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Elmer Belt, Harry Benjamin, and the Birth of Gender-Affirming Surgery in the United States

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Introduction: Gender Affirming Surgery (GAS) originated in early 20th century Europe and innovators there established some of the first surgical and social principles of GAS. GAS in the United States, however, lagged behind in practice and acceptance. Two American pioneers in the care of patients undergoing gender-affirmation therapies were Elmer Belt and Harry Benjamin. How they became dedicated to GAS and establishing a new standard of care for GAS in the United States is less clear. Our goal was to describe how Belt and Benjamin created GAS in the US, in the context of their time, and how their work influenced our current approach to transgender care.

Sources and Methods: We accessed the private papers, correspondences, and memos of Belt and Benjamin from their private libraries, donated collections to local archives or libraries including the University of California at Los Angeles, the National Library of France (Paris), and the National Library of Medicine (Bethesda). We used secondary sources as cited.

Results: The first documented GAS was performed in Berlin at the Charité Hospital in collaboration with Magnus Hirschfield's Institut für Sexualwissenschaft in 1922. Thirty years later, the sensational story of Christine Jorgensen, an American GI who underwent transgender surgery in Denmark, sparked US interest in transgenderism. By the early 1950s, US endocrinologist and transgender activist, Harry Benjamin, sought a surgical partnership with Elmer Belt, a Los Angeles urologist. Belt became the first surgeon in the US to perform gender affirming surgery, though he did so in secrecy. His surgical interventions included penectomy, vaginoplasty, and abdominal transposition of the testicles. Despite the safeguards that Belt and Benjamin created, Belt ultimately discontinued gender affirming surgeries as he feared patient regret might lead to either legal or personal retribution. These unofficial safeguards ultimately influenced the World Professional Association of Transgender Health (WPATH) standards of care, leaving a lasting impact on the field of gender affirming medicine.

Conclusions: Benjamin and Belt were extremely influential in the birth of gender affirming surgical care in the US

Key Words: Elmer Belt, Harry Benjamin, Gender Affirming Surgery, Transgender Medicine

ender affirming surgery was first documented as early as 1922 in Berlin, but its expansion to other parts of the world halted in the wake of World War II. However, wartime trauma advancements by British plastic surgeon Harold Gillies ultimately became the foundation for phalloplasty, and the post-World War II era presented a cultural shift in the American ethos that allowed for advancements in gender affirming surgery.(1) Americans in the late 1940s and early 1950s were experiencing "technological euphoria" with the steadfast belief that scientific advancement and discovery were limitless.(2) In addition, there was an increasing acceptance of individualist culture that emphasized one's right to live as they chose.(3) This atmosphere lent itself to curiosity among the general, medical, and transgender population alike, and it likely influenced Dr. Harry Benjamin and Dr. Elmer Belt to pursue gender affirming surgical care for their transgender patients.

SOURCES AND METHODS

Secondary literature was reviewed regarding the individual roles of Drs. Elmer Belt and Harry Benjamin in advancing gender affirming surgery in the United States, including scientific publications, transgender history books, and personal files of Belt and Benjamin. The UCLA Library Special Collections provided Dr. Belt's files, containing many correspondences between Belt and Benjamin. The Kinsey Institute for Research in Sex, Gender, and Reproduction at Indiana University

provided Dr. Harry Benjamin's personal files, including correspondences with Dr. Belt. In addition, we accessed the collections of the National Library of Medicine at www.nlm.nih.gov, the Library of France at www.gallica.fr, the Magnus Hirschfeld society at www.magnus-hirschfeld.de, and the German Map Archives at landkartenarchiv.de.

RESULTS

Hirschfeld and the *Institut für Sexualwissenschaft*

Transgenderism has likely been perceived in humanity from time immemorial but it was not until German Sexologist Magnus Hirschfeld (1868 – 1935) developed formal codification schemata to establish boundaries between homosexuality, transvestitism, and transsexualism (Figure 1). He termed individuals as "transsexuals" if their desired gender identity conflicted with their sex assigned at birth. Critically, this established a category separate from that of homosexual and transvestite individuals. In 1919, Hirschfeld established the *Institut für Sexualwissenschaft* (The Institute for Sexual Science) in Berlin to study gender identity and sexuality (Figure 2).(4) As a gay man himself, he advocated for and employed many of his patients at the Institute to protect them from legal troubles as they lived out their desired lives (Figure 1).(5)

One of Hirschfeld's patients and employees was Dora (Rudolph) Richter (1892-1933) (Figure 3). Rudolph Richter experienced severe gender dysphoria from a young age and, when only 6 years old, she attempted to remove her own penis with a tourniquet. After multiple arrests for cross dressing, she was released into the custody of Hirschfeld who employed her as a domestic servant at the Institute. In 1922, Richter underwent orchiectomy at the nearby Charité Hospital by German surgeon (and future convicted war criminal) Erwin Gorhbandt (1890-1965). In early 1931, reconstructive surgeon Dr. Ludwig Levy-Lunz (1889-1976) performed Richter's penectomy (Figure 3). Following her recovery, Richter then underwent the first documented gender affirming vaginoplasty, performed by Gorhbandt. In this procedure, Gorhbandt incorporated surgical principles of vaginoplasty, described in the late 19th century for the Mayer-Rokitansky-Kuster-Hauser population with congenital vaginal atresia.(5) In this procedure, a perineal dissection between the bladder and rectum was carried to a depth of 12 cm until peritoneum was reached, creating a space for the neovagina. Upper thigh skin grafts were used to line the neovagina, reinforced by an intravaginal sponge sutured in place to mold the cavity. The sponge was left *in situ* for several weeks post

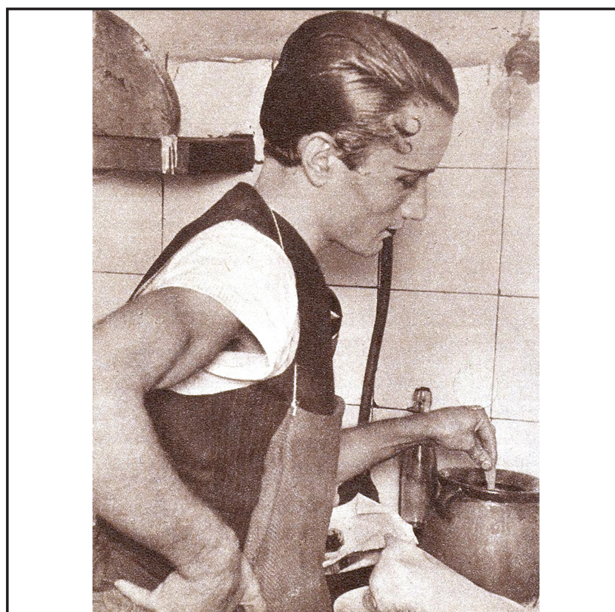


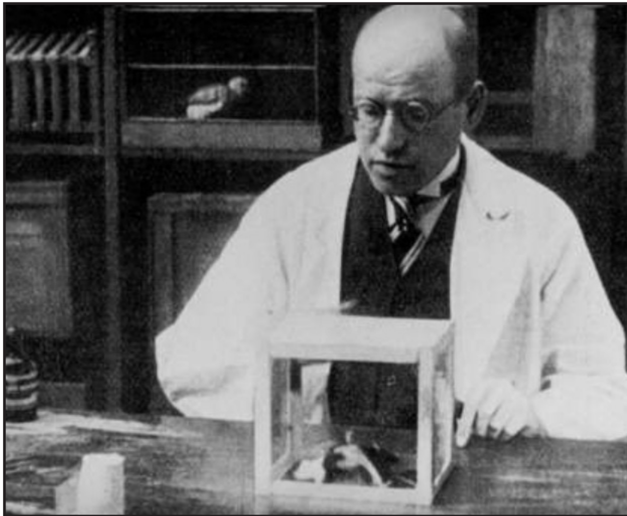
Figure 1. Magnus Hirschfeld (left) (1868-1935), in exile in Paris, early 1930s, established the *Institut für Sexualwissenschaft,* in berlin, as part research center and part shelter where many transgender individuals were employed (right) (*Voilà : l'hebdomadaire du reportage*, 7/1/1933, National Library of France).

Figure 2. 1920's Berlin, site of the world's first gender affirmation surgery. Pictured here in city center are **A**, site of Hirschfeld's *Institut für Sexualwissenschaft* on 3 Beethoven Strasse; **B**, Charité Hospital where Dora Richter's 1922 and 1931 surgeries took place; and **C**, the Operaplatz (now Bebelplatz), where marauding SS youth staged a book burning of all of the Institute's written materials on May 10th, 1933. (Pharus Berlin, 1920, *Landkartenarchive*, Germany)

operatively to help the graft adhere to the neovaginal wall. Following sponge removal, neovaginal dilations were performed to maintain the neovaginal cavity. Subsequently, Felix Abraham (1901-1937) published reports describing Richter's and Lili Elbe's (a Danish painter, 1882-1931) gender-affirming vaginoplasties in 1931. Tragically, the Institute was raided by Nazi-backed students in 1933, and its library and contents were burned in the infamous book conflagration of May 10th, 1933 (Figure 2). It is presumed that Richter did not survive the attack but others have reported that she survived the war in Czechosklovakia and then West Germany.(5) Hirschfeld himsefl had left Germany in 1930 for a world-wide good-will tour and was never to return, eventually dying in exile in Nice, France, while many of the Institute's employees were persecuted under the Nazi regime.(5)

Christine Jorgensen and American GAS

Over the next 20 years, and with Europe under the cloud of WWII, there were few advances in the field of transgender care.(5) However, in 1952 transsexualism and gender-affirming surgery was revitalized by news of Christine Jorgensen (1926-1989), the "Ex-GI" who became a "Blonde Beauty" after GAS overseas (Figure 4). Her 1953 surgery was the most frequently reported topic in the United States.(2) George Jorgensen traveled to Denmark in 1950 after learning that doctors there were hormonally and surgically treating transgender patients. She described her journey as a "one way ticket to a new life...George Jorgenson is never coming home."(6) She worked with Danish endocrinologist Christian Hamburger (1904-1992) who treated her with synthetic estrogen, a new advent in endocrinology. Christine was readily willing to be experimented upon and serve as a self-proclaimed "guinea pig".(6) Hamburger ultimately was the inspiration for her chosen name, "Christine". In 1951, following legal approval in Copenhagen, she underwent orchiectomy, soon followed by penectomy in 1952. Although reports vary, it is believed that she eventually underwent vaginoplasty upon her return to the United States.(5) Christine paved the way for transgender individuals in the United States as her publicity shed light on the societal and medical



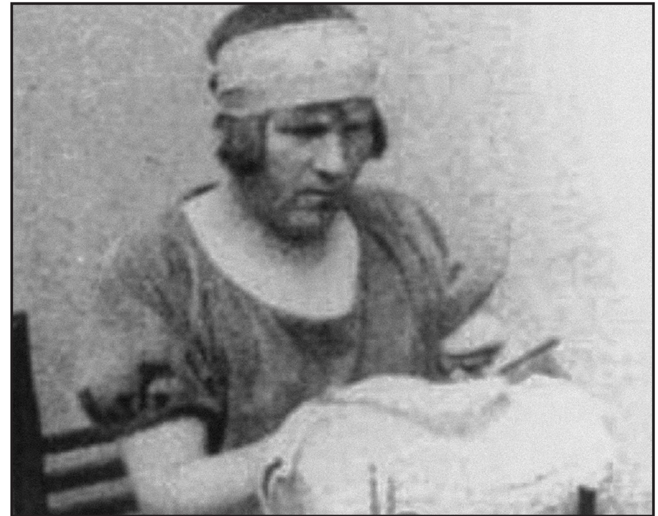


Figure 3. Ludwig Levy-Lenz (1892-1966) (left) was said to have performed penectomy, the second stage of gender affirimation surgery for Dora Richter (right), in 1931, shown here working in Hirschfeld's Institute on Beethoven Strasse, early 1920s (Both WikiCommons).

challenges faced by those considering gender-affirming therapies. She supported herself by performing on stage with songs and dance, never sexualizing her transition by adhering to the stereotypical '1950s housewife' persona.(3) Her efforts in this regard appeared to have engendered a positive public response and influenced perspectives regarding transgender individuals.(1) In his 1966 publication "The Transsexual Phenomenon", German born and educated endocrinologist Harry Benjamin (1889-1986) stated that "the case of Christine Jorgensen focused attention on the problem as never before.

Figure 4. Christine Jorgensen (1926-1989), the American actress and singer, and the US first known GAS patient. (Dare magazine, July 1953, Public Domain)

Without her courage and determination, undoubtedly springing from a force deep inside her, transsexualism might be still unknown -- and might still be considered to be something barely on the fringe of medical science."(7)

Headlines at this time focused on GAS being performed overseas, but the New York endocrinologist Harry Benjamin was by 1950 already providing hormonal treatment to transgender patients. Benjamin had a longstanding friendship with Hirschfeld and he had trained under Austrian physiologist Eugen Steinach (1861-1944). Steinach, who partnered with Hirschfeld in the 1920s, was the first to identify the morphologic effects of synthetic testosterone and estrogen on human development.(3) Benjamin eventually fled Nazi Germany for the US but had visited the Institute many times during the 1920s and early 1930s.(8) In the late 1940s, Benjamin was referred a transfeminine patient. Given his experience with hormonal treatments in the geriatric population, he felt comfortable hormonally treating the patient in hopes of improving her gender identity.(8) A large influx of patients sought Christian Hamburger's care in Denmark following the publicity of the case of Christine Jorgenson. In response, the Danish Ministry of Justice officially banned international patients.(3) Hamburger was greatly empathetic to the more than 450 potential patients who had written him and recommended that they contact Benjamin.(3) Benjamin developed such a large following thereafter that he required a surgical partnership and an ally for surgical referrals. He found one in Elmer Belt, already an established urologist in Los Angeles.

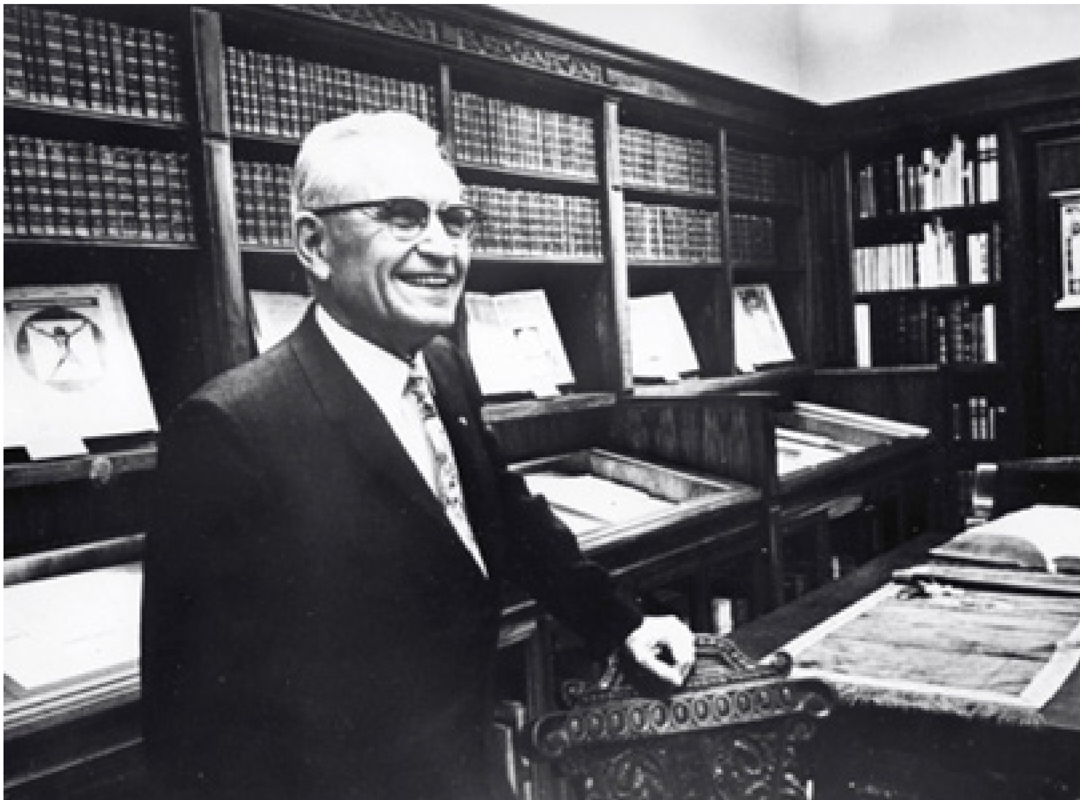


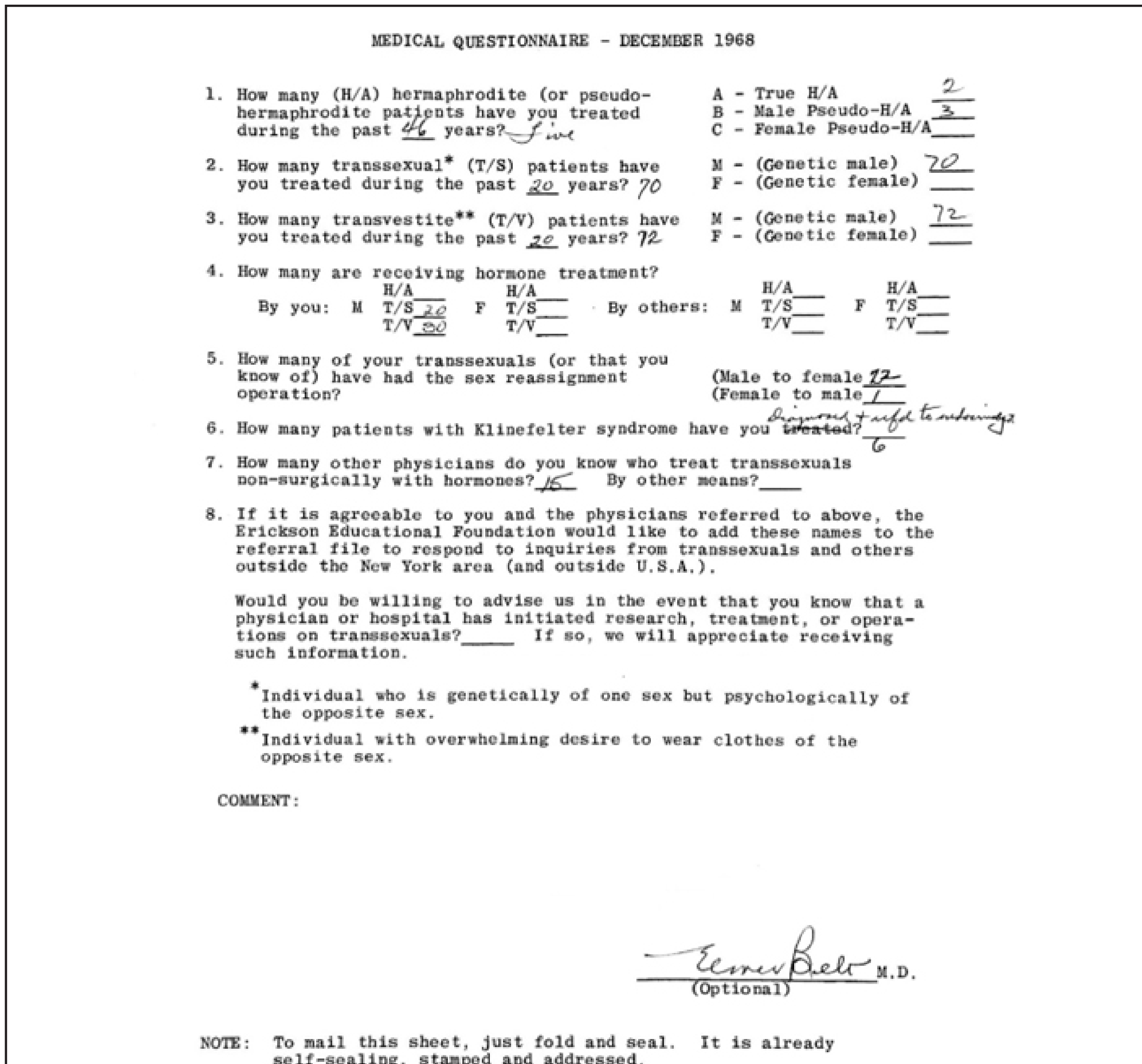
Figure 4. Elmer Belt (1893-1980), the UCLA urologist and historian, was a pioneer in American gender-affirming surgeries in the 1950s and early 1960s though struggled with the socio-economic impact on his patients who he felt had unrealistic expectations of GAS outcomes.(UCLA archives, Los Angeles)

Elmer Belt, American pioneer

Elmer Belt (1893-1980) performed gender-affirming surgeries at Good Samaritan Hospital as the University of California at Los Angeles (UCLA), where he was on faculty, objected to his performing GAS there.(9) It is reported that Belt began performing GAS including penectomy, vaginoplasty, and abdominal transposition of the testicles as early as 1950 for patients referred by Benjamin.(3) From 1950 to 1954, Belt performed at least a dozen GAS in secrecy.(1) Rather than orchiectomy, Belt performed abdominal transposition of the testes in order to circumvent California's so-called 'mayhem laws' which forbid elective castration.(10) Patients who tolerated several months of hormone therapy and still desired castration were referred to the general surgeon, JC Koch of Amsterdam whom Benjamin knew through the Dutch psychiatrist Frederik Hartsuiker of the Netherlands. With time, however, Hartsuiker became skeptical of the practice and referred all of Benjamin's patients to the Dutch psychiatrist Dr. Coen van Emde Boas (1904-1981). Following successful orchiectomy, these patients returned to the United States, often completing their feminizing vaginoplasty with Elmer Belt, as the surgeons in Amsterdam were not yet performing vaginoplasty.(10)

Little is documented about the methods of Elmer Belt's gender-affirming surgery. He practiced in relative secrecy and purposefully did not publicize his care for the transgender population. Furthermore, many of his files were destroyed in a 1958 office fire. In contrast, Benjamin was a published author and presented nationally on his experiences with the hormonal and surgical outcomes of his patients, many of whom had been operated upon by Belt. What little is known about Belt's transgender work is through patient reports and his personal files that were donated to the UCLA Library. In her autobiography, "*The Man-Maid Doll*", Patricia Morgan reported her care under Belt including her undergoing penectomy and intraabdominal testicular transposition, followed two months later by vaginoplasty. She recounted in horror the smell of tissue necrosis after neovaginal sponge removal and immense pain with in-clinic neovaginal dilations.(11) Other patients recall Belt's office staff seeming uneasy by their presence. Despite being treated rudely at times, patients felt that they had to tolerate this treatment as Belt was their only hope for transfeminine surgery in the US.(3)

Patient selection for surgery was critically important to



MEDICAL QUESTIONNAIRE - DECEMBER 1968

1. How many (H/A) hermaphrodite (or pseudo-hermaphrodite patients have you treated during the past 46 years? five
   A - True H/A 2
   B - Male Pseudo-H/A 3
   C - Female Pseudo-H/A ____

2. How many transsexual* (T/S) patients have you treated during the past 20 years? 70
   M - (Genetic male) 70
   F - (Genetic female) ____

3. How many transvestite** (T/V) patients have you treated during the past 20 years? 72
   M - (Genetic male) 72
   F - (Genetic female) ____

4. How many are receiving hormone treatment?
   By you: M H/A ____ T/S 20 T/V 30 F H/A ____ T/S ____ T/V ____
   By others: M H/A ____ T/S ____ T/V ____ F H/A ____ T/S ____ T/V ____

5. How many of your transsexuals (or that you know of) have had the sex reassignment operation?
   (Male to female 12
   (Female to male 1

6. How many patients with Klinefelter syndrome have you ~~treated~~? 6

7. How many other physicians do you know who treat transsexuals non-surgically with hormones? 15 By other means? ____

8. If it is agreeable to you and the physicians referred to above, the Erickson Educational Foundation would like to add these names to the referral file to respond to inquiries from transsexuals and others outside the New York area (and outside U.S.A.).

   Would you be willing to advise us in the event that you know that a physician or hospital has initiated research, treatment, or operations on transsexuals? ____ If so, we will appreciate receiving such information.

*Individual who is genetically of one sex but psychologically of the opposite sex.

**Individual with overwhelming desire to wear clothes of the opposite sex.

COMMENT:

Elmer Belt M.D.
(Optional)

NOTE: To mail this sheet, just fold and seal. It is already self-sealing, stamped and addressed.

Figure 5. Medical questionnaire sent to Belt on behalf of the Erickson Educational Foundation in 1968. The filled out questionnaire catalogs Belt's clinical experience and volume of gender-affirming surgeries that he performed. This questionnaire was among Belt's personal files that were donated to UCLA Library Special Collections by his family.(18)

both Benjamin and Belt who harbored fears of either personal or legal retribution from patients. In an attempt to minimize patient regret, Belt would send Benjamin's patients to psychiatrist Carroll Carlson "in accordance with our established routine".(12) However, psychiatric clearance was often not enough to convince Belt to operate.(13) Benjamin wrote that surgical, psychological, and practical outcomes were the three essential criteria to consider surgery.(13) As a result of their own stringent criteria to protect patients and themselves, Benjamin and Belt ultimately withheld surgeries from patients who otherwise had adhered to normative transgender roles.(13) Benjamin and Belt corresponded frequently about patient "EV". In one letter, Belt wrote to Benjamin that he wasn't comfortable operating on EV "regardless of what the psychiatrists say".(14) Belt joked in one letter to Benjamin that they would both likely "get shot by some patient like EV"highlighting their fear of personal retribution.(15) Belt conjectured that because EV would not "pass" as a woman in society at the time, which could potentially affect her income potential, she was at risk of developing "surgical regret".(13)

Factors of Social Impact on Surgical Results

Some patients expected Belt and Benjamin to assist them in finding jobs after surgery once the patients found themselves abandoned by their family and social support systems.(3,13) The perceived need to 'blend into society' in the stereotypical mold of the new gender identity became another requirement for Belt before he agreed to operate upon a patient. Such caution demonstrates that, while Belt and Benjamin were, in general, supportive of transgender patients' right to surgery, they were highly selective 'gatekeepers' before surgical therapies could be commenced. Despite having "a strong sense of compassion for these poor devils", Belt soured as his patients' demands increased.(16) He once wrote that "in the most successful operation we ever had, the patient came in after all was done expressing dissatisfaction because there was not a uterus with tubes and ovaries… and she could therefore not have a baby."(3) Belt and Benjamin's correspondence highlighted their desire to offer surgery only to patients "who weren't too demanding" as their self-advocacy was perceived as impatience and volatility.(13) In this early era of transgender medicine, Belt's concerns were not inconsistent with fellow practitioners fearing their patients would "ruin their lives".(13) Ultimately, Belt felt that his patients continued to demand more. "No matter what we do," he wrote "they will never be satisfied."(17) Moreover, familial pressure to step away played a role for Dr. Belt. In 1954, Belt's nephew, Willard Goodwin (1915-1998), Chief of Urology at UCLA, sat on a committee that temporarily prohibited gender-affirming surgeries there. Given the legal fears, Belt followed suit.(3) By the late 1950s, Belt quietly and reluctantly resumed his surgical gender affirming practice. He referenced that he eventually stopped offering surgery as some patients "expected more than the surgeon can possibly deliver -- even though the limitations – were most carefully set forth preoperatively."(14) The combined fear of legal retribution and frustration with patient's unrealistic expectations ultimately drove Dr. Belt to close this chapter of his career in 1962.

Belt ultimately reported operating on 72 male to female and 1 female to male patients (Figure 5).(18) Benjamin felt that one third of the surgical outcomes were "good" and approximately one half were satisfactory.(19) Psychiatrist Ira Pauly published a post-operative satisfaction rate of over 80% in his global review of outcomes after GAS, a cohort that included many of Belt's patients.(20)

International Gender Dysphoria Association

Belt and Benjamin's unofficial practice to legally safeguard themselves ultimately influenced the precedent established by the Harry Benjamin International Gender Dysphoria Association.(13) In its 1979 standards-of-care document, the founding committee emphasized that sex-reassignment on demand is contraindicated. Similar to Benjamin and Belt's assessment that patients needed to "pass" in society living in their desired gender to minimize surgical regret, the committee's "Principle 12" stated that "the best indicator for hormonal and surgical sex-reassignment is how successfully the patient has been living out, full time, vocationally and avocationally (sic), in all social situations, the social role of the genetically other sex, and how successful the patient has been in being accepted by others as a member of that genetically other sex."(21)

Standard 8 stated that psychiatrists recommending genital gender-affirming surgery must obtain peer review by another mental health professional, resulting in the well-established 'two letter' requirement, which remained controversial requirement in the updated World Professional Association of Transgender Health recommendations.(14,21) Benjamin and Belt's conservative practices shaped the way in which doctors approached gender affirming care for years to come: with trepidation and multiple safeguards to protect themselves from legal action resulting from patient regret.

Dr. Belt continued to remain in close contact with Dr. Benjamin, despite refraining from gender affirming surgeries after 1962. In their letters to each other, Belt remained passionately (though quietly) abreast of transgender news across the world. In a 1977 holiday card to Benjamin, Belt wrote "How wonderful it is to have the transsexual problem so widely and generally accepted now, all due to the wonderful start you gave it.(22) He was incredibly empathetic to the suffering of his trans patient --a self-proclaimed "softie"-- but he experienced immense societal and personal pressure to remain under the radar and protect his career.(3)

CONCLUSION

Some modern-day critics have labeled Belt and Benjamin's care as paternalistic at a time when transgender care was previously ignored. Their legacy, however, was their establishing an opportunity for medical and surgical care for transgender individuals that prioritized a responsible approach to minimize patient regret.

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