

Bence Solymár: The Situation of Transgender People in the Hungarian Social and Health Care System¹

In 2003, Háttér Support Society for LGBT People in Hungary undertook a research into the situation of transgender people in the social and health care system in Hungary. The project was funded by the Ministry of Health, Social and Family Affairs (under the heading Social Inclusion 2003) and was carried out in co-operation with TransSexual Online, and the Institute of Sociology of the Hungarian Academy of Sciences. This was the first descriptive social scientific study of the situation of transgender people undertaken in Hungary. The members of the research team were Sandra, Bence Solymár, Ferenc Szabó, and Judit Takács.

Research objectives

We undertook to explore the official and medical possibilities for gender transition in Hungary; to explore how gender transition is systematic or lacking in a system; to ask the people concerned to what extent they are satisfied with the system of gender transition and related services (“the system”), what they are missing from it, how they think it could be improved; to seek advice from professionals on good practice in the field. With a view to the experience of persons concerned and professionals, we undertook to make recommendations for establishing a system of good practice.

¹ Written in collaboration with Judit Takács; translated by Bence Solymár.

Finally, we undertook to publish a book of our research results along with an account of relevant international literature and thus make it available for professionals and the greater public.

Definitions

We distinguish “transsexualism” and “transsexuality”. Transsexualism is a medical term, transsexuality is a concept that reflects more on the existence of gender diversity in society with no necessary medical implications.

An internationally recognised definition of transsexualism is found in the International Classification of Diseases, a publication of the World Health Organisation. According to this classification transsexualism (F64.0) has three criteria:

1. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment
2. The transsexual identity has been present persistently for at least two years
3. The disorder is not a symptom of another mental disorder or a chromosomal abnormality.²

This definition does not necessarily define a possible member of our transsexual target group within our research project. A

² See: http://www.genderpsychology.org/transsexual/icd_10.html Another “tool” for diagnosing transsexualism is found in the publication of the American DSM-IV, under “gender identity disorder”. See: DSM-IV. 302.85 referring to adolescents and adults (http://www.genderpsychology.org/transsexual/dsm_iv.html)

member of our transsexual target group is a person who has entered or intends to enter the health care system, and who has considered/started/completed gender transition in their life.

It is important to note that throughout our research we did not try to re-establish/reinforce categories such as “transgender”, “transvestite” or “transsexual”. In the international literature “transgender” seems to be the widest of these categories, which refers generally to the transgression of gender boundaries whereas transsexuality is closely associated with the need for changing the person’s anatomical sex (cf. Whittle 2000). The term transgender can cover people who define themselves as transsexual, transvestite, transgenderist, third gender, intersexual, cross-dresser, drag king, drag queen, gender-gifted, shapeshifter as well as people who refuse to define themselves as belonging to a specific gender (cf. Nataf 1996). Transgender people may establish their identities in a constant state of gender transgression, they, however, do not all consciously embrace the idea of transgressing the boundaries of gendered behaviour. Our respondents gave several descriptions to define who they are. In the health care system they would be entitled to treatment as “transsexual” and therefore we refer to our target group as such.

Although we did not specifically focus on issues of representation of transgender people’s interests, we need to note that identity-based politics may not be appropriate to represent them. Whereas gender or sexual orientation have been grounds for forming social allies, vast differences between transgender people have hindered the formation of a stable, political transgender identity in Hungary. Some transgender people may form temporary allies with activists for lesbian, gay or bisexual rights. However, full equality for

all transgender people would involve fundamental changes in society, such as establishing and recognising a third, fourth etc. gender, legal arrangements for the marriage between persons regardless of their genders (cf. Monro – Warren 2004)

Methods

This descriptive research was carried out using questionnaires and interviews. We used semi-structured interviews in the case of transgender people and structured interviews in the case of professionals.³ We publicised the questionnaire⁴ for transgender people on the website of Transsexual Online, Pride.hu and on the website of Háttér Support Society for LGBT People. We also published our call for transgender respondents in a gay cultural-political magazine called *Mások* and another cultural-political weekly of greater public interest called *Magyar Narancs*. Our transgender interviewees⁵ were mostly people who had filled in our questionnaire. Further interviewees were contacted through respondents. In seeking out professionals for interviews, we relied on the list of professionals posted on TransSexual Online. In addition,

3 We interviewed 10 professionals. Eight of our professional interviewees take part or have taken part in the health care provision for transsexuals as psychiatrists (4), a clinical psychologist, a surgeon, an urologist and a genetician. Two other interviewees were a sociologist and an ethologist. Although their activities are not closely related to the health care services available for transgender people we hoped to get additional insight from their fields. The professionals we interviewed included (in alphabetical order) Béla Buda, Endre Czeizel, Nóra Csizsér, Zsolt Csobó, Vilmos Csányi, Emőke Dobos, Judit H. Sas, László Pajor, Péter Rigó, Lajos Simon.

4 39 questionnaires were filled in and returned to us.

5 17 interviews were made with transgender people.

information obtained by questionnaires and interviews, we also used written accounts of transgender people.

We found that transgender-specific literature or information is hardly available in Hungarian. Mass media (mis)represents transsexuality as a matter of scandal. Although there is some information available in medical reference books, it is mostly inaccessible and incomprehensible for people with little or no background knowledge, thus they are not a reliable source of information. Therefore we approached the Ministry of Health, Social and Family Affairs for information on the situation and rules of gender transition in Hungary. We received a written reply from the Department of Health Policy, which we included in our resources. Further assistance was received from József Kárpáti (Co-ordinator of the Gay Legal Aid of Háttér) and Don Bisson (Director of Eastern Europe, Council of Europe and Transgender Programmes, ILGA-Europe) in the overview of the current legal status of transsexual persons.

Main findings

We chose to present the main findings of our research recounting the recommendations we made for a good practice in relation with the way the state health care system and government offices treat transsexual people. The research results of the project are significantly shortened here. The recommendations, however, reveal the current situation of transsexual people and create a vision of a transgender citizen who can access public institutions as a member of the community of citizens, whose rights summarized by

Plummer's term "intimate citizenship"⁶ are granted by the state.

I. There is a need to establish a transpositive medical practice, which involves addressing professionals' prejudices where necessary

At the beginning of our interviews with professionals, we asked for a definition of transsexuality. Most respondents agreed that the main characteristic of a transsexual person is that they have a need to harmonise their self-concept and their body. However, there are significant differences in their approach. Some psychiatrists argued for the existence of a transgender continuum, which allows for certain cases to be approached by psychotherapy, while surgery is necessary in other cases. One psychiatrist, the surgeon and the urologist, however, thought that the only solution for the condition of a transsexual person is surgery. Some professionals were aware of the definition of the World Health Organisation. Our ethnologist respondent, however, talked about homosexuality throughout the interview as if transsexuality was non-existent.

One psychiatrist specifically mentioned differential diagnostics, as a method for diagnosing a patient's transsexual condition. Most respondents talked about similar ways of diagnosing transsexualism. There seemed to be a consensus about the need to distinguish transsexualism from homosexuality, transvestitism, intersex conditions and psychotic disorders. Homosexuality and transvestitism were mentioned the most often in opposition to transsexualism. The

⁶ See Judit Takács (2005) How to put equality into practice? Anti-discrimination and equal treatment policymaking and LGBT people. OSI - International Policy Fellowship, Budapest. Research paper. www.policy.hu/takacs

extent to which respondents could distinguish between these categories varied greatly.

Two respondents contended that transsexualism can be conceptualised as an extreme form of homosexuality. One of these (a psychiatrist) still thought that transsexualism can be treated medically, although allowing for a certain number of cases where psychotherapy could prevent the need for surgery and hormone therapy. The other respondent (the ethologist) argued that transsexualism as a status needing medical intervention could be prevented if societies could learn to recognise homosexuality as a matter of natural human diversity. In contrast, there was one psychiatrist who said “[transsexualism] is very far from homosexuality, but let us not waste words on this.”

Our transgender respondents often recounted a process of realising they were transsexual, which included temporary identification with a homosexual or transvestite identity. This was subsequently rejected when the need for full gender transitioning became obvious for the individuals. Some respondents felt the need to assert that they were not homosexual or transvestite, and some even considered these to be forms of social deviance.

We need to note that neither ICD-10, nor DSM-IV mentions homosexuality as comparable to transsexualism or gender dysphoria. This comparison is a construct of both professionals and transgender people. A homosexual identity as a non-conformist gender (partner’s gender-)related identity, with the sub-cultural institution of gender transgression presented in the phenomenon of “drag”, lends itself as a temporary ally or helper in expressing ways of cross-gender identification. However, a homosexual subculture is so widely

and strongly associated with cross-gender behaviour in the heterosexual matrix of heterosexist thinking (cf. Butler 1990) that it permeates the expectations/responses of both professionals and transgender people. That a transsexual person should not be homosexual is not a recognised diagnostic criterion: It can therefore be listed among the prejudices of professionals (and patients) that govern the clinical relationship.

Homophobia and transphobia exhibited by both professional and patient can be harmful when diagnosing a transsexual person, who may find him/herself conspiring in the game of transsexualism as a psychological illness. This game could get in the way of clarifying what he/she needs to ensure psychological well-being and coping with gender dysphoria.

Rupert Raj defines “‘clinical transphobia’ as follows: within the context of the professional working relationship between clinician and client, any belief, attitude, act or behavior (whether therapist- and/or client-generated) *which negatively values, denies, undermines, discourages or disempowers* trans-identified or GV [gender variant] clients in terms of their unique identities and subjective realities (including, but not restricted to, physical sex, gender identity, sexual orientation and sexual identity), quality of life, the pursuit of self-determination and human rights, and the right to comprehensive health care. (If clinical transphobia is initiated by the therapist, we can call this ‘therapist transphobia’, and if internalized by the client, ‘client transphobia (internalized)’). By comparison, ‘clinical transpositivity’ can be defined as its diametrical opposite, substituting, where appropriate, the phrase: *positively values, affirms, supports, encourages and empowers.*” (cf. Raj, 2002).

Whereas homophobia and even a specific form of transphobia may be silently agreed between a professional and a transsexual patient in a clinical setting, there are other forms of transphobic clinical practice that are based on professionals' expectations that the transsexual patient should conform to other gender-stereotypes and certain ethical premises.

The transphobic, homophobic expectations, prejudices and extra requirements that were found in our interviews with professionals conjure up an ideal transsexual patient who has always had trouble with social integration in his/her birth sex; who is heterosexual and finds homosexuality repulsive; who never had any sexual experience in their birth sex; who conforms to the stereotypes of his/her self-identified gender in appearance and behaviour; who is determined to undergo gender reassignment surgery at all costs; who is never willing to appear in the media as a transsexual person; who is secretive and will be secretive about his/her gender condition and who is not influenced by financial aspects in his/her decision to undergo surgery.

II. There is a need to set up a team of professionals working in the field of health care provision for transsexual persons

The opinions of professionals and transsexuals are in agreement; there is a need for a team of professionals working in the field.

Psychiatrists often stressed that they do not know anything about the transition of their transsexual patients after they have given referrals for hormone therapy and surgery. This does not give them an opportunity to see their decisions and

referrals confirmed. Transsexual persons often go back to psychiatrists only when they have attempted suicide, suffered depression or experienced other mental health difficulties. Our clinical psychologist respondent mentioned that transsexual people go to see her to get their diagnosis just like any person goes to have their blood-pressure taken. Some psychiatrists agree that the steps after referral, such as hormone treatment, the change in social relations and extremely hazardous surgery would probably require some psychological support.

As they have no connection with the psychiatrist who writes the referral, surgeons tend to be extremely cautious, ask for all the official documents, read referrals several times, and in some cases question the diagnosis of the psychiatrist. Our surgeon respondents felt as great a need to get to know their patients as some psychiatrists. They talked about carefully reading referrals and talking to their transsexual patients before surgery. Although whenever a hospital undertakes gender reassignment surgery as one-off occasion, there is an ad hoc team of surgeons to carry out the operation, this team focuses only on the surgical techniques.

The lack of professional teams also means that the diagnosis/recognition of a transsexual person is more subject to individual professionals' judgement, where prejudices and stereotypes may prevail as a result of insufficient experience in meeting and treating transsexual people. Our research team concluded that creating a team of professionals would help tackle clinical transphobia and consequently increase the chance to establish transpositive practice.

Some of the professionals' ideas of what a team would look like were:

- * a group of surgeons would include a urologist, a gynaecologist, a plastic surgeon and an internal specialist
- * an institution made available for people seeking advice about transgender issues on the same drop-in basis as drug policlinics are set up in Hungary
- * an institution that would provide research, advice and treatment in the field, including after-care in the form of groups for post-operative transsexual people to facilitate their personal development
- * a sexual problems clinic that would treat all sexual problems and would deal with transgender issues as well.

One psychiatrist respondent thought that some transsexual people would also benefit from the help of a social worker in finding their way through the complexities of official gender transition and getting the necessary funding for surgery.

The framework, in which a team of professionals would work, would be largely determined by the funding that could be allocated to transsexual care. The inclusion of transsexual care in a wider institutional structure could secure and regulate funding for professional development as well as create a space for team consultation, supervision and process work with patients.

Without an institution like this, transsexual people still face having to break new ground and find for themselves professionals who consider the new task professionally challenging enough to undertake it with no previous experience. Such operations lack official recognition within

the health care system, and often require patients to pay “incentives” to doctors. All of these factors reduce the effectiveness of transsexual care, make patients face often far too complicated situations and do not ensure that the patient is treated with respect.

III. A specific office within the Ministry of Health, Social and Family Affairs should take responsibility for transsexual care

Some of our respondents, both professional and transsexual, thought that there was a certain unwillingness of governmental bodies to deal with transsexual people.

The change of official documents belongs to the scope of the Ministry of Domestic Affairs, whereas gender reassignment surgery and hormone treatment belongs to the scope of the Ministry of Health Social and Family Affairs. One psychiatrist pointed out that the latter ministry is unwilling to undertake responsibility for transsexual care. This Ministry still does deal with issues around the authorisation of gender transition, although without a mandate, accountability or transparency of practice.

Respondents’ opinions agree that once transsexualism is recognised as a condition that may require medical intervention, transsexual patients are entitled to treatment within the state health care system. There is a need for the institutionalisation of transsexual care, without which treatment cannot be ensured.

The Department of Health Policy in the Ministry of Health, Social and Family Affairs has been providing some unclear basic information to transsexual people, but it does not seem

to undertake to cope with any further issues in which transsexual people may need official assistance.

Transsexual care is not institutionalised, the quality of treatment is not monitored, and both professionals and transsexual patients are missing the support of an institutional structure. Institutional reform, however, can only take place with the active involvement and facilitation of a governmental body. Our respondents thought that the vast majority of issues within transsexual care are health-related, therefore, the treatment for transsexual people should be the responsibility of the Ministry of Health, Social and Family Affairs.

The current lack of regulation, institutionalisation and official responsibility means that ultimately some transsexual patients' lives are endangered. No one is willing to take responsibility for (sometimes life-threatening) surgical failures. The patients do not even have the power of an average citizen to enforce their right to receive appropriate treatment, as transphobia is wide-spread and difficult to tackle.

IV. Gender transition should be regulated: its legal basis should be established and transparency of practice ensured

Some professional respondents recalled their first encounters with transsexual patients as people who had been redirected to several institutions that mostly refused to deal with them. They had not been able to find their place in the health care system.

There is current practice which deals with transsexual people, although no regulation provides rules for their official or medical gender transition. This makes transsexual people

extremely vulnerable as citizens and as patients, leaving them with very few rights to enforce.

When asked, transsexual respondents recounted very different paths they had to go along to officially change their names and genders, and even more diverse ways they managed (if at all) to get funding for different stages of gender reassignment surgery. Several transsexual respondents reported difficulties in accessing the health service and complained of the slowness and lack of transparency of official procedures, especially regarding the allocation of funds for surgery.

One professional respondent knew about attempts to officially settle the issues regarding transsexual care. However, our research team was not informed of the details of this by the Ministry of Health, Social and Family Affairs. We were informed that transsexual care extended no further than the change of birth certificates, mastectomy for female to male transsexuals and “castration”⁷ for male to female transsexuals. Hormone therapy and further surgery was not officially available as state funded treatment.

As it is possible to change birth certificates in Hungary, a person who has changed their official gender bears the same rights and responsibilities as anyone of his/her gender. However, transsexual citizens’ rights do suffer when their previous marriages are voided and when they lose their rights as guardians of their children. Furthermore, their rights to adequate health care are severely affected.

We were informed from current media publications that in some cases medical professionals with adequate professional expertise had used the complexity of half-official procedures

⁷ This is the word used in the official letter instead of orchiectomy/penectomy.

to postpone or passively deny treatment. In one case, a surgeon in a scientific lecture on TV recalled his former boss's opinion that the transsexual person in question would not be able to obtain the necessary referrals, anyway⁸.

We concluded that there is a need to set out the rules of gender transition in Hungary. This should be based on sufficient research to take into account the concerns and discover the needs of transsexual people.⁹

V. The scope of state funded gender realignment surgery should be defined

Many of our transsexual respondents complained about difficulties in securing funding for different stages of their gender realignment surgery. A government official informed us that other than mastectomy and orchietomy/penectomy, no surgery is officially available for transsexual people. Contrary to this, other surgery had been done in hospitals in the past, such as hysterectomy, phalloplasty and vaginoplasty, under different titles of treatment.

Apart from the obvious insecurity of this situation, transsexual patients criticised transsexual care as something entirely random and unsystematic, providing only for the more pushy and bloody-minded. Some also reported appalling and inhumane treatment from medical professionals. As there is

8 Public lecture given by **Borsos, Antal on April 5, 2004. Title: A nemek kialakulásának zavarai az emberben** (Disorders of the development of the sexes in humans)

<http://www.mindentudas.hu/borsos/index.html>

9 Our research was funded by the Ministry of Health, Social and Family Affairs within the EU-funded project "Social Inclusion 2003". This can be considered as recognition of the need to consciously include transsexual people in health care provision.

no waiting list to refer to, patients do not know when surgery might be available.

In the past, the lack of a care system for transsexuals posed a different danger to transsexual people. There was a rule, albeit unwritten, that in order to change one's birth certificate and other official documents, a person should have undergone irreversible changes. State officials required patients to go through this process without any help or recognition.

According to a professional respondent, this unfair arrangement was abandoned because of the high rate of unsuccessful and dangerous surgery. Current practice, since January 2004, leaves surgery as an option for which the state takes no responsibility.

Mastectomy and orchiectomy/penectomy can be performed anywhere in the state health care system, free of charge. This is fake and dangerous liberalism. Treatment is not available at every local hospital. Transphobia and lack of expertise make safe treatment unlikely. Furthermore, these surgical interventions are not sufficient to treat transsexual patients. Hormone replacement therapy and further surgery, such as metoidioplasty, phalloplasty for transmen, orchiectomy/penectomy, vaginoplasty, tracheal shave and electrolysis for transwomen are also required.

The quantity and types of surgery and corrective surgery vary between individuals. The current situation could be much improved, according to our transsexual respondents, if the state set out the types of treatment available for transsexual people within the state health care system. It would make the path of gender transition clearer, and transsexual patients

could plan ahead, which would have great psychological benefits.

VI. The scope of state funding should take into account the needs of transsexual people

We concluded that a revision of state funded treatment of transsexual people is necessary and that it should take into consideration at least the most basic treatment needs of transsexual people that would facilitate their overall health and well-being. At present a transsexual person may be damaged by inadequate treatment or may suffer because of a lack of treatment.

Our transsexual respondents told us about their struggles to secure state funding for their surgery. In one case, a respondent recalled the early 90s when he had to pay a significant amount of money for his mastectomy. Although the surgeon was convinced that it should be funded by the state, he did nothing to help secure funding for his patient.

In 2003-2004, when our research was carried out, the situation had changed. In one case, a surgeon specialising in breast problems, after performing mastectomy on one patient, decided to take up an interest in gender reassignment surgery. Although his patient had to pay for mastectomy and all aspects of hospital treatment, the surgeon set out to secure state funding and convene a team of other doctors for the patient's phalloplasty.

Apparently, when a professional decides to take an interest in the case of his/her patient, he/she comes up against the same barriers as the patient. Growing professional interest, however, can increase the pressure on the state health care system to provide more funded surgery to transsexual people,

which may create alliances between professionals and patients.

Lack of professional experience may result in poor quality surgery. Some professional respondents expressed a wish for the opportunity to learn specific surgical techniques and develop their professional knowledge in the field. Without this, patients who currently undergo gender reassignment in Hungary are likely to be the test dummies of semi-professional practice without even the minimum guarantee that any problems resulting from inadequate treatment will be treated as the responsibility of the health care system.

Therefore, when we talk about funding for transsexual care, such as funding for hormone treatment and various types of surgery, we also need to consider funding for professional development and corrective surgery. These funding issues further confirm the need for an institution or a centre responsible for transsexual care.

VII. The Ministry of Health, Social and Family Affairs should make available accurate information about transsexualism through several media

One of the criticisms mentioned by transsexual respondents was that there was little and incoherent information available about transsexualism. Transsexual people reported that they found information at random, and had to make their way among contradictory pieces of information regarding official changes and surgery options.

The majority of our transsexual respondents got in touch with the research team through TransSexual Online¹⁰. Most of them reported that the information they had came from this

¹⁰ <http://tsonline.uw.hu>

internet site and from people they got to know via this site. Knowledge about official procedures is anecdotal and may not reflect current circumstances. Contradictory information had been received from peers. This was being collected and sorted on TransSexual Online around the time we began our research. This individual and voluntary effort has contributed greatly to setting the standard of transsexual care and has supported patients to make informed decisions about their treatment.

The information available from peers now enables some transsexual patients to “educate” and inform the professionals treating them. Some transsexual respondents reported that the professionals who assessed or treated them did not know other professionals working with transsexual patients, nor did they know the official procedures.

Once the process of gender transition is officially set out, it needs to be made available to the wider public in a variety of forms. Although currently most information is on-line, we noted the need for information on paper and on the phone from a responsible office that is currently non-existent.

As some LGBT organisations and TransSexual Online undertake to further the case of transsexual people, official information could be made available through their infrastructure, which also involves help-line services. It would be useful to publish information leaflets for transsexual patients as well as guidelines for professionals such as doctors and nurses.

Clearly spelt out official information would furthermore enable human rights organisations to ensure that the rules are

adhered to and that the civil rights of transsexual people are respected.

VIII. State and private practice should be clearly separated

State and private health care provision are not clearly separated. The Department of Health Policy, of the Ministry of Health, Social and Family Affairs write a standard letter¹¹ to people enquiring about gender transition. The letter briefly describes the order in which one has to obtain referrals, submit a request for the changes in official documents. It also gives the contact information of a psychiatrist and a clinical psychologist. One of these professionals has a state as well as a private practice, the other one only has a private practice. The psychiatrist told our team that if a patient wants to see him relatively soon, they should use his private practice. From transsexual respondents we heard of cases that showed that the boundaries between private and state health care were being blurred.

Unclear boundaries between private and state health care provision contribute to the insecurities experienced by transsexual persons in the health care system. Patients are often being guided or pushed towards private health care, and some types of surgery are available only through the expensive private scheme. One possible reason for this is the transphobia in health care that discounts the needs of transsexual patients.

¹¹ Although the extent to which this official letter is approved is unclear, all transsexuals requesting information from the Ministry of Health, Social and Family Affairs have received the same standard letter since January 2004.

A transsexual respondent recalled a situation when he could obtain surgery only by virtually hiring state hospital facilities (ward, operating theatre, doctor's expertise etc.). The way the price was calculated and how it was fitted into the overall work of the state hospital was not explained. We are not aware of other cases, where a single patient could hire hospital facilities. This occasion was certainly an example of the blurred boundaries between private and state health care. As the privatisation of state health care has not happened in Hungary, state hospitals are not supposed to use this method of income generation.

Unethical professional attitude is reported in some other cases. A surgeon in the state health care scheme told a patient during one of their consultations how much "incentive" he would require for performing the surgery. Considering that the patient had at that time been granted state funding for the surgery, this was a case where the surgeon decided to avoid official procedures in the hope of "making the most of the patient's situation". This avoidance is generally recognised as one of the most serious defects of state health care in Hungary; unethical behaviour is not limited to transsexual cases.

We could not reach private practitioners, so we could see transsexuals' situation in the private health care from the patient's perspective and from the perspective of those working in the state sector.

One professional respondent shared with us his opinion that plastic surgeons, who practically all work privately, would like to reserve gender realignment surgery for the private sphere arguing that expertise available in the state health care is insufficient.

We found no evidence, however, that private practice welcomes transsexual patients. In one article, in a weekly publication, a well-known private plastic surgeon talked about the possible achievements of his science in performing gender realignment surgery. He made it clear, however, that he did not on principle agree with such intervention into nature. This and reports of transsexual respondents suggest that transphobia may be prevalent in private practice as well as in state health care. Expensive treatment is not refused, however, but free or discounted correction of surgical failures is reported to be unavailable.

We concluded that the clear distinction between private and state health care is hugely important in eliminating unethical professional behaviour. Furthermore, there is a strong need to create a professional environment where a patient does not need to face the obstacle of the doctor's special "financial requirements". We did not explore the ways transphobia in private practice could be tackled, as we did not get sufficient contact with private practice.

IX. Family law should be amended to provide arrangements for families in which at least one member is transsexual

Currently, Hungarian family law does not provide for the possibility of a spouse undergoing gender transition. Although persons who have legally transitioned will enjoy the rights and responsibilities of their "new" gender, they cannot carry over the rights and responsibilities acquired as the member of the gender they "left".

We argued that this legal void could be associated with the homophobia inherent in current family law, where only a man

and a woman can enter into marriage and create a family where the children belong to both of them. The official change from one gendered status to another would mean no loss of rights and responsibilities if same-gender families were recognised on an equal footing with mixed-gender families.

The lack of sufficient legal arrangement for same-gender families especially impinges on the children who may belong to the family in which an adult/parent transitions. A situation may occur where the state indirectly forces families apart.

We argued that good legal practice for transsexual citizens would include settling the questions arising in family law. Appropriate recognition of same-gender families may be necessary as well as the provision for the continuity of parental rights of transsexual parents.

Conclusion

The research team aimed to raise awareness of the situation of transsexual people and address legal, social and health issues.

In our overview of legal arrangements, we focused on three aspects of legalities: personal status, implications of family law for transsexual people and access to health services.

Currently, we cannot talk about a consistent legal framework of gender transition in Hungary. Practice tends to abandon any medical requirement for complete official gender transition, and puts transsexual citizens in a personal status where they have equal rights and responsibilities with people who did not undergo gender transition. We agreed that this practice conforms to the requirements of international good practice. However, the lack of accountable legal arrangements

causes concern for the consistency of this practice in the future. Furthermore, the legal void concerning the marital status and parental rights of transsexuals was identified as a case of possible legal discrimination.

With respect to the health care of transsexual patients, paragraphs 1, 2 and 10 of Act CLIV (1997) on the health services are to be emphasised. These state the personal freedom, autonomy, dignity and conservation of health of patients. The lack of regulated health care provision for transsexual people, and a health care system in which transphobia may be prevalent does not fulfil the requirements set out above.

The social issues we addressed were the prejudices and stereotypes transsexual people as patients face in the health services, and the social reality of our transsexual respondents. Prejudices and stereotypes are at play in the process of recognising transsexual people. They may account for the lack of regulation of their access to health services. Prejudices and stereotypes create a transphobic environment in which appropriate treatment is unlikely to be provided, without professional care and responsibility being taken.

The health issues we explored were the treatment needs and possibilities for transsexual people in Hungary. We found that treatment is not easy to access, may not be appropriate, and may indeed disregard the most basic needs of transsexual patients. Inappropriate and inadequate treatment is causing transsexual patients harm.

In Hungary, the research team presented these findings at the 9th LGBT Festival in 2004 in the presence of the Minister of Equal Opportunities. Our research has been well received and

we are preparing to publish it in our book entitled *Surgery of the Soul* that will contain our full research paper as well as additional reading.

References

Butler, Judith (1990) *Gender Trouble. Feminism and the Subversion of Identity*. New York & London: Routledge.

Monro, Surya – Lorna Warren (2004) *Transgendering Citizenship*. IN: *Sexualities* Vol.7, No.3, 345-362.

Nataf, Zachary I. (1996) *Lesbians Talk Transgender*. London: Scarlet Press.

Raj, Rupert (2002) *Towards a Transpositive Therapeutic Model: Developing Clinical Sensitivity and Cultural Competence in the Effective Support of Transsexual and Transgendered Clients*. In: *The International Journal of Transgenderism* Vol. 6, No 2, 2002; http://www.symposion.com/ijt/ijtvo06no02_04.htm

Whittle, Stephen (2000) *The Transgender Debate. The crisis surrounding gender identity*. Reading: South Street Press.