special feature . . .

The bulk of this interview took place at the Southern Comfort Convention in Atlanta, Georgia, on 6 October, 1991, and was later transcribed from tape. Dr. Gilbert was also furnished with a subset of written questions, to which he responded after some thought. His written answers have been integrated with his spoken answers.

An Interview With David Gilbert, M.D.

by Dallas Denny & Margaux Schaffer

Dr. David Gilbert is a plastic surgeon and microsurgeon who is co-founder of The Center for Gender Reassignment in Norfolk, Virginia. His wife, Deborah, is a registered nurse, and Coordinator of the Center. Plans were to interview both Dr. and Mrs. Gilbert at Southern Comfort, but Mrs. Gilbert became ill shortly after arrival, and was still under the weather on Sunday afternoon, the last possible time for the interview. Dr. Gilbert, who was obviously worried about his wife, nevertheless gave us what we believe to be the finest interview on sex reassignment surgery which has ever appeared outside, and perhaps inside, the pages of a medical journal.

Lisa Richard, the Assistant Coordinator of The Center for Gender Reassignment, was present and participated in the interview, which took place in the empty room in which Dr. Gilbert had earlier given a presentation, complete with slides of his surgical results.

CQ: How did you get involved in working with transgendered men and women?

Dr. Gilbert: The Norfolk experience in genital and urinary reconstruction dates back twenty-five years. When I moved to Norfolk to start my plastic surgery practice, one of the interests I had was in genitourinary reconstruction. My initial experience was with congenital and traumatic genital deformities. As we developed the techniques to reconstruct the male and female genitalia, we began to apply our reconstructive philosophy and techniques to the gender patients. Many of our techniques were developed in Norfolk.

At that particular time, several things were coming together. One was advancements in genitourinary reconstruction. We were constantly developing and evolving techniques. At the same time, the concept of microsurgery was coming into play. We combined those two things, pioneering the use of microsurgical techniques with genitourinary techniques. We had been doing penile reconstructions on little boys who had been born without a penis, and on men who had lost their penises. I had always felt that the gender patients were part of the group that could benefit from this particular type of surgery, and from our expertise. What we learned about the genitourinary patients we sort of transposed to the transgendered population. Soon we were doing a lot more of the gender patients.

For the past five of six years, the mainstay of our practice has been the female-to-male patients, but lately we've seen a lot more male-to-female patients, to the

point that we now see them in equal numbers.

CQ: When and how was the clinic established?

Dr. Gilbert: We'd been doing the surgery since the late seventies, but the program and the committee were, quite frankly, sporadic. When I got my wife, Deborah, involved in my practice, she came to a couple of these gender committee meetings. She said it was a date— one of our first dates was going to a committee meeting. It was after we had worked in the operating room together. She became so enthused about the gender reassignment and so interested in it that when the person who had held the position previously was retiring, giving up coordinating the gender program, he handed over all his charts to her, and she really jumped in and bit off a big chunk. She was the one who developed the concept of and named The Center for Gender Reassignment. That was back in 1984.

CQ: So the Center has been in operation for seven or eight years?

Dr. Gilbert: Yes. We began to get a lot of enthusiasm from a group of professionals there, urologists who had worked with us on genitourinary reconstruction, and the psychologist Jerry Ramsey, who had been there for a long time. We got involved with the gynecologists and endocrinologists. Mrs. Gilbert and Lisa, her assistant, really began to coordinate things and get interested in transgendered patients.

I'm very pleased that this enthusiasm has remained, and that all of the professionals involved have steadfastly supported the committee.

CQ: John Money is very concerned with what he calls the antisexual forces. Has your work with transgendered men and women drawn any criticism?

Dr. Gilbert: No, it hasn't. We don't seek to draw any flak, but we feel we wave the flag pretty strongly, and we have not drawn a lot of negative criticism, directly, or overtly.

CQ: The literature is filled with descriptions of transgendered persons as having a lot of psychopathology in addition to their gender dysphoria. Has that been your experience?

Dr. Gilbert: It hasn't. My personal experience— and I'm not a psychologist, and I don't test people— my own personal experience is that transgendered patients are no different from people out in the street.

Lisa Richard: Because they've had to look so inward, they seem to be more in tune with life. Most people don't have to look so inward as transsexuals do. That's our experience.

Dr. Gilbert: That's true. I agree with what Lisa said. I think that the transgendered patients are the most honest people, because they've had to face a lie of nature. They've had to face the fact that they are not what they seem. They are not what they look at when they see themselves in the mirror. And to be able to answer that in their own mind, I think, requires a lot of strength.

CQ: One of the problems in treatment has been that many transgendered people, being desperate, have been, as Anne Bolin pointed out, sometimes less than honest when they present for treatment. Do you have that problem with people perhaps trying to cover up medical disorders that they might have because they think it might negatively effect their chances for surgery?

So You're Thinking About Taking the Big Step...

What the Prospective Patient Needs to Know About The Center for Gender Reassignment

CQ: Tell us about your services.

Dr. Gilbert: The Center is a loose association of medical professionals from several different specialties. The Center includes a gender coordinator, an assistant coordinator, a plastic surgeon, urologists, a gynecologist-and-endocrinologist, and psychologists. The Center is committed to the goal of successfully, surgically converting transgender patients to their desired gender.

CQ: What is the best way to contact you?

Dr. Gilbert: Just write or call us.

CQ: What are the initial requirements?

Dr. Gilbert: The initial requirements include establishing a chart and filling out the standard transgender questionnaire. In addition, there is a fee for printing, publishing, and processing this questionnaire.

CQ: What information do you need?

Dr. Gilbert: Information that is important to anyone inquiring about the Center includes:

— the patient's name
— the patient's chromosomal gender
— the gender of choice
— how long has the patient cross-lived?
— is the patient on hormones?
— is the patient in psychotherapy, and if so, for how long?
— has the patient had any previous surgery or therapy?
— what are the goals of the patient?

CQ: What should prospective clients not do?

Dr. Gilbert: Anyone who is interested in transgender surgery must not smoke or use illicit drugs. The patient must be in two years of ongoing crossliving and cross-occupation in the gender of choice. If patients have a history of thought disorder, they are ruled out as being a credible candidate for surgery.

CQ: Sex reassignment is an expensive proposition. I understand that you have made a provision for a medical line of credit for your patients.

Dr. Gilbert: Associated Management Services, a subsidiary of The American Society of Plastic and Reconstructive Surgeons, and Household Retail Services, Inc., was developed exclusively for members of the Society and their patients. This Associated Management Services Personal Equity Service was developed to aid patients in receiving financing for proposed surgery. Although these financial services were designed with potential surgical patients in mind, it is organized along the same lines as any other financial institution.

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Dr. Gilbert: The way we're set up, and the way that we interview patients is such that I don't think we've been deceived by many people for too long. How I would embellish that is to say that our gender day is a very aggressive free-for-all, where there is a lot of give-and-take between the physicians and the patients. I think the patients pretty much have to come clean by being interviewed by a large battery of professionals over a short period of time. Anybody can keep a lie together for an hour or two. It's really dependent upon a patient's local psychologist and local physicians being able to evaluate the patient. We do not profess to be able to know what a patient is like within the hour we see them, although we feel that we get a pretty good idea. I do know patients who have deceived some other physicians, and they quite frankly admitted to us, "Well, I told the doctor that I just had some gynecomastia. He never examined my genitals." "I told the doctor I had heavy bleeding; that's how I got my hysterectomy." But as a rule, I think that the patients, over time, have been pretty honest with us.

CQ: I've read in the literature that at one point diabetes was considered an absolute contraindication for surgery. Would you talk about a couple of diseases— diabetes, perhaps, and HIV disease, and how that impacts the decision about surgery?

Dr. Gilbert: I think that all of these have to be taken on an individual case basis. The fact that you have a patient who is HIV-positive versus their transgenderism— basically, you have to decide, along with the patient, along with all the input you can get, where is this patient vis-a-vis both of these life problems. It has to be individualized from that point of view. Which is going to be more important? Which is going to impact the patient initially? Long-term? I think you have to take it on that basis. The same with any illness— diabetes, or chronic heart disease. If a patient basically is healthy other than having this particular disease process, and has the disease process well-controlled over a long period of time, then conceivably they would be candidates for the surgery. If they are uncontrolled— if they have a disease process that is only going to get worse, or if they aren't taking care of themselves— then that might mitigate against the surgery.

CQ: Is there something that the treatment team can do, aside from taking even more precautions than normal, to protect against transmission of HIV during surgery?

Dr. Gilbert: I am a general plastic surgeon. I treat patients on an emergency basis. I take calls at the hospital. I treat patients on an urgent basis, and on an elective basis. All of those have an input about whether I will treat a patient who is HIV-positive. It's my ethical duty to take care of patients on an emergency basis. If it's a more elective situation, then I have a choice. But in fact, any type of precautions that would be used for any patient need to be carried out. In this day and age, you have to assume the worst about any situation. We take a lot of precautions with every patient.

CQ: How many male-to-female genital surgeries have you done? And would you please describe the relative advantages and disadvantages of the use of bowel segments in vaginoplasty? What technical improvements do you see in store for vaginoplasty?

Dr. Gilbert: We have done several male-to-female genital surgeries within the past five years. Within the past two years, we've begun to utilize the sigmoid colon as donor source for our vaginoplasties. The sigmoid colon is vascularly predictable and provides an excellent replicate for the vagina. Colon segments do not require the continuous stenting that split thickness and full thickness skin grafts have required in the past. They do, however, require daily dilation, at least initially, in order to prevent any introital stenosis.

The sigmoid vaginoplasty is something that we think has made a contribution. We are favoring it more and more. We pretty much discuss this with all of the patients who are ready for the definitive male-to-female surgery. That's not to say that the other techniques for vaginoplasty— skin grafting and so on, don't have a place— they do. It's nice to have another option.

CQ: How about some of the complications that are indigenous to that particular method— colitis, Crohn's disease, and HIV transmission?

Dr. Gilbert: There are things that would mitigate against the surgery, and in fact, one patient asked me yesterday about colitis. I think you would have to consider very carefully whether a patient with colitis would be a good candidate. The HIV may be a factor. And the fact that we are taking a piece of bowel out and then rejoining the bowel is a potential complication. But overall, we've been pleased with the results in the time that we've been doing it. It's not a new procedure. Using bowel to make the vagina has been used since the turn of the century by some Europeans surgeons. So this is not a new procedure; it's a reintroduction of an old principle. The bowel has its place, and there are some technical drawbacks which sometimes make it more difficult.

I think that the transgendered patients are the most honest people, because they've had to face a lie of nature. They've had to face the fact that they are not what they seem. They are not what they look at when they see themselves in the mirror. And to be able to answer that in their own mind, I think, requires a lot of strength.

CQ: Do you construct a clitoris?

Dr. Gilbert: At the present time, we are working on developing construction of the clitoris from the penectomy segment. These clitoral reconstructions include preservation of the dorsal neurovascular bundle so that the resultant clitoris has some of the erotic sensitivity that the penis previously had. In addition, we are continuing to work on improving the aesthetic of the reconstructed female perineum.

CQ: Would you speak about undesirable results of both male-to-female and female-to-male surgeries? What are the complication rates?

Dr. Gilbert: Both female-to-male and male-to-female genital surgery should be considered as major surgery in every sense of the word. One of the problems that gender patients and their physicians get into is trying to cut corners, particularly if the patient is paying for all of the surgery and hospitalization. Gender surgery should be considered as a major surgery with all of the complications that are attendant in any surgery: hemorrhage, infection, scarring, poor results,

urethral cutaneous fistulae, urethral stenosis, pulmonary emboli, urinary infections, and bowel infections are all potential complications. Fortunately, our major complication rates are minimal and I directly attribute this to the professionalism of the surgeons involved. All of the surgeons at The Center for Gender Reassignment have had long experience with transgendered patients. This accounts for our low complication rate. However, I do warn all of my patients prior to surgery that there is a possibility that they will require some kind of "touch-up" surgery in order to maximize the functional aesthetic result.

CQ: How often do you confer with other professionals, like Donald Laub, or Stanley Biber?

Dr. Gilbert: As you know, the Harry Benjamin meeting is every other year, and it is usually very well represented by surgeons doing a lot of this work. The Genitourinary Reconstructive Surgeons meeting is every year, and it is held in association with the American College of Surgeons, so I get a lot of exposure there to some of the other gender surgeons. We also share our experiences at the American Urologic Association meeting and the American Society of Plastic and Reconstructive Surgeons. So there are several meetings where I come into contact with professionals who are doing this same type of surgery.

CQ: On that same note, how much exchange is there of screening data? When you hold clinics, you're collecting a lot of data about people's histories, their physical characteristics. Do you get to exchange that kind of information with other clinics who are screening people, in order to get some insights into common correlations and secondary symptoms that manifest along with transsexualism?

Lisa: Most of the information we get is kept in the patient's file, and is used only for the patient and the doctor. If we were to share information, it would only be under the patient's consent.

Dr. Gilbert: That's true. Individual patients' files are the property of the physician and the patient. We have generated some papers out of our experience. We have begun to distill some of this information and impart it to others.

CQ: Is the individual's presentation— the ability to look viable in the gender of choice— a factor in acceptance for surgery, and if so, how much?

Dr. Gilbert: You're asking a subjective question.

CQ: I guess I'm thinking of an extreme case— someone who is obviously going to have problems— or maybe they have neglected some things they could do, like plastic surgery or electrolysis. Would that seem to be a relative contraindication? Yesterday, Lisa and I were talking, and she said that the answer at the Center was either yes, or not yet. Never no. Would that be a not yet?

Dr. Gilbert: Not yet, certainly. If a patient feels in their own heart that everything is squared away, then perhaps yes. To take an example— I don't mean to be glib— but to take the ugliest man and make him into the second ugliest woman in the world, I still think it would be worthwhile, everything else being equal. This patient is transgendered, and physical appearance may not be as important as feeling like a woman. When we interview patients, we question them. In fact, for a large percentage of patients, the first priority is that they want to "feel like a female." And that means completing the surgery.

The metadoioplasty converts a testosterone-enlarged clitoris into a small penis.

CQ: You are known for your female-to-male genital surgeries. How many have you done? Do you see female-to-male persons coming forth in increasing numbers?

Dr. Gilbert: At present, we have carried out more than fifty microsurgical phalloplasty reconstructions in the gender patients. This series is one of the largest in the world. We anticipate an increased number of female-to-male transgender patients coming forth in the future. In addition, we also anticipate an increase in our congenital and traumatic patient population coming forth and requesting phallic reconstruction.

CQ: Please tell us the advantages of the medial forearm flap in phalloplasty.

Dr. Gilbert: The forearm flap has been the best flap so far designed for phallic reconstruction. The flap is based on either the radial or ulnar artery and its vascular territory. The flap is usually thin, relatively hairless, well-vascularized, and has the potential to be molded from a flat swatch of tissue on the forearm to a phallus when it is transferred into the perineal area. In addition, the nerve supply to these flaps is usually anatomically and physiologically predictable.

The tissues that are borrowed from the forearm include the skin, subcutaneous tissues, arteries, veins, and superficial nerves. The muscles of the forearm and hand, the nerves to the hand, and the major blood supply to the hand are not interrupted, and therefore the risk of compromising hand function in minimal.

CQ: What is metadoioplasty, and what are its advantages and disadvantages?

Dr. Gilbert: Metadoioplasty, or genital plasty, was originally designed for patients who were unable or unwilling to go through a staged phallic construction or a microsurgical phallic construction. The metadoioplasty converts a testosterone-enlarged clitoris into a small penis. In this situation, the ventral chordee, or bend, of the clitoris is released in order to give it more length. At the same time, the short female urethra is turned forward and constructed out of the tip of the clitoris. The labia majora are then transposed posteriorly and joined in the midline as a scrotum.

This procedure has the advantages of not requiring the length of time, or the number of stages, or the microsurgical expertise required in order to construct a phallus by other means. The female genitalia are converted to their male analogues with a minimal amount of surgical maneuvering.

The disadvantages of this operation are in the final function of the clitoris-penis. The penis remains short and is likened to "a man just getting out of a cold shower." These patients may or may not be able to stand to void, and may or may not be able to have sexual intromission with their clitoris-penis.

The operative procedure may be recommended for elderly patients, or those who are unwilling or cannot undergo the more lengthy phalloplasty procedure. However, most of our patient population would prefer to have a larger and more dramatic phallic construction.

Metadoioplasty is, I think, a useful adjunct to the other surgical procedures. I think it's indicated in a certain percentage of patients, where a microsurgical

phalloplasty procedure may be contraindicated. Let me make a couple of explanations here. We believe that the surgery of choice— the optimum surgery of choice, the postmodern phalloplasty, consists of a microsurgical procedure carried out by skilled surgical technicians, usually two or three surgeons together, who work long hours to transpose tissues from one part of the body to the scrotum to make a phallus. It's never a God-given penis, but a phallus. However, not all patients are optimum candidates for this particular surgery. Although they may fulfill all of the Harry Benjamin Standards of Care, they are obviously not going to be good candidates for this particular surgery. At that point, we need a surgeon to decide if we can give these patients some kind of viable alternative. The alternatives are to transpose local tissues— skin and muscle flaps from the thighs, and the perineum, and the lower abdomen— areas around the groin, which will help to give a phallus, or to convert the clitoris into a small phallus— and that is known as a metadoioplasty. The term was introduced by Dr. Donald Laub. It's Greek, and I believe that his explanation was "conversion to male of the female parts." The metadoioplasty depends upon a tremendous amount of influence of depo-testosterone on the clitoris, so that it makes the clitoris grow to a point that it has the potential of becoming a small penis. It's been our feeling that if we're going to try to make a short penis that will be, say, three inches long, if we can get enough clitoris, then there would be potential to do the surgery.

This metadoioplasty will never replace a true phalloplasty as the optimum procedure. It is indicated in patients who are middle-aged or older, patients who are in poor health and could not tolerate a long and lengthy procedure, and perhaps patients who have little or no interest in using the genitalia sexually. In these cases, I think metadoioplasty has a place.

CQ: What about revision procedures that would enhance metadoioplasty? Has much work been done in terms of utilizing implants, or utilizing implants to improve upon it?

Dr. Gilbert: Yes and no. We have used scrotal implants in order to create a scrotum out of the labia. We have not yet used a penile stiffener to place in a clitoris. I don't think it is going to be possible, or worthwhile. I think that in order to enhance the metadoioplasty, there are limited things that can be done. Trying to lengthen it as much as possible is the best that can be done. Next step is to move other tissues from the thighs, such as the gracilis muscle flaps— and we have done that on several patients in order to elongate and make a neophallus on top of the metadoioplasty.

CQ: The past decade has brought considerable improvement in phalloplasty techniques. What are these advancements? What are the remaining difficulties, and what do you see happening in the next twenty years?

Dr. Gilbert: The two greatest advancements of the decade in phalloplasty construction are the utilization of microsurgical tissue transfers and neurolization— that is, the return to the flap of erogenous and tactile feeling. These advancements have allowed our patients to masturbate to orgasm, as well as to regain good sensory feeling to the phallus.

At the present time, we are modifying our urethral reconstructions, and our recent results have had many fewer urethral cutaneous fistulae and urethral stenoses. Over the next decade, I would like to see some development by the biomedical companies for a stiffener for the phallic patient population. At the present time, the penile stiffeners that are available have been designed for anatomic penises and are difficult to adapt to our reconstructed phalluses. Within the next twenty years, it is possible that we may be transplanting penises, much like we are now transplanting hearts, kidneys, and livers.

CQ: Do you see advanced imaging techniques as providing better preoperative planning and surgical management— such as utilizing scans to assess the exact anatomy of an individual? To help, for instance in the male-to-female, to minimize the chance of rectovaginal fistulae.

Dr. Gilbert: I think that in certain cases, imaging is important. I'm not sure imaging the pelvis, for example, is going to make a difference in how we decide to do our bowel or in the actual creation of a vaginal cavity. There are certain cases in which imaging procedures do help. And I'll give you an example. There are a certain number of patients who are not good candidates for microsurgical transfer of tissues because the blood supply of the forearm simply is not good enough to remove this piece of skin from the arm and risk hurting the hand. These are patients who we examine preoperatively with what we call an Allen's test. If the Allen's test is positive— if there is a concern or question about whether they have enough blood supply to the arm, we have to stop right there. Sometimes we'll do an angiogram to actually study the blood vessels. If the blood vessels are not good— are not normal types of blood vessels— if there is some kind of anomalous flow, that tells us that microsurgery is not indicated. It wouldn't help, and therefore, we have to go to some other kind of surgical procedure.

CQ: As a footnote, what exactly is the Allen's test?

Dr. Gilbert: The Allen's test is measuring the blood supply by pressing on the radial artery and ulnar artery to study whether there is enough blood flow into the hand.

CQ: To shift gears a bit here, a proverbial problem has been that people are lost to follow up postsurgically. Do you think that is improving? Do you think that people are more willing to be followed-up than has been common in the past?

Dr. Gilbert: I'll let Lisa start with that, and then I'll respond.

Lisa: As far as the patients that we have, they usually stay in the area after their surgery. We keep in fairly close contact. The patients who come and have surgery are part of our center, so we usually keep in very close contact. We have patients who write us five or six years postoperatively and tell us they just got married, and so on. And they do come back annually for their checkup, and if problems do occur, the first place they do call is us, and we get them taken care of right away. I think they've gone through it with us, and feel that we are part of us, and so they do come back and let us know how their life is going.

Dr. Gilbert: I would answer that question two ways. First of all, we always tell the patient that they are going to need follow-up surgery, because quite frankly, they are. Our goal is to do as much surgery in one sitting as is possible, but we often need to do some touch-up or cosmetic surgery following

the initial, or big surgery. And for that reason, we get to follow them fairly far out. Secondly, as you may understand, we run a fairly conservative program, and we are very conservative about who we select to operate on, so that we are very confident before we start to operate that these patients are going to be happy with their new genitalia. We know they're happy in their new lifestyle, because we follow them closely. We know that they're happy, having made the adjustment. All that needs to be done is the genital surgery. And when it comes down to that, yes, it makes it easy to predict that patients are going to be happy after surgery and follow-up. I've never had a patient say to me, "Boy, did I make a mistake. I wish I had never started this." And this comes from being very careful about who we select.

CQ: How many people do require revision surgery?

Dr. Gilbert: I've looked at that. I would say that of the patients who require revision, approximately 80% are fixed up with one revision surgery.

CQ: Are the insurance companies loosening up? Is it getting any better? Are they willing to not claim that reassignment surgery is cosmetic, to not claim that it is experimental? Lisa pointed out yesterday that insurance companies are always on the move. Are they on the move in the right direction, or the wrong direction?

Lisa: Any time they can get out of paying money, I feel that they will. We've had some insurance companies that have been wonderful and have not fought us tooth and nail. They've been very supportive of the person carrying the plan. I don't know enough about insurance companies to tell how they feel politically. I guess it would just depend on the individual insurance company. Those who are out to make money are not going to be supportive.

Dr. Gilbert: I would substantiate what Lisa has just said. I think that the insurance companies will try to hold onto their money for as long as they can, particularly in these tight-fisted times. It seems to me that every time we hear of a patient who has been approved for surgery by some insurance company, we get another patient that has been denied. It's a constant battle, a constant tug-of-war.

CQ: One peripheral issue we wanted to question you about is in regard to illicit silicone injections. We feel that it is a very serious issue. We are aware that a number of patients withhold information from doctors. What would you have to say to patients who are contemplating silicone injections, as far as to the fact that they think that they can fool you? What would you like to say to them?

Dr. Gilbert: I'm strongly against silicone injections. I think it's bad medicine, and I think it's terrible for patients to go through this. I have seen disastrous results from breast injections of silicone, with extensive operations required to correct the problem. They were very deformed after the surgery. I would actively dissuade patients from getting silicone.

CQ: You're a board-certified plastic surgeon. Would you like to elaborate on the ancillary procedures that you perform in relation to gender dysphoria?

Dr. Gilbert: I'd be happy to. We do a lot of aesthetic surgery on the gender patients, as well. You asked me earlier about imaging, and it brought to mind that we are using much more imaging with the facial cosmetic surgery— facial feminization, reducing the brow bone, reducing the chin, reducing the size of the jaw in the male-to-females. Those are things that we're doing now. We do a lot of rhinoplasty and tracheal shaves, otoplasty, which is ear-pinning, and even face lifts, and blepharoplasties, of course. These are all areas our program is particularly interested in. We do a lot of chest wall reconstructions on the female-to-male patients— breast reductions, chest wall reconstructions— and we do a lot of breast augmentation on the male-to-female patients.

CQ: What about the newer pectoral implants and the gluteal implants and the calf implants? Implants for men. Are these procedures you've had much experience with?

Dr. Gilbert: We've had experience with the calf implants and the pectoral implants. Particularly, I think, the pectoral implants have a place in some of the patients who are having their breasts reduced and getting chest wall reconstruction, either at the time of the breast reduction, or because they have some kind of complication or deformity from a prior chest wall surgery. I've stated that I have a particular interest in this area. I see a lot of patients who are scarred by surgery— mastectomy and chest wall reconstruction. I think that pectoral implants have a particular role in this area.

CQ: How about surgery for the male voice?

Dr. Gilbert: I don't do any voice surgery, per se. I work with an otolaryngologist who does some voice training, and he does do some voice surgery. Of course, it's much easier to deepen the voice than it is to elevate it. There are some surgeons who claim that they can elevate the voice, but they are very secretive about their methods.

CQ: Sex reassignment surgery has been called experimental in nature. In your opinion, is it experimental in a medical sense? In a social sense? Does it differ for male-to-female and female-to-male patients?

Dr. Gilbert: I do not believe that sex reassignment surgery is experimental in any way, shape, or form. The surgical procedures that have been developed and that are carried out for sex reassignment surgeries have undergone a long developmental process. The improvements in our techniques occur one stage at a time and are based on scientific hypotheses and facts. Most sex reassignment surgery is merely an adaptation of surgery that has already been developed for other medical problems.

In a social sense, I do not believe that sex reassignment surgery is experimental, either. Because of our high standards, we believe that all of our patients who are approved for surgery will be successful in their new gender role, no matter how the surgery turns out. In fact, it is very important to operate only on people who have totally adapted their lives to their new gender, rather than on those who hope that the surgery will convert their lives to the new gender.

There are some differences in male-to-female and female-to-male patients in a social sense. It appears to our committee that the male-to-female patients initially have a much more difficult time in adapting themselves to their new persona in society. However, postoperatively, we have found the same satisfaction in both groups of patients. ♀♂