INSUBORDINATION VERSUS IDENTITY: CHALLENGES OF A TRANSSEXUAL PSYCHIATRY RESIDENT

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REQUIEM BY BEI DAO (TO THE VICTIMS OF JUNE FOURTH)

Not the living but the dead
Under the doomsday- purple sky
go in groups
suffering guides forward suffering
at the end hatred is hatred
the spring has run dry , the conflagrations stretches unbroken
the road back is even further away

Not gods but the children
Amid the clashing of the helmets
Say their prayers
Mothers breed light
Darkness breeds mothers
The stone rolls , the clock runs backwards
The eclipse of the sun has already taken place

Not your bodies but your souls
Shall share a common birthday every year
You are all the same age
Love has founded for the dead
An everlasting alliance
You embrace each other closely
To the massive register of their deaths

I know it is unusual to start a lecture in medicine or psychiatry with a poem, however I believe that this poem is apt. It talks of the revolution of the democracy movement, which began in Tiannamen Square in Beijing in 1989, and of the dead there on the fourth of June of that year. It talks of suffering and hatred, and no revolution is won they say without blood spilled, nor with tears shed. I am a revolutionary, as the first transsexual and / or transgendered physician to get a medical residency " out of the closet ", every time and every element of my existence in the dual Internal Medicine and Psychiatry residency from the years 1995 to 2000 changed not only the medical world that I inhabited, but me as well. Since, all really great revolutions begin within, and then those of us who might have the courage, or be placed there in time, might begin to take the steps toward change. Change happens slowly, but it does happen, almost imperceptibly. I hope that my story about the challenges I faced in the residency help someone else. I am aware, that after the first, there comes a second, a third and then others. I know of at least two others now present in the APA in the United States, as well as Junior Doctors in UK, France, New Zealand – I dedicate my story to them, as well as to all of us courageous enough to be ourselves

Coming Out

I had struggled with the decision of "coming out" on interviews with Joy Schaffer MD, another transsexual physician on the West Coast for over a year. However, the decision was finalized once a former training director had decided to "out " me, whether I wanted it or not, and despite his promises to the contrary, and in such a way that could never be proven although the damage to my career was done. I had left his institution, where I had done an osteopathic rotating internship, having had death threats and sexual harassment done to me, during both my transition year as a doctor, from medical school to a physician with an unrestricted license, and from transition to woman from being a man. My parents and I fondly call my year of application, my " Year of Hell ", since I was unemployed as a physician, barely employed as a pharmacist, without any prospects for either. Finally, my mother encouraged me to apply again, this time " out of the closet ". My mother and I worked on sending out my applications, all 122 of them, to programs in Family Practice, Internal Medicine, and on a lark, Internal Medicine and Psychiatry. I really only wanted to be a medical doctor, and to practice medicine whether it be from an Internal Medicine or Family Practice perspective, it really did not matter. I only added IM / Psychiatry programs because in my " out " status, I was also proposing to integrate the two in terms of primary care for the transgendered. I got about 75 to 85 interviews, in about 5 different states, which I went on from mid November to Mid January. If the interviews were in the morning, I knew I would not be invited for lunch. If it were in the afternoon, I was asked why I had applied in a particular place. In one interview, I was asked about changing in women's' rooms as if that would be a problem, and when I stated that it would not since I had changed in them anyway, I got a look of shock. I was asked by one person on a panel for an FP Program, what I would do or say if one of them (a panel member) representing a patient would say that they were repelled by me, and the very idea of me. I was often asked why I had picked their particular program, and answered it with the fact that any program should accept me.

When I had to fill out my form for the Match, I could only fill out 11 of the 15 allotted spaces, despite the amount of interviews, since only those programs had given me even a smidgen of confidence of " possible " acceptance. I mailed the envelope out, certain of impending failure and doom, and ready to turn my hunt for a residency into a nationwide search the next year upon certain failure. Match day arrived, and I found that I had earned a place in a residency in Internal Medicine and Psychiatry at a program in Brooklyn, New York. I was heartened and had high hopes that there would not be a repetition of my experiences in the osteopathic rotating internship.

RESIDENCY

Year One

I had hopes that I would not be subject to the challenges that had plagued me during my transition year from male to female in my osteopathic rotating internship, because I had applied " Out of the closet ", and certainly all the programs would be preparing faculty and fellow residents, as to the differences and the dilemmas of the transgendered, and of myself in particular – that was my fantasy. My reality was that each time, from the first time when I was doing my medicine rotations in med/surg units where the rumor was going around that there was a doctor who had changed from man to woman, to the time that a division head, had repeated what was once said to me – " did not want my kind of people being doctors " and therefore gave me a failing grade in his rotation, by another internist at the hospital where I was previously an intern, it was looked upon as my own fault, since whatever damage control I tried to do , was not sanctioned by my residency directors (who essentially did crisis management) , and since I was only a trainee , what knowledge did I have that was relevant to the situation anyway.

When I went onto my first inpatient psych unit, I had to correct my attending for pronoun errors – calling me he instead of she, many times. This was done not only within the context of team meetings, but in other meetings on the unit as well. When my correction of the pronoun errors was brought up as an incident of insubordination, not only by the chief resident on that unit who repeated the same errors, but by my residency training directors, I knew I had to fight back. I went to one of my mentors who was a 3rd year resident, who told me to dress more " femme " so as to cause conditions, where she could not use gender ambiguity as a defense. My mentor also told me to " be paranoid ", because in a psychiatry residency, your attendings are not only doing MSE on patients, but on residents as well. I kept this knowledge in my stead, and always listened rather than reacted. Thus ended my pronoun problems, and the first instance where my own identity became an instance of insubordination

Second Year

Adolescent Boys Unit

Once Medicine ended, again as in previous years, transition came from an ICU/CCU Rotation to Psychiatry. I knew I was supposed to have my first 2 months be Child Psychiatry, but my team and unit were not specified. Since the Child Residency Training director was on vacation, and since I did not receive any input from my own psychiatry residency-training directors, I headed to the Child units myself, and was chosen by one of the attendings to go to the

Adolescent Boys Unit. I did not know that had the Child residency training director been present, I would have done the Latency unit instead, so as to minimize potential damage to the patients, and minimize disruption on the wards. I was immediately accepted not only by the Unit Chief, who as a woman, allowed me to share her office with her, but by the psychologists, art therapists, and other attendings on the unit, as well as the fellows. I was immediately assigned several patients and got to learning about them by studying the chart and listening to my attendings, as well as meeting my patients. All was good for my first month, and I easily had no difficulties although it was the normal stress of being a resident. It was easy for me to relate to the teenage boys since I could remember my own teenage years and readily identified with all of my patients. In my second month, there was a boy who came who had lived on the streets, and was familiar with the “street queens “, who “read me “, that is recognized that I was a transsexual. Well, everyone on the ward including myself was concerned about what to do. The unit chief asked me directly, I stated that I saw no need in hiding what I was, and since the psychologist was already teaching about sexuality, that it could be integrated into the boys' curricula. However, I asked that she give me time to do an in-service about the transgendered to all the staff of the Child units ASAP. It was agreed on, and I did at least two in-services of an hour each the following week for all the staff. It seemed to go well. We then waited. Finally, at a group rap session, a boy brought up my sexuality. I stated what I was, and that it was no different than being Hispanic, since I too had also experienced prejudice. Then came a few more questions, which I limited due to learning levels and my privacy, and then the rap session ended. The boys had no more questions. Funny thing was, it even helped me be even more accepted by them. I left there a much loved resident with a triumph to prejudice under her belt. Little did I know about Nursing Station 52 (hereafter known as NS52), and the dangers that lay ahead?

NS52

NS52, it is a typical nursing station name, but it still brings chills down my spine. When I was assigned to it, it was a mandatory second year inpatient rotation. All psychiatric residents had done the G53 rotation in the G Building of the County Hospital, which taught us how involuntary or locked wards operated, 2 PC and voluntary hospitalization, and of the particular laws which regulate mental health, as well as psychopharmacology, basic psychometrics and group protocols. NS52 was a completely different animal, a milieu unit at a time when group and individual psychotherapy and skills for psychiatric residents when such skills were not in demand. A strictly psychodynamic unit with multiple levels of supervision and training for different types of therapeutic milieus involved, as well as a ward itself which was undergoing change as a consequence of fiscal and managed care restraints from a voluntary ward with non violent patients, to a dual diagnosis or MICA unit ward, not unlike G53 with similar sorts of patients with multiple drug dependencies and violence in their histories. I was first invited to a

party about the loss of the old residents and the gaining of new residents in my last month of Child Psychiatry, and I handled it much the same way as any other resident. However, unbeknownst to myself, the supervisors – both psychology and social work, along with all the psychiatric attendings and the unit chief, including my own attending to be, had agreed that I had to disclose my sexuality and identity to all my patients. I was only made aware of this on my first day on the unit when I was greeted by the attending and then told what to expect. She outlined the rules for all three residents on her team, and then held me back, and informed me of the special conditions associated with me. Needless to say, I disagreed with her formulation and reasoning and specifically told her why and how, at least 3 separate times, but instead I was ignored and told to do my duty. I had been assigned only 4 patients that were specifically my own, and only told 2 of them that day – one of whom was a paranoid schizophrenic gay S/M man, the other a borderline polysubstance malingerer – each of which whom were surprised. The reasoning that was used to justify such action was if I met a disorganized or hebephrenic schizophrenic, they would not be able to differentiate body boundaries much less male versus female and this was a necessary reality test for my patients .It was also thought that my presence was more sexually provocative than another physician since all those gender issues in the " genderfuck " might show up, and that I would be more seductive to my patients as an object than a monogendered / nontransgendered therapist would be to those patients . My other patients a demented older woman, and straight paranoid schizophrenic with multiple somatic delusions were not informed. However, once I told the borderline patient, before too long the whole unit knew. At the same time this was occurring, parallel processing was occurring with other teams as well as with the nursing staff. No one knew how to deal with me, and because of it I was stigmatized. Needless to say my supervisory sessions were also challenging. My attending physician attacked me as " not looking feminine enough " or of being " too masculine " while she was one of the most " butch " straight women I had ever seen. This criticism led to increasingly diminished self confidence which inhibited my own ability to " Pass ", and leading to me being " read " on too many real life situations and thus at one point even physically endangered me. The Psychologist in charge of the milieu immediately told me that he disagreed with my presence on the unit (which was provocative), I told him I appreciated his honesty, since it was good to tell one's enemies from one's allies, which turned every interaction into a learned philosophical /political / psychological debate. The psychologist on my team, an isolated person who was more invested in academics than patient contact had prior to my presence formulated that I was a narcissistic personality who had done what I had done to seek the spotlight, with evolving borderline traits. Social work supervision was done by a social worker well experienced with the unit, who had taken my teams' psychologist formulation of me as gospel, and doubted I could do anything, while simultaneously my teams' social worker had stated to me on my first day of family therapy with

one of my new patients (the schizophrenic Gay S/M man) that I was going to" use my transsexualism as the focus for all my group and individual therapy ". When I heard that, I was post call and because of that and my heavy schedule that day in addition to the provocative statement hit the roof, and said that I had completed my own therapy having to do with transsexualism prior to coming to the program and that the focus of my patients' therapy would be their issues not mine, since that was what they were here for. After that, as well as my previous insubordination with my attending, my attitude was noted and was looked upon by all those who trained me at this place as proof that I was an "unstable / problem resident ", that since I was a " trainee ", I was unable to grasp the full significance of my actions and therefore more of a danger to patients. However, I looked upon it then, as I do now, that my identity at its very core was under attack by the very people who were said to be willing to safeguard it and me. I also looked upon it as crisis management, when situations did not go as they had formulated, and an unwillingness to see the trainees' side and experiences and validate them. These attacks continued. and were even used later by someone as a basis for their own attacks , since many of the distortions and prejudices of the permanent staff were used by the transient staff such as medical students , residents , psychological and social work interns , and art therapy / occupational therapy interns

It happened very innocuously. A note appeared in my mailbox in the main receptionist area (which patients were prohibited to be). The note contained a crudely drawn penis and a remark about my castration . When, I saw the note, I was apoplectic. I was "flashing back " to the death threats directed at me in my osteopathic rotating internship year. I hid my anger for about a half an hour, and then presented it to my attending, telling her what it was doing to me. I also told my psychological supervisor, whom I felt would be more sympathetic to my plight. They both went to the Unit Chief, who with asked me whether or not instances like this were a normal instance of working, and doing CYA by stating that possibly a patient had done it, when he knew that was in and of itself a false statement – in essence I was being blamed for a transphobic attack to me, by the very people who were there not only to train me, but to protect me as well. Discussions were animated in supervision with both my attending, as well as my psychological supervisor, notwithstanding the job of my own psychiatrist on the outside once this occurred. My PTSD was activated, and I was unable to sleep nights because I was afraid of the nightmares. Going on the ward, became a journey of a thousand miles, and I became increasingly suspicious, paranoid, and feeling persecuted. I refused to go sit with the other residents on the ward with me. I doubted all my superiors – attendings, supervisors, and even to some extent the whole department. I did not attend T group sessions, and felt that I was being judged unfavorably by the whole department. I was so suspicious that I suspected everyone, and

anyone. It was fortuitous that I noticed some of the male medical students, and noticed one who snickered whenever I was around, and then getting silent when I noticed. Then, I noticed he began to ask rather impertinent questions regarding my sexuality on the ward, and when I cautioned him not to speak about it there, did not respond to my admonitions at all, and then started laughing. I reported my suspicions to my attending, as well as the psychology supervisor, and after a discussion with the Unit Chief, he was informed of his behavior and what the suspicions were, but was still allowed on the unit, and to be around me as well. This incident began to show me that Transphobia was present on the unit, and that the reasons that it had come about, was that it was a manifestation of the staffs' feelings about me. Amazingly, to me, my attending agreed with me. I then saw that she was beginning to see that I was a capable practitioner, and fluent in issues regarding my own sexuality. She was engaged in the problem of helping me, as was the psychology supervisor and the other teams' psychologist. I saw that, and I brought up the example of me doing an in-service, much like I had done on the Adolescent Boys' Unit. While she agreed with the idea, she did not agree with me presenting it, since she felt as a trainee I was far too ignorant of the psychodynamics involved and of psychodynamics in general. Instead, a former attending on the unit who was both openly gay, an analyst, and well versed in sexual identity (although not on gender identity to my own level) was chosen. My attending then printed up flyers about a case conference obliquely written so that no one on staff could know the purpose, although there were many attendees from different areas, including 2 out of 3 chief residents, and all of the residents in my class. Naturally, all medical students were required to attend, as well as any staff on the unit. He began by defining sexual identity, sexual orientation, gender and gender identity. Questions were then asked about the experience of staff on the unit with the transgendered as patients, which the attending then segued into staff feelings about me. Then, the room exploded with the prejudice and the hatred. My team psychologists' formulation of me was stated as gospel by all the social work staff, as well as much of those who agreed with it simply because a psychologist had stated it. Nursing was supportive, as it had been when I first came into the ward, and only cited confusion about pronoun errors, and difficulty understanding my handwriting. Art Therapy chimed in about gender ambiguity that I exhibited and her confusion with it and me, while Occupational therapy told of my kind and caring attitude towards patients. I tried to hold my anger , and my tongue , since I was now the subject of a case conference instead of my usual presenter . However, I was unsuccessful, sometimes stating my own feelings towards what was said about me. My resident colleagues remained silent, observing, listening and hearing and waiting to make their own judgments. The milieu coordinator, who was also my supervisor from psychology was enthusiastic to see the group dynamics, and to finally see the hatred of me, as well as difficulties in dealing with me, stated openly. He wanted another session later on, and felt much productive had taken place. I was unsure.

However, I was gratified to hear one of the chief residents to say that he understood my situation since he viewed it much like his of racism as an undergraduate at Columbia University, as an African – Caribbean man. My resident colleagues also elicited much of the same support of me. However, when I wandered onto the ward, I saw a cabal of psychology staff, social work and Art Therapy staff, all restating that the whole purpose of this exercise was because of some narcissistic needs that I had. I reported what was said to both my attending and psychology supervisor, who essentially told me that I had to accept the hatred and prejudice. I went home and cried, and attempted to sleep, but the nightmares had returned, and were to stay with me all year. It was then that I had contemplated quitting the program, since I had previously been offered to complete my Internal Medicine at a Manhattan Hospital, due to my own success in setting up two primary care units for the transgendered within that borough. . I had experienced failure of such a magnitude, that I doubted whether or not is possible for a transsexual to be both out of the closet / out of the woodwork, and a practicing psychiatrist. This was further validated by my Ombudsman / Supervisor who felt that an inpatient psychiatric unit would be unable to support an attending psychiatrist in my position, or any position, because of my experiences on the NS52. However, soon it was going to end, and as a way of keeping me afloat, that supervisor had also recommended that I start counting my time on the unit, to the nearest second, so that I may then continue to do my work. Then, I learned of the power of Parallel Processing on the unit.

Many of the patients had learned of my sexual identity from the rumor mill that was started by my borderline dual diagnosis patient who had since been discharged from the unit. It was becoming a topic of discussion in all of the groups, and patients and staff were using projective identification on a patient of mine, who was an undifferentiated Schizophrenic, who was religiously and sexually preoccupied, with sexual preoccupation manifesting itself in making improper advances using crude language and gestures to all the female staff. His sexual preoccupation, became a sexual identification with his primary therapist and psychiatrist, and staff were unwilling to redirect behavior as I had instructed (without knowing that the patient himself was giving me his punishments) because they either viewed it as too harsh, and by the fact that I was the one giving the orders in these circumstances. Group leaders were looking for the right words to disclose my status to the patients, without causing undue distress. Unaware that the patients' were very aware of the staff's distress and discomfort with me, and capitalizing on it as a way of misdirecting them from treating their own problems. Simultaneous, at this time I was dealing with some problems of my own with patients other than this young man. My S/M gay men, as well as a disorganized Schizophrenic Greek American man were both having erotic transferences to me. This was ironic in the fact that I

was being blamed for having caused these erotic transferences through my behaviors, but in essence due to my existence. What made this even more ironic, is that my Greek patient who had visual and auditory hallucinations of John Gotti, would have been classified as hebephrenic in the past, and was a perfect example of someone who was so disorganized that gender may not be a boundary, as my supervisors had feared before I came on the unit. Yet, he knew himself as a man, and as a heterosexual man, attracted to his female therapist, who was very attractive to him because she was his psychiatrist, and a female, not because she was born a male. My gay male patient also used his erotic attraction to me to begin doubting his own sexual identity, and defining himself as bisexual, which only ceased once I told him that gay men can also see the attraction in women, but it is not as powerful to them as the one driving them towards men. These circumstances forced my psychology supervisor, also the milieu coordinator, to persuade me to “come out “ in a community meeting. I was also forced to give a sentence to the group facilitators in order to disclose my identity. This was thought to succeed due to the choice of words, not taking into account how they were said, or who said them, which the patients were well aware of those staff with discomfiture towards me. This escalated the situation, allowing my supervisor to coerce me into “ coming out in a community meeting “. This was only stopped by my Ombudsman who pointed out the ultimate futility of the goal, and with him being a white , heterosexual man saying about the prejudice I was experiencing on the unit , finally convinced me not to go through with the plan . My psychology supervisor experienced a narcissistic injury and thus brought forth about my “ seducing “ the two patients above. I ignored him, and proceeded to treat my patients .All seemed well until one night on call in the Emergency Room

Emergency Room

Our Emergency Room had municipal hospital police in it at all times, a large holding area for patients waiting to be seen, a forensic area for prisoners, and a metal detector where all patients were searched by police prior to being interviewed and examined by the nursing staff. Most prominent was a large table where all the staff ate, and observed all the patients prior to examining and interviewing them in separate rooms off the side of the table. One night on call, I was eating dinner with a bunch of nurses, and as usual in the ER, and in ED departments all over, the talk was raunchy. A male aide was walking by and a nurse made a comment regarding his attraction. This was followed by similar remarks by other nurses and me. I thought that there was nothing wrong about it. Next, I start hearing from the social worker how I had “ sexually harassed “ the male aide. I was shocked. However, I sought to correct the situation by talking to him and defusing it via an apology . I was met with invectives directed at me, so I quickly exited the room. A week later, it seemed as though the whole emergency room knew about it, and several of

my allies there had tried to dissuade the aide, telling him that it was his own feelings of homophobia that were the driving force, not my intent nor my motive. Nevertheless, they were unable to persuade him, and he had a meeting with the head of CPEP. When I heard this, I was ready to meet with the head of CPEP and tell my side, but that was never to occur, since it was bumped up to the head of Inpatient Psychiatry. I met with him, scared out of my pants because of all the " fun " I was also experiencing at NS52 at the same time, as well as remembering the whole past year. Instead, I explained the situation, and the excuse that was used for me was that physicians are the leaders and should not get involved in the first place. It was at that time that thoughts of quitting the program became predominant and of my paranoia and distrust for others was validated. Hereafter in the ER, I never spoke or said a single thing to any staff member that was not clinically related, and I used that same strategy on NS52 as well. This continued onto the end of my second year. What they also did not know was that I was also planning on having my Sexual Reassignment Surgery in my third yr vacation, and that I had to make reservations at least 6 months in advance, and that this would be causing me problems in my third year

Termination

We had been taught termination as a psychodynamic process on NS52, and prior to that, I was speaking at a Gender Convention in Pennsylvania. I was well aware of its implications to my patients, but little did anyone know how I would use it back on the staff. By then, I had almost finalized my plans to end the year and the program and to move on. The offer was attractive, and I could see how problematic a resident like me could be like in the abstract world of psychiatry, in contrast to the concrete world of medicine. This had been the second time that this offer was tendered. I went to the convention and spoke about the Psychoanalysis and GID, and was a hit, since I deconstructed much of the present theory. I came back amazed at how much I had learned, and how much of an impact I had in the outside world. I came back to my environment of NS52 and calls in the Psychiatric ER, and I felt I could win. Therefore, at a time when my supervisors were planning on termination with me, I was planning a more permanent termination from them, and constructed the rest of our sessions together to reflect this. My method was to reflect back their errors in supervision with me, and the consequences, since I had just read about Homophobia in a Supervisory Relationship in a psychoanalytic journal. They sat back, and listened, although I doubt they knew the gravity of the situation as it related to myself. I was saying goodbye to psychiatry and back to a more hopeful, optimistic life as an internist. I was also saying goodbye to their image of me as a " trainee ", since I had now subverted that image with my previous lecture. Once I had said this, I was glad to go onto Internal Medicine, and a longer year of it.

THIRD YEAR

Most of my third year was occupied being an Internal Medicine Resident. I had made my appointment for SRS, and was due to have it at the beginning of February of the upcoming year, right after my MICU Rotation. I thought that all would be well, after the horrors of the previous year. In some ways, I was right, but in many, I had misjudged myself. Rumors arising from my interactions with a heme / onc attending in my internship year had damaged my reputation as a good doctor and a good resident, and nothing seemed to help it. I was also not given a time for vacation from the Dept of Medicine, since this year was their year to schedule my vacation. I frantically made a deal for vacation to coincide with my surgery, but when I was asked why by the chief resident in charge of second years, I refused to answer. He had taken the rumors about me to heart, and nothing would change his mind. About a month prior to my MICU rotation, I was given notice that I was going to be still on the MICU on the same day as my surgery, as well as the day prior to it – which I needed for travel time to the surgeon. I asked for a change in schedule from the chief, who inquired about my reasoning, and I again used the " burnout story " in order to justify it, since it had been nearly 16 months since I had a vacation. He agreed, but given his past word I doubted him. I did still not trust anyone from my previous years experience, and this person was never a friend nor an ally. Well my time in the MICU came up, and I was informed by the surgeon that I should stop my Cross Gender Hormonal Therapy for a month before the surgery, because of increased bleeding time secondary to the hormones. I had been aware of this, and aware of the fact that often transsexuals like me experience Dysphoric Disorder, or reexperience the clinical symptoms of depression. However, I did not foresee what would occur. In MICU, a resident is on call every 3 days – that is you are either precall, oncall, or postcall. With a 24 hr call and multiple blood draws as well as invasive and / or operative procedures done on critical patients. To say it is fatiguing to one unused to it, is to minimize the experience. To do it when going off a major antidepressant, or on something that has an antidepressant effect like CGHT (estradial and Provera) on an MTF transsexual is to court tragedy. Not only was I dealing with the reemergence of anhedonia, loss of concentration, guilt over hiding my status as a presurgical transsexual, as well and alteration in sleeping and eating habits secondary not only to my emerging mood disorder, but exacerbated by my schedule as well. I was also having suicidal ideation secondary to my previous years experiences, and homicidal ideation to both the resident who was in charge of me as well as the chief for their treatment of me while I was on this rotation. My work suffered, because I was unable to maintain myself on all the levels that I had in my first year, because all my inner supports had been lost. I could not tell anyone of my predicament, since they would view it as still another reason to see me as " not able to cope with the stresses of

medicine and medical life, and therefore prove that transsexuals are patients, not treating physicians “. I could only cope. I was eager to leave, looking upon SRS as a respite rather than the complex surgery that it was. Finally, the day was coming up. I hoped that my relief for the day I was out would come; otherwise, I would miss my surgery. I prayed that there would be no incident, since both he and I had agreed by phone that I would exchange this day, for one of his later in the year. I did not view this as a problem. However, due to the decline in my work habits, I was called in by the attending physician, and was informed that she did not view me as having the minimal knowledge. I kept silent, wanting to explain why my work habits had declined, but knowing her correctness and at least applauding her honest in dealing with me this way, instead accepted the poor performance record and kept the rest silent. Later, my parents and I flew to where I was going to have surgery. I was given the presurgical examination and all went well. The next thing I knew I had the surgery and now had a neovagina where before I had a penis. I was elated because I was now who I was meant to be, but still thinking repeatedly about the consequences of the previous rotation. My only previous surgery prior to this had been the removal of my wisdom teeth , so I wasn’t expecting the type of pain , nor of the intensity . My neovagina was packed, and I was on a Morphine drip that was making my mind wander off into never never land, giving me the sleep I needed. Finally, the packing was removed and I was instructed in dilating my neovagina, which I had to do six times daily in order to keep it patent for the first month, and then down to 4 times in the next two months, and finally to one time daily after that. I was also glad because I had been catheterized, and I wanted to urinate. However, after the packing was removed, I was unable to urinate and another larger catheter was placed inside me. This was kept in for another day and then removed in the hopes that I would urinate. This did not occur. This resulted in an emergency call by the nurse on duty to my surgeon, who used the largest gauge catheter coated with Viscous Xylocaine in order numb the pain of insertion I was never so grateful to have a catheter inserted, and hoped that I would be as gentle the next time I did the same procedure myself. I was then given bladder training with this, and then this was removed. I prayed to urinate, and finally did after reinstruction in this. I then actively started dilating and waited to go home. However, the trouble urinating had delayed my trip to my parents’ house to recover by a week , losing me a week of recovery before work . However, I still had two weeks and thought that would be sufficient. I came back to work, back in Psychiatry. This time on Consultation – Liaison that was something which combined both medicine and psychiatry, but involved a lot of walking as well. My body still hurt from the surgery, yet still I told no one. On call was now a 24 hr call covering NS52 as a physician, as well as all of both hospitals in the system as a consult in the emergency rooms. This was made even more challenging by my having to dilate at least twice while on call without anyone finding out, even with an oncall room adjacent to the Renal Fellow, and across from both the medical interns and

the Cardiology Fellow and the medical resident on call. Somehow, I did it. The C/L service people had always treated me with respect, and had always taught and judged me only on my performance as a resident. The former head of this division used to curse at me enormously when I was on Medical rotations since I was always used as the liaison to call consults due to my dual status, even though he felt me capable of doing the job while in a medical rather than psychiatric milieu. Initially I viewed his cursing at me as due to my status. Yet, I was able recognize that he did this to everyone in the department regardless of rank, and that he always used female pronouns and went out of his way to respect me, at least on the same level as others. My relationships with this division were further cemented because I was very familiar with all the attendings not only from my Emergency Room on calls as a PGY1 and PGY2, but also from seeing them and interacting with them on the medical wards, both as a resident and as an intern. Trouble this rotation, except due to the physical stress, which I hid from everyone. Also began doing OPD / Clinic calls for several patients who were adolescents with HIV /AIDS, as well as doing it for parents of these children who needed psychiatric treatment, initially on a case by case basis as a favor to the head of my department, and later on to develop into my own patients (I referred to myself, which caused me no end of trouble both with the head of the OPD Division and my training directors). This job continued to the end of my residency (since I was able to manipulate my elective time on Internal Medicine to include Pediatrics rotations, which included these clinics) and has now developed into a full time consulting position as an attending physician. I was able to identify quite easily with the patients, due to my undergoing puberty so soon before for the second time due to my transgendered status, as well as that of marginalization, also due to my status. After the C/L rotation, I was transferred to an OPD Clinic that specialized in PTSD at a VA hospital, which I also did well at, due to my own empathy with those symptoms.

FOURTH YEAR

My year was uneventful on medicine, with only a bit of fallout due to my poor performance on the MICU. However, my PGY4 and PGY5 years were the beginnings of my year straight on Psychiatry from January to January, which was done so that I would have a year straight of continuing outpatient work as a psychiatrist. Patients seemed to go well this year, although I did dread one placement at a hospital far away in Queens that was affiliated with us. I often " played hooky " from these rotations and got into trouble with it, but dealt with it honestly with my residency directors. At this time, I had a transsexual patient with pronounced borderline/antisocial traits not only were not a surprise but were a " given ". She had been transferred to me by an out of the closet gay man, who was finishing up his general psychiatry residency and going on to do a child and adolescent fellowship at the same institution, which

required him to terminate with many of his adult patients. He had chosen me, because it was felt that the patient would benefit from having me, due to my own " out " status as a transsexual woman, as well as my training in both Internal Medicine and Psychiatry. I had presented it to my supervisors as a chance to show that I could be the best person to give treatment to this patient, in terms of both psychiatry and primary care. However, in our meetings, and especially when I was on a medicine rotation – which was when this patient was first transferred to me, this patient was troublesome. She demanded attention, but did not take responsibility for any and all of the deleterious consequences. I discussed with both the patient and all of my supervisors the assumption of the dual role, and all agreed that it would work. Finally, the patient came to see me on a day in which I had Medical Clinic. Luckily, I was training an OB / GYN chief resident in treatment of these patients, since we were both involved in a study in her department that involved them at this time. She performed the genital exam, under my supervision, so that I did not have to touch the patient. However, the patient was demanding attention from me, equal to that of a psychotherapy session within a medical clinic, which I was unable to do, because of my patient load in the clinic. She was also seeing how the nurses as well as other people addressed me as a " Doctor " and was deferential to me, treating me with respect. These were things my patient was unable to bear, since I had the life that she had " fantasized about ". I was living and working as a woman, and was treated as such. One of the conditions of my therapy was that I not disclose surgical status. However, the patient was aware that I unlike she, was legally a woman, and this caused a conflict with her noticeable in our sessions. We also differed in terms of class and ethnicity that were obstacles to her progression in treatment. However, this clinic visit was the last straw for her. In her mind, there could be only one transsexual in the relationship, and that would be her. She started calling up her previous therapist, telling him about me using only the masculine pronoun. He, in turn, called me and transferred her back to me. This then resulted in death threats on my answering machines, both at home and at the offices (medicine and psychiatry). I asked for help from my supervisor in charge of this case, who felt I should allow it to continue. Finally, I played the messages back to her, and she told me to terminate with this patient via letter and to include it in the chart, and to wait for an answer. After this, I never saw or heard from the patient again. I was lucky in the fact that the only other of my psychiatric outpatients to cause this much trouble was a nursing student who also was a borderline who had an erotic transference to me, but was subsequently terminated in my last year, because of an inadvertent disclosure of my medical status when I was sick to her. She had inquired as we had progressed in therapy to asking about my sexual identity, stating that she did not want a man due to previously unsuccessful and abusive relationships that reminded her of her father. Yet, her attachment to me grew, and continued to grow as she came for her weekly appointments. When she was hinting about my sexuality in sessions, I

brought it to my supervisor who noted that if she asked directly, I should tell her. I informed my supervisor at the time (my former psychology supervisor on NS52), that she was dependent as well, and had a transferential relationship with me, equating her with her abusive and distant father, so that she was unlikely to ask me directly. However, he persuaded me to use all my tools to allow her to ask it. She did one day, surprisingly it took over little of the session, and we were able to proceed onto other work. However, because her erotic transference was marked, both my supervisor and I speculated that, by the patients own admission – that I was both father and mother symbolically to her, since I was like both man and not man to her. This relationship progressed well until the final problems occurred with me medically in my fifth year.

FIFTH YEAR

My final year as a resident was a continuation of psychiatry, which was driving me crazy since I had never spent a year straight in any one department, and was craving to go back to medicine. As stated before, it was relatively uneventful except with the hospitalization a Schizoaffective woman with multiple somatic delusions and rather unique illusions and hallucinations present secondary to incest and sexual abuse when younger, as well as with the past patients. I was excited, but nervous, since although I was graduating, I remembered the difficulty of obtaining the residency and doubted I would ever get another job, even as an attending physician. This year I had also planned finally to get my labiaplasty – to make my neovagina look more realistic to myself and others, as well as have time off for amending my birth certificate to reflect my new anatomical status, by going in court. None of this was known by the residency-training directors, or my anyone within the department, nor did anyone ask. Well, as per usual, I used my vacation as a working vacation and had my labiaplasty done in the two weeks, and then headed back for Thanksgiving and Christmas holidays. It was there that I finally found out I had a urethral stricture secondary to my SRS 2 years ago that was responsible for my continuous UTI's that never resolved. I was placed on Vicodin, which soon gave me a dementia. Because behaviors associated with the dementia were unknown to me, and because many of them could be perceived as psychotic, since I could not differentiate my fantasy world and thoughts from that of reality, as well as having my time sense distorted as well, my training directors did not know how to handle it. Since I had not disclosed about any of my surgeries prior to this, they were surprised and astounded to find out what I had done and when, to the point that the Residency Training Director himself, fell off his chair. Needless to say, I needed both psychiatric and medical clearance prior to coming back to the program, and I was sent to another municipal hospital Psychiatric ER in order to assess my mental status An organizing influence was the structure of having my parents on my side, as well as having them providing structure back in

Philly for me. I took two weeks and it resolved. However, one of my preoccupations was of obtaining a position and this formed a central part in my consciousness even though I was demented, and continued onward till I found a position .The residency year ended with me picked to moderate our Psychiatric Film Series, on the film, " Boys Don't Cry ". A fellow resident who had created this program felt that this would be an excellent promotion, and an excellent idea to end my residency, using all the skills I had learned, as well as my knowledge from both sides. It was one of the better attended of the presentations. Multiple attendings and division chairs attended many even deferring to me in terms of knowledge base. I was doing this knowing I had a position as an attending. It was my triumph, since finally I was able to turn the tables around, from a projective identification by my colleagues as a patient, to that of an equal .I finally felt at home, and yet sad, for with all of this trouble I was soon to leave and to start a new life. The circle had turned 360 degrees. I was now accepted.

THE END