

“Legally, we’re alright, but ethically, I don’t know”: research, regret and trans medicine at the University of Washington, 1968-1972

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Abstract: This paper explores the history of the University of Washington Gender Identity Clinic – a clinical research unit operating from 1968 until 1972 undertaking both scientific work, and patient care, relating to transgender medicine. Exploring the history of the clinic – its origins, process, and untimely end thanks to financial fraud by the surgeon – I expand on our understanding of the histories of transgender medicine in the 1960s-1970s, documenting the practices of a clinic off the beaten path of many histories of transgender care. The results demonstrate the practical and bioethical complexity of hybridizing clinical research and care, particularly under charged cultural circumstances, and the value of inquiring further into this era and structural form of trans care. This carries lessons for both historians seeking to study clinical research generally (and clinical research around trans medicine in particular), and efforts to legitimize transgender medicine in this current moment.

Keywords: transgender medicine; clinical research; bioethics; medical malpractice; transgender history

Introduction

This article tells the story of the origin, practices, and untimely end of the Gender Identity Clinic (GIC) at the University of Washington. Originating in the 1960s, the GIC model for the provision of transgender medicine was prominent in the early institutionalization of care. Often numbered at over 20 in total, the GIC constituted a “one-stop shop” for medicine, involving psychiatrists, endocrinologists, surgeons and many others in a single setting for the evaluation and treatment of patients. Simultaneously, their creation epitomizes what Susan Stryker refers to as the field’s “big science era”.¹ This is because the clinics - as usually conceptualized - were not only designed as sites of medical care, but as sites of research, established in part to gather data on diagnosis and - particularly - patient outcomes following treatment. The studies they performed, more than the procedures, were viewed as a way to formalize and legitimize trans healthcare - and their processes and personnel were vital resources and figures in formalizing both “transsexualism” as a diagnostic entity and the Standards of Care under which medical treatment is regulated.

The GIC model has been of longstanding interests to both historians of gender, and historians of transgender medicine. As well as contemporaneous works examining the impact of clinic practices on patients (and patient populations) and their ideas of gender,²³ and more recent

¹ Susan Stryker, *Transgender History* (Seal Press, 2008), 93.

² Deborah Heller Feinbloom, *Transvestites & transsexuals: Mixed views* (Dell, 1977).

³ Anne E. Bolin, *In search of Eve: transsexual rites of passage* (Bloomsbury Publishing, 1987).

histories of “the transsexual” as a figure,⁴ the last few years have seen multiple books and myriad journal articles set in or focused on the GIC. The works of Jules Gill-Petersen and Sandra Eder have explored the way that the clinics articulated, deployed and promoted particular senses of gender as a concept,⁵⁶ while Jacob D. Moses has explored the research and practice of the GIC as a case study in the conceptualization of regret within medicine.⁷

Simultaneously, however, there has been a shift *beyond and away from* this focus. Sometimes this looks like moving beyond North America: the recent works of Bakker and Slagstad, amongst others, have provided valuable and in-depth histories of care in Dutch and Scandinavian contexts, respectively.⁸⁹ Sometimes it looks instead like moving beyond the GIC as a model: recent papers by Howard Chiang and Beans Velocci have examined the informal, private-sector

⁴ Joanne Meyerowitz, *How sex changed: A history of transsexuality in the United States* (Harvard University Press, 2004).

⁵ Jules Gill-Peterson, *Histories of the transgender child* (University of Minnesota Press, 2018).

⁶ Sandra Eder, *How the clinic made gender: the medical history of a transformative idea*. (University of Chicago Press, 2022).

⁷ Jacob D. Moses, "Medical Regret without Remorse: A Moral History of Harm, Responsibility, and Emotion in American Surgery since 1945." (PhD diss., Harvard University, 2020).

⁸ Alex Bakker, *The Dutch Approach: Fifty Years of Transgender Health Care at the VU Amsterdam Gender Clinic*. (Boom, 2021).

⁹ Ketil Slagstad, *Standardizing Sex: A History of Trans Medicine* (University of Chicago Press, 2025).

predecessors to the GIC model,¹⁰¹¹ with Chiang explicitly situating his work as part of a broader suite of scholarship that aims to “rethink the foundations of trans history” as conventionally described.¹²

With this paper, I both move away from *and* extend our understanding of North American GICs and their place in the history of trans medicine. I do this by documenting the history of a different clinic – not that at Johns Hopkins, as most scholars have focused on, but that at the University of Washington, which (although explicitly heavily-influenced by Hopkins) existed in a different institutional context, and followed a different trajectory. Using a mixture of archival and interview-based resources, I document how the clinic was founded, functioned, and came to cease – and the ways that the mixture of research, regret and care in clinicians’ motivations and approaches shaped both patients’ experiences, and the ultimate consequences of the clinic’s existence. This analysis extends our understanding of the GICs of the 1960s-1980s through making multiple interventions in how we have conventionally studied the North American GIC, and with what focus.

With few exceptions,¹³¹⁴ those histories that exist focus on one particular GIC – that at Johns Hopkins. From Meyerowitz’s *How Sex Changed* to Gill- Peterson’s *Histories of the Transgender*

¹⁰ Howard Chiang, "Hide and Seek: Elmer Belt, Agnes, and the Battle over Castration in Transsexual Surgery, 1953–1962," *Bulletin of the History of Medicine* 98, no. 3 (2024): 394-427.

¹¹ Beans Velocci, "Standards of care: uncertainty and risk in Harry Benjamin's transsexual classifications," *Transgender Studies Quarterly* 8, no. 4 (2021): 462-480.

¹² Chiang, “Hide and Seek” (n.10), 396.

¹³ Emmett Harsin Drager, "Early Gender Clinics, Transsexual Etiology, and the Racialized Family." *GLQ* 29, no. 1 (2023): 13-26.

Child, the Hopkins clinic comes to stand in for all of the 20+ GICs of the 1960s-1980s. And when existing writers have studied Hopkins, they have often done so in order to analyze the high-level theoretical or cultural work of the clinic: what the clinic's research and publications demonstrate about conceptualizations of "the transgender child", or of gender more broadly.¹⁵ In contrast, this paper focuses on a different clinic, and specifically on its *practices*: the granular work involved in patient selection, treatment and evaluation, much as scholars such as Latham have done with contemporary programs for gender-affirming care.¹⁶¹⁷

Further – in looking at these practices, I attend specifically to the relationship between the multiple motivations of practitioners: how their interest in providing care was coupled with a deep desire to avoid patient (or practitioner) regret, and an equally-deep interest in studying trans patients for the sake of producing research data. Historians of medicine have often framed the

¹⁴ Cole Roblee et al., "A History of Gender-Affirming Surgery at the University of Michigan: Lessons for Today." *Seminars in Plastic Surgery* 38, no. 1 (2024): 53-60.

¹⁵ Eder, *How the clinic made gender*, (n.6) and Gill-Peterson, *Histories of the transgender child* (n.5).

¹⁶ J.R. Latham, "(Re) making sex: A praxiography of the gender clinic." *Feminist Theory* 18, no. 2 (2017): 177-204.

¹⁷ Another perspective is provided by Plemons and Straayer, who emphasise the need to “pay attention to the practices of trans surgery” in studying trans medicine; Eric Plemons and Chris Straayer, "Introduction: Reframing the surgical." *Transgender Studies Quarterly* 5, no. 2 (2018):

consequence of multiple motivations as one of tension;¹⁸ of research and care “trading off” against one another. But as this study demonstrates, multiple motivations, each characterized by power disparities between clinician and patient (or researcher and participant) can also be multiplicative: can *exacerbate* the costs for the more-vulnerable party in the relationship.

Simultaneously, I situate these practices and experiences in the overarching context of the state of trans care at the time. There is extensive documentation of the long history of already-marginalized people being disproportionately used as subjects in clinical research.¹⁹ In the case of trans medicine at this point in time, a particular reason for and consequence of that marginalization was the difficulty of accessing care outside a GIC: when the UW clinic was founded, it was, quite literally, the only game in town. Patients’ experiences of care at the GIC – and their willingness to engage with it, and the consequences this engagement had for both their health and the research data that was produced – have to be understood in the context of an environment where, despite the presence of “informed consent” processes and protocols, patient-participants found it hard to say no to even the most outrageous demands of their doctors. Taken together, this paper produces multiple insights on the relationship between research and care, the relationship between marginalization and participation, and the consequences, at a time of high scrutiny of gender-affirming care, of framing and practicing such care as research. Each of these, I argue, are differently useful for historians of trans medicine, historians of medicine

¹⁸ Renee C. Fox, *Experiment Perilous: Physicians and Patients Facing the Unknown*. (Transaction Publishers, 1998).

¹⁹ Sydney A. Halpern, *Dangerous medicine: the story behind human experiments with hepatitis*. (Yale University Press, 2021).

more broadly, and contemporary practitioners and policymakers seeking to respond to conflicts around gender-affirming care.

Studying the GIC

One very good reason historians have focused on the Hopkins clinic is a practical one: written records are simply not available at and for most of the GICs that existed during the 1960s-1980s. As part of a broader project seeking to correct this,²⁰ I conducted 205 oral histories of patients, participants and policy figures involved in transgender care during this period, simultaneously visiting some 30 archival institutions and producing new collections from materials entrusted to me by participants.

For both geographic and prosaic reasons, the University of Washington GIC was one where I was particularly successful gathering materials – both identifying archival sources, and performing qualitative interviews. The archival sources includes not only inter-departmental correspondence, but also the reconstructed medical records of the vast majority of the patients given treatment, along with several who were evaluated but ultimately not accepted into the program. The interviews are largely of clinic staff, including surgeons, psychiatrists, psychologists and secretaries, with the addition of one interview with a former patient. Both my

²⁰ A 205-interview (and 30 archive) history of each of the Gender Identity Clinics in North America, from 1966-1985. This is currently under contract with the University of Washington Press, to be published as Os Keyes, *Trans Science: Research, Medicine and the Politics of Proof*, (University of Washington Press, 2028).

access to these records, and my conduct of the interviews, were approved by the University of Washington IRB.²¹

Interviewees were contacted via email, letter, or existing interviewees, largely based on traces within the archival materials I was able to gather. The interviews themselves were semi-structured in nature, and focused on what practitioners and patient-participants recalled of the process through which the clinic was established, their participation in it, and their experience - then and now - of how patient-participants were treated, screened and assessed. Interviews were recorded and transcribed, and subsequently inductively coded for key themes by the author of this paper. Several interviewees were subsequently shown various drafts of this manuscript and afforded the opportunity to comment; where appropriate, their comments have been incorporated into the work.

Archival sources included the University of Washington Special Collections - specifically, the archives of the University itself - fragments from the Kinsey Institute Special Collections where they pertained to figures involved in the UW clinic, and both court and patient records. To preserve anonymity, patient records (and patients) are referenced exclusively through pseudonyms (where possible, pseudonyms selected by the patient in question), with the exception of court records, where this was not possible.

Gathering these materials was the work of over two years of searching that at various points involved court indexes, trips to three or four different archival repositories, and conversations

²¹ Specifically, STUDY00016433 and STUDY00014340.

with the friends and family of a (now-deceased) patient.²² To protect future researchers from having to undertake the same work, the transcripts and records are - where possible - being preserved as part of a new collection at the University of Washington archives. This collection is named the Dayton/Hunt Collection, after the first patient and last physician, respectively. Some small aspects are also drawn from interviews as part of a broader project investigating the history of clinical research around transgender medicine; these interviews are being preserved for inclusion in a collection at the University of Michigan, the Os Keyes Collection.²³

My research revealed enough to reconstruct the narrative story of how the clinic began, functioned, and closed. But it also highlighted several key themes within this story that are resonant in modern trans care, and contemporaneous clinic practices – namely, the presence of a fear of regret in structuring clinic practice, and the tensions between care and research as motivations for clinicians’ behavior. In what follows, I both tell the narrative story of the clinic, and explore how these fears and tensions influenced that story and impacted patient (and research) outcomes.

²² A more complete story of the process by which this material was gathered is described in Os Keyes, “Beyond Trans Archives, Beyond Trans Medicine”. *Logic(s)*, 1 no. 21 (2024): 90-117.

²³ I did not name it after myself. In fact, I repeatedly asked the archivists not to name it after me. I begrudgingly agreed on the condition that they, in turn, agree to take all of my materials and not just the bits that they immediately cared about. I am not a narcissist, but I *am* a packrat who is running out of office space.

The Beginning

In common with many of the other Gender Identity Clinics that sprung up in the 1960s-1970s,²⁴ the story of the UW clinic begins not with doctors but with patients. Following the formal announcement of the clinic at Johns Hopkins in 1966, press reports ensured a wide range of possible patients became aware that - at least in theory - university medical schools and institutions might have an interest in providing treatment. Correspondingly, many of them reached out to their local institution. At UW, patients independently seem to have contacted John Hampson, a psychiatrist; J. William McRoberts, a urologist; and Robert V. DeVito, a plastic surgeon, as early as 1967. In some cases this contact was mediated by Patrick Gandy, a social worker who played a key role in the early Seattle homophile movement (which Hampson circulated in) and later worked as a coordinator at the Stanford University Gender Identity Clinic.²⁵ Initially, there was no organized effort - DeVito wrote to John Hoopes, the plastic surgeon (and first GIC chair) at Hopkins, hoping they would take his patient on because he “would hesitate to attempt evaluation on [her] in the disjointed fashion that would be necessary in Seattle inasmuch as we don’t have adequate experience with this problem”.²⁶ But by the start of the following year, a growing group of doctors at UW were aware of trans patients, and interested in the possibility of some form of treatment.

²⁴ See Meyerowitz, *How Sex Changed*, (n. 4) Ch. 6.

²⁵ Interview with Mitsue Schilling, December 12, 2023.

²⁶ Letter to John E. Hoopes from Robert V. DeVito, November 10, 1967, Karen Alfred Medical Record.

Most prominent in this group was John Hampson, a psychiatrist with a track record of work on sex, gender and sexuality,²⁷ who took the lead in organizing the group and seeking support to begin a formal, clinical project. This support materialized via the UW Clinical Research Center (CRC), a unit funded by the National Institutes of Health that served as a home and clearing house for clinical research. In contrast to attempts at standalone clinical research, where doctors had to independently find research funding and hospital support, projects approved by the CRC could use both a dedicated hospital ward and cover treatment costs with CRC funding. As a result, care would – at least in theory – be functionally free for patients. Seeking to draw on these resources, a document was submitted to the CRC on 10 January, 1969: “proposal for human experimentation: Surgical Treatment of Transsexualism”.²⁸

Led by Hampson, McRoberts and DeVito, the team behind the proposal also included Ronald J. Pion (Ob/Gyn), and John “Jack” Carr (Psychiatry). Their framing to the Clinical Research Center had little to say about the clinical side of the plan. The Transsexual Research Project was, as the

²⁷ Along with his wife, fellow professor Joan Hampson, he had coauthored the original research with John Money - a prominent player in the Hopkins clinic - that had defined the term “gender role”. See John Money, Joan G. Hampson, and John L. Hampson, "Imprinting and the establishment of gender role." *AMA Archives of Neurology & Psychiatry* 77, no. 3 (1957): 333-336. The Hampsons’ work was both important to Money’s project and regularly under-credited - see Eder, *How the Clinic Made Gender* (n. 6).

²⁸ Attachment 1: CRC Scientific Advisory Committee Meeting, January 10, 1969, Box 1, Folder 6, Dayton/Hunt Collection, University of Washington Special Collections, University of Washington, Seattle, WA.

name suggests, first and foremost about scientific research, including research into novel vaginoplasty techniques and an entire host of other, more tangential projects (the original application emphasized that the patients “have research interest for the cytologist and geneticist; chromosomal and karyotype studies will be encouraged”).²⁹ At the heart of the desired research was an evaluation of treatment outcomes: a plan to provide care in order to conduct a *follow-up study*, following the patients for an indefinite period to see how hormones and surgery impacted their lives. This would involve evaluating patients’ psychiatric states and societal experience before, during, and at multiple points after, treatment.

After some alterations to the proposal to bring evaluation of patients more in line with that at Johns Hopkins – specifically, by relying more on the Hopkins questionnaires to “ensure similar pre- and post-operative research analyses”³⁰ - the Transsexual Research Project was approved on 14 February, with funding to provide both hormone replacement therapy and vaginoplasty to “approximately 20 patients”, all trans women.³¹ This focus on trans women – a consequence of

²⁹ Attachment 3A, “Objectives and Aims”: CRC Scientific Advisory Committee Meeting, January 10, 1969, Box 1, Folder 6, Dayton/Hunt Collection, University of Washington Special Collections, University of Washington, Seattle, WA.

³⁰ Minutes, CRC Scientific Advisory Committee Meeting, January 10, 1969, Box 1, Folder 6, Dayton/Hunt Collection, University of Washington Special Collections, University of Washington, Seattle, WA.

³¹ Minutes, CRC Scientific Advisory Committee Meeting, February 14, 1969, Box 1, Folder 6, Dayton/Hunt Collection, University of Washington Special Collections, University of Washington, Seattle, WA.

the project's distinguishing factor from a research perspective, the use of a novel vaginoplasty technique – meant that trans men were entirely excluded from the formal study process. Some were ultimately given care in line with the research protocol (and in some cases, several years after the project formally ended), but entirely at their own expense due to the CRC application's focus on trans women.³²

Within the context of trans medicine specifically, formalizing care as research was relatively common. But the choice to frame the clinic as specifically a research project is contextually interesting more broadly: the late 1960s were, after all, the era of the Beecher Report, although the institutional consequences of that (and the later publicity surrounding the Tuskegee syphilis study) in the form of the National Research Act had yet to occur.³³ UW was relatively unique amongst U.S. medical schools in having already established an IRB prior to this point – one that mandated informed consent protections for participants, including those in the Transsexual Research Project. None of the surviving documentation, however, indicates that consent in particular (or research ethics in general) were a particular concern to the clinic staff. Instead, the structuring of care as research appears to have reflected the additional resources this enabled

³² Interview with Richard Soderstrom, March 2, 2023, Box 2, Folder 16, Dayton/Hunt Collection, University of Washington Special Collections, University of Washington, Seattle, WA.

³³ As Sydney Halpern has documented, of course, engagement with questions of research ethics – while informal and inconsistent – was not entirely alien to physicians prior to this period. See Sydney A. Halpern, *Lesser harms: The morality of risk in medical research*. (University of Chicago Press, 2019).

clinic staff to access, a genuine interest in research itself, and the legibility and legitimacy that a research framing provided – something also documented at other clinics of the era, particularly that at Northwestern.³⁴

Nevertheless, it would be a mistake to treat the framing of care as research as unexceptional simply because it was unexceptional *within trans medicine*. As many historians of medicine have documented, including most recently Sydney Halpern,³⁵ there is a long history of already-marginalized populations bearing the brunt of clinical research. This not only raises societal questions about who, and why, bears the consequences of research's costs and potential failures: it also creates problems for both formal informed consent processes, and the underlying premise of those processes that patient-participants be free – as much as possible – to choose their form of engagement and determine their participation based on their own comfort. In the case of trans medicine, many of the GICs that existed in the 1960s-1980s did so as the “only game in town”: as the only site for formalized care that many patients had access to without vast travel time or informal stitching-together of multiple providers. UW was no exception – and as a consequence, exclusion from the Clinic often meant exclusion from gender-affirming care writ large, something with profound implications for how, and to what degree, patient-participants were able to push back against their physicians' demands.

³⁴ Passavant Gender Identity Clinic Staff, 8 August, 1968, “Trans-Sexual Project”, Archives of Northwestern Hospitals, Chicago, IL.

³⁵ Halpern, *Dangerous Medicine* (n. 19).

The Process

With the clinic's existence now cemented, the story turns to the *process* that patients (and prospective patients) went through; their trajectory to, through and from treatment. In particular, this section looks at how the desires, concerns and motivations of the clinician-researchers structured patients' trajectories, and in what ways.

Some early patients heard about the clinic as a result of prompting its creation; others through word-of-mouth, or via the (limited) press coverage the unit received. By November of 1968, word had already spread; some patients living out of state heard about it through the grapevine,³⁶ and Hampson reported they already had "about a dozen persons requesting such help".³⁷ However they contacted the clinic, the first step in the evaluation process was a telephone screening, usually conducted by Hampson's secretary.³⁸ The interview focused on patients' existing living situation, particularly whether they were financially self-supporting and had been living as their desired gender for a year or more. Following the phone screen, patients would be sent an extensive, essay-formatted intake form that included questions on everything from applicants' family dynamics to their level of employment and health insurance coverage. They would then be interviewed by Hampson or one of his residents, subject to a battery of extensive

³⁶ Interview with Emma Carter, April 18, 2023, Box 2, Folder 16, Dayton/Hunt Collection, University of Washington Special Collections, University of Washington, Seattle, WA.

³⁷ Letter to Emma Carter from John L. Hampson, November 25, 1968, Emma Carter Patient Record.

³⁸ Interview with Connie Clemmens, May 23, 2023, Box 2, Folder 16, Dayton/Hunt Collection, University of Washington Special Collections, University of Washington, Seattle, WA.

psychometric exams overseen by Jack Carr and Norman Kosky (see Figure 1), and, finally, invited to meet with the full Gender Identity Committee.

<< Figure 1 here >>

Figure 1 caption: Norman Kolsky, a Psychology Department technician, administers the Halstead Category Test to a patient, “Angela”. Source: Dayton/Hunt Collection, University of Washington Special Collections, University of Washington, Seattle, WA.

The Committee’s membership was predominantly medical, consisting largely of surgeons, psychiatrists and psychologists, and almost-exclusively male: the one exception to both was Jennifer James, an anthropologist of sexuality working as a Professor in the Psychiatry Department. This was not unusual; most GICs were largely male and medico-psychological, with the occasional presence of social workers,³⁹ and the Cleveland Clinic Foundation’s appointment of a sociologist, the exceptions.⁴⁰

If the Committee (unanimously) approved of the candidate, they entered the second part of the process, commonly referred to as the “real-life test” or “real-life experience” (RLT/RLE) by

³⁹ Roblee, "A History of Gender-Affirming Surgery at the University of Michigan" (n. 14)

⁴⁰ Although it is worth noting that the aforementioned sociologist, Suzanne Powers, was careful to couch herself as a “clinical sociologist”. See Suzanne Powers, "The role of clinical sociologist in a multispecialty health facility." *American Behavioral Scientist* 22, no. 4 (1979): 543-555.

scholars involved in trans care.⁴¹ This was a period of time in which the candidate was expected to “have demonstrated an ability to pass by having lived for at least six months as a member of the opposite sex”.⁴² But this period was regularly longer than six months, being extended to multiple years; worried about the possibility of regret, the doctors took the attitude that “we would never rush into surgery. We felt it’s always better to wait for some period of time, even up as long as a year in some instances so that we get a clear longitudinal picture of how stable a person is before surgery is done”.⁴³ What “stability” looked like was not unpacked – but is heavily implied (as documented below) to be, in part, a willingness to participate in the process without disrupting it, and consistently maintain the desires and life trajectories, however stereotypical, that doctors imagined trans people to have.

This statement segues nicely to the question of requirements; of which norms shaped clinic practices and expectations for patients, and why. Throughout the evaluation period, a range of

⁴¹ See, for example, Garrett Oppenheim, "The Snowball Effect of the “Real-Life Test” for Sex Reassignment." *Journal of Sex Education and Therapy* 12, no. 2 (1986): 12-14 and Helen Barker and Kevan Wylie, "Are the criteria for the ‘real-life experience’(RLE) stage of assessment for GID useful to patients and clinicians?." *International Journal of Transgenderism* 10, no. 3-4 (2008): 121-131.

⁴² Letter to Richard M. Yarvis from John L. Hampson, June 24, 1969, Box 1, Folder 7, Dayton/Hunt Collection, University of Washington Special Collections, University of Washington, Seattle, WA

⁴³ Deposition of John Hampson, pp.10-11, Box 2, Folder 3, Dayton/Hunt Collection, University of Washington Special Collections, University of Washington, Seattle, WA

requirements and constraints were placed upon the patients. These were motivated, in part, by a fear of *regret* should patients access surgery. Physician fears of regret continue to shape trans care in the 21st century, as documented in MacKinnon *et al.*'s work on clinician practices in Canada.⁴⁴ And as Moses historicizes in his explorations of the Hopkins clinic,⁴⁵ Velocci documents before and around the rise of the GIC,⁴⁶ and MacKinnon *et al.* note contemporarily, physicians' conceptions of regret often had as much (or more) to do with their own reputation and the possibility of legal jeopardy as it did the outcomes for patients. This can be seen in the criteria for UW patients, which included not only expectations that patients would demonstrate their comfort living as their desired gender prior to accessing medical care, but that patients would sign "an agreement not to involve the physician or hospital in any legal action *or to publicize, notorize or capitalize on the unique sexual status which results from surgery*"⁴⁷ (emphasis mine). A desire to avoid scrutiny, and a fear of the professional consequences for practitioners, heavily shaped how patients were treated. Even in early press coverage of the clinic, the faculty involved were referenced anonymously.⁴⁸

⁴⁴ Kinnon R. MacKinnon et al., "Preventing transition "regret": An institutional ethnography of gender-affirming medical care assessment practices in Canada." *Social Science & Medicine* 291 (2021): 114477.

⁴⁵ Moses, "Medical Regret without Remorse" (n. 7).

⁴⁶ Velocci, "Standards of care" (n. 11).

⁴⁷ Letter to Richard M. Yarvis, Dayton/Hunt Collection.

⁴⁸ Ammons, Dave and Bailey, Judy (December 5, 1968). *Team Performs Sex Changes*.

University of Washington Daily, No. 37, C25

And, as the concern about “an ability to pass” suggests, part of the process motivated by regret avoidance was a desire for patients who would, after treatment, fade into the background, a standard that often ended up benefiting people who were strongly and conventionally feminine in the eyes of the (almost entirely male) Committee. Various Committee members were explicit about this when I spoke to them; Jennifer James noted that the doctors were:

“dealing stereotype[s]...the [patients] would come in, just dressed to the nines, you know...the ultra feminine presentation of female. The committee never noticed that.”⁴⁹

Even more explicit were the recollections of Jack Carr; the doctors, he said, were looking to be “taken by [her]”. He emphasizes one case he particularly remembers was a “beautiful, strikingly attractive person...I remember a couple of the residents saying “oooh-er” [a guttural noise communicating physical attraction]”.⁵⁰ Expectations and evaluations, then, were shaped by a desire for stereotype – one also found in many other clinics, inside and outside North America.⁵¹⁵²

⁴⁹ Interview with Jennifer James, March 21, 2023, Box 2, Folder 16, Dayton/Hunt Collection, University of Washington Special Collections, University of Washington, Seattle, WA.

⁵⁰ Interview with Jack Carr and D. Daniel Hunt, May 11, 2023, Box 2, Folder 16, Dayton/Hunt Collection, University of Washington Special Collections, University of Washington, Seattle, WA.

⁵¹ Sandy Stone, “The empire strikes back: A posttranssexual manifesto,” in *The Transgender Studies Reader*, ed Susan Stryker and Stephen Whittle (Routledge, 2013), 221-235.

⁵² Slagstad, *Standardizing Sex* (n. 9).

Beyond ideas of regret and normalization, patient experiences were also shaped by the doctors' interest in *research*, as well as *treatment*. Take, for example, the questionnaires and interviews: the GIC organizers were explicit that interviews be structured not only “for the purpose of case selection [but] research into etiology”,⁵³ expanding out the depth of the interrogation and breadth of information covered. In fact, all but one of the formal psychiatric tests done, including IQ tests, speech sounds perception tests, and the Halstead Category Test seen in Figure 1, “played no role in committee decisions as to candidacy for surgical procedures”.⁵⁴ Many were not regularized parts of most conventional psychiatric practices: the Halstead, for example, is traditionally a test for brain damage.⁵⁵ The testing was for research purposes: indeed, so were many of the selection criteria, with Hampson requiring patients to sign “An agreement to participate in the preoperative evaluation and long-term followup studies necessary to evaluate all aspects of the procedure more thoroughly”,⁵⁶ something integrated into the informed consent process.

⁵³ Attachment 3A, “Objectives and Aims”: CRC Scientific Advisory Committee Meeting, Dayton/Hunt Collection.

⁵⁴ D. Daniel Hunt, John E. Carr, and John L. Hampson. "Cognitive correlates of biologic sex and gender identity in transsexualism." *Archives of Sexual Behavior* 10 (1981), 69.

⁵⁵ Ward C. Halstead, "Preliminary analysis of grouping behavior in patients with cerebral injury by the method of equivalent and non-equivalent stimuli." *American Journal of Psychiatry* 96, no. 6 (1940): 1263-1294.

⁵⁶ Letter to Richard M. Yarvis, Dayton/Hunt Collection. Expectations that patients would participate in follow-up studies were fairly commonly expressed within the overall pool of GICs

Most prominent in the research-oriented aspects of the process was the monetary deposit. As mentioned above, running the project under the auspices of the Clinical Research Center meant that “in-hospital” treatment was actually free, to both the doctors and university: it cost them nothing, and so generated no treatment costs that could plausibly be passed on to the patient. But despite that, Hampson and colleagues had a practice of requiring a deposit, often \$1,500 (around \$14,000, with inflation and cost of living changes, in 2026). This, in conversation with other clinicians at a conference in 1971, they simply labelled “hostage money”.⁵⁷

The idea behind the hostage money was this. Since the primary goal of the project was evaluating the long-term consequences of treatment, patients should reliably return to the clinic for psychiatric interviewing and testing over the course of years or decades. But patients, they worried, could not be relied upon to do this out of the goodness of their hearts: one was noted as “always extremely diffident, if not antagonistic, toward returning for followup”,⁵⁸ and it is likely she was not alone (for reasons that will become clear below). More generally, Hampson wrote, he believed that “transsexuals are a very mobile group – perhaps as a result of their fear of

– but I have yet to see a medical record at a non-UW clinic at which this expectation was explicitly written into the consent form.

⁵⁷ John Hampson, in “Transcript: Comments at New Orleans Symposium”, 1971, Box 1, Folder 14, Dayton/Hunt Collection, University of Washington Special Collections, University of Washington, Seattle, WA.

⁵⁸ Psychiatric Followup Note, June 16, 1973, Karen Alfred Medical Record.

detection and other adaptive problems”,⁵⁹ and so needed to be encouraged to stay in contact with, and local to, the clinic. The doctors’ solution was the “hostage money”: a sum that would be held in an account by the University, and returned piecemeal to the patient whenever they came back for followup evaluation. As Hampson admitted to colleagues when discussing the approach, “legally, we’re okay, but ethically, I don’t know”.⁶⁰ Despite this, he had no problem requiring the hostage money of almost all prospective patients, with the exception of one who had been treated before the idea had occurred to him.

The reasons for Hampson’s ethical disquiet are unknown – he does not expand on his reasoning in the conference recordings – but likely relate to its simultaneous resonance with and departure from longstanding discomforts in medicine with how money and clinical research intersect.

Medical sociologists, bioethicists and physicians have long-studied (and raised concerns about) the common practice of soliciting research participation through paying participants token or not-so-token sums of money.⁶¹ The fear (bioethical, and scientific) is that such direct payment compromises the purity of the informed consent process, and the objectivity of the data that results from any studies, by incentivizing patient-participants to quash their own concerns (and disjoints between their own experience and what they imagine clinician-researchers desire them

⁵⁹ Letter to Richard M. Yarvis, Dayton/Hunt Collection

⁶⁰ John Hampson, in “Transcript: Comments at New Orleans Symposium”

⁶¹ Amie Devlin, "Compensation in Medical Research: Is Money the Problem?." *Voices in Bioethics* 6 (2020).

to report) in order to continue participating.⁶² In the case of the “hostage money”, patients did not *profit* from their continued participation – but they did lose out in the event that, subsequent to treatment, they chose not to return. The result was an unusual financial relationship, one largely without precedent – and with consequences that will become clear later in this paper.

The Costs

What we have in the UW GIC, then, is an example of a clinical program simultaneously structured for research purposes, and for treatment. This is not an unfamiliar story, to historians and sociologists of medicine. To the contrary, it has been well-studied – from the work of Renee Fox, in *Experiment Perilous*,⁶³ to Steven Epstein’s documentation of the difficulties in maintaining a placebo arm for drug trials during the early HIV/AIDS crisis.⁶⁴ In each case, the emphasis is on *tension*: Fox describes one of the central difficulties of the clinical researchers she studied as “meeting both their responsibilities as clinicians and their commitments to medical research to the fullest extent possible; ascertaining the limits of each set of obligations; and preventing or reconciling some of the conflicts that existed between them”.⁶⁵ Such tensions are hardly the only conflicts present in and around gender-affirming care: trans studies scholars and bioethicists, including both Latham and Velocci, have documented how the shape of treatment is

⁶² Jill A Fisher, *Adverse Events: Race, Inequality, and the Testing of New Pharmaceuticals*. (NYU Press, 2020).

⁶³ Fox, *Experiment Perilous* (n. 18)

⁶⁴ Steven Epstein, *Impure science: AIDS, activism, and the politics of knowledge* (University of California Press, 1996).

⁶⁵ Fox, *Experiment Perilous* (n. 18), 43

often dependent on reconciling patient desires with clinicians' own self-interest.⁶⁶ But in the specific context of a clinical *research* program, it is that clinician-researcher (and patient-participant) dichotomy that comes to the fore. From existing scholarship, we would expect the goals of research and care here to be in conflict with each other: what makes good patient care, after all, is not always the same as what makes good study design (and vice versa). And, in part, that is exactly what we see: a range of negative consequences from this intertwining, consequences that simultaneously undermined both patient health, and, paradoxically, the very research studies that motivated many of the constraints.

On patient health, there are many signs that participation was somewhere between stressful and immiserating. As part of the focus on regret - and as a demonstration of the power he had over them - Hampson would regularly stall patients from participating further, extending the real-life test indefinitely, for often-contradictory reasons. Patients were rejected for not wanting surgery enough; contrastingly, some were rejected for the opposite reasons. One patient was declared "much too emotionally unstable to be a viable candidate for that type of surgery".⁶⁷ But a look at her records show that the thing discomfiting the psychiatrist was simply a fear she had a "hidden agenda" to get treatment;⁶⁸ that her answers to questionnaires, and their truthfulness, were compromised by how much she desired care. Another was, even more explicitly, barred for being "rather pushy regarding conversion surgery".⁶⁹ That same patient later wrote to Hampson,

⁶⁶ Latham, "(Re)making sex" (n. 16) and Velocci, "Standards of Care" (n. 11).

⁶⁷ Letter to B.E.. Andersen. Jo Minter patient record.

⁶⁸ Psychiatry notes, December 8, 1969, Jo Minter patient record.

⁶⁹ Clinical Record - Psychiatry, September 8, 1971, Judy Prince patient record.

communicating how the deferral was impacting her mental health: “before, I was disturbed, now - I just hurt inside...Only you and the committee can make my dreams come true. Please, Dr. Hampson, inform me of my relative standing with the committee and the possibilities of future corrective surgery”.⁷⁰

Even more directly, participating could - paradoxically - *delay* access to gender-affirming care compared to not. One patient went to a private clinic seeking mammoplasty and rhinoplasty; the surgeon refused to “undertake the procedure unless [Hampson] felt comfortable with doing so...I am concerned about her tendency to seek help outside of the study group”.⁷¹ Although Hampson ended up approving of the procedure, it is both demonstrative of the tensions at play, here, and concerning, that the patient’s status as a research subject led to other doctors (at other institutions) delaying and deferring care. Both patient-specific stalling by Hampson, and the structure of the RLT overall, echo the experiences of many trans people seeking care contemporarily: an experience of processes as (as the title of Victoria Pitts-Taylor’s work puts it) “a slow and unrewarding and miserable pause in your life”.⁷²

Whether patients were ultimately approved for surgery or not, the drawn-out nature of evaluations were still costly: some were travelling from not only different states but different countries, particularly Canada, and had to do so over and over again for the testing; “twice each

⁷⁰ Letter to John L. Hampson, June 22, 1971, Judy Prince patient record.

⁷¹ Letter to John Hampson, November 8, 1971, Judy Prince patient record.

⁷² Victoria Pitts-Taylor, ““A slow and unrewarding and miserable pause in your life”: Waiting in medicalized gender transition.” *Health* 24, no. 6 (2020): 646-664.

month” for six to eight months.⁷³ The interviews themselves were exhausting; patients still remembered, fifty years later, that they were “constantly barraged with questions, and they would say the same question but [in] a different way. And they would just keep twisting the same question to become really redundant”.⁷⁴ And they were accompanied, due to the focus on research and regret, with extensive (and invasive) other forms of testing and documentation. Early patients were subject to “androgen studies with [a] Dr. Paulsen”,⁷⁵ something they were never asked to consent to, and many patients’ interviews were videotaped for research and educational purposes. In the case of at least one patient, her wife was also interviewed - and their (individual and shared) interviews were conducted “before the psychiatric faculty and the assembled group of 4th year medical students”.⁷⁶

Navigating the expectations outside of the formal tests and interviews led to their own stresses. The expectation that patients pay a substantial deposit and otherwise be “self-supporting as a woman”,⁷⁷ put patients in a seemingly-impossible position. They were expected to find a job that was substantive enough to save that money, respectable enough to pass Hampson’s moral mores, and feminine enough to constitute “gender-appropriate” employment - all while dealing with

⁷³ Letter to U.S. Immigration Officer, March 26, 1971, Sharon Green Patient Record.

⁷⁴ Interview with Emma Carter, April 18, 2023, Box 2, Folder 16, Dayton/Hunt Collection, University of Washington Special Collections, University of Washington, Seattle, WA.

⁷⁵ Clinical Record - Gender Identity Committee, February 27, 1970, Emma Carter Patient Record.

⁷⁶ Clinical Record - Psychiatry – September 3, 1969, Barbara Dayton patient record.

⁷⁷ Hampson, John L. Letter to M. Blades, October 28, 1971, Sharon Green Patient Record.

transphobia and misogyny both. These goals regularly clashed; one pair of patients ended up working as go-go dancers; they explained that “we must be accepted as women. What better way to prove it than by dancing at a go-go club in costume?”⁷⁸ This rationale both made sense, and led to potential difficulty when the head of the clinic was - as Hampson was - someone who often made demeaning and critical notes in the files of patients who engaged in sex work or entertainment.⁷⁹

Another patient had to take out a loan to pay for the deposit - again, a deposit for treatment that did not cost the University or its doctors any money in the first place - that left her with, after paying rent, \$35 a month as a result of the poverty it put her into.⁸⁰ Yet another worked “two jobs for the past three or four years” to pay for surgery.⁸¹ The situation was even worse for the transmasculine patients, who, although included in the later data analysis, and subject to the same research process, were not covered by the CRC funding and had to pay their own way. One had gone to three other clinics before finding the UW GIC, “all to no avail. They either said they

⁷⁸ G.L. Jason, *Sex Change* (Sun Publications, 1971), 92.

⁷⁹ It is notable that the followup studies used - and advocated the use of - a rating scale which penalised patients for a lack of “job skills” and/or criminality. See D. Daniel Hunt and John L. Hampson, "Follow-up of 17 biologic male transsexuals after sex-reassignment surgery." *The American journal of psychiatry* 137, no. 4 (1980): 432-438.

⁸⁰ Social Service Report: Initial Interview, August 10, 1972, Sharon Green Patient Record.

⁸¹ Social Service Report, April 8, 1972, Mary Carter patient record.

couldn't help me or wouldn't help me". He ended up quitting school "so I could earn money to afford this operation", and was only making \$400 a month.⁸²

All of these burdens and costs undermined patients' experience of the GIC as a site of care – and many were justified through invocations of the need to structure those experiences in a fashion optimal for research. But research, too, was undermined by the strict scrutiny and control patients were placed under. In patient notes, Hampson repeatedly raises the worry that patients are lying to present an optimal picture to him, while the outcomes study eventually published noted that some patients refused to take any tests as part of the follow-up process "because of the large amount of psychological testing done before their surgery and their reluctance to repeat it".⁸³ Reading Hampson's notes and the clinic's research output, one is reminded of Steven Epstein's documentation of clinical trials for HIV/AIDS drugs – where efforts to force patients into a placebo arm, functionally denying them possibly-life-saving care, led to patients (quite understandably) seeking to evade researcher controls, producing difficulties for not only patients, but the studies that resulted.⁸⁴

But there was another cost and issue, beyond all of these, raised by the structure of the clinic and its intertwining of research and medicine – one that appears when we look not at how it began or operated, but at how it ended: at why the clinic closed its doors in 1972.

⁸² Biographical Questionnaire. April 12, 1972, John Starr patient record.

⁸³ Hunt and Hampson, "Follow-up" (n. 79).

⁸⁴ Epstein, *Impure Science* (n. 64), Ch. 5-6.

The End

The surgical team was, over time, a large one, containing at various points a plastic surgeon, a urologist, a gynecologist, and an array of residents and interns. But the central figure was J. William McRoberts, the urologist who designed the vaginoplasty technique used and had the most enthusiasm, of the surgeons, for the project as a whole. Other surgeons had interest in the program or the expertise to lead surgical procedures - but not both. This became a problem in mid-1972, when McRoberts announced that he was leaving the University of Washington to take up a role as Chief of Urology (and Associate Professor) at the University of Kentucky medical center.

McRoberts had a range of reasons to want to leave, from his ongoing frustrations competing for operating room time to the simple fact that Kentucky was offering him a salary substantially greater than UW.⁸⁵ But as he prepared to leave and the University administration began tidying his books and projects, they quickly found he had been stealing from patients. Specifically, and as far as I can tell exclusively, the trans patients.

The problem was the “hostage money” program. From what I can tell, patient-participants’ financial deposits were initially held in a bank account operated by the Office of Grant and Contract Services - an arrangement that Office staff quickly became uncomfortable with. Their standard situation was a bank account attached to a documented grant proposal, where grant

⁸⁵ Letter to Robert van Citters from Julian Ansell, April 27, 1972, Box 1, Folder 2, Dayton/Hunt Collection, University of Washington Special Collections, University of Washington, Seattle, WA.

moneys would be deposited on a regular basis by the grantor and paid out to other parts of the University. In contrast, the “hostage money” fund was not attached to a grant at all, and consisted of randomly-deposited cheques from different bank accounts held by different people - followed by requests to pay out smaller amounts *back* to those same people. It is no surprise the Office asked McRoberts to take administering the fund out of their hands, which he promptly did, storing the money in a departmental account controlled exclusively by him known as the “Urology Research Fund”.

At this point, then, you have a bank account where nobody but the person who signs the cheques has insight into how much money is in it, deposits come from third-parties in positions of extreme vulnerability relative to that person - and as long as there is always \$150 in it whenever a patient comes back to be interviewed, nobody will ever know money is missing. You have, in other words, the perfect arrangement for a Ponzi scheme. And that is precisely how McRoberts began to treat it.

Over the years, McRoberts’ purchases using patient funds included (but are not limited to) the following: first-class plane tickets to New Orleans (\$700); the recording costs for the UW clinic documentary (\$1,200); a copy of the 1971 Merck Manual (\$8); and, finally, “frames for my academic diplomas for my office...[and] an office rug”,⁸⁶ together coming to around \$2,150 - or \$20,000 in 2026 dollars. Not only did he spend money from the Urology Research Fund for these

⁸⁶ Letter to Robert L. Van Citters from J. William McRoberts, October 16, 1972, Box 2, Folder 1, Dayton/Hunt Collection, University of Washington Special Collections, University of Washington, Seattle, WA.

items, but there is evidence he simply bypassed the Fund entirely to accept other, otherwise-untracked money into his personal bank account - and then attempted to involve his own victims as accessories to his fraud once it was discovered. One of his patients – who had sued him over her surgical outcomes – testified in court as an aside that:

“We made the cheque out to Dr. McRoberts and he accepted it and it was no more problems, then all of a sudden about seven months later when I went back in, the nurses started saying, “I think there is some kind of problem going on with McRoberts and the clinic, and the funds, there has been some kind of hassle,” then that afternoon Dr. McRoberts came to me and my husband and said....”[Patient Name], I need a favour”, and I said, what kind of favor, he said, “I want you to take this cheque”, and he gave me a cheque for \$1,200.00, [and] said, “I want you to have your husband re-deposit it in your account”, said, “send the cheque back down to the gender identity clinic in the gender identity clinic’s name”, rather than his, and with a note apologizing for taking so long to pay the money that should have been paid at the beginning”.⁸⁷

When McRoberts began his move and this was discovered, it was reported to Robert Van Citters - the Dean of Medicine - who was furious. Writing to McRoberts, he noted that at one stage it was recommended that everything be whitewashed by putting it in the hands of the State Auditor”, and that he had only held off from this action due to the adverse publicity it might

⁸⁷ Patient testimony, pp.56-7, Box 2, Folder 3, Dayton/Hunt Collection, University of Washington Special Collections, University of Washington, Seattle, WA.

cause for the university and staff.⁸⁸ Privately, he wrote to James Haviland - the Associate Dean - simply saying “this is a mess”.⁸⁹ McRoberts’ defense was that his use of the money was not fraud, but simply compensation for his own expenses associated with the project; that he had spent his own money “assuring that certain otherwise non-cooperative transsexual patients keep their post-operative visits...[and] carry them over short-term economic hardships”.⁹⁰ That such short-term economic hardships might have been avoided had the patients been \$1,500 richer is ignored.

To resolve the situation, van Citters demanded that McRoberts give the patients back whatever money *remained* in the accounts and shut down the Fund.⁹¹ McRoberts himself bitterly declared this plan to be an “obituary to the long-term research aims of the transsexual project...I am totally disheartened and predict that, at best, we will be left with a patch work [sic] follow-up

⁸⁸ Letter to J. William McRoberts from Robert L. Van Citters, November 28, 1972, Box 2, Folder 1, Dayton/Hunt Collection, University of Washington Special Collections, University of Washington, Seattle, WA.

⁸⁹ Letter to J.W. Haviland from Robert L. Van Citters, October 24, 1972, Box 2, Folder 1, Dayton/Hunt Collection, University of Washington Special Collections, University of Washington, Seattle, WA.

⁹⁰ Letter to Robert L. Van Citters, October 16, 1972.

⁹¹ Letter to J. William McRoberts from Robert L. Van Citters, Van Citters, September 26, 1972, Box 2, Folder 1, Dayton/Hunt Collection, University of Washington Special Collections, University of Washington, Seattle, WA.

that will have little scientific merit”,⁹² arguing that patients simply would not return to be interviewed if there was no financial incentive for them to do so.

Still, he and van Citters came to an agreement on the plan, and communicated a (false) explanation to the patients in a letter accompanying the cheque for the remaining funds. The money was being returned to each patient, they wrote, because “the recent cooperation has been so good that we no longer feel that these follow-up monies are absolutely necessary to ensure patient follow-up visits and, furthermore, that the patients, in the spirit of the transsexual study program, will continue faithfully on their own to keep their follow-up appointments”. The missing money was attributed not to McRoberts fraudulent practices, but to “the cost of supplies for and the manufacturing of the silastic vaginal molds and, for most patients, retention girdles”.⁹³ By the doctors’ own admission, those molds cost \$70,⁹⁴ providing an indication of just how much money had been genuinely misspent - and how thin the excuse and explanation was.

Other than this letter, patients were given no explanation at all for the end of the clinic and the return of their money. While other doctors (particularly Warren H. Chapman, who continued seeing former patients for endocrinological updates into at least the 1980s) took over ongoing care for those who had received treatment, those still being evaluated were simply left in the

⁹² Letter to Robert L. Van Citters, October 16, 1972.

⁹³ Appendix C, Letter to Robert L. Van Citters, October 16, 1972.

⁹⁴ Deposition of John L. Hampson, Box 2, Folder 3, Dayton/Hunt Collection, University of Washington Special Collections, University of Washington, Seattle, WA.

lurch, including at least one who had already been promised and scheduled for surgery.⁹⁵ As one patient put it, “everybody in the clinic disappeared...it was almost as though the entire clinic had never existed. Everyone but Dr. Hampson was transferred to different hospitals.”⁹⁶ This extended even to clinicians; Carr was never explicitly told the clinic had been discontinued at all. As he recounted, “I would get a memo saying there's going to be a meeting or we're going to interview a patient, and then suddenly there were no memos. It just seemed [it] quietly went away”.⁹⁷

The Aftermath

With the end of the “hostage money” program, and administrative disquiet about the research program as a whole, the formal clinic was brought to an end. Patients – despite having been assured in the closing letter that followup care would continue – were largely left to their own devices, with the exception of a couple of patients whose revision surgery was provided by other UW surgeons following McRoberts’ departure.⁹⁸ This did not stop them reliably and consistently, as promised, writing to Hampson to update him on their whereabouts and life circumstances – indeed, one of the most tragic aspects of the aftermath of the clinic is that,

⁹⁵ Interview of Rita Okura, May 11, 1995, Dayton/Hunt Collection, University of Washington Special Collections, University of Washington, Seattle, WA.

⁹⁶ Patient testimony, Box 2, Folder 3, Dayton/Hunt Collection, University of Washington Special Collections, University of Washington, Seattle, WA.

⁹⁷ Interview with Jack Carr and D. Daniel Hunt, May 11, 2023, Dayton/Hunt Collection.

⁹⁸ Ensinn, John W. Letter to John L. Hampson, April 26, 1973. Box 1, Folder 6, Dayton/Hunt Collection, University of Washington Special Collections, University of Washington, Seattle, WA.

despite Hampson's distrust of patients and the imagined necessity of the hostage money program, many patients continued upholding their end of the bargain into the 1990s.⁹⁹

As this suggests, the end of the clinic did not mean an end to the *consequences* of the clinic. On the negative side, the departure of McRoberts, combined with the cloud hanging over the clinic as a whole, also undermined the development of future sources of gender-affirming care at the University. While physicians still provided some mastectomies for transgender men, up until at least 1975,¹⁰⁰ it is notable that these occurred at Virginia Mason Hospital, rather than University Hospital itself.¹⁰¹ At the University hospital, there are brief references to one surgery being provided to a trans woman in the early 1980s, but nothing further.¹⁰²

But there were also positive outcomes from the Clinic's (brief) life, for both patients and providers. In the case of patients, those I have been able to trace have invariably lived rich, vibrant lives; we have a stand-up comedian, a racehorse breeder, a pastor, a recreational pilot.

⁹⁹ Or in some cases, further. When I managed to reach out to the patient I interviewed, one of my first questions was why she agreed to talk to me. Part of her answer was that she assumed my interview was part of the followup expectations – 50 years after treatment. I had to quickly backpedal and clarify before continuing.

¹⁰⁰ Letter to Carl F. Berner, February 7, 1977, James Richards patient record.

¹⁰¹ Interview with Richard Soderstrom, March 2, 2023, Dayton/Hunt Collection.

¹⁰² Letter to J. William McRoberts from Julian S. Ansell, May 11, 1982, Box 1, Folder 7, Dayton/Hunt Collection, University of Washington Special Collections, University of Washington, Seattle, WA.

The patient I managed to speak to had nothing but positive things to say about the program, albeit in ignorance of the financial malpractice, and they were not the only people whose lives changed as a result of their participation. The same was true of the physicians. Jean Wyman, a nurse at the Clinical Research Center in 1972, subsequently became a prominent gerontological nursing researcher. When we spoke, she remarked that her time treating trans patients at the CRC “shaped my thinking and the kind of research that I do”,¹⁰³ improving physician empathy and the quality of care for people with stigmatized medical conditions.

Hampson’s career largely stalled following the close of the clinic; he published, and taught, very little. But he did end up, in the late 1970s, sharing an office with a newly-hired professor named Dan Hunt. Hunt ended up looking at the contents of “four filing cabinets [containing] the files of the 400 individuals who had applied for transgender surgery”, and went out of his way to provide psychiatric care to transgender patients for over a decade, including referring them to surgeons at other institutions and supporting the Ingersoll Gender Center - a local, trans-led support group that is still running.¹⁰⁴

¹⁰³ Interview with Jean Wyman, January 10, 2024, Box 2, Folder 16, Dayton/Hunt Collection, University of Washington Special Collections, University of Washington, Seattle, WA.

¹⁰⁴ Interview with D. Daniel Hunt, May 7, 2022, Box 1, Folder 14, Dayton/Hunt Collection, University of Washington Special Collections, University of Washington, Seattle, WA; Interview with Marsha Boltzer, 6 July 2022, Keyes Collection, University of Michigan Special Collections, Ann Arbor, MI.

This interest by Hunt was catalyzed by his work interviewing the Clinic's original patients – because the promised follow-up study did, thanks to him, end up eventually. In collaboration with Hampson, Hunt published “Follow-up of 17 biologic male transsexuals after sex-reassignment surgery” in 1980, having phoned, written and in some cases driven around the country to seek out former UW patients and ask them about their experience. The resulting paper – which concluded that “for a select group surgery is still the best means of coping with transsexualism”¹⁰⁵ – was covered in the press as making an active intervention in the debates around the efficacy of care, coming so soon after the publication of a more-pessimistic study out of Johns Hopkins.¹⁰⁶

None of this makes up for the harms the program did - or raises the question of what patients' lives could have looked like with the money that went missing. Although many patients eventually had happy lives, some experienced extreme hardship; one patient ended up suing the clinic over her surgical results, and the fees for the lawsuit led to her losing her house. It is fair to ask how different things might have looked for her if she had access to the thousands of dollars misappropriated by McRoberts.

To make the story even more complicated, even McRobert's legacy for trans care is not limited to his actions at the UW clinic. Under his leadership as Chief of Urology, the University of Kentucky ran a gender reassignment surgical program for the next 20+ years, providing gender-

¹⁰⁵ Hunt and Hampson, “Follow-up” (n. 79), 432.

¹⁰⁶ See for example David Perlman, “Christine Jorgensen and Beyond”, *San Francisco Chronicle*, November 30, 1981, p.6

affirming care at a public institution in the south until at least the 1990s.¹⁰⁷ He continues as an emeritus professor at the University of Kentucky, having trained a vast number of surgeons over his career, including those providing gender-affirming care, who continue to practice. Before imagining this means a happy ending, however, it is worth mentioning that the University of Kentucky felt a need, in 1987, to sue him in state court. The lawsuit was for misappropriating the contents of a departmental bank account - an account named the “Urology Research Fund”.¹⁰⁸

Lessons from Seattle

In this paper, I have described the history of the University of Washington Gender Identity Clinic – a hybrid clinical research unit that sought simultaneously to provide treatment to patients, and to study them at the levels of psychology, surgery, endocrinology, and more. I have extensively documented the practices of the clinic, the way those practices were shaped by these simultaneous investments in care and research, the consequences of the overarching focus by clinicians on regret and the avoidance of scrutiny, and the ultimate fate(s) of the clinic itself, and the patients and practitioners involved in it. What are the implications of this history – and for

¹⁰⁷ Interview with Richard Sadove, September 14, 2023, ANON COLLECTION, University of Michigan Special Collections, Ann Arbor, MI.

¹⁰⁸ *University of Kentucky v. J. William McRoberts MD*, 89C1-0764. I did attempt to interview McRoberts; after writing to him and starting a brief exchange of emails, he ceased replying to emails, phone calls or additional letters.

whom? In both the introduction, and throughout the work, I have alluded to multiple lessons for multiple audiences, which are each worth digging into in more detail here.

One obvious contribution is how this case study adds new context to our understanding of the place (and use) of trans medicine in the history of medicine more broadly. Although trans medicine is often exceptionalized inside and outside academia, many of the tensions that appear in this case study are familiar ones to historians: questions of the relationships between doctors and patients, between care and research, and between formalized processes and ethical action. But when we discuss these tensions, we often – as mentioned in the introduction – frame them *as* tensions: as oppositional, as a matter of “conflicts” between interests or actors that must be “reconciled”.¹⁰⁹ But something present in both care and research is a differential between patient and doctor, or participant and researcher: a differential of power.¹¹⁰ As Jill Fisher evocatively demonstrates in her discussion of a patient-participants’ experience of a lumbar puncture in the clinical study she investigated, both clinicians *and* researchers hold tremendous power as a result of their role.¹¹¹ Still, when we investigate such environments, it is tempting to hold fast to our framing of those roles as in tension – as that power as, by default, in conflict.

As this case study demonstrates, tension is not the only relationship those roles can have, or have had: they can also be additive, *compounding* the power imbalance. When clinical research takes place, combining the two dynamics (and so sets of imbalances), the result can often be magnified

¹⁰⁹ Fox, *Experiment Perilous* (n. 18), 43

¹¹⁰ Howard Brody, *The healer's power* (Yale University Press, 1992)

¹¹¹ Fisher. *Adverse Events* (n. 62), Ch.8.

and heightened inequalities. The interweaving of clinical and research work makes the patients' refusal of the latter more difficult - and the conditions of clinical scarcity under which research studies are "the only game in town" to access treatment makes it far easier for clinical researchers to, as we've seen here, exploit the patients. In the case of the UW clinic, it was McRoberts' role as a clinician, and the authority and deference he accrued from patients and colleagues, that allowed the patient deposits to be gathered so willingly and dissuaded patients from asking questions. But it was his role as a *researcher* that provided the justification for those deposits in the first place – and the structuring of care as research, and the corresponding heightened costs to patients from participating – and thus, heightened costs for choosing to leave – that enabled the harms to patients to continue. And although the hostage money discussed here is the most extreme example of the (negatively) productive relationship between research and care, it is hardly the only one: much of the research data collection, including the parts patients found exploitative, distressing or actively traumatizing, was justified as research, but made *possible* because of the linking between participation in that research and access to care.

This case also adds detail to our understanding of the range of trajectories at North American GICs – which historians have, as mentioned, previously generalized solely from the clinic at Hopkins. One example of this focus (and its consequences) is the repeated academic emphasis on how the Hopkins clinic *closed*. The conventional story of this is that the Hopkins clinic closed in 1979 – something often described as prompted, or at least excused, by a widely-criticized outcome study that concluded medical treatment was ineffective at improving trans lives – which, the conventional narrative goes, then led to the closure of the remaining GICs over the next few years. Such a story often serves as a sort of morality tale, seemingly demanding that

future GICs attend to, and particularly prioritize, the integrity and rigor of their scientific research,¹¹² and that *more* rigorous research might resolve any dispute over the efficacy of gender-affirming care.¹¹³ But as the story of the UW clinic demonstrates, there are many possible failure scenarios for this kind of multi-disciplinary, research-oriented program – some of which are enabled *by* a decision to prioritize research (and researchers) over care.

All of these lessons and insights matter for historians of trans medicine, demonstrating that there is still much to be learned in examining the GIC, and historians of medicine more broadly, by pointing to resonances and applications for the history of trans medicine in the wider field. But as the Hopkins story above suggests, studies of GICs are not undertaken solely for reasons of historical completeness. Rather, it is with the intention of learning from these histories in a moment of unsurpassed political pressure on and scrutiny of gender-affirming care.¹¹⁴¹¹⁵¹¹⁶ The

¹¹² Alex S. Keuroghlian and Asa E. Radix, “A Cautionary Tale: The Doomed Gender Identity Clinic at Johns Hopkins Hospital,” *Ann Intern Med* 175, no. 10 (2022): 1483-1484.

¹¹³ Nnenaya Agochukwu-Mmonu, Asa E. Radix, and A. Mark Fendrick, "Determining the Benefits of Gender-Affirming Surgery—A Call for Action," *JAMA surgery* 157 no .3 (2022): 183-184.

¹¹⁴ Walker J. Magrath, "The fall of the nation's first gender-affirming surgery clinic." *Annals of Internal Medicine* 175, no. 10 (2022): 1462-1467.

¹¹⁵ Elliot Marrow, "Breaking cycles of harm: Lessons from transgender history for today's clinicians," *The Behavior Therapist* 45, no. 6 (2022): 191-199.

2020s are, for North America and Europe, just such a moment, with an inescapable moral panic around gender-affirming care that is often rhetorically framed as a concern about science: as a demand for *more research* and *more data*.

When access to gender-affirming care is restricted with the argument that there is insufficient research, it is understandably tempting for clinicians to attempt to correct this: to refashion the ongoing provision of trans medicine *as* a site of clinical research, seemingly killing two birds with one stone. Patients will have care provided, and providers and future patients will have the results of the studies interwoven with that care to draw from in seeking to buttress gender-affirming care against the vast amounts of political pressure currently being brought to bear. But the story of the UW GIC demonstrates that such optimistic images of alloying (and allying) care and research will inevitably be somewhat tarnished in practice. Far from being an uncomplicated additive to care, research is an entirely different world of practices and priorities, and the merging of it with medical research can produce contradictions that undermine the desired purity of both. Patients are immiserated by extensive testing that adds nothing to their care; providers are frustrated by the ways that patients' understandable desires to shy away from such testing confounds the purity of research data. Further, even when we do find points of commonality between the worlds of research and care, these commonalities are not always *good*. Power imbalances, and the inevitable temptation of coercion, appear in both worlds. When the two are brought together, the result can be additively, or multiplicatively, unjust.

¹¹⁶ Elliot Marrow, "'I hope that as our selection becomes more accurate, the number... will be very few': The creation of assessment criteria for gender-affirming care, 1960s–1980s," *Psychology of Sexual Orientation and Gender Diversity* 11, no. 2 (2024): 183.

