Sawbones 454: Gender-Affirming Care for Minors

Published May 2, 2023

Listen here at themcelroy.family

Clint: *Sawbones* is a show about medical history, and nothing the hosts say should be taken as medical advice or opinion. It's for fun. Can't you just have fun for an hour and not try to diagnose your mystery boil? We think you've earned it. Just sit back, relax, and enjoy a moment of distraction from that weird growth. You're worth it.

[theme music plays]

Justin: Hello everybody, and welcome to *Sawbones*, a marital tour of misguided medicine. I'm your cohost, Justin McElroy.

Sydnee: And I'm Sydnee McElroy. Justin, um, I'm gonna—I think you're not gonna have as much to do this week.

Justin: Oh yeah?

Sydnee: Yeah. This topic that we're gonna cover this week is a little more serious, you know? I know that we're a comedy show, but we also sometimes cover things that are, um... I don't know, a little heavier, but important and timely. Um, and also a lot of people have been asking for us to talk about this.

Justin: Okay.

Sydnee: So I know that on our show we have talked about gender-affirming care for adults. We've done an entire episode about our concept of gender, and how we—how that has evolved, or how it's maybe always been evolved across cultures and such. But we've never really talked about specifically gender-affirming care when it comes to those under 18.

Justin: Right.

Sydnee: Because it's a different—from a medical standpoint, we approach it differently, first of all.

Justin: Mm-hmm.

Sydnee: I personally take care of a lot of transgender adults and provide gender-affirming care for them. I do not, um, provide gender-affirming care for minors. Not because I'm opposed to it, just because I have not been trained in that specific area of medicine.

Justin: Right.

Sydnee: I do work alongside our local clinic that does, refer to and try to coordinate with for various political and advocacy reasons. But I think that right now there is a lot of misunderstanding and misinformation, and then some of it is not a misunderstanding, it's intentional.

Justin: Right. It's crap—crappy.

Sydnee: Targeting, yes, of trans individuals and specifically trans kids. So, um, I thought we should talk about it. The history of our medical management of gender dysphoria is long. We've talked about that on the show before. Um, our history of the medical management of gender dysphoria in those under 18 is actually not as long. It's actually—us having protocols and a good, firm medical understanding of best practices is, in the big picture, more recent, as in the 90's, 1990's.

But there's still—there's a reason that we provide the care we provide now. There's a reason that every major medical organization supports the care that is provided now. And I thought maybe walking through this would help people understand what's happening and why it's so dangerous.

Justin: [sighs] I'm frustrated, Syd, because I had this whole plan that the first time you talked about gender-affirming care for minors and it being banned I was gonna say something like, "Just because you dig minerals out of the ground doesn't mean you should be prohibited from any sort of gender expression," and that was, like, one of the... jokes I was gonna do, that I thought would be okay to do, and... it just completely passed me by. It was one of, like, very few jokes, I think, that I might have to do.

Sydnee: But you got it in there just now.

Justin: Yeah, but was the delivery everything that it needed to be to really sell it? I don't know. It seemed almost apologetic, right? A little bit.

Sydnee: I think that's appropriate for the time and the—

Justin: You think apologetic is appropriate, considering the... okay. Well... yeah, okay. What's next? Got more science? Any more science today?

Sydnee: [laughs] So I'm gonna talk about that, and I also want—as we're talking about this, I think—we mentioned this on a show a couple weeks ago. And I think this even more so sort of—

Justin: It was The Late Show with James Corden. [wheezes]

Sydnee: [laughs] We—

Justin: [through laughter] No, it was an episode of our podcast.

Sydnee: No, it was... [laughs quietly] We mentioned it on some show that we're on. Well, that's harder for you to know than me.

Justin: That's fair.

Sydnee: Um, but this is another area of medicine where I was trained in evidence-based medicine. We are training students and residents currently in evidence-based medicine. And meanwhile there are state legislatures that are passing laws that prohibit the practicing of evidence-based medicine.

Justin: And real quick, couple sentences, what is evidence-based medicine?

Sydnee: [holding back laughter] Well, medicine that's evidence-based.

Justin: Don't be like that.

Sydnee: I know. [laughs quietly]

Justin: Everybody hates that side of you, Sydnee, and they're just afraid to tell you.

Sydnee: We have—we are taking care of patients in a way that is supported by clinical studies, um, large, double-blind trials. Research has been done to look at different ways of addressing these problems and has arrived at the conclusion that these are the best practices. They are based on medical evidence. It's not based on gut feeling, or "what we've always done."

Justin: Or any old books.

Sydnee: No.

Justin: That your grandpa and grandma may have been wild about.

Sydnee: We have been trying to skew away from consensus opinions. Now, sometimes that's necessary in medicine. We don't have an exact research-based question—we have a lot of data, but then we have to kind of get a bunch of experts in the room to interpret the data and give you an opinion based on it.

Justin: Yeah.

Sydnee: I mean, which is not—I mean, that can work. Sometimes that's what we have to—

Justin: Interpretation is maybe a better word than opinion, right?

Sydnee: Yes, exactly. Interpretation. That is a better word. But we're talking about is, we did a study in this is what worked best. There it is.

Justin: Fair.

Sydnee: No one's guessing. Nobody was trying to make it one thing or the other. This is just what it is. That's evidence-based medicine. Um, it's what differentiates us from, you know—we've talked about—

Justin: The wolves?

Sydnee: [laughs quietly]

Justin: [laughs quietly] The simians? What differentiates us from the sea life?

Sydnee: Well, it's dif—like, it differentiates the medicine I practice from homeopathy, for instance.

Justin: Okay, right, yes. Broadly speaking. Less broadly speaking, I guess.

Sydnee: Uh, so as we have talked about before, when it comes to our concept of gender—we've done a whole episode on that. Just to sort of outline the idea that this sort of idea that gender is a binary... and that that can be determined by either a defined set of chromosomes, XX, XY, for example, or by a physical characteristic like external genitalia, is flawed and incomplete, and not accepted across all cultures.

It is a very specific belief, and has not always been—has never been true, but has also not—not just—everybody says, like, "Well, it's just common sense." Well, no, it's not. A lot of people have always felt differently about this, and there are many cultural traditions that have always understood the idea that gender is a spectrum, there are many different genders, that there is—that human beings are infinitely more complex than XX equals girl, XY equals boy, and there's a specific set of genitalia associated with those.

Justin: It would be like saying that Santa Claus has to appear in the movie for it to be a Christmas movie.

[pause]

Sydnee: [hesitantly] Ye—yes?

Justin: Listen, I'm just trying to make it relatable, and that's just something I was thinking about. Like *Die Hard*, right? A lot of people say that's a Christmas movie. But really there's a lot of different factors that go into that, and what you really should do is ask *Die Hard*, like, "Are you a

Christmas movie or not?" And then it can decide for itself. That's what I'm saying. It's not—you can't make a—people say, "It's not a Christmas movie 'cause it doesn't have Santa in it!"

Well, you should probably just ask... if it does or not. If people don't agree, maybe it shouldn't be a consensus thing. Maybe you should just... ask *Die Hard* if it's a Christmas movie or not. That's all I'm saying.

Sydnee: How do I ask *Die Hard*?

Justin: Again, the metaphor starts to—

Sydnee: [laughs]

Justin: You've actually—very intuitive and incisive, as always. You've really cut to the quick of the problem with the metaphor, for sure.

Sydnee: Uh-huh, yeah. I think that's—yeah. Um, the, uh... [laughs quietly] Anyway, so gender is—

Justin: You're trying—you had an expression just then where you were looking at me and trying to decide if what I was saying was the dumbest stuff possible of maybe had some glimmer of, like, insight. Am I wrong? Were you trying to suss out if that was actually, uh, insightful or—

Sydnee: I guess I was trying to figure out, is that the best metaphor? I don't know.

Justin: Well, when you're talking into a mic for a podcast, Syd, you just say whatever words show up to the party! You don't always have time to sit down and write the best words.

Sydnee: I don't do that. I research things. I don't write the words, but I have outlines so that my words... my words are climbing ladders of thoughts that have already been constructed.

Justin: Imagine—beautifully put. But imagine—

Sydnee: [laughs]

Justin: —if it was more like that game Lemmings, and the words just showed up at the mouth and they're gonna jump off the cliff, so you better give 'em an umbrella... and hope for the best.

Sydnee: All I was trying to say is that the idea of gender is way more complex, and you can't boil us down what sorts of peoples, if they hang out alone in a room together long enough would produce an offspring. Gender is way bigger than that.

Justin: And the holiday movie genre is bigger than that! Let's not argue over whether it's a Christmas movie, 'cause it's none of our business!

Sydnee: When it comes to the treatment—and when I say... let me say, too, the term "gender dysphoria," meaning that your feeling, your sense of who you are, is different—or well, I should say, when we're talking about trans identities, your feeling of who you are is different than the gender you were assigned at birth, right? As opposed to cis, when the two align.

Um, and then gender dysphoria is a set of characteristics that is defined in the DSM, basically expressing displeasure and discomfort with that assigned gender because it does not align with who you are, right?

Even the term ‘gender dysphoria’ by today's standards is somewhat problematic, because it insists that you have to feel that way about your assigned gender in order to count, in some way. You know what I mean? And again, it pathologizes it, as opposed to just a difference of expression. I use the term, one, because as a doctor we need a terminology to... I mean, especially in the state I practice, to justify the treatments that I'm going to pursue.

Not to a person or their family or their friends or to society, but to the insurance companies that I'm gonna order tests from, that I'm gonna ask to pay for medications, that may at some point pay for surgeries, we have to have a diagnosis. This is the diagnosis we use.

This is a very pragmatic approach to using this term, just in case anybody's curious. 'Cause there are some that would argue we should never use it. From a very practical standpoint, in this country, where we have a for-profit medical system, we gotta have some diagnosis to link stuff to so that we can get it paid for.

Justin: Sure.

Sydnee: Um, and you know, because the medical treatment of younger people with gender dysphoria is relatively new, you'll hear a lot of people discount it as, like, experimental. And I want to get into why it's not, and I think the easiest way to start with that is to think about the fact that we sadly do not have a cure for most cancers yet.

So all cancer research, all cancer treatments are also research in some way. And I don't wanna—not always experimental. Some are, though. And we sign people up for trials with new experimental medications all the time, right? Because we know we haven't cure it yet, but one day we will. I believe that.

And so just because we need to do more research into the exact best practices of how to implement these treatments doesn't negate the fact that we know these treatments work, are effective, are lifesaving, and are better than the alternative. We can still know all that and have a ways to go, right?

Justin: Right.

Sydnee: We've seen that evolve in hypertension, and diabetes, and a million other conditions. We've gotten much better over time, but we got some core things right from the very beginning.

In the US, the history of the treatment of gender dysphoria and specifically a gender identity clinic, a place you could go where you could actually talk to specialists who would, instead of challenging your gender identity would actually confirm it and affirm it, that really goes back to the ‘60s.

And again, we did a whole episode on this previously, but there were some ideas that were brought overseas. There were some clinics in Europe. And

doctors made their way over to the US, brought along with them their knowledge base, their techniques, their medications. And doctors at the gender identity clinic at Johns Hopkins in 1966—that was the first year we officially established a university-based gender identity clinic in this country—were treating transgender patients both with medication and then with surgeries, as people were trained in these procedures.

And a lot of the origin of these surgeries, I think it's important to point out, they actually come from a pretty dark place. We have a history of doing surgeries with the explicit goal of assigning gender on children, because we've been doing them for a while on people who are born with ambiguous genitalia, or people who would identify as intersex.

Um, there was a long history of doctors and patients deciding what gender this child would be, and doing a surgery to sort of make the outside congruent, in their minds, with what they believed was on the inside.

Justin: And now, speaking of the surgery, but the idea of people being born that way, that's not as uncommon as we often think, right?

Sydnee: No.

Justin: That's... people who identify or—

Sydnee: Who are, mm-hmm.

Justin: —who are intersex, um, they're—it's more common than you think, I remember.

Sydnee: Yes, because there are a variety of expressions of that. Sometimes it is something that you can visualize with physical characteristics externally, meaning that when the baby is born, looking at the external genitalia doesn't necessarily define gender... which doesn't anyway. But at that moment you wouldn't know what to assign, because you're not sure. It's ambiguous in some way.

And then expressions that aren't necessarily external, things that might not show up till later in life, till puberty, when certain characteristics do or don't

develop. And then some things that you might never know that chromosomally you have differences. And those can all express in a variety of ways. So there are lots of ways that humans can develop in terms of what we think of as their sex, I guess, at this point.

It's never been as simple as boy, girl.

Justin: Okay.

Sydnee: So these surgeries, by the way, has, since these early days, been called into question and highly criticized, because the gender that the parents and the doctors would decide for the child obviously would not necessarily be congruent with who that child would grow up to know that they were, right?

Justin: Right.

Sydnee: So this is not—this is not something that anyone would endorse. But from these early procedures, there was a knowledge based that developed about how to do gender affirming procedures in a way that we would want them to, not in this example.

The medication part wasn't unfamiliar either, because in the ‘60s was also the rise of—there began to be this concept that cis women could experience this forever femininity. This was a very popular idea.

Justin: Oh...

Sydnee: Uh, through the utilization of hormone replacement therapy for post-menopausal cis women. So this idea was becoming very popular around the same time, that there is this natural drop in your estrogen levels after menopause, and there are changes physically that, um, that are uncomfortable for a patient to experience, but also I guess society was deeming undesirable.

Justin: Is that—is that not something that happens still? Hormone repla—like, for—

Sydnee: Mm-hmm, no, it definitely does. But this was the rise of it. We're talking about the same time period that we were talking for the first time about, hey, you could take estrogen as a cis woman, and it would keep you, whatever, more feminine [laughs quietly] forever. Um, at this same moment we were saying, hey, trans women could take estrogen, and it would be feminizing for them, too. It feminizes everyone, right? So this sort of—what I'm saying is it's easier for us to understand a type of care if it's with medications that we already understand well.

Justin: Okay.

Sydnee: That's why whenever I train people in gender-affirming care, they're always shocked at how kind of simple the actual, like, logistics of the medicine seem. Um, and I'm not saying this is all simple. [laughs] It's important and—

Justin: I couldn't do it, for example. Probably not.

Sydnee: —nuanced and complex, but the medicine part, the like, what med, what dose, is pretty simple, you know, full disclosure. And part of that is because we're also trained how to do this for cis people. We give estrogen and progesterone to cis women.

Justin: It's not—it's not uncharted territory, as much as it may seem.

Sydnee: No. Yeah, we give testosterone to cis men. And then some of the other medications we use, like spironolactone, I mean, heck, we use that medicine to block testosterone, yeah, but we also use it for acne, and we use it as a diuretic, and there are a lot of patients with congestive heart failure who are on it, so.

Justin: That's what Proactiv is. Right?

Sydnee: What?

Justin: The—the—the acne replacement, the Maroon 5... Proactiv?

Sydnee: No, it's not spironola—[laughs] Why do you think it's spironolactone?

Justin: Because if I had said that and been right it would have been very impressive, so I just took a shot.

Sydnee: I certainly hope you can't order online a bunch of facial creams that actually have a diuretic in them. [laughs]

Justin: Yeah. Okay, that's fair. Yeah, okay. You got a great point.

Sydnee: Um, so let's talk about, if that sort of started in the '60s, it would be... well, another 20, 30 years before we would start to consider how this might affect younger people, that the idea of gender identity isn't something you just discover magically when you're 18.

A lot of people know who they are earlier than that. Much earlier, sometimes. So is there care we should be providing before people are adults?

Justin: I don't know.

Sydnee: Well, I'm gonna tell you about it, but first we gotta go to the billing department.

Justin: Let's go!

[ad break]

Sydnee: So, Justin.

Justin: So, Syd.

Sydnee: One of the problems that the early physicians who practiced this care—and let me say, too, there's this really weird thing that would happen with gender-affirming care, and I think—I say weird, but I mean, if you expand your scope outside of medicine, it's fair to say that in the United States, we were progressing in a sense as a society, moving in a more progressive direction, for a while.

Justin: Yes.

Sydnee: And then we had this sort of cultural backlash where things got, um...

Justin: Worse.

Sydnee: Less progressive.

Justin: Oh. Yeah, that too.

Sydnee: [laughs quietly] And you see this for gender-affirming care where there is this progress being made, there are more clinics opening all over the country that do medical treatments, more doctors being trained in gender-affirming surgeries. You see this rise, and then in the later ‘70s and into the ‘80s, you see this kind of push back against it where first of all there was, like, a flawed research paper released that suggested that perhaps trans patients were no happier after medicines and surgeries than they were before, basically calling into question, like, is any of this necessary? Are you putting your patients through treatments and surgeries with absolutely no benefit?

Well, this was later found to be deeply flawed, and erroneous, and wrong, and totally contradicted. But because of it there was this wave of fear that swept through a lot of these clinics, and you saw a lot of these services shut down, actually. The availability of gender-affirming care for everyone became harder, became more difficult to obtain, and a cultural backlash occurred.

And this is the same time when we're seeing a cultural backlash against a lot of marginalized people in this country. Sort of the real... I don't know. When we start to see the origins of our, like, conservative being tied with a very religious fundamentalist view, and that being used to dictate policy in this country, that's where we're really seeing this push.

Justin: Mm-hmm.

Sydnee: And this affected a variety of things in our lives. Providers in the Netherlands had already recognized one issue as they're treating these adults with gender dysphoria, is that it is much more difficult to reverse—well, you can't really technically reverse puberty that has occurred—than it would be to, before a patient developed those secondary sexual characteristics, what we think of as going through puberty, if we could somehow start treating them then...

Justin: Okay.

Sydnee: Okay?

Justin: Okay.

Sydnee: But the problem with that is that you have to—you want to be really certain, right?

Justin: Right.

Sydnee: If you're gonna start someone who's just going through puberty, you want to make sure that this is who they are, this is what they want, and we all agree that this is in the best interests of the patient.

Justin: Okay.

Sydnee: And these are early days so, you know, we're trying to figure this out. So what they came up with instead is a way—what if we could put a pause button on puberty and give young people a chance to figure out who they are and be certain of their identity, and then you unpause and pursue whatever that looks like, right?

So what they started using were what are called gonadotropin hormone-releasing hormone analog. [laughs quietly]

Justin: Ah, very catchy.

Sydnee: Puberty blockers is the easy way to think of it. And basically, it works like this. There is a part of your brain called the hypothalamus.

Justin: Okay.

Sydnee: There's another part called the pituitary. And then there are the gonads. Ovaries, testes, whatever. The hypothalamus releases a certain hormone, GNRH, gonadotropin-releasing hormone, which stimulates the pituitary to release other hormones. Luteinizing hormone, follicle stimulating hormone, all the other hormones that are released. And then those act on the testes or the ovaries or whatever, to release hormones. Progesterone, estrogen, testosterone.

Justin: The works. Gotcha.

Sydnee: Et cetera, et cetera. Okay?

Justin: Yes.

Sydnee: So if you block that first part of the system, where the hypothalamus is gonna stimulate the pituitary, where the hypothalamus is gonna send a message to the pituitary, "Hey, get busy," if you can stop that signal, intercept that mail, then puberty doesn't start yet. And that's exactly what these medicines do. They block that piece of mail. They sort of—they stop that one signal, temporarily, until we're ready for it to continue. Okay?

Justin: Sure. Okay.

Sydnee: And they—the first case report of this was actually written in 1998, and basically they had an adolescent who was treated in this way, and they walked through, like, the improvements, because instead of going through a puberty that was dysphoric for them, that created great discomfort, um, and perhaps thoughts of—perhaps depression or thoughts of suicidality, those things that we know can go with improperly treated gender dysphoria—instead of all that, they didn't have to go through that puberty, 'cause it was blocked.

And then they were allowed, at the appropriate age, to start hormone therapy that would be congruent with who they were. And the outcomes

were better. Why wait until adulthood if we know how much these adolescents and teens can suffer waiting until their 18th birthday?

This is a safe way to treat it. Because the great thing about puberty blockers is that if you decide, "You know what? Actually this isn't my gender identity. The way I was assigned at birth is who I am."

Justin: You can just...

Sydnee: You just stop the puberty blockers. You unpause, and continue with puberty. And these are, again, medications that we already know how to use. We know how to—this axis the I'm talking about, this stimulating the hypothalamus, stimulating the pituitary, stimulating these other—this axis is something we understand very well and we utilize in other ways for children.

There are kids who go through something called precocious puberty, meaning that they begin the puberty process way earlier than most kids do. We can treat it with these medications, to say, "Wait. Let's put a pause on this, because you're a little too young for all these changes. Okay, now let's wait."

The other thing we worry about is that you can't reach your full height potential if this starts too early and ends too early. Does that make sense?

Justin: Yeah, makes sense.

Sydnee: So we use these medicines anyway to put a pause on that. We use medicines like growth hormone if especially—and this is again—we talk about gender-affirming. We live in a society where we generally—and this is not me, but I think it's fair to say—we generally expect men to be taller than women, generally speaking. We can give you growth hormone if your child is lagging behind on the growth curve to help them reach their full height potential.

Justin: Well, good.

Sydnee: Which is gender-affirming in a way.

Justin: Yes, that's true.

Sydnee: So we already understand this axis well. These are already things that we can do very safely. These are medications that are well understand, and they demonstrated this in the late '90s, um, by treating patients with gender dysphoria, first with a blocker and then once they had reached a certain stage of, uh—well, first you start the blockers when you're at Tanner 2 or 3 stage. These are stages of pubertal development, which we judge based on breast development or hair certain places and things like that, right?

Justin: Right.

Sydnee: So you pause. You probably are working with a whole multidisciplinary team of counselors, and doctors, and maybe a psychiatrist if necessary. Whoever is needed in this team to talk to you about who you are, until around the age of 16. If you're ready to make that decision, then you carry on with the appropriate hormone treatment, and then after 18 you would consider surgeries if those were desired. 'Cause not everyone wants medicine or surgery. These are just the options.

So basically they developed this whole protocol that they would call the Dutch protocol. And it was very codified, and it was then introduced over to the US. Hey, these are things that we do.

And again, we're in the early 2000s now by the time this is catching on in the US. Um, we kind of did our own thing in this country. We didn't exactly follow the Dutch protocol.

Justin: Mm-hmm. Very American of us.

Sydnee: Yes. There are a couple different groups that are used, their guidelines and standards are used. There's the—we use the Endocrine Society standards, there's the Pediatric Endocrine Society of course, specifically, which is helpful, obviously, in this issue.

There's the World Professional Association of Transgender Healthcare, which is WPATH. You'll hear that a lot. So there are a lot of different standards that

are used, but basically throughout the 2000s, different clinics throughout the US began to come up with their own set of guidelines based on the Dutch protocol, based on the Pediatric Endocrine Society, based on WPATH, um, to do this same thing.

And the general idea is always the same. You have a multidisciplinary team of doctors and counselors and therapists, and professionals in all arenas, maybe endocrinology, pediatrics, family medicine, med-peds, psychiatry, psychology. You have all—adolescent medicine specialists, pediatric gynecologists sometimes.

You know, we have all these different specialists who come together, work with a patient and their caregivers—in this country the guardians are always involved, parent—parents or guardians, whoever.

Everyone works together to come to a consensus of what is the best course of treatment to affirm this young person's gender identity. And then at that point you may or may not start a blocker, and then at some point you may or may not start hormones. And then after they're an adult, they may or may not be referred to surgery.

And that's, generally speaking, how it works throughout the country to this day.

Justin: Okay.

Sydnee: So what you might be wondering is, if we've come this far and we have all of these different programs around the country that are recognized as, you know—there are 60 recognized around the US as, like, multidisciplinary gender programs that offer all these services. Why are we talking about it?

Justin: I don't know.

Sydnee: When it’s just a medical treatment, and this is the history of how we developed it. Um, and from a medical standpoint, it is not controversial. The controversies—the controversies in medicine, the things that doctors get all worked up about, are not at all what I feel like society as a whole gets all

worked up about. Like, we will argue forever about, I don't know... in the hospital everybody's got their favorite fluids that they love to use. Everybody's got their favorite go-to SSRI that they want to start. People have all their fa—this is the regimen for pain control that I find works best. We will take each other to the mat over whether or not we should use Macrobid—that's an antibiotic—in this patient.

But this is not controversial. We have a huge body of evidence that suggests this is the best way to treat these patients. We have a rigorous set of guidelines that have been reviewed by multiple medical societies across the globe.

Justin: Now, this does not mean, though, that all doctors are all on board with this, right?

Sydnee: No.

Justin: Like, I know I've personally overheard your half of phone conversations with doctors that would indicate that that is not the case.

Sydnee: No, not all doctors are on board with it, and I think that's because even though medically, scientifically, it is not controversial, from a research standpoint it is not controversial, there has been a backlash against the appropriate medical care for transgender people as long as we've been providing care for transgender patients in this country.

You know, a lot of—it was interesting. As I was reading about this, a lot of our kind of ideas now—and some of them are just outright discriminatory, prejudiced, ignorant, "I'm afraid of things that are different," right? Some of it is just that simple, and that applies to anybody that's different from you.

There's specifically a line of criticism that is used, and I would say a pseudointellectual line of criticism that is used against transgender people that stems from this idea that, uh, trans women specifically are a threat to cis women, that they undermine our femininity, our identities, our independence, in some ways undermine our struggle as women to achieve, you know, equal rights in this country.

Justin: Hold on. I'm about to make a point about this. [snort-laughs] Just kiddin'! Just kiddin'. Not with my worst enemy's microphone would I, a straight white dude, wade into this one. I'm just gonna... whatever you say, Syd.

Sydnee: I know, but I'm assuming you're on the right side of this.

Justin: I am on the right side of it! And that is all anybody wants to know from me.

Sydnee: I found as I was reading about, like, the sort of—the medical community and how we managed gender dysphoria over time, I came across the term, "The Transsexual Empire."

Justin: Ooh.

Sydnee: And The Transsexual Empire was a book written by a Janice Raymond back in 1979, and if you're wondering where some of these ideas that maybe other authors whose books you used to enjoy quite a bit—

Justin: [snorts]

Sydnee: —and maybe not so much these days, if you're wondering where these ideas came from, a lot of 'em can be traced back to—not sp—I mean, she wasn't the first person to ever think of this stuff, but this book was very influential. The Transsexual Empire is actually all of us in the medical healthcare profession who affirm transgender identities and provide medical treatment when needed for gender dysphoria. We are the problem. [laughs quietly]

Justin: Hmm.

Sydnee: Because we're affirming trans identities as opposed to pathologizing and trying to... correct trans identities. And again, this comes from this idea that trans women specifically are upholding sort of a stereotype of women, like a caricature of femininity, and that us cis women have to fight out against it. And if you're—again, if all of this sounds familiar,

yes, this is the beginning of trans-exclusionary radical feminism, or TERFs for short.

This is where this sort of—this is back in the ‘70s is where these began to, like, germinate, these horrible ideas. And all of it is is a way of defi—of trying to decide what makes a woman. Um, which, you know, I would say it's 'cause I say I'm one. And that's about all that's needed.

But anyway, against kids specifically—so there's this undermining of our ability of doctors to appropriately provide this care for everybody that's been around for a long time. In recent years, it has specifically been aimed at kids. I think in part it's a fear related to the fact that so many more young people identify as trans or gender-nonconforming or genderfluid than older people. We know that demographic is shifting, right?

Like, if you look at the percentage of trans people in this country, it has not grown hugely, but if you then just, you know, narrow it down to people under 30, it's a much larger number. So we're shifting in terms of how open and accepting we are with gender identities that fall outside of that sort of prescribed binary. We're more accepting, and so therefore you're going to—more people are going to admit that's who they are. Right? We know that.

Justin: Right.

Sydnee: Like, it's okay to be that, so more people will be that. The other thing is we give language to people who weren't sure. You can't be something you can't see. If you don't know that that's a thing that exists or that's a way people are, then you can't be that thing. So why are all these laws being introduced then?

Justin: Um... because... it's a useful tool for evil people to radicalize their followers against an imaginary enemy, so they can continue to hold political power over an increasingly divided nation.

Sydnee: That's actually a good answer, Justin.

Justin: [relieved sigh]

Sydnee: [laughs quietly]

Justin: Okay! [breathes heavily] Alright.

Sydnee: I think that, um, there are all these—there are always people who get to a point in their cognitive development where they lock everything in place and can't learn anything else. No one has to get there, by the way. That's a choice you make. That's not—

Justin: "Aren't going to learn anything else" is actually what I would argue.

Sydnee: Yes. Um, you can always open your mind to things you didn't understand. There are a lot of people, older people today who did not really understand the idea of someone being transgender when they were younger, who have managed to expand their minds and accept people exactly as they are and, you know, accommodate that into what—their view, their understand of what humans are and what they can be.

That's always possible. Um, I am—I am concerned when I look at—so, we live in West Virginia, and our state passed a gender-affirming care restriction for minors. And basically, it put a lot of restraints on who can access this kind of treatment. Some things that we already did, ensuring that appropriate specialists were involved in the care, ensuring that a mental health specialist was involved in their care, ensuring that parental or guardian consent was always obtained, all of these things were the same.

There's some extra restrictions that have been placed, some definitions that really aren't, um—like, severe gender dysphoria isn't really a concept. There's no mild, moderate, and severe for gender dysphoria. But these sorts of stipulations have been put in place, which provide a much more narrow path for people to access care, and the concern being that this will limit the number of people who can access this care.

And I know that in our state, even, this is not nearly as severe as some of the outright bans that have been put in place in other states where, you know, there are young trans people who can no longer access necessary, evidence-based medical treatment that is, in many cases, lifesaving.

Uh, as a physician, outside of the fact that there is a movement in this country that would seek to... um, what were the words? That we have to eradicate transgenderism, was the word of somebody at CPAC?

[pause]

So if that sounds like, you know, when you start talking about eradicating groups of people, if that sounds like something that concerns you, it should.

Justin: Yeah.

Sydnee: Also, please don't say transgenderism. That was a quote. I would never—I train students not to use that term, and I don't want to—[laughs] I do want 'em to think I'm a hypocrite.

Um, but the other thing, too, as a physician, and I've said this somewhat in a couple episodes ago, but I would say it again.

Um, how much are we going to let the state restrict our ability to practice the care we took an oath to provide? I took an oath to not harm my patients and I took an oath to do the best I can for them, and I also vowed to do it with a sense of justice in mind, that all people have equal access to the care they need.

Justin: Mm-hmm.

Sydnee: Well, the state is limiting access of my patients to the care they need. How much further do we let it go?

This is unprecedented, by the way. The state coming in—I mean, I know when we talk about issues related to abortion care, definitely the state gets involved. But this isn't about somebody trying to argue about when life begins or when life ends or these sort of questions that start to ease into the religious, the metaphorical, the whatever.

No. This is medical care that is necessary for a group of people that is being banned by the state. Why are we okay—why is an—why is every doctor not burning their white coat in the street? Why are we not rising up? Why are we

not fighting these institutions that are limiting our ability to do—we're the experts. We know what we're doing. The state should not be telling me how to practice medicine.

I went to school for that and I read lots of studies for that, and I'm standing on the shoulders of giants who have been doing it—I mean, listen to this podcast—for as long as we have been alive as humans. We have gained this knowledge base. And to think that you can legislate against it because it scares you, worries you, bothers you, or it's some sick, cynical power grab by, you know, leveraging power against the most marginalized among us, it's disgusting!

Justin: Yeah.

Sydnee: And on a final note, I'll say this. Does this sort of care work? We've always known it did because, you know, talk to patients. But we have recent studies that have been released just this year and last year that have affirmed over and over again that specifically trans youth who have access to gender-affirming behavioral therapies, gender-affirming medical treatments, and gender-affirming—well, we don't even really talk about surgeries in this country.

There are other countries where the age at which one may obtain surgery might not be the same. That's not as common in the United States of America. But gender-affirming medical treatments in the form of medicine, hormones, we know that it greatly reduces depression and that it greatly reduces suicidality, and their quality of life is improved.

So when I was asked repeatedly by legislators, "Why can't we just wait ‘til they’re adults?"

It's because a lot of these kids will not survive until adulthood if we force them to go through a puberty that does not align with who they are, that causes them severe dysphoria, and may lead to the loss of their life. That's why we can't wait. And we know this because we have the evidence and the studies to support it.

So I would really urge you, everyone, to pay attention to this. If it hasn't come to your state—I mean, I know there are some places in the United States this is gonna happen. Some of you live in blue havens. [laughs quietly] Where this will never happen. But many of us don't. And a lot of people will suffer because of this, and I have no doubt that things could get worse here, in the state where we live. So I urge everyone to pay attention. If you're in healthcare and you're not screaming at the top of your lungs about this, I would really urge you to do some soul searching as to why.

We have to start speaking up. We are the ones who care for our patients. We are the line of defense against these sorts of forces, whether they're infections, pandemics, or ignorant politicians.

Justin: Thank you so much for listening to our podcast. Uh, we do one almost every week. Thanks to The Taxpayers for the use of their song, Medicines, as the intro and outro of our program, and thank you so much to you for listening. We really appreciate it and we hope that you are hanging in there. Until next time, my name is Justin McElroy.

Sydnee: I'm Sydnee McElroy.

Justin: And as always, don't drill a hole in your head.

[theme music plays]

[chord]

Maximumfun.org.
Comedy and Culture.
Artist Owned.
Audience Supported.