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Endocrinology, 'Transsexual Agency', and the Boundaries of Medical Authority

In 1954 the *Daily Mirror* announced that 'war time fighter pilot, motor-racing ace and father of two children' Robert Cowell, had 'changed sex' three years previously.[2] Hormones and genital surgery had altered Cowell's body, and Robert had become Roberta. Cowell is now often cited as one of the first British transsexuals, in spite of the fact that her sexual transformation occurred 'without the label "transsexual", years *before* this category had come into circulation'.[3]

This article seeks to build on – and complicate – existing histories of transsexuality. Historical scholarship on the subject presents (in the main) two competing narratives; one that looks to changes in medical technology, and another that underlines the importance of 'transsexual agency'.[4] The former argument is most closely associated with Bernice Hausman. The emergence of transsexuality in the mid-twentieth century is explained, according to Hausman, by developments in medical technology, specifically plastic surgery and endocrinology.[5] Proponents of the second major scholarly narrative, such as Jay Prosser, have loudly countered the suggestion implicit in Hausman's work – that transsexualism was medically led. Taking issue with Hausman's constructionist approach, Prosser's work depicts late-twentieth century transsexual persons as 'participants and actors' who shaped medical practices as much as they were shaped

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[2] *Daily Mirror*, 8 Mar. 1954, p. 8.
[3] Jay Prosser, 'Transsexuals and Transsexologists: Inversion and the Emergence of Transsexual Subjectivity' in *Sexology in Culture: Labeling Bodies and Desires*, ed. by Lucy Bland and Laura Doan (Cambridge: Polity Press, 1998), pp. 116-132 (p. 125).
[4] Jay Prosser, *Second Skins: The Body Narratives of Transsexuality* (New York: Columbia University Press, 1998), p. 8.
[5] Bernice L. Hausman, *Changing Sex: Transsexualism, Technology, and the Idea of Gender* (London: Duke University Press, 1995).

by them.[6] Prosser's work thus suggests a continuation of the narrative of patient agency that has been propounded by historians of early-twentieth century intersexuality.[7]

Focusing on the use of hormonal therapies utilized by British transsexual persons between the 1950s and 1980s, this article seeks to synthesise (to some extent at least) the seemingly incompatible narratives presented by Hausman and Prosser. An examination of transsexual endocrinology, a previously underexplored area in the history of medicine, complicates the 'agency' debate by suggesting that transsexual persons may have occupied a more complex and ambiguous position than previous scholarship suggests. It is hoped that the following analysis will offer some new insights into both the histories of sexuality and endocrinology, particularly to the histories of oral contraception and hormone replacement therapies.

The article begins with a brief discussion of intersexuality. Then, utilising primarily medical publications, the reasons why British physicians were initially unreceptive to the notion of medical intervention in cases of cross-sex identification will be examined, as will the effect this had when treatment was provided. Finally, with a specific focus on the memoirs of transsexual persons, the ensuing relations between clinicians and transsexual persons will be assessed.

A Note on Terminology and Pronouns

Terminology regarding sexual categories has changed a great deal over time, with multiple words often used to identify the same group. In the late-nineteenth century a number of sexologists published case studies of cross-gender identification. These early sexologists often considered such individuals under the broader rubric of "inversion", associated primarily with same sex attraction. In the early twentieth century sexologists such as Magnus Hirschfield and Havelock

[6] Prosser, *Second Skins,* p. 8.
[7] Geertje Mak, "'So we must go behind even what the microscope can reveal": The Hermaphrodite's "Self" in Medical Discourse at the Start of the Twentieth Century', *GLQ: A Journal of Lesbian and Gay Studies*, 11, 1 (2005), 65-94 (p. 70).

Ellis defined 'transvestism' or 'eonism' as an independent category that included cross-gender identification as well as cross-dressing.

Transsexualism, defined in part by the request for hormonal and surgical sex change, did not, however, appear as a medical category until the late 1940s and early 1950s, when American physician David O. Cauldwell and German-American endocrinologist Harry Benjamin first coined and then publicized the term.[8] Benjamin described transsexualism thus in his 1966 publication *The Transsexual Phenomenon*:

> The transsexual […] male or female is deeply unhappy as a member of the sex (or gender) to which he or she was assigned by the anatomical structure of the body, particularly the genitals […] These persons can somewhat appease their unhappiness by dressing in the clothes of the opposite sex, that is to say, by cross-dressing [...] But while 'dressing' would satisfy the true transvestite (who is content with his morphological sex), it is only incidental and not more than a partial or temporary help to the transsexual. True transsexuals feel that they *belong* to the other sex, they want to *be* and *function* as members of the opposite sex, not only to appear such.[9]

In current academic discourse the use of the term 'transsexual' is declining – although it remains a part of the vernacular. In the past twenty years the term 'transgender' has increasingly supplanted it as it allows for individuals to identify as "someone whose identity transcends the culturally sanctioned dichotomy", thus permitting greater flexibility regarding sex-role expression.[10]

While the article does not employ the modern term 'transgender', it should be noted that many

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[8] Joanne Meyerowitz, *How Sex Changed: A History of Transsexuality in the United States* (London: Harvard University Press, 2002).

[9] Harry Benjamin, *The Transsexual Phenomenon* (New York: Julian Press, 1966), p. 13.

[10] Alison Oram, 'Cross-Dressing and Transgender' in *The Modern History of Sexuality*, ed. by H. G. Cocks and Matt Houlbrook (Basingstoke: Palgrave Macmillan, 2006), pp. 256-85 (p. 257); Dave King, 'Gender Blending: Medical Perspectives and Technology' in *Blending Genders: Social Aspects of Cross-Dressing and Sex-Changing*, ed. by Richard Ekins and Dave King (London: Routledge, 1996), pp. 79-98 (p. 97).

of the individuals discussed in this paper might now be considered under this rubric, as they did not readily pursue anatomical changes with the view to aligning their sex with cultural standards of masculinity or femininity. Although the idea of 'sex change' was widely used in the popular press from the 1930s onwards, particularly following Cowell's transition, it does not accurately reflect the actual experiences of many late-twentieth century transsexual persons. Some individuals who identified as transsexuals in the late-twentieth century were content with modifying their body subtly with hormones; they did not feel obliged to surgically alter their body and genitals as Cowell had. Female-to-male transsexual persons were particularly unlikely to seek a full somatic transition, as phallic surgery was rarely satisfactory.

To deliberate in detail on each of the definitions mentioned is beyond the scope of this article. 'Transsexualism' will, therefore, be used as the sole term of reference henceforth in order to best represent the terminology used in medical and autobiographical sources between the 1950s and 1980s.

Finally, I think it is important to state explicitly how the transsexual persons that are mentioned in this work will be referred to. Today, as in the past, the English language is deeply gendered. As historian of sexuality Joanne Meyerowitz has commented, in 'current English usage, we cannot avoid labelling people as boys or girls, women or men'. Writing about people who have lived part of their lives as females and part as males thus presents some linguistic hurdles. For absolute clarity, this paper will follow Meyerowitz's example, using 'pronouns that accord with a person's public presentation of gender'.[11] For example, if someone lived and identified as a female, the pronoun 'her' will be used. This approach has already been adopted with regards to Roberta Cowell. Furthermore, it has become customary 'to designate transsexuals by the direction of [their] transformation' (male-to-female or female-to-male) so these terms will also be employed

[11] Meyerowitz, p. 13.

throughout the article.[12]

The Intersexual Precedent

The first transsexual persons used hormones to alter their bodily sex before the category of transsexualism was widely discussed in medical publications. Harry Benjamin's 1966 monograph was the first major work to discuss the possibility of physiological sex reassignment, and was published over ten years after Roberta Cowell 'changed sex'.[13] As a medical understanding of transsexuality did not exist at the time of Cowell's transition, she was required to articulate her sense of self using the cultural forms available to her, namely the rubric of intersexuality.[14] Intersexuality, or hermaphroditism as it was commonly referred to in the late-nineteenth and early twentieth centuries, was a commonly accepted medical diagnosis by the time of Cowell's sexual transformation in 1951. Coined in the early 1900s, the term 'intersexuality' was used to describe individuals with various physical conditions in which genitals or other reproductive organs did not conform to the standard dichotomy of sex.

As historian of sexuality Geertje Mak has suggested, British doctors commonly treated intersex patients using hormonal and surgical techniques that aimed to more fully align the individual's anatomy with a single sex. From the early twentieth century, which sex that was became unimportant. Sex hormones, first discovered by scientists in the late-nineteenth century, moved the biology of sex from the visible realm of the genitals to the microscopic gaze. Their existence indicated that sex was less apparent than it had previously appeared, and seemed to suggest that changing sex was a possibility. Once conceptualised as the 'chemical agents of masculinity and femininity', in the 1930s endocrinologists found, contrary to what was previously believed, that

[12] Colette Chiland, *Transsexualism: Illusion and Reality*, trans. by Philip Slotkin (London: Continuum, 2003), p. 23.
[13] *Daily Mirror*, 8 Mar. 1954, p. 8.
[14] Prosser, 'Transsexuals and Transsexologists'.

sex hormones were not 'strictly sexually specific in origin and function'.[15] In 1934 it was discovered by V. Korenchevsky (a scientist working alongside the Sex Hormones and Therapeutic Trials Committee) that the urine of both males and females contained 'not only the hormone specific for the respective sex, but also of the hormones of the opposite sex, or at least of a similar hormone often in about equal amounts'.[16] Essentially, Korenchevsky's findings suggested that female sex hormones could not only be found in females, but also in males. And male sex hormones were present in females as well as males.

The findings of Korenchevsky and others forced medical professionals to rethink the dualistic explanation of sex that had dominated medical opinion for years. The idea of maleness and femaleness as clearly defined endocrine states was discarded, and it became widely recognised that the concept of "true sex" was misleading.[17] This new definition of endocrinal sex marked a return to the pre-eighteenth century one-sex model that cast all humans as bisexual, or partly male and female. This new way of thinking about sex indicated that the delineation between bodily masculinity and femininity was flexible, and thus placed greater emphasis on gender. Mak has suggested that the re-emergence of the theory of human bisexuality, and its consequent emphasis on gender identity, encouraged physicians treating intersex patients to provide treatment 'on the basis of the patient's wish'.[18] So if an individual's sexual anatomy was predominantly male, but their 'sex-gender identity' was entirely female (and, importantly, they wanted their body to reflect this), British physicians were likely to use hormones and surgery to help develop the patient's feminine physiology. Intersex patients thus played a decisive role in their medical treatment.

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[15] Nelly Oudshoorn, 'On the Making of Sex Hormones: Research Materials and the Production of Knowledge', *Social Studies of Science*, 20 (1990), 5-33 (p. 7).
[16] Wellcome Trust Archive: PP/ASP/C.2, Sex Hormones Committee Minute Book 1930-34, loose in bundle, letter to Dr. Parkes from V. Korenchevsky, April 24 1934.
[17] Mak, p. 70.
[18] *Ibid.,* p. 66.

It is perhaps not surprising, therefore, that individuals such as Cowell used the discourse of intersexuality to articulate their desires to medical professionals – they hoped to be given a similarly decisive role in their sexual transformations. By utilising the precedent set by intersexual treatment, individuals such as Cowell justified their unconventional usage of hormonal technology, and influenced subsequent medical practice by creating an implicit link between the treatment of intersexuality and transsexuality. When the medical category of transsexuality was formalised in the 1960s, British doctors' approaches to their transsexual patients were heavily influenced by their knowledge and experience of intersex patients. Indeed, intersex and transsexual patients were often treated alongside one another at Charing Cross Hospital.

Prosser has suggested that the appropriation of intersexual discourse by early transsexual pioneers such as Cowell speaks volumes of early transsexual agency. This seems like a fair assessment. It is clear that individuals such as Cowell played a significant part in their sexual transformations, perhaps suggesting that the stories of early transsexual pioneers should be viewed alongside histories of intersexual agency. In the years shortly after Cowell's transition, however, the opportunities available for transsexual persons to actively shape their hormonal treatments became increasingly limited. Although there were some openings following the official medical recognition of transsexuality (notably the black market), access to hormonal technologies became frequently mediated by medical professionals.

Medical Reluctance to Recognize Transsexuality

In spite of the fact that individuals such as Cowell had utilised sex hormones for the purpose of sexual transformation in the 1950s, transsexuality only became recognised as a discrete diagnostic category by the British medical establishment in the 1960s. In the 1960s the British doctors and scientists who studied transsexuality began to organize programmes, conferences and associations to promote the study of and potential treatments for transsexual patients. In spite of

this apparent medical recognition, transsexual patients remained the "step-children of medicine" for several decades; there was 'no place for them'. They were 'often sent from doctor to doctor, each one trying to get rid of them as quickly as possible'.[19] Although Lennox Broster and his colleagues had been providing surgical and hormonal treatment for intersex patients at Charing Cross Hospital from the 1930s, and occasionally treated transsexual patients during the 1960s and 1970s, no formal unit specialising full time in the treatment of transsexuals existed in the United Kingdom until the 1980s.[20]

There were significant internal disputes regarding the merits of medical intervention in cases of cross-sex identification. Many British practitioners were initially unreceptive to the notion. Indeed, a study published in the *British Medical Journal* in 1966 that intended to assess professional attitudes towards sex transformation procedures found that only '9% of psychiatrists, 6% of GPs, and 3% of surgeons' would agree to actively assist transsexual patients.[21] The reluctance of physicians to approve a patient's request for sex transformation procedures in the 1960s and 1970s may be ascribed to a preoccupation with gender normativity coupled with concerns about inadvertently causing disease.

Mirroring wider contemporary medical concerns regarding hormonal intervention in otherwise healthy individuals (the idea that contraceptives might cause cancer dogged the reception of the contraceptive pill), the pages of medical journals and lay publications alike discussed the fear of inadvertently causing disease in transsexual patients undergoing hormonal treatment.[22] A 1968 article in the *British Medical Journal* noted, for instance, the increased risk of breast cancer in male-

[19] Harry Benjamin, 'Transvestism and Transsexualism in the Male and Female', *Journal of Sex Research,* 3 (1967), 107-27 (p. 126).
[20] Dave King and Richard Ekins, 'Pioneers of Transgendering: John Randell, 1918-1982', The Seventh International Gender Dysphoria Conference, <http://www.gender.org.uk/conf/2002/king22.htm> [accessed 17 December 2014].
[21] Richard Green and others, 'Attitudes Towards Sex Transformation Procedures', *Archives of General Psychiatry*, 15 (1966), 178-82 (p. 180).
[22] Kate Fisher, *Birth Control, Sex, and Marriage in Britain 1918-1960* (Oxford: Oxford University Press, 2006).

to-females after treatment with female hormones.[23] Hypertension and 'blood clots' were also reported as potential side effects.[24] Female-to-males also faced increased risks of certain diseases, such as heart disease and liver damage. Medical practitioners thus pondered whether hormonal intervention was justified by the Hippocratic oath's primary tenet – do no harm.[25]

In addition to the question of ethical medical practice, it could also be argued that a preoccupation with heteronormativity affected some physicians' willingness to treat transsexual patients. In spite of the apparent sexual revolution of the 1960s, many medical men retained rigid views regarding gender roles and their expression, so may have been unwilling to treat transsexual persons who did not intend to conform to the culturally enshrined sexual dichotomy. Even practitioners who were actively involved in transsexual treatment appear to have been subject to such preoccupations – including the foremost medical specialist of sex transformation in Britain, John Randell. Randell, who in an interview with *The Times* in 1969 claimed that 'he had seen about 183 [transsexual and intersex] patients' in the previous twenty years, would likely have had at least some involvement with almost every transitioning individual in Britain between the 1960s and 1980s.[26] Indeed, all the memoirs of transsexual persons discussed later in this article mention Randell at some point.

In spite of his key role in the medical assistance of British transsexual patients, Randell was unwilling to surgically treat a large number of the individuals referred to him. Dave King and Richard Ekins, sociologists who have written widely on Randell's place in the history of transsexualism, have suggested that as few as 15 per cent of individuals referred to Randell

[23] W. St. C. Symmers, 'Carcinoma of Breast in Trans-Sexual Individuals after Surgical and Hormonal Interference with the Primary and Secondary Sex Characteristics', *British Medical Journal*, 2 (1968), 193-205.
[24] *The Guardian*, 30 Jan. 1980, p. 11.
[25] Anon, 'The Hippocratic Oath', *British Medical Journal*, 2 (1948) 616.
[26] *The Times*, 28 Jul. 1969, p. 2.

underwent a sexual transition with hormones and surgery.[27] Randell's medical publications further suggest that he was only willing to treat patients who would convincingly 'pass' in their desired sex role. This meant that British transsexual persons seeking medical intervention were required to conform to Randell's personal (traditional) views regarding gender roles. As he commented in a paper in 1969 regarding male-to-females, 'I think if they are going to be ladies they should be lady-like. Conformity… is surely what we are looking for.'[28] Randell's insistence that patients conform to gender normative standards of dress and mannerism indicates the continuing propensity of the medical profession to police normative boundaries, particularly those surrounding gender.

When treatment was provided it varied dramatically. No medical protocol existed regarding the treatment of transsexuality meaning that physicians had free rein to treat patients as they saw fit. As *The Times* reported in 1970: "It is for the doctor to decide what treatment is necessary in the interest of his [transsexual] patient."[29] As there was little consensus regarding the best mode of treatment, this meant that a plethora of therapies was employed and there was little uniformity. The absence of a clearly defined hormonal treatment plan for transsexual transformation may have been due in part to the fact that even by the early 1980s, no systematic study had been published regarding the effects of hormonal therapy in transsexual persons. British physicians who chose to treat transsexual patients with hormonal therapy between the 1960s and 1980s thus had no real precedent to follow in terms of what to prescribe and how to prescribe it. There was a bewildering array of options.

There were several different types of hormones available. Whilst female-to-males were

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[27] Dave King and Richard Ekins, 'Pioneers of Transgendering: John Randell, 1918-1982', The Seventh International Gender Dysphoria Conference, <http://www.gender.org.uk/conf/2002/king22.htm> [accessed 17 December 2014].
[28] John Randell, 'Indications for Sex Reassignment Surgery', *Archives of Sexual Behaviour*, 1, 2 (1971), 153-161 (p. 159).
[29] *The Times*, 21 Dec. 1970, p. 2.

predominantly prescribed testosterone, for male-to-females both oestrogen and progesterone could be used. For each hormone there was considerable choice of what to prescribe, as different manufacturers produced hormones of different strengths and types using a variety of techniques.[30] Once a decision had been reached about the type of hormone to use, there were then several options available for physicians to advocate in terms of the administration of hormones. Some hormones were only available to administer in pill form, whereas others could be administered 'orally, intramuscularly or subcutaneously'.[31] Dosage was also widely variable. Whilst some endocrinologists favoured intensive hormone treatment, hoping to 'shock the body into transition' with 'massive dosages' and levelling these off once the patient's body had adjusted, others favoured prescribing smaller doses.[32]

Treatment of transsexuality in Britain clearly lacked uniformity, even after it began being widely discussed in medical publications in the 1960s. Several competing hormonal treatment plans were possible, and a lack of agreed medical protocols meant that many were utilized. This lack of uniformity suggests that even after transsexuality was recognized in medical circles, the medical profession did not monopolize what transsexuality 'meant'. As no consensus existed regarding the best mode of practice, transsexual persons in late-twentieth century Britain sometimes had opportunities to influence their treatment plans – sometimes, not all the time. Medicine acted as a mediator and gatekeeper of hormonal technologies; transsexual persons were not guaranteed the hormonal treatment they sought. Some physicians feared inadvertently causing disease, so were reluctant to prescribe large doses of hormones (if they prescribed any at all), and others (notably Randell) were only willing to provide treatment to individuals they felt would conform to traditional sex/gender roles. As the memoirs that form the basis of the next section make clear however, many transsexual persons endeavoured to challenge this medical hegemony by

[30] Benjamin, *The Transsexual Phenomenon.*
[31] Wellcome Trust Archive: PP/ASP/C.2, Sex Hormones Committee Minute Book 1930-34, Therapeutic Trials Committee, substance: 'Proviron'.
[32] Prosser, *Second Skins,* p. 1.

becoming experts on their diagnosis, and thus undermining the professional authority of medical practitioners. If all else failed, and they were denied the hormonal treatment they sought, some took their transformations into their own hands, choosing to take hormones bought on the black market outside of medical purview.

Medicine: A Gatekeeper of Gender?

Although the modern language of transsexuality suggests the ultimate power of medicine – transsexual persons are often classified as 'preoperative' before surgery, and 'postoperative' after, thus defining transsexual persons by their relationship to the activities of the surgeon – such language overstates the dominance of medical practitioners.[33] Indeed, dynamic and complex relations existed between clinicians and transsexual persons in late-twentieth century Britain. The complex nature of patient-practitioner relations has often been attributed to the knowledgeability of transsexual persons. Both self-knowledge of one's own sex/gender identity and detailed medical knowledge of hormonal treatment options allowed transsexual persons significant bargaining power in the clinician's office. Transsexual persons were able to negotiate with clinicians in a way that many other patients were not.

From the point of view of the physician, 'medical examinations and psychological tests could determine a person's sex and verify a person's gender identity', but from the point of view of their patients, sex and gender were 'usually matters of self-knowledge'.[34] Indeed, from 1989, following The Resolution of the European Parliament regarding transsexual diagnostic criteria, the importance of "self-diagnosis" became underlined in law.[35] Although it had been advised as early as 1969 by Harry Benjamin, from 1989 transsexual diagnosis in Britain became based solely on the patient's life history – by their 'showing cross-gender identity from earliest childhood [and

[33] Morris Meyer, 'I Dream of Jeannie: Transsexual Striptease as a Scientific Display', *The Drama Review*, 35 (1991), 25-42 (p. 37).
[34] Meyerowitz, p. 6.
[35] Colette Chiland, *Exploring Transsexualism*, trans. by David Alcorn, (London: H. Karnac, 2005), p. 30.

in later life] […] by their pronounced emotional rejection of their genitalia and their secondary sex characters, and also by their insistence upon a surgical trans-formation'.[36] As historian of sexuality Colette Chiland has suggested, the role of physicians thus became limited 'to helping patients to make their own diagnosis and to confirming this'.[37]

Although some, such as female-to-male transsexual Raymond Thompson, 'never really wanted to talk or read about […] [their] condition', many transsexual persons 'read widely in the medical literature'.[38] It was thus possible that transsexual individuals might know more about hormonal treatment options than the physicians that they encountered. This is, undoubtedly, the reason why the personal memoirs of transsexual persons who transitioned in the late-twentieth century often adopt the theme of medical incompetence.

Julia Grant's autobiography, detailing her experiences as a male-to-female transsexual in the 1980s, gives just one example of this narrative trope. Grant's memoirs document her sense of bewilderment following her first appointment with her doctor, John Randell, at the Charing Cross Gender Identity Clinic. She recalls in *Just Julia*: 'I hadn't really learned anything new in the interview, and hadn't been given any advice. I presumed I had to make my own way, hoping I did the right things'.[39] Grant's memoirs record similar sentiments regarding her second appointment eight weeks later:

> As usual his three students looked on; I answered questions, was patted on the head, given another prescription and left his office having learnt no more than I'd known when I entered. The doctor had drained me of information but given me no advice.[40]

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[36] Harry Benjamin, 'Newer Aspects of the Transsexual Phenomenon', *Journal of Sex Research,* 5 (1969), 135-41 (p. 140).
[37] Chiland, *Exploring Transsexualism*, p. 30.
[38] Raymond Thompson with Kitty Sewell, *What Took You So Long? A Girl's Journey to Manhood* (London: Penguin, 1995), p. 94; Meyerowitz, p. 6.
[39] Julia Grant, *Just Julia: The Story of an Extraordinary Woman* (London: Boxtree, 1994), p. 203.
[40] *Ibid.* p. 209.

Although the argument could be made that memoirs such as Grant's overstate criticisms to serve a certain narrative purpose (namely the incompetence of the medical profession), the force of her criticism suggests that such beliefs were deeply held; such conviction is surely worthy of historical acknowledgement.

Not all transsexual persons experienced as little professional guidance as Grant. A handful of medical practitioners were incredibly knowledgeable on the subject of sex transformation. Caroline Cossey, a male-to-female transsexual who rose to fame in the 1970s as a model and actress under the name of Tula, felt that she was provided with a great deal of helpful information by her physician. Cossey's autobiography documents her experience with a doctor at a consultancy on Edgware Road:

> He wrote me out a prescription for hormone tablets. He explained that these would develop my breasts but that, if I wanted to, I could go further, I could have a complete sex-change operation.[41]

Her physician's insights were instrumental in Cossey's determination to embark on a full somatic transition, with hormones and surgery. In Cossey's case, the medical profession thus wielded significant influence.

Cossey's experience seems, however, to have been uncommon. In many instances the expert knowledge of transsexual persons destabilized the traditional patient-practitioner relationship in which the latter assumed professional dominance. According to expert on female-to-male transformation Leslie Martin Lothstein, many transsexual persons placed 'enormous pressure on the medical establishment to provide them with hormones'.[42] Indeed, in an interview that appeared in *The Observer* in 1974, Randell stated that most transsexual persons 'demand[ed] an

[41] Caroline Cossey, *I am a Woman* (London: Sphere Books, 1982), p. 44.
[42] Leslie Martin Lothstein, *Female-to-Male Transsexualism: Historical, Clinical and Theoretical Issues* (Boston: Routledge & Kegan Paul, 1983), p. 289.

operation at their first interview with him'.[43] Randell's reaction to female-to-male Raymond Thompson's requests on first meeting further support this contention. Thompson's autobiography records the event:

> He [Randell] looked at me quietly for a while and then said, "Now, what do you want me to do for you?"
>
> "Just help me!" I implored him.
>
> He looked at me more closely and after a while he said, "Well, I have never had it put to me quite like that before […] I usually have people coming in here and telling me that they want this done and they want that done."[44]

Randell's surprised response is telling of the usual conversations that he had in initial meetings. Transsexual persons, it seems, had often made informed and specific decisions before consulting a physician such as Randell.

Medical practitioners did not, however, always agree and act upon these decisions. Julia Grant's autobiography recalls the fraught meeting with John Randell in which she admitted using hormones bought on the black market:

> I then upset the doctor for the first time. I admitted to being on hormone tablets that I had bought on the black market, he stuttered […] and then agreed to give me a prescription. I had been on six five-milligram Stilboestrol tablets daily. He prescribed me three 2.5 milligram tablets [of Premarin].[45]

Grant, who had used her knowledge of transsexual hormonal treatments to obtain and use hormones outside of medical purview, was convinced to alter her treatment plan after meeting with Randell, suggesting that her knowledgeability did not ultimately alter the traditional power dynamics between patient and practitioner.

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[43] *The Observer*, 28 Apr. 1974, p. 30.
[44] Thompson with Sewell, p. 100.
[45] Grant, p. 203.

The memoirs of transsexual persons present a complex narrative. A shallow reading of texts, such as Grant's *Just Julia*, seems to suggest a straightforward narrative of medical incompetence, transsexual knowledge and agency, and, ultimately, patient empowerment. Considered in light of the medical sources examined in the previous section, however, the ambiguous status of such memoirs is revealed. Although transsexual persons, such as Grant, were often actively involved in their sexual transformations, they were not always able to use hormonal technologies in the way they wanted. While the expert status of some transsexual persons allowed them to enter into negotiations about their treatment plans in a way that was uncommon in the late-twentieth century, these did not always end favourably, as in Grant's case. Medical professionals, such as Randell, ultimately mediated access to the technologies of sex change; they had the final word when transsexual persons sought treatment through official medical avenues.

Use of hormones outside of medical purview, as Grant had done before meeting with Randell, was not uncommon, however. Medical practitioners recognised that transsexual persons, such as Grant, sometimes self-medicated with hormones bought on the black market as early as 1966. An article in the *British Medical Journal* noted that by the time male-to-females sought medical help facial hair was often reduced, and the testes were likely to be 'atrophic', lending them an intersexual appearance.[46] It seems that some individuals actively sought to present themselves as intersexed, in the hope that this would encourage otherwise reluctant medical professionals to provide them with further hormonal and surgical treatments. Whilst taking hormones outside of medical purview is often framed positively in transsexual memoirs, it highlights the vulnerability of many transsexual persons. As noted in the previous section, hormonal intervention in otherwise healthy transsexual persons increased risks of breast cancer, liver damage, and heart disease. Taking hormones (of often questionable quality) without consulting medical

[46] Anon, 'Transsexuality', *British Medical Journal,* 1 (1966), 873-74 (p. 874).

professionals was not, therefore, without risk, a factor that is rarely acknowledged in transsexual memoirs.

Conclusion

The history of transsexuality engages a number of key themes of the twentieth century. It illustrates the rise of a new concept of the modern self (a concept that placed heightened value on self-expression and self-knowledge) and, as Meyerowitz has suggested, 'offers a new angle of vision into the breakdown of traditional norms of gender'.[47] The history discussed in this article, on the place of endocrinology in sexual transformation, complicates one of the most dominant themes – that of patient empowerment. The uses of hormonal technology by transsexual persons and medical practitioners do not suggest a straightforward narrative of 'transsexual agency', as described by Prosser, or a history of patient passivity, as implied by Hausman's analysis.[48] The position of transsexual persons in late-twentieth century Britain was rather more ambiguous, suggesting a break with the tale of patient empowerment that has been told of intersex patients in early-twentieth century Britain and with that of early transsexual pioneers, such as Cowell. While transsexual persons were often actively involved in their sexual transformations, they were not guaranteed the hormonal treatment they sought. As no medical consensus existed regarding the best mode of practice, knowledgeable transsexual persons in late-twentieth century were in a stronger position than most patients to negotiate with medical professionals, and thus influence their treatment. Ultimately, however, medical professionals such as John Randell mediated access to hormonal technologies.

The history discussed in this article demonstrates the boundaries of medical authority and the limits of patient agency in late-twentieth century Britain suggesting that the theme of

[47] Meyerowitz, p. 9.
[48] Prosser, *Second Skins*, p. 8.

straightforward patient empowerment that has dominated many recent medical histories may require reconsideration. One final note: it is important to remember that the history of transsexuality is a distinctly 'human history'.[49] As Meyerowitz has astutely commented:

> They were either symbols, emblems detached from social milieus, nor heroes or villains engaged in mythic battles to further or stifle progress. They were instead ordinary and extraordinary human beings who searched for workable solutions to pressing personal problems.[50]

Their stories illustrate the complexity of patienthood in late-twentieth century Britain.

[49] Charles Rosen, 'Levels of Integration in Medical Historiography: A Review', *Journal of the History of Medicine and Allied Sciences*, 4 (1949), 460-67 (p. 465).
[50] Meyerowitz, p. 13.

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