pattern hair loss face a difficult obstacle. They must rectify this through medical procedures like hair transplants or scalp advancement, or through prostheses such as wigs and hair replacement systems.

Facial feminization procedures

Males and females have, on average, differentiation on some craniofacial features. Reducing or eliminating male-typical facial characteristics can make a major difference in how one is perceived by others.

This can include bone/cartilage work:

- Reduction of brow bossing
- Making the forehead convex in all planes
- Reducing the mandible and chin
- Feminizing the nose
- Feminizing the throat (trachea reduction)

It can also include soft tissue procedures

- Cheek augmentation
- Lip augmentation
- Skin resurfacing
- Face lift

While there is a relatively weak argument for soft tissue procedures, it is clear that in many cases bone and cartilage FFS procedures are medically necessary for those who wish to be accepted as women.

Many women in my community observe the anniversary of their vaginoplasty as the apex of their transition, but I feel my own turning point occurred a decade ago when I had facial feminization surgery. That was the point I was able to move through the world as a woman, to transition on the

job in a professional setting, and to have personal relationships with people who saw me as I saw myself. I believe the reason my transition has gone as well as it did is because of my focus on face and voice, and I continue to advocate that others make these their top priorities if they wish to assimilate.

Of course, many of these issues would be irrelevant if puberty-delaying androgen blockers were available to gender-variant women at the onset of puberty, but that topic will have to wait for another discussion.

I urge HBIGDA and all helping professionals to place a greater emphasis on voice and face in the Standards of Care, and I especially urge you to consider advocating for the medical necessity of facial feminization procedures for those exposed to androgens during puberty. I am happy to discuss this further with anyone who is interested. I run several websites related to trans consumer issues which get over 10,000 visitors each day (about 4 million annually). I also co-founded a production company that focuses on trans depictions in the media. This letter is a distillation of what I have learned in ten years of correspondence with women in transition.

Thanks for considering this very important issue.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrea James". The signature is fluid and cursive, with a long horizontal stroke at the end.

Andrea James

Founder, tsroadmap.com

Founder, hairfacts.com

Co-Founder, Deep Stealth Productions (deepstealth.com)

andrea@tsroadmap.com

213-840-2602

June 16, 2006

Appendix A

Internet Resource on Facial Feminization Surgery and Selected “Before and After” Photographs

August 2006

Sources for “Before and After” Photographs

It’s understandably difficult to locate good before and after photographs of individuals that have had extensive facial feminization surgery. After transition we are naturally reluctant to publish pictures of how we appeared before. Even in Internet groups (e.g. ffs-support@yahogroups.com) that are dedicated to facial feminization and post extensive before and after collections tend to be characterized by terrible photographic quality (both before and after). I’ve collected a few representative images for presentation here. Additional images may be found at any of the sites dedicated to facial feminization surgery on the Internet and listed on the next page.

A partial list of Web resources regarding Facial Feminization Surgery

International List of Facial Feminization Surgeons

<http://www.drbecky.com/facesurg.html>

Plastic and Maxillofacial Surgeons Specializing in Facial Feminization Surgery

United States

Toby R. Meltzer, M.D

Email Address

tmeltzer@tmeltzer.com

Website

<http://www.tmeltzer.com/>

Douglas K. Ousterhout, M.D., D.D.S.

ousterht@cris.com

<http://www.drdouglasousterhout.com/>

Dr. Jeffrey Spiegel

info@drspiegel.com

<http://www.drspiegel.com/>

Mark L. Zukowski, M.D., FACS

anewyou@elnet.com

<http://www.mlzukowski.com/>

Europe

Mr Brian Thomas Musgrove MB., ChB., FDSRCS., FRCS

<http://www.manchester.com/creamof/services/cosmetic.html>

Dr Frans Noorman van der Dussen

drnoorman@monica.be

<http://www.monica.be/dokters/fiche.asp?recnr=384>

Thailand

Dr.Chettawut Tulayaphanich M.D.

info@chet-plasticsurgery.com

<http://www.chet-plasticsurgery.com/>

Suporn Watanyusakul

ffsassessment@supornclinic.com

<http://www.supornclinic.com/>

Important Web Resource Pages for Facial Feminization Surgery

Facial Feminization Surgery page

<http://beginninglife.com/FFS.htm>

The TS Road Map

<http://www.tsroadmap.com/index.html>

Virtual Facial Feminization

<http://www.virtualffs.co.uk/index.html>

Personal pages describing Facial Feminization Surgery and it's effect on a individual

Transsexual Road Map, Facial Feminization Surgery (FFS)

<http://www.tsroadmap.com/physical/face/facesurgidx.html>

Lynn's Facial Feminization Surgery(FFS)

<http://ai.eecs.umich.edu/~mirror/FFS/LynnsFFS.html>

Teresa - A True Story of Transformation: The Facial

<http://www.heartcorps.com/FFS/>

Madeleine Facial Feminization Surgery Page

<http://www.cinematter.com/surgery.html>

Becky's Home Page, "Make Me Pretty" Experiences with
Cosmetic Surgery

<http://www.drbecky.com/pretty.html>

Kara Flynn

<http://members.aol.com/karaflynntg/index2.html>

Sally's Resource Morsel, Facial Surgery with Dr. Douglas Ousterhout

<http://tsresource.info/ouster.htm>

Nicole Ashley Hamilton

<http://www.hamiltonlabs.com/FacialSurgery.htm>

Gender Identity and Gender Role Transition

<http://www.genderandtransition.com/myffs.htm>

Sara's Solutions

<http://tsinfo.freehomepage.com/photo.html>

Kate's Home Page

http://www.europeants.org/surgeons/results/noorman_van_der_dussen/kate/

AmyNews.com

<http://www.amynews.com/>

Andrea's Transition Page

<http://www.avonk.com/FFS.html>

Janet's Gender Transition

<http://members.aol.com/janetxx1/>

Angie Girard

http://beginninglife.com/Bios/angie_girard.htm

Dianne's FFS Diary

http://www.geocities.com/WestHollywood/Chelsea/9081/FFS_Diary.html

Transsexual Women's Resources - Facial Feminization Surgery in San Francisco

<http://www.annelawrence.com/ffsinsf.html>

Facial Feminization Surgery

with Dr. Douglas Ousterhout, example: Sally Sally

Obtained from the following website
<http://tsresource.info/ouster.htm>



Before Surgery

9 Days After Surgery

6 Months After Surgery

After Hairline Revision

Profile changes as the result of facial feminization surgery



BEFORE

AFTER

Final Appearance after Transition



Transition consumes your life when you're in the middle of it, and for me the aftershocks lasted quite some time. But life does settle out, and I welcomed a sense of normalcy that began to settle in. **The facial surgery was without a doubt an absolutely critical factor in the success of my transition. I can't stress this enough.**

<http://www.tsresource.info/index.html>

Facial Feminization Surgery with Dr. Douglas Ousterhout - example Diane



Diane : (left) is before and
(middle) is after surgery on day 8Picture
(right) is with my hair normal August 1st 2005 3 months after surgery.

Taken in May this picture reflects the different person I have become, because for the first time in my life I can worry about simple things like money, my hair and little things that have always seemed so distant from my life. I have been given a chance to live my life as a normal healthy women, that enjoys getting up in the mornings now, the hand stomach turning feelings of what I look like have disappeared, I am not the stunner that I would dream of being, but normal now in the whole being of a women, everything in my life is ordinary, what a waste of 45 years before this, I have a lot of catching up to do.



<http://www.drdouglasousterhout.com/>

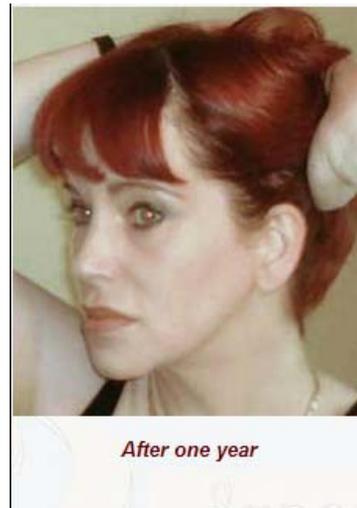
Facial Feminization Surgery Example Suporn Clinic, Thailand

Facial Feminization Surgery January 2004 39 years old patient, UK



These photographs were submitted by the patient who had previously had surgery for upper blepharoplasty, fat graft to lips followed by skin graft to top lip, and chin reduction. In 20 January 2004, the patient undertook the following procedures:

- (1) scalp reduction*
- (2) forehead resetting
(exclusive & proprietary to Dr. Suporn)*
- (3) upper blepharoplasty*
- (4) forehead lift*
- (5) rhinoplasty/alarplasty*
- (6) jaw line reduction*
- (7) chin reduction*



Obtained from the following website
<http://www.supornclinic.com/restricted/FFS/Results.aspx?cs=5>

Facial Feminization Surgery Example Suporn Clinic, Thailand

Obtained from the following website
<http://www.supornclinic.com/restricted/FFS/Results.aspx?cs=6>



Before



Before

Facial Feminization Surgery January 2005 48 years old patient, USA

These photographs were submitted by the patient who had not undergone any previous cosmetic/plastic surgery. In 18 January 2005, the patient underwent the following procedures:

- (1) scalp reduction
- (2) forehead reconstruction (Forehead III)
- (3) forehead lift
- (4) forehead treatment with Dermalive
- (5) upper blepharoplasty
- (6) reconstructive rhinoplasty/alarplasty
- (7) upper lip lift
- (8) augmentation mammoplasty (AM)



After



After

Facial Feminization Surgery – Forehead Contouring

Dr. Chettawut, Thailand



Description about the procedures:

Forehead contouring for type 3 by orbital rim burring / frontal sinus set back, done together with forehead/ brow lift.

The rhinoplasty and otoplasty were done separately as additional procedures.

- Comparing the degree of deformity and treatment necessary to correct the corresponding deformity, the various forehead contours have been divided into three groups.

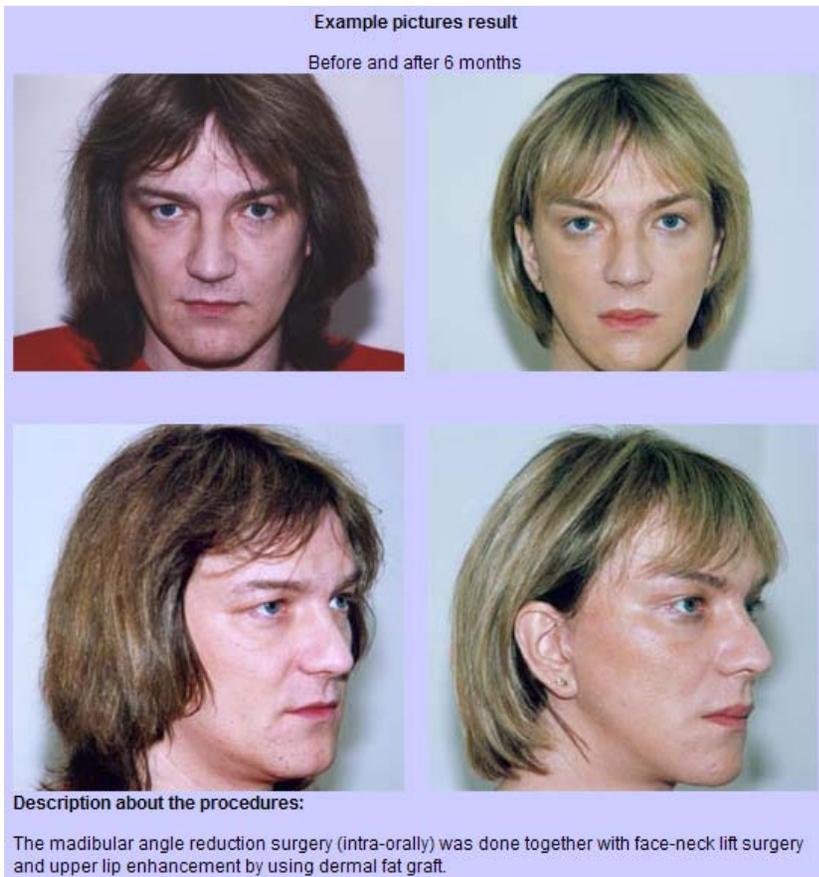
- Group 1** includes those patients with normal or slightly anterior projection of the supraorbital rims, minimal to moderate bossing and thick skull bone over the frontal sinus and/or absence of the frontal sinus. These deformities can be corrected by bone reduction alone utilizing a surgical burr.

- Group 2** includes those individuals with slightly anterior projection of the supraorbital rims but in whom the frontal bossing is combined with relatively thin bone over the frontal sinuses, the sinuses being of normal size. Correction requires completing as much contouring of the bones as possible without entering the sinus and then augmenting the concavity above the frontal bossing with methyl methacrylate and contouring to a final desired shape.

- Group 3** includes those patients in whom the anterior projection of the supraorbital rims is so excessive that adequate bone reduction contouring is impossible without entering the frontal sinus. In these individuals, the frontal sinus must be opened through a sinus osteotomy and the entire anterior sinus wall and associated supraorbital rim set back and fixed into position by using wires or micro-titanium plates and screws.

Source: http://www.chet-plasticsurgery.com/forehead_bone.html

Facial Feminization Surgery – Mandibular Angle Contouring Dr. Chettawut, Thailand



Mandibular (Jaw) angle contouring surgery

Prominence of the mandibular (lower jaw) angle, which makes the face square with masculine look, is considered to be unattractive for females as well as transsexuals. The shape of lower jaw in female tends to have a more gradual curve

- The concept of surgery is to contour the mandibular angle to be small, smooth and sloping.
- The cause of prominence of the mandibular angle comes mainly from the bony part rather than from the cheek muscle.
- I normally do not reduce the amount of cheek muscle as this will have an effect on your chewing ability and prolonged swelling.

Preoperative assessment

- The amount of the muscle is estimated through physical examination. The exact amount and line of bone resection is determined through clinical examination and specific X-ray views.

Source: http://www.chet-plasticsurgery.com/mandible_bone.html

Lynn Conway



March 29, 2000: Lynn at 4-1/2 months post-op from FFS, and 5 weeks postop from face-lift surgery

<http://ai.eecs.umich.edu/~mirror/FFS/LynnsFFS.html>

Appendix B

Summary of Recommended Facial Feminization Surgery Procedures For Jennifer Milburn

Projected Effects of Facial Feminization Surgery

August 2006

Introduction and Commentary on the “Virtual” FFS Images

I'd like to provide some commentary on the images presented on the following pages.

One of the first things that you will undoubtedly notice is that I'm just plain “old”. I was 50 years old when I started to transition (soon to be 51) and nothing will turn back the clock. I have absolutely NO interest in fighting a futile battle with age and I would NEVER subject myself to massive surgery for transitory gains. It's not that I'm lacking in vanity or that I consider “cosmetic” surgery wrong in any sense but simply not worth the potential risks for transitory gains. I would never try to have insurance pay for procedures that were just designed to make me look better. I think I look damn good for my age and most of my friends just assume I'm much younger than I actually am. We all fight a losing battle with time and age and I hope to approach it with some dignity. On the other hand, I have struggled with my gender identity for my entire life and I approach facial feminization surgery with great anticipation despite the risks. My quest for facial feminization surgery is rooted in a simple desire for final gender conformation with the goal of assimilating as a female member of society at large.

The other comment I'd like to make is that while I don't think I'm unattractive I am clearly “male” based on my facial features alone. My protruding brows, long chin and prominent trachea are automatic, instinctive and incontrovertible signs of gender. No one looking at me will ever see a woman particularly if they see me in profile. In some camera views I can look remarkably feminine and quite attractive but a slight change in position brings one of the “male” gender markers into stark relief and the viewer automatically changes their interpretation.

My body has responded remarkably well to hormone therapy and I finally have a sense of connection and indeed “pleasure” with my body; something I have never experienced before. Although I'm quite tall, I'm thin and well proportioned and have the “potential” to be reasonably attractive. Eventually, my body will largely be transformed into a fair approximation of an attractive (if older) woman's by hormones and genital surgery. For the first time in my life I have a genuine desire to enhance my body with exercise and diet with a true sense of “ownership” in the results. It's hard to convey to others the sense of disconnection that gender dysphoria causes in those that suffer from it. For me at least it wasn't a hatred of my body or my genitals but a sense of profound disconnection that made diet and exercise pointless and ultimately made everything else fairly futile.

I challenge anyone that doubts the importance of facial feminization surgery in my case to just imagine trying to walk down the street with a woman's body and the face they see in the photographs here. I'm not ugly but my face is profoundly masculine. In my case facial feminization surgery is an essential part of gender conformation. Genital reassignment surgery is extremely important in the broad societal sense because it confirms legal recognition of the change in gender and confers all of the rights and burdens associated with being female. But from a purely social perspective it does little to change the gender gestalt. If one

appears outwardly female the conformation of one's genitals is not called into question except in formal legal situations.

I'd also like to comment that I think it's far from delusional to think that some subtle and well-done surgical modifications could make a tremendous difference in my appearance. From the right perspective I often look remarkably feminine and the basic proportions and structure of my face are acceptably close to being those of a woman. While no surgery could ever flawlessly hide the fact that I'm transgender under close scrutiny I think it's possible to change the gender gestalt enough to make life profoundly easier for me. Without facial surgery I frankly face a life consigned to a transsexual ghetto that I can only leave if I'm willing to face stares and confused looks everywhere I go.

The "Virtual FFS" images presented in the following pages are based on the written recommendations of the four surgeons that supplied letters (Appendix D). The artist has provided a commentary on how and why each feature has been modified. The artist only disagreed with the recommendation for a narrowing of the mandible and she provided a second set of photographs showing the effects of this procedure. I have chosen to present the images without the modification of the mandibular angle. She also felt that cheek implants were not necessary and has not simulated this feature.

I was extremely pleased with the quality of the work done by the artist (Alexandra) and I would like to point out a couple of subtle aspects of her work. The goal of the surgery I am currently planning is to change the "gender gestalt" from male to female and I think the procedures recommended by the surgeons will do exactly that. The end result will not make me magically younger or even that much more attractive but they will make me female and that is really the point. You can still clearly see the crow's feet at the corners of my eyes and the laugh lines around my mouth. All of the experiences I've had in my life are written on my face (e.g. years of field work in archaeology and geology caused deep wrinkles on my forehead and nose) and most of these features remain. The basic point is that facial feminization surgery is an essential part of gender conformation and without it I will always be seen as simply "a guy in a dress". With facial feminization surgery I will still be the same age and face many of the same problems but I will have a chance at a normal life.

Sincerely,

Jennifer Milburn
Hollywood, California
August 13, 2006

Virtual Facial Feminisation

Statement of Qualifications and Methods

To whom it may concern.

I am writing this to confirm that I run the website called "***The Virtual Facial Feminisation Website***" (<http://www.virtualffs.co.uk/>). I advise people on their FFS and simulate the likely effects of the surgery using Photoshop.

I have been running this business for about 4 years in which time I've performed over 300 simulations for people. My work is recognised and respected by some of world's top FFS surgeons.

I am also a male to female transsexual and have been through most of the main FFS procedures myself.

Kind regards,

Alexandra.

**Virtual Facial Feminization for Jennifer Milburn
August 13,2006**

Hi Jennifer.

I had a couple of spare days this week and have been able to complete your pictures slightly ahead of schedule ☺

The eye takes a little while to tune-in to facial changes so you may be disappointed at first glance. I urge you to spend a few days getting used to the pictures before you reach any decisions.

Hairline:

Your hairline is a little high as can be particularly seen in the 3/4 profile and I have moved it forwards. As I mentioned before, I don't think this should be done too aggressively as you have a long face and that can be emphasized by too short a forehead.

Forehead:

You have very strong bossing over the frontal sinus and the orbital rims and this is emphasized by a deeply indented area across the center of your forehead. I have set back the frontal bossing, shaved down the orbital rims and filled the indented area to bring your forehead into normal female ranges.

Eyebrows:

Your eyebrows sit in a low position and point downwards towards the outer ends. I have given you a fairly strong brow lift to correct this and to open and feminize your expression.

Eyes:

There is some loose soft tissue above the eyes that is hiding the upper eyelids though mainly the problem is above your left eye. I have given you an upper blepharoplasty to correct this. The problem may be partially corrected by the tightening caused by the brow lift and you may find you don't need the procedure on the right eye, however I do think you'll need it on the left at least.

Nose:

Your nose is reasonably narrow but overall it is a bit large with a high and slightly humped bridge. There are also various bumps and asymmetries along the bridge. I have lowered the bridge to make the nose smaller overall and to give it a fairly straight profile. I have also given the tip a gentle turn-up and blended it better into the rest of the nose and I've smoothed out the various asymmetries along the bridge.

Cheeks:

I think your cheek bones are fine. There is quite a bit of hollowness in the mid-cheek area but I suspect that fixing that would require a fat transfer rather than cheek implants. I've not simulated this.

Lips:

You have full lips with an attractive and feminine shape but the distance between your top lip and the base of your nose is too long. I have given you a lip lift to correct this.

Chin:

Your chin has a reasonably rounded and therefore feminine shape but it is tall. I have shortened your chin fairly aggressively but have maintained the feminine shape.

Jaw:

Your jaw is not particularly wide when compared to the middle and upper thirds of your face. I think there is an optical illusion going on here to some extent in that the hollowness of the cheeks in front of the jaw angles makes them look more defined than they actually are. From the side the sharp angle of the mandible can be seen although the actual height of the jaw in this area is quite mild. As this seems to me a very borderline procedure, I'm sending you an extra set of pics where I've narrowed the jaw a touch and shaved off the angle. You can then decide which set you prefer.

Adam's apple:

You do have a visible Adam's apple although it's not severe. I have simulated a tracheal shave to reduce it for you.

Face lift:

I have not simulated a face lift but there is a chance that a small lift of some kind will be required to take up any slack caused by the large chin reduction.

Overall:

I'm broadly in agreement with you and the surgeons - the only borderline decision I feel is the jaw narrowing.

A good way to view your pictures is to lay the before and after shots side by side and keep looking from one to the other or placing one print on top of the other and quickly flicking between them. However, if you have a way to overlay them on your computer and click between them, that is ideal.

The pictures are yours so feel free to share them and the assessment with any support groups you are member of if you want some second opinions.

Please email me to confirm that the pictures have arrived. If you have any questions or opinions about your pictures and your assessment please feel free to email me.

Thank you very much for entrusting me with your virtual FFS - I very much hope the pictures are helpful.

Good luck and best wishes,

Audrey.

<http://www.virtualffs.co.uk>

Facial Feminization Surgery: Jennifer Milburn

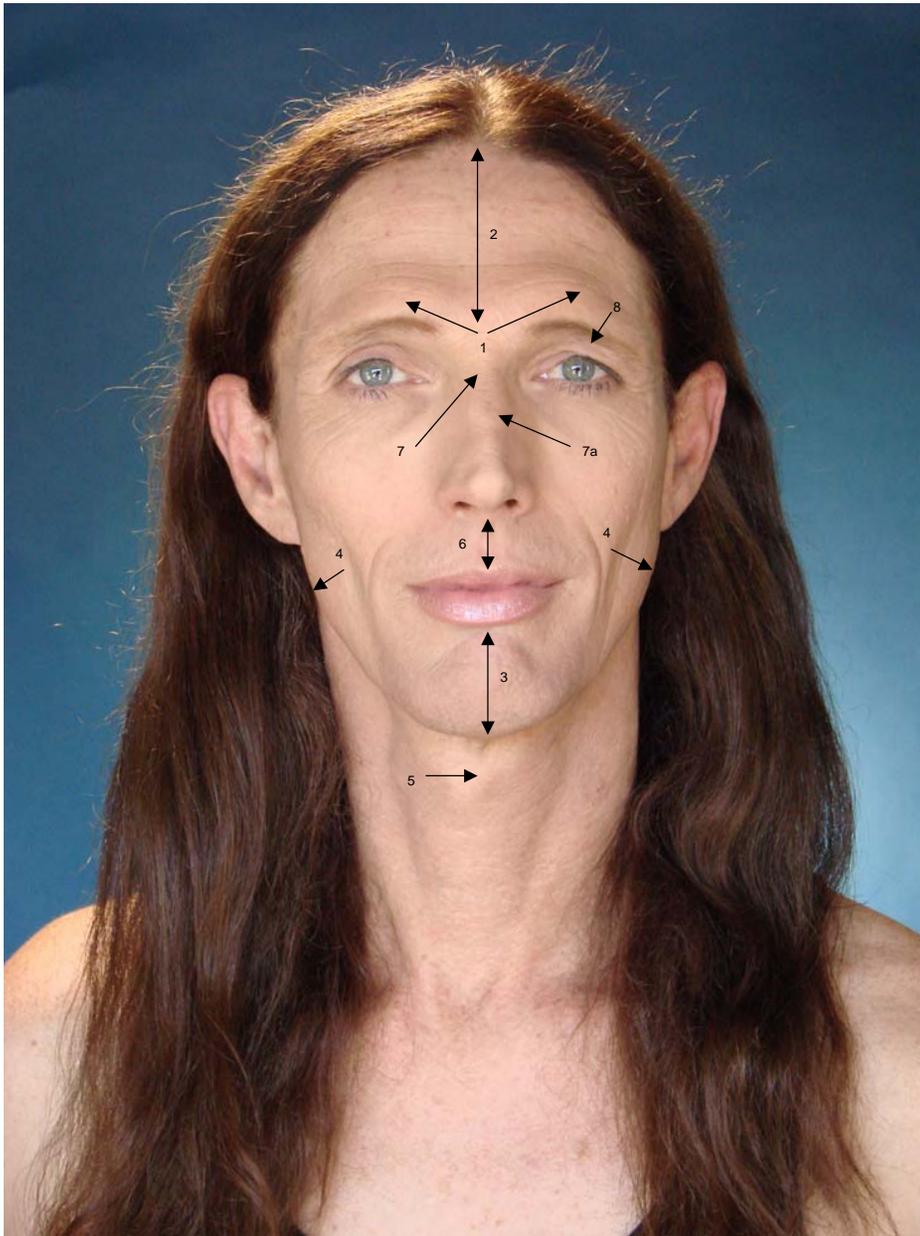
Summary of recommended surgical procedures based on

consultations with Ousterhout, Zukowski, Suporn and Chettawut 2006

The gender gestalt is heavily influenced by the anatomical structure of the face. Testosterone promotes the development of several gender specific facial features that we unconsciously use to determine the gender of an individual

- (1) BROW BOSSING -Presence of brow "bossing" created by a large frontal sinus and bone thickening of the supraorbital rims. (most important bony modification)
PROCEDURE: Forehead contouring CPT 21139
- (2) FOREHEAD HEIGHT -An extremely high forehead height despite the absence of any recession of the hairline.*
PROCEDURE: Scalp advancement CPT 14041
- (3) CHIN HEIGHT AND SHAPE The height of the chin and the generally square shape are important gender cues. Chin height in this context is much more important than shape.
PROCEDURE: Chin feminization CPT 21122
- (4) MANDIBULAR ANGLE AND WIDTH – The mandibular angle is slightly sharp and The width of the entire mandible is fairly wide. (least important bony modification)
PROCEDURE: Jaw tapering CPT 21209
- (5) THYROID CARTILAGE – The "Adam's Apple" is prominent but not excessively so. (most important direct soft tissue gender marker)
PROCEDURE: Thyroid cartilage CPT 31599
- (6) LENGTH OF THE UPPER LIP – The upper lip (i.e. distance between the edge of the upper lip and the base of the columella) is quite long (a subtle but distinctive gender cue). (the only primary soft tissue modification needed)
PROCEDURE: Upper lip reduction CPT 40799
- (7) WIDTH OF THE NASOSINUS – The upper bony portion of the nose is broad and slightly deformed (7a) due to an assault in February 2006. X-rays indicate a slight break and a deviated septum. (modification required due to both the need to reconstruct the nasal sinus in concert with the brow modification and to correct injury). (secondary bony structure modification required by primary structural modifications).
PROCEDURE: Rhinoplasty CPT 30420
- (8) EXCESS SKIN ABOVE EYES – Although this is primarily a sign of age the upper eyelids need to be modified to remove the excess skin created when the forehead and brow are reconstructed. (secondary soft tissue modification)
PROCEDURE: upper blepharoplasty

*In case anyone is interested I want to point out that this is in fact my real hair. I'm not wear a wig nor do I have hair extensions or anything like that. My hairline has never receded even a millimeter (just lucky I guess). I'll admit that a friend helped we straighten it slightly for this photo session but other than that this is simply the way it looks every day.



Photographed July 31,2006 Hollywood,California

Facial Feminization Surgery: Jennifer Milburn

A summary of the "Virtual Facial Feminization" Images

"After" Images *Artist's Conception by Alexandra, "Virtual FFS" <http://www.virtualffs.co.uk/> August 2006*
Based on written surgical recommendations by Ousterhout, Zukowski, Chettawut and Suporn



"Before" Images *Photographs taken July 31, 2006 in Hollywood California*



Current and Projected Appearance after Facial Feminization Surgery: Jennifer Milburn August 2006



Before

Photographed July 31, 2006 Hollywood, California



www.virtualffs.co.uk

After

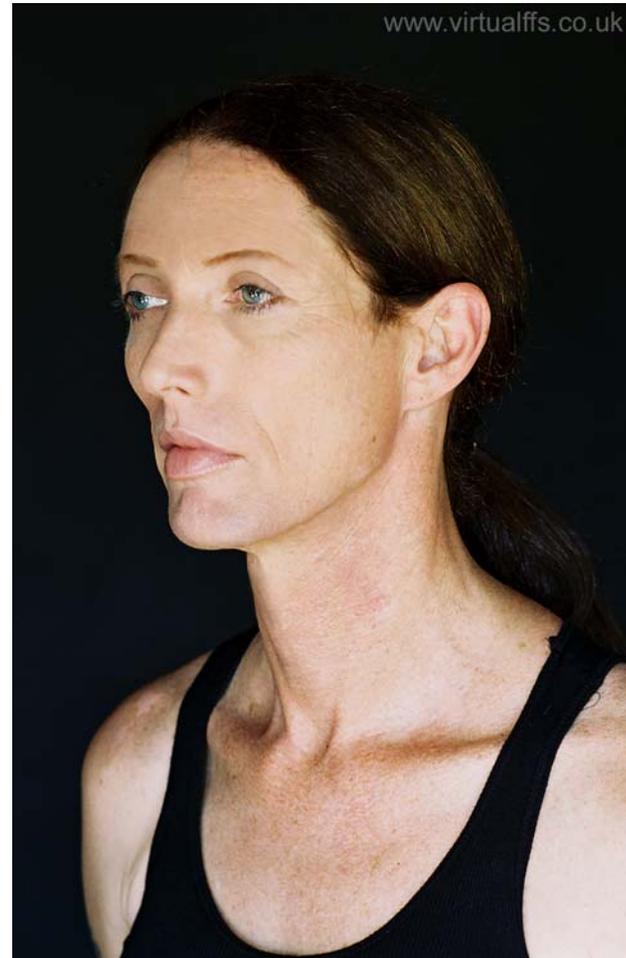
Artist's Conception by Audrey, "Virtual FFS" <http://www.virtualffs.co.uk/> August 2006

Current and Projected Appearance after Facial Feminization Surgery: Jennifer Milburn August 2006



Before

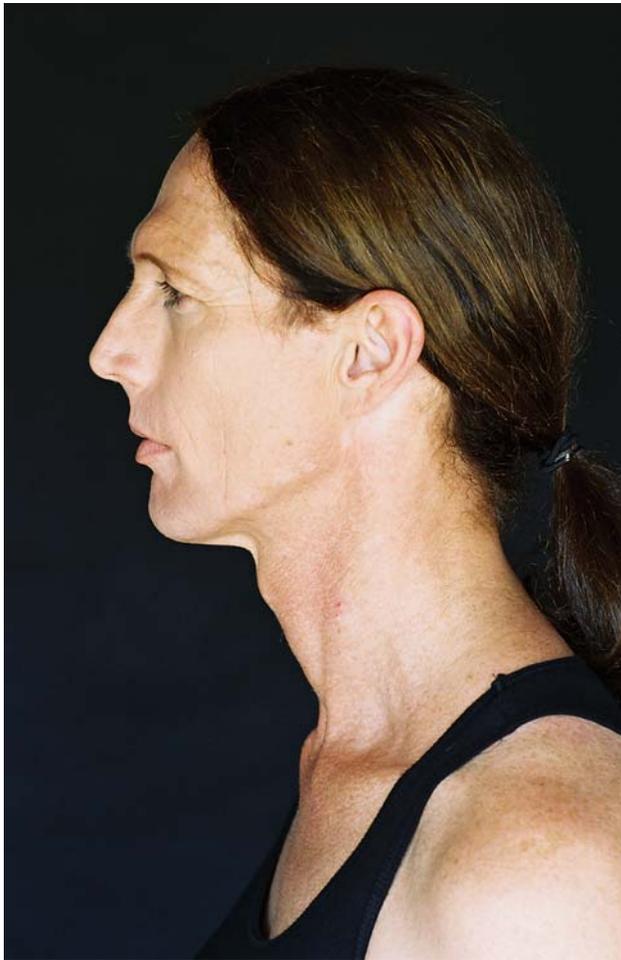
Photographed July 31, 2006 Hollywood, California



After

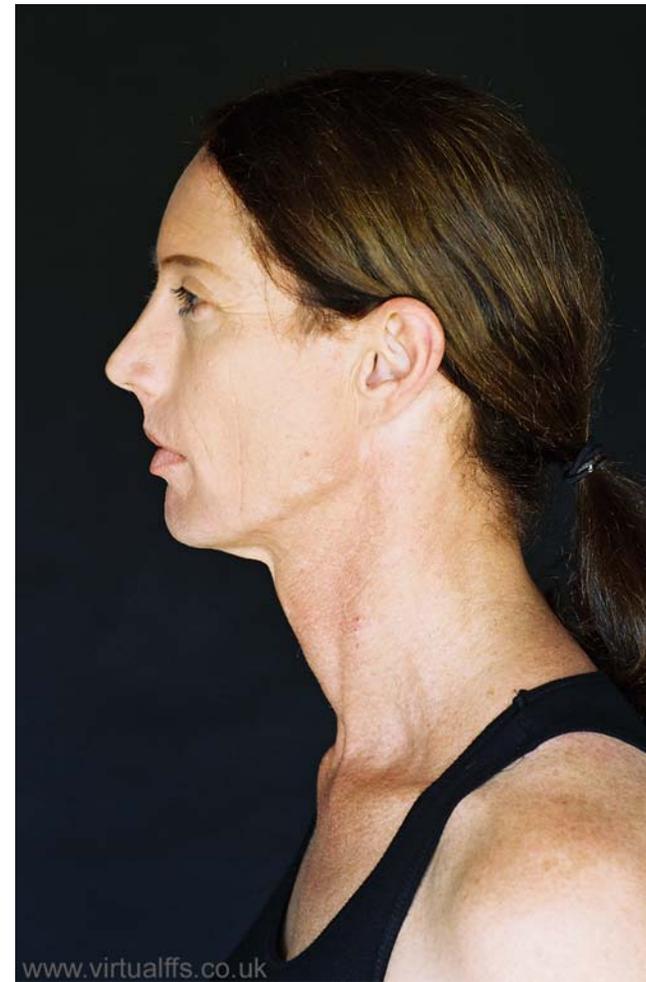
Artist's Conception by Audrey, "Virtual FFS" <http://www.virtualffs.co.uk/> August 2006

Current and Projected Appearance after
Facial Feminization Surgery: Jennifer Milburn August 2006



Before

Photographed July 31, 2006 Hollywood, California



After

Artist's Conception by Audrey, "Virtual FFS" <http://www.virtualffs.co.uk/> August 2006

Current and Projected Appearance after Facial Feminization Surgery: Jennifer Milburn August 2006



Before

Photographed July 31, 2006 Hollywood, California



After

Artist's Conception by Audrey, "Virtual FFS" <http://www.virtualffs.co.uk/> August 2006

Current and Projected Appearance after Facial Feminization Surgery: Jennifer Milburn August 2006



Before

Photographed July 31, 2006 Hollywood, California



After

Artist's Conception by Audrey, "Virtual FFS" <http://www.virtualffs.co.uk/> August 2006

Current and Projected Appearance after Facial Feminization Surgery: Jennifer Milburn August 2006



Before

Photographed July 31, 2006 Hollywood, California



After

Artist's Conception by Audrey, "Virtual FFS" <http://www.virtualffs.co.uk/> August 2006