

OREGON HEALTH & SCIENCE UNIVERSITY ORAL HISTORY PROGRAM

a project of OHSU's Historical Collections & Archives

an interview with:

Toby Meltzer, M.D.

interview conducted on: May 3, 2019

by: Morgen Young



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Interviewee: Toby Meltzer, M.D.

Interviewer: Morgen Young

Date: May 3, 2019

Transcribed by: Teresa Bergen

Morgen Young: My name is Morgen Young and I'm interviewing Dr. Toby Meltzer for the OHSU Oral History Program. It is May 3, 2019, and we are in the BICC building at OHSU.

So, let's start at the beginning. When did you first become interest in medicine?

Toby Meltzer: I became interested in medicine when I was probably in middle school. My favorite uncle was an internist and he got me kind of interested in it. I always thought I wanted to go be a doctor like my uncle, who was an internal medicine doctor. And that's what I went into medical school thinking I was going to do. It wasn't until I rotated into internal medicine I realized it wasn't for me. And yet I had no desire to go into surgery. Not because I don't like working with my hands, because I do. But I never had met a surgeon I really liked. So, it wasn't until I met a plastic surgeon that really they kind of turned my head. And I enjoyed surgery because the time went so fast during the day, versus being in clinic and just seeing patients. It was a whole different world. And it was where I went to medical school with primary trauma center, so it was pretty exciting stuff. But the plastic surgeons were the nice guys who were calmly doing their surgery. And no one was screaming and hollering at each other. And it was very artistic. And so, I got interested in plastic surgery.

Young: Where did you go to med school?

Meltzer: I went to medical school in Louisiana State University in New Orleans.

Young: Are you from Louisiana?

Meltzer: Well, mostly. My dad was in the oil business. So, we lived in Mississippi and Louisiana. But I moved to New Orleans when I was thirteen, and I stayed there until I finished my residency in general surgery.

Young: And then you came to Oregon in the '90s?

Meltzer: Yeah. I trained, I did my plastic surgery training at the University of Michigan. I did a burn fellowship at Wayne State University. And then I took an academic position here in 1990. So, I moved here from Ann Arbor, Michigan.

Young: Why Oregon?

Meltzer: You know, it's kind of an interesting question, because it was not on the radar. But in 1990, academic jobs were kind of put on hold because of Reaganomics. So, there weren't very many academic jobs across the country. There were not very many openings, because they basically couldn't hire. Everything was frozen. And this job kind of popped up on the radar. My chief of plastic surgery at Michigan had heard about it and put me in contact with Alan Seyfer,

who had just taken the job here from Walter Reed. And we immediately got along, because he was from the South and went to medical school actually at LSU. And so, we immediately got along. And I met with him at a meeting. And then I came here and I'm from the South. So, I'm not used to rain. I'm not used to cold weather. So, I couldn't stay in Ann Arbor. I had to get out of there. So, I came here in the middle of the winter. It wasn't cold, in my mind. It was rainy, yeah, but I thought no big deal. So, you know, it was probably one of the best academic jobs in the country at the time, and I feel very fortunate to have gotten it. Because there weren't a lot of good jobs. I interviewed in many places. But this gave me the most freedom to do everything, and that's what I wanted to do.

Young: What was the department or division that you were working in?

Meltzer: There were three of us when I got here. It was Dr. Seyfer and then Robert Demuth, who was here almost since the inception of plastic surgery at this place. And within six months of my getting here, Dr. Demuth decided he was going to retire. So, it became Dr. Seyfer and I for a couple of years. And this is a busy place. This was an extremely busy place at the time. There was, at that time there were no airbags in cars. So, cranial facial trauma was rampant. I mean, people—and we had 100 percent of all facial trauma. So, we'd get what we called two to three pan-facial fractures a week, which is an enormous amount of those. We did 100 percent of hand. We didn't split that with anybody, so all hand trauma went to us. And we were the only Level I trauma center in the state at the time. Not only that, but there wasn't in Idaho, northern California, and southern Washington, so all sent patients to us. If they couldn't get them here by helicopter, they'd put them on a fixed-wing and bring them here, particularly the replants. So, we had, at that time, I believe we had four residents, two each year. And between the residents and myself and Dr. Seyfer, we were doing a huge amount of work. So, it was crazy busy.

And the physical plant was radically different from what it is now. I mean, this building didn't exist. All there was was South Hospital, North Hospital. And the old North Hospital actually had ORs that were functioning ORs over there. And there weren't that many ORs. Basically there weren't that many spaces.

The VA wasn't connected by a bridge. So, we used to have to walk around the roads. Because one of my jobs when I first came here was chief of plastic surgery at the VA. So, to get to the VA, I would have to take the long route around the road to get there for a long time. Then obviously nothing down the hill.

I had this little bitty office in, I think it was the Mackenzie Building, which is next to the Baird Building. I don't know what they call it now. But there was a tiny little office. I used to keep a sleeping bag underneath my desk because there were so many nights I'd just have to, we'd be waiting for surgery to go, and I'd come and lay on the floor and sleep a little bit while I was waiting for the residents to get the patient to the OR.

Young: I was just going to ask how many hours a week do you think you were working.

Meltzer: It was worse than residency in terms of the—and my general surgery resident, that was done, my residency was done in the '80s, early '80s. And back then, residents had no rights. We were basically on call every night, in many place and times. Because we had to go outside of New Orleans. We would cover Baton Rouge, Lafayette, and Lake Charles. And when we were out there, we were really on our own. So, we were on call out there most of the night. When we

were in town, we were basically on call almost every other night. And as you got to be a chief resident, you were on call every night. But here, it was almost the same. The only difference is that I was much better paid than as a resident. But I literally would work from seven in the morning till eight or nine o'clock at night every day. Then come home, eat dinner, put my head on the table and fall asleep at the table. And then start over again the next morning. It was that busy.

And it was that busy almost entirely the entire time I was here. Because even as we got more faculty members, we eventually got two more faculty members. So, there were four of us by the time I was leaving. It just got busier and busier. With the exception of what happened in 1993, they mandated airbags in cars, and so, our facial trauma plummeted. I mean, it went from being a huge part of the practice to almost none. Not none, but I mean, airbags really prevented that problem. So, we stopped seeing the massive facial traumas when those came out. But in the interim, my practice has just gotten bigger and bigger, and it was just out of control in my mind.

We had a hand and microsurgical fellow, and they kind of offset some of my edge because frequently, again, back in the early '90s, you could run two or three rooms at a time as a single attending. So, you had to have people you could rely on so you could literally run between rooms to make sure everything went smoothly and be there for the critical parts. But it was a challenge.

Young: So, while you were so busy with the reconstruction from plastic surgery, you're also developing this other practice with transgender care.

Meltzer: Right. And that wasn't on the radar. That wasn't what I came here to do. It wasn't even in the back of my mind that I would ever do it. In fact, I knew almost nothing about it. I'd never seen a case. When I did my burn fellowship, there was a, Neil Wilson was, as part of that compound, I don't remember which of the groups that he had an affiliation with, but he was just doing a small amount of transgender surgery. And I knew that was kind of going on in the building, but I never saw any of it. So, I had no introduction to it at all. I knew a couple of trans people growing up. But even then, we only speculated they were trans. We never really knew, because everything was very covert.

But when I came here, they were already doing the surgery. Ed Tank and Robert Demuth had been doing the surgery for years. Ed Tank was a pediatric urologist and he did most of the female to male genital surgery. And Bob did the male to female, mostly. And chest surgery. And so, they approached me shortly after I got here about taking this over. Because they were both planning to retire soon. And I'm like, I know nothing about this. It's like, so we'll show you. So, Ed showed me one metoidioplasty and Bob showed me one vaginoplasty. And that was effectively my training. And they started referring patients to me.

Back then, you know, this was before the internet, so no one knew anything about, and the only way they knew that they could have the surgery was just by word of mouth. People knew that they could come here and have the surgery. But it was something I had no idea what I was doing.

So, even after the first operation I did with Bob Demuth, I just looked at that and said, "This is out of my league. I have no idea." It's not the plastic surgery part. It's really the urology part I didn't understand. And it's 90 percent plastic surgery but 10 percent very complicated urology. And so, I swore it off after my first operation. My boss when I left Michigan said, "don't do anything really crazy your first year there." Everybody said you're going to establish

your reputation your first year in practice. So, keep it good surgery. Don't go out on a limb. Make sure you do everything right, everything has good outcomes. And I always kept that in the back of my mind. I'm like, I have no idea what I'm doing here.

But I will tell you that what happened was that patient sent me the nicest note, thank you note, that I've ever had, probably. Not nicest, but it was, it just totally, it took me off my feet. It changed the way I looked at it completely. Because I realized it wasn't a good surgery. We hadn't done a good surgery on this patient. But she was so appreciative. She was so appreciative. And yeah, I looked at that and said, I've got to find a way to make this work. Because I immediately, as soon as I got that letter it's like okay, okay, I've got find, yeah, I'll do it.

So, I kind of floundered around here for a little while trying to do the surgeries. And I just, I wasn't comfortable with it. I just didn't know the anatomy well enough. It's not anatomy you can learn from working a cadaver. It's not anatomy that urologists my age has any experience with. Because what we're doing is a perineal approach to the anatomy, which is something that is taken out of the urology texts. Because no one does anything from below anymore. Everybody does suprapubic approaches.

So, what I did was I went down and I contacted Stanley Biber. Now Stanley is the true pioneer of transgender surgery. He was in the little town of Trinidad, Colorado where somebody approached him. Again, it's a problem. And he said, "Well, we can call this a hernia repair." It was a male to female transgendered patient. And he said, he figured he'd call the guy at Hopkins, or send the guy at Hopkins a letter, I don't know whether he called them or what, but asked them if he could get a copy of the one published paper that they had done. And he read the paper and figured out how to do it.

So, he let me come down. And there two patients scheduled for surgery, so I thought I was maybe going to get to see a lot. But only one could make it to town because of the weather. Because Trinidad is just above New Mexico. I mean, it's in the middle of nowhere. It's a small coal mining town in Colorado. So, I got there to watch him do one operation.

Dr. Biber is an incredibly gifted surgeon. I mean, when you watch him operate, you just go, wow. I mean, he was really good. And very smooth, very fast. And very matter of fact. Everything was in its simplest form.

And so, as I was watching him operate, he sort of flew through the perineal section. I was watching him, like how'd you know to do that? And he's like, "It's just a perineal prostatectomy."

So, I came back and I used to help the pediatric urologists on their cases with [unclear] and stuff like that. So, Steve Skoog, who's still here, and I used to work together. So, I came back to Steve. I said, "Steve, I need to learn how to do a perineal prostatectomy."

"Lots of luck. No one does those anymore."

And Bruce Lowe was here at the time, too. And Bruce was a, dealt with cancer. He was a urologist who just worked with the cancer patients. And Bruce maybe did two perineal approaches a year back then. Everything was done suprapublically. But I got Steve involved and I said, "You've got to teach me the anatomy." It's like well, I've done some, but we kind of learned.

And so, we worked together probably on about the next fifty cases that I did. I would get to where I was uncomfortable in the perineum, which was very shortly in at the beginning. Basically I'd start it and then call Steve. Say, "Come help me out." To the point where I would say, "I'll call you if need you" sort of thing to where I did everything myself.

So, I think it was really at a time when, particularly in the early '90s, when I wasn't having complications, I was brand new out there. There were only three or four places almost worldwide outside of Thailand that you could go to. So, there weren't a lot of surgeons. There wasn't a lot of communication between patients, because this was before the internet.

But in 1992, there was an article published in *The Journal of Plastic and Reconstructive Surgery* about making a sensate clitoris using the glans penis, which wasn't a new idea. In fact, it was originally published back in the early '80s, I believe, by Perovic. But they published it and I looked at that and I thought, that makes sense. Because what I was shown was basically just amputate the penis, meaning deglove the penis, turn the skin inside out, and make a vagina out of it. And I thought, it doesn't make any sense. We're not making a clitoris. Well, we used to cut the dorsal nerves of the penis and lay those up against the front wall of the vagina. We'd call that a clitoris. But you're cutting the nerves. It's never going to be the same. And so, this preserved the nerves.

The interesting thing about it is that people who reviewed the article, well I remember the main person who reviewed the article was Milt Edgerton. I don't remember there was more than one. But basically Milt said, he said, "Oh, I tried it. And all the patients had were pain. So, I wouldn't advise it." Or something to that effect.

And I thought well if all they have is pain, I'll cut it off and we'll be right where we were. So, again, I went to Steven. I said, "Isn't this like a corporal reduction clitoral recession, like what you all do on those kids who are born with clitoromegaly, with an enlarged clitoris?" And he said yeah. "Well, don't we just have a larger clitoris here?" Well, yeah.

So, he basically, we worked together on one and came up with how to do that. And I've made a bunch of modifications to that over the years. But if you look at historically what happened there was, first of all, I was successfully doing the surgery without really any significant complications, which was very unusual back then, because there were a lot of complications going on worldwide. Two, I hit it right at the cusp of the internet. So, in 1993, when I did that the first time, that patient put her pictures and a little expose in some chat room. And all of a sudden, I started seeing people from not just Oregon, but I started seeing people from northern California and Washington state. Like how did you find that out about me? Because we didn't talk, we didn't advertise this. In fact, we kept it very low back then because, really for patient safety. We just didn't talk about it. And everybody was very stealth. But they were on chat rooms. And so, everybody, like how do you know a person in California? You live in Washington. And so, what I was seeing was the effects of the internet on a practice. I had done something different, meaning maintain sensation. And that wasn't being done in the US. It wasn't being done really anywhere in the world at the time. I think everybody was basically coming up with different ways, but I'm not sure that even in the '80s, when it was described, they described it as an unreliable operation. That they thought the neurovascular pedicle was too long.

Anyway, so it literally overnight this became half my practice. It happened that fast. From '93 to '96 it went from a very small amount to over half my practice. And yeah, if you look at it, the patients that you get the most appreciation from, the most gratitude from, are the trans patients. Still to this day. And most of them are insured these days. Back then, no one was insured. But these days, almost everybody is. You still get thanked and get appreciated. You get notes from people all the time. And it's just, it's a whole different practice of practice surgery than anything I had done. I mean, I did a lot of replants here, and revascularization of hands. I did lot of head and neck cancer reconstructions, and you never got the same degree of gratitude

from those patients. And it's not that they didn't appreciate it. But the trans patients are different. They really are. They appreciate everything you do. Back in the '90s, they just appreciated the fact that you treated them kindly. It was a whole different world. If you put your hand on them when you talk to them, it was like an HIV patient. They felt as stigmatized as that back then. Just showing them basic human kindness, they really appreciate it. So, it's an entirely different practice.

Young: Were you at all familiar with the history of transgender healthcare at OHSU prior to you starting this?

Meltzer: No. No one told me about that before I got here. So, I had no idea that it was even going on. And it was really started by Bob Demuth and Ed Tank. I don't think anybody did it before them. If they did, I was unaware of it. I heard there was somebody back in the early '80s that they did some cases, I don't know. But doing it sporadically, you'll never be good at them and you'll never get consistent results. So, I don't think it's a practice to dabble in. I think it's a very difficult thing to teach residents. Because every time you do these operations, you're about two millimeters or so from creating a disaster for the patient. And you know, it's not just having a bad outcome. Because as surgeons, we see bad outcomes. But it's a lot more at stake every time you do this emotionally and mentally to these patients. You don't want things to go bad. Not that they're that fragile, but this is a major, probably the biggest event in their life. And you want it to go well. And I'd never felt that I knew enough, or comfortable enough to be able to let my residents even really be able to see much. Because only one person can really see most of the time when you're working down there. And so, it was all done by me. And so, I think it's a very difficult thing to be able to teach residents.

And I think that, well, if you don't want complications. And I think I understood early on the importance of not having complications. For several reasons. One is again, we talk about the emotional and mental issues. But also, patients were paying cash out of pocket to have the surgery done. If they had complications, it wasn't going to be covered by their insurance because it was a procedure that the insurance company had already denied. So, if they had a complication that was really bad then you could financially ruin that patient. So, you just didn't want those things going on.

Young: When you started doing general reconstructive surgery, was it only through your own practice? Or was it through your position at OHSU?

Meltzer: No, it was, well, they were coming initially, the very first patient or two came, or a couple of patients, just came because they knew OHSU. After that, it became, people started hearing about me. I was the youngest person out there at the time. I mean, no one in their first year of practice is doing this stuff.

Young: How old were you?

Meltzer: That was my first year in my practice. In fact, I had the American Board of Plastic Surgery, because I had to take my boards. You take your boards two years after you complete your residency. And the American Board of Plastic Surgery wanted to, they pick which cases back then they wanted you to review and show them. So, they picked ten cases of all of the stuff

that I submitted. And I had a huge file of cases. I mean, so many cases here, it was crazy. And one of those, of course, was a vaginoplasty. And they're like, okay. Show us these. And they were like, blown away. Those are great! And when I look back in retrospect, that just shows you they didn't know a lot about it, either.

But, yeah, no one had a big interest in it. I was the youngest person out there at a time when most everybody else was kind of hitting retirement age or having a lot of complications. So, I think I kind of developed the practice kind of alongside of OHSU.

Young: Was the university supportive at all of your—

Meltzer: Well, I mean, the university, I don't think they quite understood, you know. These are big surgeries. I couldn't convince them to let me keep my patients in beyond two nights because beds were at a premium. And since everybody was having to pay out of pocket, the university did give them a break in fees quite a bit. But they saw that as a loss every time we did a case, I think, a lot of times. Just because most hospitals, I've dealt with a lot of hospitals over the years. And most of them look at charges, not actual costs. Because they were actually still making quite a bit of money on my patients. But they always look at insurance reimbursement as being something better. Even though insurance, a lot of times, particularly now they have pre-negotiated rates. They may bill out a certain amount, but they're only going to get paid a certain amount. Whereas my patients were paying out of pocket. And so, they kind of looked at it as okay, we've got to get other patients in those beds. So, two nights in the hospital was woefully too short for patients. So, what I'd have to do after these crazy long days, at the end of my days, at two days when my patients left the hospital, I had to start going to all the little hotels in town that they were staying at and checking on them and helping them with their dilations and things like that, because that was just what we had to do. They weren't in the hospital.

And they would never guarantee me OR time for that. Block time was very difficult to get back then anyway. And as the plastic surgery division, we had a certain number of days of block time, which of course always got filled. But these patients came on top of that. And so, they would never guarantee me a bed. And they just kind of looked at them as more, I think, well, you can do them or you cannot do them, we don't care, sort of attitude. And I know they later regretted that, because it was a lot of money I was bringing into the hospital. And I had kind of moles around here who would keep me informed about what was going on. But you know, so I know they felt some of the financial loss when I left. But they never would have, never brought that to me. And they basically just said, you know, this is the best we can do. And I said, well, you know, you're going to force me out of here if I'm going to maintain this practice.

I came to that juncture where really I looked at it and said, I wasn't that old, but I couldn't keep up that sort of pace for forever. And I had to make that decision of who I was going to take care of and what I was going to do with my life. Because I had never, ever conceived of being a private plastic surgeon. That just wasn't what was in the radar. I was always going to be, I was a career academic. And I just had to look at the writing on the wall and say, you know, I like surgery. I just want to be busy. And I'd much rather be taking care of my trans patients. So, that's where we came to the impasse. I decided to make it all of my practice, effectively.

Young: Did you ever try to develop working relationships with other hospitals in the Portland area?

Meltzer: None of them wanted me. The one place that took me was Eastmoreland Hospital, which is actually the smallest hospital in the state at the time. I think it was built for 200 beds. Its average in-census was eleven. And they were over on the eastside next to Reed. And they liked the fact that I was bringing them a lot of money. I was keeping them afloat with all my patients. Because they immediately gave me five nights in the hospital. They kind of bent over backwards at first. And they did while I was there. But no one really wanted me there. You know, they liked having my income, but they didn't really want me there, per se. No other hospital in town would give me privileges. I went to every one.

The interesting one was St. Vincent's said they would give me privileges. But the physicians, medical board, wouldn't let me in. I actually, when the nurses went on strike here, I did a couple of cases at St. Vincent's. They let me bring my practice over there. So, their religious and ethics committee didn't have an issue with it. It was the physicians that had an issue with it there.

So, what happened in 2002, was I was called in by the hospital administrators of Eastmoreland and said, "We don't want you here anymore."

I said, "What do you mean you don't want me here?"

They said, "Well, we can't attract other physicians here as long as you and your patients are here."

I said, "Well, you know, we have an anti-discrimination clause in this city, and you can't tell me that."

They said, "Well, we're telling you that." So, they basically pulled the rug out from underneath me and said, "We want you out of here, regardless."

And we tried to contact the mayor, and never responded to my calls. We got an attorney who fought it out so we could get a six-month stay, and that was it. And so, in the interim, I went to every hospital in the state. Not every hospital. I went as far south as Eugene. And we went over to The Dalles. We went to every place in town, obviously. And every one of them denied me. Most of them, I mean, I heard the words, "It's too much of a hotbed right now," and things like that. Basically, no one would give me privileges in the state. And so, the writing was on the wall for me. I had to leave the state. Now I can't say they ran me out of here, because I was going to leave anyway at some point. Because I'm from the South. The rain was killing me. I'm a cyclist and a runner. I wanted to be back, you know, I ran every day when I lived here, but I ran in the rain a lot. So, I wanted to get back someplace sunny anyway. But that wasn't in the radar then. My kids were in high school, and I didn't want to leave while my kids were in high school. I didn't want to pull them out of their something year, in particular.

So, what I ended up having to do was when I moved to Arizona I left my younger son here. And he stayed, and spent his last six months so he could finish high school here. But I was fortunate that the health system that I had went to in Arizona, of all places, because you think of, you know, what could be more I guess liberal area than the Northwest. And I'm going to Arizona and they're like, "Yeah, no problem."

Now, of course, my agreement with Arizona is we will not talk to the media. We keep everything very low. But they were like, no, we'll take it. So, they let me come up early. They expedited my privileges, let me come up early. So, I don't think I missed a day of surgery. But I did have to leave my family here. I had to be able to maintain a practice because I got to that point where it's like okay, I either give up this practice and stay here, or I do something else. And that's why I did something else.

Young: I want to go back to something you referenced about the city of Portland had anti-discrimination legislation that had passed—

Meltzer: Right.

Young: And was starting to pass in different cities, and eventually at the state level. And yet you're not getting support to—

Meltzer: No.

Young: —provide care to LGBTQ patients.

Meltzer: Exactly.

Young: Ironic.

Meltzer: I know. I mean, when I tell people that story, they're dumbfounded. When I tell them where it is. Like, "Not in Portland!" But yeah, they wouldn't answer my calls. I still have a letter I sent to the mayor. A copy of the letter that I sent to her, kind of pleading with her to get involved. But never heard a word back. So.

Young: And the mayor was Vera Katz, I'm guessing?

Meltzer: Yeah. Yeah.

Young: Who tried in the 1970s to pass LGBTQ protection and legislation when she was in the state legislature.

Meltzer: She didn't answer my calls.

Young: Well, by the time you moved to Arizona, were there more surgeons practicing genital reconstruction?

Meltzer: Not really. Not very many more. There were, you know, back then, again, there is no formal training. And you have to learn how to stay out of trouble. And really, my practice has always been probably, if you look at statistically, about two-thirds male to female. The other third is female to male. So, I did all my own urology. I mean, I got pretty self-sufficient doing that, working with Steve. Again, he taught me a lot of the anatomy and how to manage urethral issues. I mean, I'm not a urologist, but I do all the urology for my patients, including the secondary repairs and reconstructions, because back in the early '90s, no one would see the patients, you know. They'd have the surgery done in Serbia, or there was a guy doing a lot of surgery back at the time around Nashville. And they were having a lot of complications. But they couldn't get anybody to see them. They were persona non grata in most urologists' office. Partly because they didn't understand, the urologists didn't understand the anatomy. But also, they just didn't want to be involved. Their insurance didn't cover that stuff.

So, is started doing all those repairs myself, just because Steve taught me a lot about how to do that. So, I just did it. And when we worked together, I always did half the surgery anyway, because they're my patients. So, I wanted to learn to do half of it. But if you look at it back, when I left for Arizona, there may have been a half dozen more surgeons in the country. Now if you ask me now, there are dozens of surgeons all over because they're popping up everywhere. Because now with the insurance carriers covering this, the hospitals look at it differently. Obviously socially things have changed a lot.

So, it's now a huge growth industry. And that's good in the sense that there's better access. It's bad in the sense that I think a lot of people are getting harmed by inadequately trained surgeons, or surgeons who do weekend courses and convince a hospital to give them privileges. Or come and watch me for a few times and then claim they've done a mini fellowship. I don't think that's how you learn. You've got to be, I think, physically involved with those cases for about a year to be good at it. And I think you have to do them almost every day to be really good at them.

And that's the way I trained the person that I brought into my practice four years ago. I spent a year training her with basically every case she did, well, every case I did for the first six months, she scrubbed in. And the first person to actually vocalize, I said when I taught residents, I really couldn't feel like I could teach them anything. Because I wasn't going to pass off any portion of that procedure. But with the person I trained, I actually let her put her hands on things and see and kind of verbalize what I had done. It made me rethink everything I do, because I never really, I was doing a lot of things just because I knew how they look and feel and stuff like that. I didn't really verbalize it. But I taught her like that for six months. And then the second six months, I scrubbed on every case that she did and kept her out of trouble. And I think that's the only way to really learn.

But right now, again, you can go to Amsterdam and do a five-day course, a cadaver course, and come back certified to do bottom surgery on a female. Or you can, if you can convince your hospital of your credentials, or an insurance carrier, then you can do the surgery.

And I'll give you a very good example. There was a patient who had a horribly performed surgery. Horribly bad outcome. Who came to me for a, it was for a repair. And she was, the kids are, when they have bad outcomes, they're train wrecks. It's hard on some of the kids because they've really had a good life up until that point. Because they're allowed to live that way. My adults, on the other hand, tend to have had to deal with this obviously a lot longer, and a lot of suppression. A lot of times they're on antidepressants and things like that. But the kids, when things go badly, they're not prepared for it. It's not that you can't, you can tell them all you want, but to them, you're just fixing a problem they've had from birth.

But anyway, this kid had such a bad outcome. And their insurance carrier was telling them they had to go back to the surgeon, who really didn't have any significant training, and have it repaired. And so, I called the chief medical officer and said, "Listen, this isn't right. This person's doing bad surgery." And I don't get involved in cases like that usually. But it was like no, you can't make this kid go back to them.

And they're like, "Well, they don't have any malpractice suits and they don't have any complaints with the Board of Medical Examiners. So, there's nothing I can do." He's in that work. So, that was the way they view it. So, that's the way they view it now. So, since there's no formal fellowships. There's a couple of fellowships around the country right now. But it's not like you have a residency review committee that goes by and checks and makes sure of the

training and how they're doing it. It's basically people just saying, "Oh, I'll train somebody and we'll call it a fellowship."

Young: I want to talk more about your practice in Arizona. But when you left OHSU, and left Portland, did you maintain contact with anyone at the university? Was there anyone doing that type of surgery?

Meltzer: Well, Steve and I have always been good friends. Steve Skoog and I have always been good friends. And Steve actually contacted me about five years ago when Dr. Dugi started getting interested in doing surgeries and asked if they could come down and watch some surgery, which obviously I let them do. Back then, I usually just refused everybody. Because that frequently got misrepresented as "a fellowship," a mini fellowship or something like that, because they'd watch me. And I never felt that that was a way to learn. But I couldn't refuse Steve, you know. I didn't know Dan Dugi at the time. But I did know Steve for many years.

And you know, the guys I maintained contact with were the guys like Steve Skoog and Jamie Cohen, who was a laryngologist who I used to all the head and neck reconstruction with. And Dr. Seyfer and I still, I haven't heard from him in years, but we maintained contact for a long time. And Dr. Demuth periodically still contacts me. So.

Young: So, then you set up this private practice in Scottsdale?

Meltzer: Yeah.

Young: Has it always been in Scottsdale? Was it elsewhere?

Meltzer: Yeah, it's always one place.

Young: Okay. And tell me about that. So, it started with just you?

Meltzer: Well, it just started with me. And it happened again. We came into Scottsdale very quietly. This is 2003, we started in 2003. But we were pretty shell-shocked by what went on here. And we had never advertised here. Never. We kept low. I never did any media interviews or anything. I refused them all. Because most of the people in contact were people like *People* magazine and stuff like that. We didn't want to get involved in stuff like that. So, we kept it very low. And that was our agreement with the hospital, which we put in writing. We will not advertise. We won't show the outside of the building. It was that stigmatized back then. And again, we were pretty shell shocked. We were kind of like if this falls through, we've got nothing to fall back on.

So, we did. And we came in there. And I had to have a sensitivity training, a couple of sensitivity training classes. One for the physicians where I presented and talked about, the medical board. What we do and how we do it. Some of the questions I was asked were just like mind bogglingly bad. I mean, yeah.

And I remember talking to the hospital people was my second talk there. And there were several people that just kind of glared at me, and sat there with their arms crossed. And wanted nothing—I could tell these people wanted nothing to do with me.

And early on, there were people that were kind of assigned to my practice. They were like, okay, these are Dr. Meltzer's, the people who, Dr. Meltzer's special cases. Then they, and certain people in the recovery room didn't want to take care of my patients.

But what happened over time, and it happened kind of gradually, but fairly, within, fairly quickly—because the hospital, the administration was very supportive—was that the people who didn't want to be involved with my patients, they just started getting rid of them. It wasn't acceptable to say you wouldn't, couldn't take care of my patients. You had a religious conflict or whatever. They're all, we're all children of God. And everybody gets a right. So, the people who didn't want to take care of my patients, eventually said, "Well, you either take care of the patients or you find another job" sort of thing.

The interesting thing, though, is that some of those people who sat there with their arms crossed and glaring at me became some of my biggest advocates. Because until you get to know the patients, you don't know what it's all about. So, what I've seen over the years, in fact, people who wanted nothing to do with me when I first got there have come to me and said, "Oh, you know, I've got a trans friend now." And my friend's got a trans child. And things like that. So, things that get closer to home, all of a sudden they start seeing.

And I think the bigger thing is working with the patients. Because when I first moved, when I first was in Scottsdale, I had the OR at the very far end of the hall. They brought them in the back way. My patients all stayed in the same, we have a second floor recovery area. And they all stayed in the same rooms. Kind of on the corner there. But as people go to know them, it's like, they like them. The nurses upstairs who initially were like oh, really enjoy taking care of my patients. Because again, they're not sick. They're post-op. They're very appreciative for everything you do. They're not difficult patients. I mean, it's a whole different world. So, most of them rather take care of my patients than everybody else's patients. So, you know, it's kind of one of those things that's been kind of slowly evolved. But it went from kind of again, we don't talk about, we don't do anything, kind of keep them in the corner. To where I'm now in OR 1. So, I'm in the front of the hallway. Dr. Ley, my associate, is in OR 2. We have a side-by-side, so if she has issues that she wants me to take a look at, I can step in her room. Or if I have ideas I want to show her, she can come in my room with just stepping through the sub-sterile area.

You know, so a lot has changed. And I think it's more, again, the community perception has obviously changed. But also, you know, no one's from Scottsdale. They're all transplants. So, everyone has kind of a live and let live attitude there.

Now, if you went into southern Arizona, I think things might be different. But with more and more people coming out, everybody knows more trans people. But still, there are some still very redneck areas and very remote areas in Arizona that I might not want to be in. But in Scottsdale, it's never been a problem. In fact, there's never been a negative article run about me. Well, I can't say that. Somebody from the hospital leaked out that I was coming. Because they took my hospital picture and posted it on this magazine. It's their version of the *Willamette Week*, which is the *East Valley Tribune*. And said, "Sex Change Surgeon Moving to Town." In big letters, front page. Or bringing his practice to town. The president of the Arizona Society of Plastic Surgeons, who I didn't know at the time, responded by saying, "Well, that's great. We think that these people are underserved. We're glad to have him here." [unclear] public comment. And that just like, I never heard a second word from it. So, it's never been an issue.

Young: Do you still provide sensitivity training to new people who work at your practice?

Meltzer: No. We don't have to. We only hire people that are the right fit. And kind of the interesting thing about it is that when I left OHSU, I took three employees that worked with us, my patients and me with me. And two of them still work for me. One lives here and telecommutes. And basically she's a nurse who spends a lot of time talking with patients, making sure that everything's going well. If they have questions or concerns, she knows how to triage those things. She tried moving to Arizona but she couldn't handle the weather. So, she moved back here.

My practice manager who started, I met her, she started I think my second year here, was basically kind of forced into the clinic position. Well, no, billing. She was, I think, initially in a billing position, but really wanted to take care of patients. So, she's been with me the whole time. She still works with me. And the other girl got married and moved to the East Coast, so we couldn't keep her any longer. But my practice has grown from those three people that we had when we left the medical school to eighteen employees now. Because when you operate on patients from out of town or out of the country, you have to provide an entirely different level of care than when you're operating on local people. So, a very small amount of my practice comes locally. Most of it comes from across the country.

Young: In prepping for this interview, I reviewed your website pretty thoroughly. And you have just a tremendous amount of logistical information for, I think, existing patients and prospective patients. Because there are just different aspects.

Meltzer: It's a whole different world.

Young: I think that your, I'm assuming your patients come in quite informed and have done a lot of research.

Meltzer: Yeah. I think again, I think that they're very well-informed. I mean, even the kids. We're seeing kids now, some as young as thirteen or fourteen, who are getting in the network eventually for surgery. And some of those thirteen- and fourteen-year-old kids are better informed, a lot of them are better informed than their parents, because they research everything on the internet. And I also think that, yeah, they come from all walks of life. But the majority of my patients are really smart. There's a disproportionate number of people in the tech industries. But yeah, they're smart people and they do the research. Even if they're not the most gifted person, they'll do the research and they know what goes on. You can find out a lot on the internet. You also see a lot of bad stuff on the internet that's not necessarily always good or true. Because it doesn't take, you know, I think you have to look for trends on the internet. And most people figure that out. You can find every, one person can love you and put a ton of things out there and it sounds like a hundred. And the same thing can happen with a bad person. But people in general are looking for trends. It's kind of like your Google writing or things like that. But they're very, very well-informed. They know what's going on. But I think, we started all this a long time ago when we had to kind of walk them through it. And we still walk them through a lot. Because I think one thing that's always been very important to myself and my practice manager, Linda Takata is aftercare. You don't want to operate on people and not follow them. You don't expect your patients to call you if you're having a problem; you call them to make sure they're doing well, because the ones that you think are doing well because you're not hearing from them frequently are not. So, we've always been really good about aftercare, making

sure they're doing well. And there's a lot of information on our website about that. But there's also, people know that they can call our office anytime, even if they're not my patient. And we'll answer their questions. We can sort out, see what there is. And I take care of a lot of people who've been operated by other surgeons. Particularly more now, because there's a lot of complications going on right now. But we don't ever turn anybody away. But you do have to navigate them through the process.

Young: Are you still doing more male to female than—

Meltzer: Yeah. Only because with male to female, you start with facial feminization, breast surgery, genital surgery, body contouring. There's just so much to do in terms of, procedurally wise. Whereas female to male, they don't need facial work the majority of time, unless they want their nose done or something like that. But most of them don't need facial surgery. Chest surgery, we do a lot of. But a lot of plastic surgeons will dabble in chest surgery and not consider themselves transgender surgeons. They'll just, oh, I can do this. I don't think you do them as well, because you haven't really thought the whole process out. And I think people who do the best chest surgery are the ones who've really thought it out and made a science out of it.

And then there's genital surgery. And genital surgery for females to males is, in many times, is the lowest priority in their mind. Their probably biggest priority, a lot of times, is their chest surgery. The genital surgery, because we don't have as many good options, we have a lot of options, but not all of them are good. And every one is a tradeoff between benefit/risk. So, we don't have a perfect operation for them. And yet, the only thing we're lacking, I think, in a vaginoplasty is the lack of secretory tissue. And that's about it. Because we can do everything out. Whereas with the guys, the best looking penises come with the biggest scar burden. And they're the most complicated procedures and have the highest complication rate. So, you know, it's a balance between what's available.

For some guys, they'll never even have lower surgery. But they look at it as incomplete and don't want to do it, and feel totally content in their position. I mean, just because you don't have a penis doesn't mean that you can't be a man.

Young: Absolutely.

Meltzer: And right now, because again, we're in a growth industry, and a lot of insurance carriers are suddenly, I mean, insurance is covering these procedures. When I was at the medical school here, the microsurgical phalloplasties I did, the patients had to pay out of pocket for. And the hospital, I think the total package was eighty thousand dollars, back then. This was in early '90s. And any complication they had was going to be extra charges. And you look at an operation, and in the best of hands has somewhere between a 40 and 70 percent major complication rate. It's crazy. So, I stopped doing them in '97. I said, I can't sleep at night after these cases.

So, I stopped doing microsurgical phalloplasty back then. But now, they're covered by insurance carriers. So, we're doing microsurgical phalloplasties again. But, I think that it's not always the best operation for the patient. And I think sometimes a metaoidioplasty, which is a local tissue rearrangement of the genitalia. Basically it's like taking a perineal hypospadias on a kid born with a hypospadias and rearranging everything, and just masculinizing it for them. And some of those patients are the happiest patients. Because that's all they wanted.

So, I think that what we're seeing though is that patients are getting heavily driven towards phalloplasty right now, because it's possible again. Versus mostly it was unobtainable unless they were insured before. And now, people are kind of stepping away at least offering metaoidioplasties. Not because the patients don't want it. But they see it as well, they're going to have a small penis, so why bother? They can't use it for penetrative sex, so why bother? But if that's all they want, if that's what they're coming here for, they're going to be very happy with that operation.

So, I think that people are getting steered away from that, necessarily. But I think there are two patients you see in the guy world. Which is, they come in and say, "I want a metaoidioplasty. This is the operation I want for me. I've got a partner. Everything's working already. I just want to have something done to masculinize it, and get the best outcome. And low complication rate."

Or they come in and say, "I want a metaoidioplasty, and if it's not good enough, I'll go on to a phalloplasty." So, if they're ambiguous about it, like, "Okay, I'm going to see if it works for me and then move on to a phalloplasty," I think the conversion rate is enormously high on those patients. Because they're not really sure that's what they want. But if they want it, I think it's a good operation. Yet I think right now we're seeing people getting steered away from it a lot. Because the surgeon's perception is not an adequate operation. Again, it's a guys' world. They're like oh, you've got to have a big penis or it's not going to work. But it's not the case.

Young: How many GRS procedures have you performed to date?

Meltzer: I never, I mean, the only thing I know, vaginoplasties, about 4,000 vaginoplasties. I've never counted how many metaoidioplasties, I've been doing them thirty years now, twenty-nine years, so a lot. A whole lot. I know in two thousand and, I'm trying to think when I modified my technique. I think it was in 2010 I modified my technique in urethra lengthening with the metaoidioplasties, and I looked at my next 100, which I did in about four years. And since then, I've done a few hundred more. So, I've probably done, in metaoidioplasties, over 500. Probably more than that, metaoidioplasties. Now phalloplasties, a couple dozen, maybe. Meaning microsurgical phalloplasties, because I didn't start doing them again until a few years ago. I cut off, when I was here. And then started again just about two years ago doing them.

And then, I do a lot of facial feminization. Mostly using craniofacial techniques to feminize a face. I mean, sometimes you'll do a total face, meaning you'll do chin, jaw, nose, forehead, trach shave. Those are huge cases. But, and sometimes the only thing they need is a more female looking nose, or what bothers them. There's not, it's not a complete science. I think that a lot of times the most interesting people are the people that don't necessarily fit into the standard aesthetic feminine proportions. So, not everybody needs everything. But I think that there's obviously I've done, I can't count how many of those I've done.

Young: How has trans healthcare changed in the US over the past thirty years of your career? I mean, we've discussed some of it. It seems insurance is a large part.

Meltzer: Yeah, well, in 1990, no one was insured. Zero. And over the years, really, very, I mean probably until the city of San Francisco mandated the coverage for city employees, no one was insured. And how long ago was that? Eight years? Nine years ago? It wasn't that long ago. So,

twenty years plus of practice, I had zero collections. Everything was basically cash up front. To where now it's about 95 percent insurance that I'm doing.

And really, to give credit where credit is due, it was really the city of San Francisco that got that started. But when they made it for city employees, what they also included in the law was the city, that was an ordinance voted in by the city. But they also included contractors of the city. Well, who are contractors of the city? Anybody that flies into San Francisco. Anybody that had any sort of business there. So, by San Francisco mandating that order, all of a sudden it starts spreading all through California.

And then I think what happened naturally after that was that people started looking at things a little bit differently. And again, if you look at the, a lot of these patients, our patients, our coming from the tech industries. And tech industries tend to be more liberal. And they started including it as part of their coverage. Just because the company in California was covering it, that tech company, they also have a location in Massachusetts. They had to start covering it. So, it started kind of spreading out. So, now if you look at the states that are heavily mandated coverage, there's Oregon, Washington, California, Colorado. On the East Coast, Massachusetts, Rhode Island, Vermont, New York. There's mandated coverage. But that's where a lot of the tech industries are. That's where it all started.

And then probably the thing that kind of really firmed it up was the HRC human rights campaign bonding with the trans community. And there wasn't an easy bond at first. But they did eventually bond with the trans, or incorporate the trans community into the human rights campaign.

And Human Rights Campaign were very savvy. And what they did is they basically said, "You want your highest rating? You want to show, if you're diversity-minded, you need to have a platinum rating with the HRC. And if you're going to do that, we expect you to include trans benefits." And so, initially I said it was kind of an uneasy relationship. Because when they came out with, when HRC got, they were the ones who negotiated the nationwide anti-discrimination clause. But they didn't include trans with it. So, there was a real falling out with the community at that moment. But what they pointed out was, they said well we have to get something. Baby steps. Get us in. And that's what they did. So, they came in and afterwards they mandated that to get a platinum rating, you have to include trans benefits. So, big companies now all cover the procedures. Because they can't compete, you know, if they don't.

And historically, some of the worst companies to work for back in the '90s, and I guess I can say by name. But I'll give a very good example is Boeing. They were horrible to their trans employees. You could not transition on the job, basically. You could dress androgynously. You still had to go to the male bathroom if you were male to female. They wouldn't do anything to make your life easy. And it was very, very discriminatory. And now they're one of the best companies to work for. They cover everything. And they're really trans-inclusive.

So, I've seen that over and over again. I'll give you another examples is Raytheon, was a huge missile industry. My patient who ended up ultimately working in the White House fought them and fought them to get coverage. And she never got coverage for her surgery. But they changed their benefits after she fought them out. And I think she may have eventually got reimbursed, but it was all because of her just fighting it out. And Raytheon's a huge company.

So, it's changed a lot. But most of that's changed in the past eight to ten years. For twenty years that I first did this, it was a non-issue, because no one was covering it. They had exclusions in their insurance policy. They had written exclusions.

Young: So, then I'm assuming that the socioeconomic aspects of your practice have changed as well? That perhaps your patients are coming from more diverse backgrounds now that there is insurance coverage?

Meltzer: Exactly. Exactly. I think, yes and no. I think that my patients haven't really changed much over the years. I think it's just more accessible. I think that, I used to see people, even when they had to pay cash up front, I used to see people who bagged groceries for a living. They would just save every cent and do it. It was that important to them. So, I think I saw across all backgrounds. But I think that the people now, those people that are bagging groceries, if they work for Whole Foods, they'll be covered. Or they work at Starbucks as a barista, they'll be covered. So, I think that the only difference is, they're covered now and they don't have to save all their money and use their 401K to have their surgery done. Because even if they feel like they can't do it, or socioeconomically shouldn't do it, it's stronger than they are. Sooner or later, they're going to want surgery. And it's a very tough thing to deny. I've seen patients that I have known for almost twenty years before they ever have surgery. Because they'd come in for a consult and they would put themselves on the schedule, back off a bit, thinking they could—again, there was a lot more of that going on years back because a lot of times they just were trying to find ways to afford it. But they almost always came back.

Young: I'm assuming that your clinic has seen a fair number of patients who have experienced discrimination in other healthcare settings?

Meltzer: Oh, yeah.

Young: So, what kind of education or outreach is done by the clinic to reassure these patients?

Meltzer: Well, you know, first of all, we take care of our own patients. We always want the patient in a good relationship with a primary care doctor. But our instructions are always, call us first. Because I've been doing this so long from remote that we can handle almost everything remotely. And we know how to do that. But I do, over the years as we've developed this huge practice across the country, we've maintained that database. So, if somebody's in a small town in North Carolina that needs a primary care doctor, I can find one for him that's trans-friendly. Because I've kept those data up, and we always, or I'll just look and say who's in that town, or who's one town over. Find out if Sheila has a primary care doc and if she likes her. And so, we've networked for people like that before. I mean, for over the years, many years, we've been doing that.

So, I think that, well we do, I do educational talks. Basically talking to primary care doctors about how to take care of the patients. And what's a complication you can manage, what's something you need to call us about. So, I do a lot of those talks across the country to primary care, because again, in the past ten years, there's been a huge interest in this, is how do we take care of these patients in the primary care setting? Including even Planned Parenthood does a lot of hormone therapy and not necessarily aftercare, but they're interested in helping out in the aftercare. So, it's across the board. I talk to a lot of managed care, primary care. In fact, I've got a talk coming up for one of the major insurers. Because again, they want to know more about it. So, we do a lot of that sort of thing.

I don't think you can teach people how to be sensitive. I think, you know, outside of knowing the patients, I think the person, you can't make somebody sensitive. I think you can only educate them about the patient. But you know, a good example would be, I mean, at University of Michigan I was a Reed Dingman Professorship and, which is a huge honor. This was years ago, I was still living in Oregon at the time. And they asked me to come up and give a lecture and all this. And it was one of the bigger honors. But at the end of it, somebody came up to me and said, "I'd never operate on those patients. They're crazy." You know, and I'm like, well I obviously didn't get the point across to him.

Young: How far out are you booked with surgeries?

Meltzer: Well, at one point it was three and a half years. Yeah. That's why I brought in Dr. Ley. And honestly, I had been looking for a while when I found Dr. Ley. It happened. It was not—it just happened. She didn't walk through my door thinking she was going to ever be trained in how to do this. But I had to find somebody. And I had been looking, just because I felt like now everybody's got coverage. They walk through your door thinking they're going to have surgery next week and you're telling them it's three years down the road. I mean, it's just horrible. And I hated going to clinic, because every day I'd go to clinic, I'd see like six or eight more patients who I had to tell that to.

So, I was looking, but I couldn't find the right person. And I met Dr. Ley just because she's a plastic surgeon and was one city over. And I started talking to her and I liked her right away. So, I brought it up. "Have you ever thought about learning how to do this?"

And she's like, "I heard you never teach anybody."

I said, "Well, I don't really want to teach anybody, but I need to teach somebody." And that's how it all started. So, what happened is that now, for about a year and a half. And what also we see because of the effect of insurance is that insurance coverage changes. Patients don't get their prior authorization slip back and things like that. And so, now, we suddenly get holes in the schedule because of insurance stuff going on. And so, we feel, we have to move up lists and things like that where we juggle people around. It's always done very fairly. Like the first guy gets called and we do [unclear] so a lot of times they're kind of hopscotch and kind of jumping up in stages. But for the most part, a year and a quarter to a year and a half is what we can expect to get people done.

But you know, if somebody walked through our door totally ready to go and needed short notice, they could probably get done within a few months. It's just those are pretty rare. If they can fill a last-minute hole, those are great. Because every once in a while we do get those where you just like, you're scrambling to get somebody in there. I kind of embrace those days if I get the day off. So. But we try to keep it reasonable. But, yeah, so probably about between a year and a quarter and a year and a half.

Young: Are you concerned about provider burnout? It doesn't seem like your practice is slowing down.

Meltzer: No, it's not. Well, I'm only operating three days a week now. I used to do, when I was here, I operated five. In fact, up until I left Oregon, I operated basically five days a week. And now I operate three days a week. So, I backed off a half day. Because I did three and a half days of surgery for probably fifteen years. And now I'm doing three days of surgery. Dr. Ley, on the

other hand, my associate, wants to do five. And she's younger than I am, so that's fine. You know, if you like what you do. I feel very fortunate. I really like what I do. I make a difference in people's lives. But I really, I so enjoy working with my hands, and I enjoy surgery.

So, I'm not going to work for forever. But you know, I think that, I'm not willing to give up what I do now. I won't slow down probably any more than I have now. Because operating three days a week means I get four days a week off, effectively. So, I can't really complain about that. And I still like what I do. And I like, I really like taking care of the patients. Every day you get that thank you. And it's like, and people say it like you don't know it. They say, "You know, I just want you to know how much I appreciate everything you did." And it's like, of course I know it. But it's really nice to hear it.

But, yeah. I don't think burnout, I think if you're doing things for the wrong reasons, you'd get burned out. If you're doing it just to get cases done, just so you bring in an income, that's a different story. I think it's a lot harder to maintain. I don't particularly enjoy operating twelve or thirteen hours in one given setting. But I mean certain operations obligate us to do that. But at the end of the day, I always feel good. So, yeah. I don't think, neither Dr. Ley or I will see burnout in our career. Because I think both of us really like what we do, and we like taking care of the patients.

Young: Well, we're doing this interview in Portland rather than in Scottsdale, because you're here working with your new partnership with Legacy Good Samaritan.

Meltzer: Right.

Young: That's quite a change from what you were telling me earlier about hospitals not wanting to work with you.

Meltzer: I did remind them when they, because they had kind of reached out to me. It started, years back I started getting contacted by people here. Particularly, it was a therapist who started contacting me, saying, "Is there any way we can get you to come back and work in Oregon?" I'm like, no. First of all, I can't get privileges anywhere. And they said, "Well, things have probably changed now." I was like, I don't know.

So, we put some feelers out there. You know, would you, they'd all refused me before. So, it's like, who's going to take me now, all of a sudden? Well, you know, because for one, Good Samaritan had twice denied me. And other ones had denied me three times.

So, Good Samaritan sounded interested. So, we came up and met with them. And the first thing I told them was like, "Hey, guys, you know, last time I met with you, you told me no. your CEO called me personally to tell me no."

And they said, "Oh, things have changed." And they really have. They've been very accommodating, and they really want to make this work. So, you know, we kind of looked at it and said, if we look at where our patients come from, the Northwest is by far, and Northeast, again, because those are the huge corridors, this is where the majority of our patients go. And so, we started thinking well, you know, and part of the problem is, just getting to Arizona for a consult is a major, major expense. And some of them just can't afford to do that.

And so, we started by thinking well, we'll just have a clinic here. Just an outreach clinic. Reinstate my license and just start taking patients here. But then when we started talking with Good Sam, we realized, well, we could spend a couple of weeks or months down here during the

summer. Because I like it, the summers are gorgeous here. They're not long enough, but they're gorgeous. And compared to summers in Arizona, which are brutal, like okay, I could do this.

And so, we started working with them. And they've been bending over backwards to make everything just like what we offer in Arizona. I still don't do outpatient surgery. I mean, I admit almost everything I operate on, because I'm not going to send them to a hotel room by themselves after a surgery. I keep patients in the hospital nine nights now. Which from my two nights here, and now nine nights. My hospital stay's only gotten longer. But I think that's important, because bad things can happen on day six and day eight that turn a successful operation into a complete loss, that if you have an OR right below you and take the patient right back to surgery, you can salvage. So, I don't bend on that. But they're accommodating me to that. Because I'm not going to treat people differently in one state than the other. I want everybody treated the same.

And so, the way we'll work it is that we'll split the summer. Dr. Ley will come up for the first few weeks, and then I'll come up for the second few weeks. Then I'll stay for an extra week to make sure that everybody's out of the hospital before we leave. And that way, we'll make sure everybody's doing well. And part of my life's changed as well in the sense that my wife, who's worked for thirty plus years, has decided she's retired this year. So, all of a sudden I don't have to work by—she was a special ed teacher—so I don't have to work by the school vacation. I can go vacation whenever we want to vacation. And she can travel with me. So, we can spend more time away.

But this is, being in Oregon allows us to service people in both Washington and Oregon. And I've already got a building here where, it's a small office space that my nurse and insurance people work out of. So, it just kind of seemed to make sense.

Young: What do you foresee as major challenges regarding equity in trans healthcare?

Meltzer: Well, I'll tell you, the insurance companies are starting to look twice at these things. I think one of the things that I saw early on, which actually forced me to go to, coerced me to go to California for about three years and operate, was that patients had caps on their insurance policies. So, they would have a certain amount of coverage. And my hospitals was using up that coverage in one operation. And frequently I needed to do another procedure as a secondary, or whatever, it was complementary, like a vaginoplasty, I do a two-stage vaginoplasty, which I think are much better than one-stage operation, they look much better and work better. So, I've never bent on that. But they were using up my patient's lifetime benefits in one operation.

So, I started working out of Kaiser in San Francisco, because that's who I was servicing a lot of patients for. Trying to maintain those coverages. Because then they would keep eating up their cap. But those caps went away because of Obamacare.

The other thing that went away because of Obamacare is preexisting. So, no caps, no preexisting. So, people suddenly got better coverage.

What we're seeing now, and the trend, and the gradual trend now is that insurance carriers are hiking up the copays, and they're hiking up, I'm starting to all of a sudden see caps appear on people's policies again. So, I don't know how they can get away with the cap, I thought that was unlimited. But they're capping coverage now.

In fact, I just met with a patient last week—no, this week—who said that her insurance company came to her and said, "We'll give you \$15,000 to have the surgery. We'll reimburse you up to \$15,000 to have the surgery." Which, for her surgery, probably would have only been

about \$10,000 short. But I mean, the insurance companies are starting to look at ways of reducing their costs. So, copays are going up, deductibles are going up, and we're starting to see caps.

The other thing they're starting to do, which is kind of the newest turn of event, is that by far the most important operation for most trans men is their chest surgery. Single most important, probably more important than genital surgery for a lot of them. And I think it should be done when they're kids, if possible. Because I think, it's not like they're going to have regrets. They've lived this way since they were five, in most cases. Just get them off before they develop much breast tissue. Get them off while they're young. And we've been able to convince insurance carriers almost 100 percent of the time until recently. Now all of a sudden they're saying, "Oh, no, they need to wait till they're eighteen." And I think it's just finding ways to defer coverage. It's not like they're going to, two years later, kids aren't going to, when they turn legal age, they're going to, they'll still have the chest surgery done.

So, to me, it's really unfair to make somebody, you know, that's the single most important thing for them to have. So, they give them two more years of trauma having those. It just makes no sense. But we're seeing that. We're seeing that on both sides, the male to female as well. Because I've started doing sixteen-year-olds, probably about five years ago, based on conversations that were going on with me and the chief at Boston Children's, who has a very large trans practice. And we came to this conclusion that the kids do much better when they have a year at their parents' house versus going away to college the year they can do them. Because no one does anything they're supposed to do when they go to college, [unclear].

So, we started doing them at a younger age. And the kids do exceptionally well. I mean, as long as they don't have a complication, they don't do well with that. But they do really exceptionally well in terms of their life's already in order when they come to you. They're not on antidepressants. They're not on anxiolytics. They're normal kids. They just have this birth defect they need to have fixed in their mind. So, denying them coverage till they're eighteen to me is crazy. Because we're going to be operating on them at their worst time in their life, right before they go to college.

So, we're fighting them. We've successfully fought that. I think this weekend, I fought it for a patient from the Northeast. And the medical, we always had peer-to-peer reviews. And the peer reviewer I was dealing with was a pediatrician who agreed with me 100 percent. So, she's submitting an appeal. But they had to deny me on paper right now. Even though we know it's the right thing to do.

Young: Are there any questions you wish I had asked? Anything else you wanted to—

Meltzer: I don't know. I'm trying to think. No, I mean, I didn't really come in, I didn't see your list of questions, I didn't even—I saw them a while back. But then I was going to review them today. It's like, I don't know whether, Miki kept on trying to forward your emails to me. And it wouldn't, they wouldn't go to me. And then when I finally got them, there was no attachment. So, I have no idea.

Young: Well, you said at the beginning, before we started recording, you're best off the cuff.

Meltzer: I think so. I think I'm best off the cuff. I don't think I do as well with the standardized questions.

Young: Well, I really appreciate you sitting down with me. This has been really wonderful.

Meltzer: Thank you.