The Transgender Athlete (Part 2)

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All right, so let's talk about policies. Where is the stance coming from on how transgender [? athletes? ?] So we're going to go back into that. So you have to understand where the female athlete and why we have these gender divisions to fully understand how the transgender athlete fits into athletics.

So the IOC policy-- any female-to-male is eligible to compete in a male category without restrictions. So they just blanket statement that if you have a female-to-male athlete, they're able to compete. It is when you have a male-to-female, they have to fit into one of these-- they have to apply or they have to follow these four categories.

They have to declare their gender identity as female, and it has to be for a minimum of four years. So prior to being eligible to compete, they have to be female and living as a female for four years.

They have to demonstrate that her testosterone level serum is below 10 nanomoles per liter in the last 12 months prior to her first competition. If the athlete's testosterone levels do not remain below that, then they immediately restart the clock on that 12 month period, otherwise they're ineligible to compete. Compliance with these conditions are monitored by testing.

So going back to Laurel Hubbard-- the athlete that competed in the powerlifting competition in Australia-- she met and was compliant with all the rules and regulations set up by the international committees for her to compete in that powerlifting competition. So although there are female-- biologically sexed female athletes-- that are unhappy that Laurel won, she competed within the rules, and it is her right to be able to do that.

So hyperandrogen [? syndrome ?] in the female athlete-- this is another issue that can hurt [? or can ?] cause increased testosterone. So this is an Indian sprinter who was suspended for two years due to failing a testosterone test in 2014. She sued saying, I'm female. I've always competed as a female. I'm sorry my testosterone test came back.

She is from a small village in India, actually had no idea why she was having testing performed. She wasn't explained what was going on until after the test came back. And they said, sorry, you are ineligible to compete because we think you have too much male hormone. The testing was put in place because someone said that her stride was too aggressive and she had too masculine of arms. And that is why she was forced to go through gender testing.

Because of everything that went on with Dutee Chand, they have had to change policies on what they consider testosterone levels in a female if they have no use of hormones. And it's really

become a mess. They tried to update the policy, then it got changed. They're really sitting in a hard place with this one.

Another individual that has been going through all issues is Caster Semenya from South Africa. She has dominated in the women's 800 meter run, the 400 meter run. She was suspended in 2009 but then reinstated after passing all her gender verification testing.

And I just-- think about what the Olympics is for. It is to contribute to building a peaceful and better world by educating youth through sport practice without discrimination of any kind in the spirit of friendship, solidarity, and fair play. I pulled that from the Olympic website.

With a lot of these athletes that are put through sex verification testing, if they fail and are stripped of their wins, and yet have done nothing wrong, quite a few of them actually commit suicide, because they are ostracized in their country, they are tortured by the media, they are yelled at for cheating, and they just end it. We're causing these athletes to do that. It's just not right.

The NCAA has policies specific to a female-to-male athlete. In this case, if a female-to-male athlete is allowed to take testosterone, but then if they're taking testosterone, they can only compete in the male division. If a female-to-male [? transition ?] decides to not take testosterone, they can compete in either division. So they can either go with the team that [? fits ?] with their gender, or they can go with their biological sex at that point. It all is based on their choice with hormones.

And it is not required for a transgender individual to take hormones to transition. That is each individual's choice on how they want to complete their gender affirmation [? during. ?] Now, if you have a male-to-female athlete, they do have to have the hormones to compete in the female division versus If they are taking hormones, they would then only be allowed to compete in the male division.

Now, so we've talk internationally. We've talked at the college level. Now we have a K-12 school policy. And this varies by state.

And really, when you look at it, children-- no matter what their gender identity is-- they should be allowed to experience the benefit of sports when it comes to the physical, mental, and social aspects. By allowing them to participate, you're one, affirming their gender. When you look at the statistics of what transgender individuals deal with when they are fighting their biological sex, when they know that-- so if you have a female who knows that they're a male, and you're forcing them into the gender stereotype of a female, they're depressed, they're anxious, they have suicidal ideation.

This is one of the populations of people that commit suicide and are successful at completing it. How can we support them? One is allowing them to compete at the gender that they specify with.

Now, within the states, this was a map pulled from the website Transathlete. It is put on by Chris Mosier. He is the first transgender athlete to compete for the US Olympic Committee, and he is a distance runner.

And what this is is you have a variety of states. So eight states, which are the blue ones, have no policy on the books concerning transgender athletes. Seven states, which are the red ones, have discriminatory policies. And that could either be that they're gender-based on their birth certificate is what they-- or they're sex-based on their birth certificate is what they have to compete at. They may have surgical requirements, or that the transition has to occur prior to the start of puberty.

North Carolina has one of the most discriminatory policies. And it prevents trans athletes from participating and only off their biological sex. It also had locker room and bathroom ban policy that prevents someone from using the gender of choice restrooms.

Texas being one of the most discriminatory just had the Texas State champ for wrestling was a transgender male forced to compete in the female division. This athlete stated in newsreels, I didn't want to fight girls. I want to wrestle the boys, but they're forcing me. And I don't want to give up the sport I love just because they won't let me wrestle in the division I want to.

The thing is is based on Texas policy, that athlete was legally taking testosterone for their transition, and still forced to compete in the women's division. So now you have a transgender male on testosterone fighting females. You are in a lose-lose situation with this athlete.

So now they're being ostracized in the news-- because I saw this story come across the Minnesota back in January news feed-- and now they're in a fight. And they may not even be allowed to compete come next year to defend their title, or vice versa, were not allowed to compete at all. They'll be a senior next year.

Then you have yellows, which need some modification, and are a case-by-case basis. And that's about 20 states. Then there are 15 states that are inclusive.

And what that means is they do not require hormonal treatment of the athletes to compete as the gender they want or surgery. Minnesota is one of those inclusive policies that if you have a transgender student, they are not required to have surgery or take any hormones. And they can compete in whatever sport that they would like, which is fantastic.

So into the important clinical considerations-- within the sex and gender minorities, they were officially recognized as a disparity population. And this occurred in 2016. So this population of people do not see health care services outside of getting their hormones because of how they are treated within the doctor's office.

Within that population, 31% that do actually see doctors have not told their health care provider that they're transgender. They have transitioned to a point that their appearance matches their gender, which is fantastic. And they have chosen not to tell their provider that they are transgender for fear of how they will be treated.

Within the barriers of health care, there is verbal harassment, refusal of care, unnecessary or invasive questioning, or they just go to a provider that is uneducated in the care that they need. And this can consist of simply understanding that if you have a female-to-male patient, that although they still have a uterus and ovaries, and they may need to have a gynecological exam, it can really destroy their emotional well-being to have that, or be questioned about it. So it may be an uncomfortable position for you as a provider, but when dealing with a transgender patient, you may want to ask them if they have assigned different names to their genitalia so that you can refer to them in a trans friendly way.

So they may have-- if you had a female-to-male rename their clitoris a penis, and that is how they refer to it. And you need respect for them. And that's very uncomfortable as a provider to ask those questions and have that open dialogue with them.

With intake paperwork, it is incredibly challenging for a transgender individual to change their name. It can cost them up to $300, a court date, and having witnesses confirm that this is who they are. This is how they would like to change their name for them to actually [INAUDIBLE]. So they may on their drivers license still have their legal name and legal sex, versus having their name of choice and their gender of choice, because that is just how the system works right now.

So having blank boxes put in just to fill in versus having check boxes allows for the variety of information to be taken. They went back and forth because the legal name may go through all their insurances, you need to use their chosen name so that they feel comfortable coming to your office. It's a common mistake that occurs when you have a patient that has two different names to call them by the wrong name if you're moving quickly and that can make them feel alienated.

There are some provisions within the Affordable Care Act that provides protection but not all care is covered. A lot of gender affirmation care is out-of-pocket costs. And with the fact that this population has a high risk of mental illness, within the depression, anxiety, trying to fit into their gender [? role ?] [? to ?] what gender, and then dealing with having all the surgeries, if they decide to go that route, that becomes extraordinarily expensive.

Depending upon the level of surgery, it can be $25,000 to $30,000 to complete gender affirmation surgery, so it's not always possible within the US for [? them to ?] [? that. ?] And it's not covered unless they're diagnosed with gender dysmorphia, which then puts a psychological stigma to their gender. But right now in the DSM-5-- I believe they have dropped gender dysmorphia as an actual psychological condition. So they can no longer be put through trying to remove that or put into treatment to try to correct it.

When having a patient come in, looking past their transgenderedness-- so if they come in with shortness of breath, don't just think if it's a male-to-female, that it's from their chest binding. So male-to-female, to deal with the fact that they may have gone through puberty and they may have had breasts develop, will bind their chests so they appear flat. And that can reduce breathing.

It can have issues if they're participating in sport like that, but don't also ignore the fact that it could be allergies. They could have asthma. They could have some other condition going on.

The other thing is if they're on hormone therapy, don't assume all their conditions are coming hormones. Although, when you are transitioning, especially taking testosterone, there are a lot of musculoskeletal complaints that we as musculoskeletal specialist can best care for them.

When they go to the doctor and we mis-pronoun them, or use their birth name or dead name, it can trigger body dysmorphia. So we can cause them to have even more issues with them coming into their gender. So we as providers can do our best to make them feel welcome, and that we are a individual that can care for them safely.

They no longer want the term preferred, because it is not their preferred gender. It is not their preferred pronoun. It is their pronoun, and it is their gender.

Within the trans population, 50% of them are seriously considered suicide and 25% have attempted. So if you're talking to one of them, they probably at some point had suicidal ideations. It's kind of terrifying when you consider a main cause of it is having providers not take care of them.

So moving past that into sports injury considerations-- this is where it gets really-- because it's so new, there aren't any real good epidemiological studies. I did find a case study discussing female-to-male and distance running having an increased risk of stress fracture. When you have a female-to-male athlete as well, do they follow the typical female injury pattern of increased ACL risk or increased knee injury?

And is there [? the ?] chest binding, and then with how that affects the cardiovascular system-- these are just things you need to take into consideration with managing these patients. That's a picture from this past weekend of our Minnesota Vixen, which they're a unique population of individuals that are great fun to work with and have really emphasized the point of how to manage a transgender athlete.