Journal of Health & Biomedical Law, XIII (2018) 289-322

Suffolk University Law School

TESTOSTERONE AND TRANSGENDER MEN: THE DISCRIMINATORY IMPACT OF TESTOSTERONE'S SCHEDULE III DESIGNATION ON TRANSGENDER MEN SEEKING MEDICAL CARE

Skailer R. Qvistgaard*

I. INTRODUCTION

November 20th is the Transgender Day of Remembrance, a day where the transgender community comes together to mourn those who were killed in that calendar year due to "anti-transgender hatred or prejudice."[1] Anti-trans hatred and prejudice can manifest itself in the extreme through physical harm and homicide, or in a more subtle manner such as misgendering a transgender person.[2] Prejudice against transgender people

*J.D. Candidate, Suffolk University Law School, May 2018; B.A., Boston University, 2015. Mr. Qvistgaard can be contacted at sqvistgaard@suffolk.edu.

[1] *About TDOR*, INTERNATIONAL TRANSGENDER DAY OF REMEMBRANCE (2007), https://tdor.info/about-2/ (last visited Dec. 27, 2017) (discussing the International Transgender Day of Remembrance's history and current purpose); *Statistics and Other Info*, INTERNATIONAL TRANSGENDER DAY OF REMEMBRANCE (2012), https://tdor.info/statistics/ (last visited Dec. 27, 2017) (providing the date and death tracking information of qualifying transgender deaths). *See generally Transgender Terminology*, NAT'L CENTER FOR TRANSGENDER EQUALITY (Jan. 15, 2014), http://www.transequality.org/issues/resources/transgender-terminology. The term "transgender" refers to someone "whose gender identity, expression or behavior is different from those typically associated with their assigned sex at birth" and the term trans can be used as shorthand for transgender (e.g. transgender people can be phrased as trans people). *Id. Full Definition of Prejudice*, MARRIAM-WEBSTER'S DICTIONARY, http://www.merriam-webster.com/dictionary/prejudice (last visited Dec. 27, 2017) (providing the sociological and legal definitions of prejudice). Prejudice is defined as "an irrational attitude of hostility directed against an individual, a group, a race, or their supposed characteristics." *Id.*

[2] Elliot A. Tebbe, Bonnie Moradi & Engin Ege, *Revised and Abbreviated Forms of the Genderism and Transphobia Scale: Tools for Assessing Anti-Trans* Prejudice*, 61 AM. PSYCHOL. ASS'N J. COUNSELING PSYCHOL. 581, 585 (2014) (providing statistics on the prevalence of different anti-trans behaviors and opinions). *See also About TDOR*, *supra* note 1 (discussing physical anti-trans violence as a manifestation of prejudice); *Misgender*, ENGLISH OXFORD LIVING DICTIONARY, https://en.oxforddictionaries.com/definition/misgender (last visited Dec. 21, 2017) (providing the definition of "misgender"). To misgender someone means to refer to them "using a word,

also can manifest in medical settings when receiving transitional and non-transitional care.[3] When pursuing medical transitions transgender men and transmasculine people are most commonly prescribed testosterone, which is a Schedule III controlled substance.[4]

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especially a pronoun or form of address, that does not correctly reflect the gender with which they identify." *Misgender*, *supra*.

[3] *See* Tonia Poteat, Danielle German & Deanna Kerrigan, *Managing Uncertainty: A Grounded Theory of Stigma in Transgender Health Care Encounters*, 84 ELSEVIER SOC. SCI. & MED. 22, 23 (2013) (discussing specific instances of anti-trans discrimination in medical settings); Taylor M. Cruz, *Assessing access to care for transgender and gender nonconforming people: A consideration of diversity in combating discrimination*, 110 ELSEVIER SOC. SCI. & MED. 65, 66 (2014) (discussing barriers to transgender healthcare and discriminatory behaviors in medical settings). *See generally Transgender Terminology*, *supra* note 1 (providing the definition of transition). In the context of the transgender community the word transition refers to "the time when a person begins to live as the gender with which they identify rather than the gender they were assigned at birth" and transitional medical care ("medical transition") refers to the parts of transition that occur under the supervision of medical providers, such as "taking hormones [and] having surgery." *Id.* Non-transitional care would be care that does not specifically pertain to a transgender person's medical transition, such as care for a broken leg or a flu vaccination. *Id.*

[4] *See What Are Commonly Used Medications For Transition*, TRANSLINE: TRANSGENDER MED. CONSULTATION SERV., https://transline.zendesk.com/hc/en-us/articles/229373208-What-are-commonly-used-medications-for-transition- (last visited Dec 27. 8, 2017) (describing most commonly used medications for transgender people's medical transitions); Bos. Univ., Sch. of Med., Endocrinology, Diabetes & Nutrition, *Practical Guidelines for Transgender Hormones Treatment*, http://www.bumc.bu.edu/endo/clinics/transgender-medicine/guidelines/ (last visited Dec. 27, 2017) (describing common doses of testosterone); WORLD PROF'L ASS'N FOR TRANSGENDER HEALTH, STANDARDS OF CARE FOR THE HEALTH OF TRANSSEXUAL, TRANSGENDER, AND GENDER NONCONFORMING PEOPLE, 1, 33-50 (7th ed. 2001) (describing the medical necessity for hormones, risks, and regimes for masculinizing hormones, such as testosterone). *See also* Controlled Substances Act, 21 U.S.C. §§ 801, 812 (amended 1990) (providing lists of controlled substances and their schedule classifications); *Testosterone*, MARRIAM-WEBSTER'S DICTIONARY, http://www.merriam-webster.com/dictionary/testosterone (last visited Dec. 8, 2017) (providing the definition of testosterone). Testosterone is "a hormone that is a hydroxyl steroid ketone $C_{19}H_{28}O_2$ produced especially by the testes or made synthetically and that is responsible for inducing and maintaining male secondary sex [characteristics]." *Id.* Transgender people taking cross-sex hormones develop the secondary sexual characteristics associated with that cross-sex hormone, which in the transgender community can be referred to as a second puberty. WORLD PROF'L ASS'N FOR TRANSGENDER HEALTH, *supra*, at 36. *See generally Transgender Terminology*, *supra* note 1 (providing the definitions of transgender man ("transman") and FtM ("female-to-male")). The word transgender man, or abbreviated transman, refers to someone who currently identifies as a man, but was not assigned male at birth. *Id.* FtM is another way to refer to transgender men, more commonly found in the medical field, which indicates the individual's birth sex and gender identity. *Id.* "Transmasculine is a term used to describe transgender people who were assigned female at birth, but identify with masculinity to a greater extent than with femininity. This includes transmen, but transmasculine can also describe someone with a non-binary gender who views themselves as significantly masculine." *Genderqueer and Non-Binary Identities & Terminology*, GENDERQUEER & NON-BINARY IDENTITIES (July 24, 2015), http://genderqueerid.com/gq-terms. Many transmasculine people struggle with the medical community taking them and their medical care seriously due to pervasive myths about when

This means transgender men and transmasculine people who seek to lawfully and medically transition with prescriptions will need to interact with the medical provider industry, an industry which has routinely discriminated against transgender people through institutional policies and interpersonal interactions.[5]

This note will detail the social and legal benefits to the schedulization of testosterone when compared to the discriminatory impact this designation has on transgender men and the transmasculine community.[6]

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transgender people are "trans enough" to transition and be encompassed in community outreach. Kelsie Brynn Jones, *When Being Trans Is Not Trans Enough*, THE HUFFINGTON POST (Jan. 4, 2015, 12:49 PM, updated Feb. 2, 2016), http://www.huffingtonpost.com/kelsie-brynn-jones/when-being-trans-is-not-t_b_6340728.html (discussing the "trans enough" myth); Mia Violet, *Yes, You're 'Trans Enough' to Be Transgender*, THE HUFFINGTON POST (Feb. 29, 2016, 3:05 PM, updated Mar. 1, 2017), http://www.huffingtonpost.com/mia-violet/yes-youre-trans-enough-to_b_9318754.html (discussing the trans enough myth in the binary trans communities). WORLD PROF'L ASS'N FOR TRANSGENDER HEALTH, *supra*, at 33. Cross-sex hormones for a majority of transgender men would be any form of testosterone because the predominant hormone in a transgender man's body prior to hormone therapy would usually be estrogen. *Id.*

[5] *See Prohibited Employment Policies/Practices*, U.S. EQUAL EMP'T OPPORTUNITY COMM'N, https://www.eeoc.gov/laws/practices/ (last visited Dec. 27, 2017) (describing policies that would constitute discrimination). *See also* Saffron Karlsen & James Y. Nazroo, *Relation Between Racial Discrimination, Social Class, and Health Among Ethnic Minority Groups*, 92 AM. J. PUB. HEALTH, 624, 624 (Apr. 2002) (defining interpersonal discrimination). Interpersonal discrimination refers to discriminatory interactions between individuals, which usually can be directly perceived by the targeted individual. *Id.*

[6] *See* Richard D. Collins, *Drugs and the Body Beautiful: A Guide to Defending Anabolic Steroid Cases*, 26 CHAMPION 12, 13 (2002) (discussing common reasons people use non-prescription testosterone and its side effects); Ryan J. McGrew, *Raising the Bar: Why the Anabolic Steroid Control Acts Should be repealed and Replaced*, 15 HOUS. J. HEALTH L. & POL'Y 233, 238-39 (2015) (discussing the legislative history of the Controlled Substance Act and the testosterone black market); Lexis Nexis, COURTROOM MEDICINE SERIES: PSYCHIC INJURIES § 9A.60 (2015) (discussing the negative side-effects testosterone can have on the human body); Poteat, *supra* note 3, at 25-26 (discussing the prevalence of anti-transgender discrimination in healthcare settings); Deidre A. Shires & Kim Jeffee, *Factors Associated with Health Care Discrimination Experiences among a National Sample of Female-to-Male Transgender Individuals*, 40 HEALTH & SOC. WORK 134, 136 (2015) (discussing factors that make transgender people more likely to experience discrimination); Jaclyn M. White Hughto, Sari L. Reisner & John E. Pachankis, *Transgender Stigma and Health: A Critical Review of Stigma Determinants, Mechanisms, and Interventions*, 147 ELSIVIER SOC. SCI. & MED. 222, 223 (2015) (discussing the ways discrimination can be disrupted and mitigated); National LGBT Cancer Network, *Ovarian Cancer in Transgender Men*, http://cancer-network.org/cancer-information/transgendergender-nonconforming-people-and-cancer/ovarian-cancer-in-transgender-men/ (last visited Dec. 27, 2017) (discussing the risks of cancer due to hormone therapy in transgender men); Comm. on health Care for Underserved Women, *Health Care for Transgender Individuals*, THE AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS (Dec. 2011), http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-

Section II of this note discusses the legal history of testosterone, anti-transgender discrimination, transgender medical care, and anti-transgender discrimination in medical settings.[7] Section III discusses developments in the de-schedulization of controlled substances, concerns transmen and transmasculine people have about the schedulization of testosterone, and the adverse legal and health risks transgender people face when using black market hormones.[8] Part IV of the note discusses the costs and benefits of keeping testosterone a Schedule III substance despite the discriminatory impact it has on transgender men and the transmasculine community; this section will also make policy suggestions based upon other regulated controlled substances.[9]

II. THE HISTORY OF TESTOSTERONE AND TRANSGENDER DISCRIMINATION

A. The Legal History of Testosterone

Testosterone's primary derivatives are "anabolic androgenic steroids" which are the primary subject of governmental regulation.[10] Synthetic testosterone, which would qualify as a steroid, was first synthesized in 1935 and has been used for therapeutic reasons, as well as aesthetic and sports performance reasons.[11] However, due to

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Health-Care-for-Underserved-Women/Health-Care-for-Transgender-Individuals (last visited Dec. 27, 2017) (providing statistics about illegal hormone usage in the transgender community); NEWSDAY, *Some Transgender Youth Look to Black-Market Hormones*, http://www.newsday.com/news/new-york/some-transgender-youths-look-to-black-market-hormones-1.2802396 (last visited Dec. 27, 2017) (discussing transgender youth and the usage of black market hormones to transition).

[7] *See infra* Section II and accompanying text (providing historical context of testosterone, transgender medical, and anti-transgender discrimination).

[8] *See infra* Section III and accompanying text (providing current status of substance de-schedulization, testosterone's Schedule III status concerns, and black market hormones).

[9] *See infra* Section IV and accompanying text (establishing the discriminatory impact of testosterone's legal designation and considerations in the scheduling of testosterone).

[10] John M. Hoberman & Charles E. Yesalis, *The History of Synthetic Testosterone*, 272 SCI. AM. 76, 77 (Feb. 1995) (describing the history of synthetic testosterone and its uses).

[11] *See* Hoberman & Yesalis, *supra* note 10, at 77. Elite athletes have been using synthetic testosterone to enhance their performance since the 1940's and this usage has been maintained by a one billion dollar international black market. *Id. See generally Bioidentical Testosterone*,

testosterone's ability to enhance muscle performance all major sports regulatory bodies have banned its use.[12] Testosterone is also a Schedule III controlled substance under the United States Federal Controlled Substance Act ("CSA").[13] The penalties for the first offense of illegal possession of a Schedule III controlled substance are a fine of "not less

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HUDSON'S FTM RESOURCE GUIDE, http://www.ftmguide.org/bioidenticalt.html (last visited Dec. 27, 2017) (discussing the differences and similarities between natural, bioidentical, and synthetic testosterone). Natural testosterone is testosterone produced in the human body, whereas bioidentical testosterone is made outside of the human body but has the "exact same chemical structure as a hormone that is naturally produced in the body." *Id.* However, synthetic testosterone would not occur naturally because the testosterone molecule itself has been changed by "adding a side chain or functional group." *Id.*

[12] *See Drug Program Resources*, NAT'L FOOTBALL LEAGUE PLAYERS ASS'N (2016), https://nflpaweb.blob.core.windows.net/media/Default/Active%20Players/2016NFL_PES_Policy_ProhibitedSubstancesList.pdf (last visited Dec. 27, 2017) (listing substances banned by the National Football League, including testosterone); *Prohibited Substances List*, MAJOR LEAGUE BASEBALL (July 1, 2015), http://mlb.mlb.com/pa/pdf/prohibited-substances.pdf (listing substances banned by Major League Baseball, specifically listing testosterone and all Schedule III substances); *NHL, NHLPA Team Up Against Performance-Enhancing Substances*, NAT'L HOCKEY LEAGUE (July 22, 2005), http://www.nhl.com/ice/page.htm?id=26397 (describing the National Hockey League's new commitment to anti-doping in conjunction with WADA guidelines); World Anti-Doping Agency, *Prohibited List*, WORLD ANTI-DOPING CODE INT'L STANDARD (Jan. 2016), http://www.usada.org/wp-content/uploads/wada-2016-prohibited-list-en.pdf (listing prohibited substances, which is followed by the NHL, the IOC, FIFA, and ITF); Henry Abbott, *The NBA's banned performance enhancers*, ESPN TRUEHOOP (Jan. 14, 2013) http://www.espn.com/blog/truehoop/post/_/id/51309/the-nbas-banned-performance-enhancers (describing the National Basketball Association's anti-doping stance and banned substances, including testosterone); The Int'l Olympic Comm., *Anti-Doping Rules applicable to the Games of the XXXI Olympiad, In Rio de Janeiro, in 2016*, INT'L OLYMPIC COMM. (2016), https://www.wada-ama.org/sites/default/files/ioc-anti-doping-rules-rio-2016-en.pdf (describing the International Olympic Committee's anti-doping policy, which is the WADA policy); *Keeping Football Free From Doping*, FÉDÉRATION INTERNATIONALE DE FOOTBALL ASS'N, http://www.fifa.com/development/medical/anti-doping/ (last visited Dec. 27, 2017) (describing FIFA's anti-doping policy which follows the WADA guidelines on banned substances); *Tennis Anti-Doping Programme 2016*, INT'L TENNIS FED'N (2016), http://www.itftennis.com/media/224382/224382.pdf (describing ITF's anti-doping rules and regulations which follows the WADA guidelines on banned substances).

[13] *See* Controlled Substances Act, 21 U.S.C. § 812, Schedule III (e) (amended 1990) (listing the different schedule categories, including anabolic steroids, e.g. testosterone, under Schedule III controlled substances). *See also* Mayo Clinic Staff, *Performance-enhancing drugs: Know the risks*, MAYO CLINIC (Oct. 15, 2015), http://www.mayoclinic.org/healthy-lifestyle/fitness/in-depth/performance-enhancing-drugs/art-20046134 (explaining the risks of anabolic steroid use and what constitutes an anabolic steroid). "The main anabolic steroid hormone produced by your body is testosterone." *Id.* Testosterone is not explicitly listed in the Controlled Substances Act ("CSA"), but because testosterone is an anabolic steroid, it is covered under subsection (e) of the Schedule III category. Controlled Substances Act, *supra*, at Schedule III (e); Mayo Clinic Staff, *supra.*

than $1,000" and "up to 1 year" imprisonment.[14] Congress enacted the Controlled Substance Act in "an effort to categorize regulated drugs based on their potential for abuse, as well as the benefits they provide from a medical standpoint."[15] Congress acknowledges many of the scheduled controlled substances have "legitimate medical purposes," but when obtained through illegal means they "have a substantial and detrimental effect on the health and welfare of the American people."[16] Despite testosterone's historic use in treating gender dysphoria, many transgender men and transmasculine people have a dire need for testosterone and find it difficult to access because of the CSA.[17]

B. The History of Transgender Medical Care and Hormone Therapy

In the early 1900's, the study of sexology evolved to include transgender people through the work of sexologists Richard, baron von Krafft-Ebbing and Magnus

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[14] *See* Controlled Substances Act, 21 U.S.C. § 844 (2010) (explaining the penalties for simple possession of a controlled substance offenses). *See also* Brian T. Yeh, *Drug Offenses: Maximum Fines and Terms of Imprisonment for Violation of the Federal Controlled Substances Act and Related Laws*, CONG. RESEARCH SERV. 8 (Jan. 20, 2015), https://www.fas.org/sgp/crs/misc/RL30722.pdf (listing in charts the different penalties for different CSA violations). Simple possession will be the focus of this note's discussion because that is the most prevalent form of violation that impacts transgender men and the transmasculine community. *Id.* at 1-14. However, the Congressional Research Service report also covers the trafficking, racketeering, smuggling, online sales, money laundering, and tax violations in a clear and concise manner. *Id.*

[15] *Controlled Substance Law*, HG LEGAL RESOURCES, http://www.hg.org/control.html (last visited Dec. 27, 2017) (describing current controlled substance law and the history of the Controlled Substance Act).

[16] *See* Controlled Substances Act, 21 U.S.C. § 801 (1)-(7) (current through Pub. L. 115-90 (2017)) (listing the congressional findings in regards to the enactment of the Controlled Substances Act). The congressional findings and declarations (1)-(7) explain Congress' power to legislate controlled substances despite the issues that may arise from the tenth amendment, but Congress justifies its power under the commerce clause. *See id.* §§ (2)-(7). Controlled substances that travel through intrastate commerce are indistinguishable from those that travel through interstate commerce and the federal control over intrastate controlled substances amounts to interstate control. *See id.*

[17] *See* discussion *infra* Section II, B. (establishing the history of medical treatment and testosterone in treating transgender men and transmasculine people).

Hirschfield.[18] Additionally, some of the first-ever recorded gender affirmation surgeries were performed in the 1920's and 1930's, specifically a mastectomy for a transgender man and a vaginoplasty for Lili Elbe, a transgender woman.[19] As early as the 1910's transgender people were very publically transitioned and these individuals began to

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[18] *See* Stephen Whittle, *A Brief History of Transgender Individuals*, THE GUARDIAN (June 2, 2010), https://www.theguardian.com/lifeandstyle/2010/jun/02/brief-history-transgender-issues (discussing the history of transgender people and their medical care). Krafft-Ebing was known as a neuropsychiatrist and professor of psychiatry. *See* Editors of Encyclopædia Britannica, *Richard, Baron Von Krafft-Ebing*, ENCYCLOPÆDIA BRITANNICA, https://www.britannica.com/biography/Richard-Freiherr-von-Krafft-Ebing (last visited Dec. 27, 2017) (providing a brief description of Krafft-Ebbing's life and work). Krafft-Ebing is best known for his work *Psychopathia Sexualis* which was written in 1186 and detailed sexual aberrations. *See id.* Hirschfeld was a physician who was a sexuality theorist and gay rights advocate in the early 20th century. *See* Aleksandra Djajic-Horváth, *Magnus Hirschfeld*, ENCYCLOPÆDIA BRITANNICA, https://www.britannica.com/biography/Magnus-Hirschfeld (last visited Dec. 27, 2017) (providing a brief description of Hirschfeld's life and work). He is best known for his theories of "sexual intermediaries, which held there were many types of naturally occurring sexual variations . . . such as . . . homosexuality, and transvestism." *Id.*

[19] *See* Whittle, *supra* note 18 (describing the first doctors to perform gender affirmation surgeries, previously called sexual reassignment surgeries). *See also Transgender Terminology*, *supra* note 1 (providing the definition of sexual reassignment surgery). Sexual reassignment surgery is any surgical procedure that is undertaken by a transgender person to better align their physical body with their gender identity. *See id. See generally Transgender Terminology*, CORNELL UNIV., https://hr.cornell.edu/sites/default/files/trans%20terms.pdf (last visited Dec. 27, 2017) (providing the definition of gender affirmation surgery). Gender affirmation surgery is the most updated way to refer to surgeries a transgender person may seek to better align their body with their gender identity. *See id.; FTM Top Surgery Procedures*, FTM SURGERY NETWORK, http://www.topsurgery.net/procedures/ (last visited Dec. 27, 2017) (describing different mastectomy techniques for a transgender men's breast removal, referred to as top surgery); *Penile Inversion Vaginoplasty*, BROWNSTEIN & CRANE SURGICAL SERV., http://brownsteincrane.com/penile-inversion-vaginoplasty/ (last visited Dec. 27, 2017) (describing the vaginoplasty procedure, frequently referred to as "MTF bottom surgery"); Meredith Worthen, *Lili Elbe Biography*, BIOGRAPHY.COM & A&E TELEVISION NETWORKS (last updated Oct. 3, 2016), http://www.biography.com/people/lili-elbe-090815 (describing Lili Elbe's life, career, and transition). Lili Elbe, a transgender woman, was a Danish painter and one of the first documented recipients of gender affirmation surgery. *See* Worthen, *supra.* She received four different gender affirming surgeries throughout her lifetime, including a penectomy and ovarian transplants. *See id.* However, before her fifth procedure she died due to "paralysis of the heart" which was linked to surgical complications. *Id.* Plastic surgery is another way transgender people seek gender affirmation, and many cisgender Americans also have plastic surgery for aesthetic reasons. *See* Ariana Eunjung Cha, *Plastic Surgery Is Surgery is urging in America – the Trends in Six Simple Charts*, WASH. POST (Mar. 2, 2016), https://www.washingtonpost.com/news/to-your-health/wp/2016/03/01/the-surge-in-butt-implants-in-america-and-other-plastic-surgery-trends-in-5-simple-charts/?utm_term=.5ac0c540151e (discussing plastic surgery trends in America).

advocate for the transgender community at large.[20] In approximately 1939 Laurence Michael Dillon was the first documented case of a transgender man or transmasculine person transitioning by using testosterone.[21] Since this first instance of testosterone being used for hormonal transition the prescription of testosterone has become a widely accepted medical practice in the treatment of transgender men and transmasculine people.[22] Now, Fenway Health in Boston, Massachusetts is one of the leading healthcare organizations setting the nationwide standards for inclusive care of transgender clients.[23]

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[20] *See* Whittle, *supra* note 18 (describing transgender people who were known socially throughout history for their transitions). One highly visible transgender person was Christine Jorgenson, an American GI who passed away in 1989. *See id.* She was known for being a "tireless lecturer on the subject of transsexuality, pleading for understanding from a public that all too often wanted to see transsexuals as freaks or perverts." *Id.* Another very public transgender advocate was Jan Morris, a travel writer who wrote an auto-biography about her life and transition. Jan Morris, CONUNDRUM 1-2 (Faber & Faber eds., 2002 ed. 1974) (detailing Jan Morris' life, work, and transition through auto-biographical writing).

[21] *See* Joshua Riverdale, *A Brief History of FTM Trans Civilization*, TRANS GUYS (Oct. 29, 2012, updated May 27, 2016), http://transguys.com/features/ftm-trans-history (providing the history of transgender men from ancient times to modern accounts of their lives). Laurence Michael Dillon worked with Dr. George Foss for his hormonal transition. *Id.* "Testosterone's androgenic effects were not yet understood," but, nevertheless, Dr. Foss provided Dillon with oral testosterone tablets. *Id.* This is believed to be the first documented instance of testosterone being used by an FTM individual for transition related purposes. *See id.* Dillon died in 1962 at age 47 due to oral testosterone's effect on the liver. *See id.* It is worth noting that transgender individuals that were the pioneers of medical transition were routinely dying due to their medical transitions, but the importance of transition was recognized by their physicians, regardless of the associated risk. *See id.*; Worthen, *supra* note 19.

[22] *See* WORLD PROF'L ASS'N FOR TRANSGENDER HEALTH, *supra* note 4, at 33 (discussing hormone therapy as medically necessary for many transgender people's transitions). Through hormone therapy some transgender people seek the "maximum feminization/masculinization, while other transgender people experience [dysphoria] relief with an androgynous presentation resulting from hormonal minimization of [their] existing secondary sex characteristics." *Id.*

[23] *See About Us: Mission & History*, FENWAY HEALTH, http://fenwayhealth.org/about/history/ (last visited Dec. 27, 2017) (describing the mission and history of Fenway Health). Fenway Health's mission is to "enhance the wellbeing of the lesbian, gay, bisexual and transgender community and all people in our neighborhoods and beyond through access to the highest quality health care, education, research and advocacy." *Id.* Fenway Health specializes in gender affirming care and is dedicated to "changing the landscape of trans masculine health." *Transgender Health*, FENWAY HEALTH, http://fenwayhealth.org/care/medical/transgender-health/ (last visited Dec. 27, 2017) (describing the wide range of inclusive health services available for transgender people at Fenway Health); *Trans Masculine Sexual Health Collaborative*, FENWAY HEALTH, http://www.transmaschealth.org/ (last visited Dec. 27, 2017) (describing Fenway Health's new sexual health initiative dedicated to transmasculine people). Additionally, Fenway Health houses the Fenway Institute which "[conducts] innovative research and [develops] education and advocacy programs grounded in the LGBT community." *The Fenway Institute*,

Fenway Health advocates for the use of informed consent hormone therapy which allows transgender people better access to hormonal transition and removes some institutional barriers transgender people face when attempting to receive gender affirming care.[24] While Fenway Health is one of the leading medical providers for transgender people, not every medical group, insurer, or individual staff person in an office has undergone inclusion training for transgender patients, which may lead to increased discriminatory incidents.[25]

FENWAY HEALTH, http://fenwayhealth.org/the-fenway-institute/ (last visited Dec. 27, 2017) (describing The Fenway Institute's goals and programming).

[24] *See* Timothy Cavanaugh, *Cross-Sex Hormone Therapy*, FENWAY HEALTH (2015), http://www.lgbthealtheducation.org/wp-content/uploads/Cross-Sex-Hormone-Therapy1.pdf (describing Fenway Health's protocol on cross-sex hormone administration). Informed consent allows a medical provider to explain the benefits and risks associated with a medical treatment and if a person is deemed able to consent, and understands what they are consenting to, they have the choice to undergo that treatment with a prescription written by the provider. *Id.* at 20. Informed consent "does not preclude mental health care" (standard consent requires psychosocial assessment prior to hormones being prescribed). *Id.* at 19-20. In the recent past, transgender people, specifically non-binary transgender people, were not supported in their identities by mental health providers which created unnecessary barriers to lawful medical transition. *See* Evan Urquhart, *Gatekeepers vs. Informed Consent: Who Decides When a Trans Person Can Medically Transition*, SLATE (Mar. 11, 2016), http://www.slate.com/blogs/outward/2016/03/11/transgender_patients_and_informed_consent_who_decides_when_transition_treatment.html (describing the balancing act WPATH standards of care attempt to perform with informed consent). Gatekeeping by medical providers perpetuated "narrow stereotypes [that] medical professionals once expected trans women to conform to in order to merit a medical transition." *Id.* By utilizing an informed consent model the transgender community "sidesteps these kinds of biases." *Id.* Sometimes doctors "follow outdated standards, requiring a pathological diagnosis, extended counseling, or even a dangerous 'real life experience' period in which non-passing individuals must live in their preferred gender role." Shay O'Reilly, *Shunning Medical Hoops, Transgender Patients Turn to 'Informed Consent' Model*, GENERATION PROGRESS (Feb. 28, 2012), http://genprogress.org/voices/2012/02/28/17609/shunning-medical-hoops-transgender-patients-turn-to-informed-consent-m/ (describing the different experiences transgender people have when attempting to access hormonal transition).

[25] *See infra* Section II, C. and accompanying text (discussing the history of anti-transgender discrimination in modern medical settings).

C. The History of Anti-Transgender Discrimination in Medical Settings

Transgender people have historically faced discrimination in the United States.[26] This discrimination is particularly difficult to overcome in medical settings.[27] Transgender patients "anticipate . . . . that providers w[ill] not only be unprepared to meet their medical needs, but may also be unprepared for their very existence."[28] This anticipated discrimination leads to a "community-wide disengagement from the health care system that results in dire health outcomes for transgender people."[29] One example of health

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[26] *See Transgender Rights*, AM. CIVIL LIBERTIES UNION, https://www.aclu.org/issues/lgbt-rights/transgender-rights (last visited Dec. 27, 2017) (detailing the ACLU's current initiatives to advance transgender equality). The American Civil Liberties Union ("ACLU") is currently undertaking work to disrupt anti-transgender discrimination in:

> employment, housing, and public places, including restrooms. We're working to make sure trans people get the health care they need and we're challenging obstacles to changing the gender marker on identification documents and obtaining legal name changes. We're fighting to protect the rights and safety of transgender people in prison, jail, and detention facilities as well as the right of trans and gender nonconforming students to be treated with respect at school. Finally, we're working to secure the rights of transgender parents.

Id. Transgender people are unprotected in many legal arenas and areas of life from discrimination based on gender identity which is due to deeply held anti-transgender biases. *Id.*

[27] *See* Jaime M. Grant, Lisa A. Mottet & Justin Tanis, *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*, NAT'L CTR. FOR TRANSGENDER EQUALITY & NAT'L GAY & LESBIAN TASK FORCE (Sept. 11, 2012), http://www.transequality.org/sites/default/files/docs/resources/NTDS_Report.pdf (providing statistics regarding anti-transgender discrimination). This survey found that 19% of transgender people were denied healthcare due to being transgender or gender non-conforming, and these rates were significantly higher among transgender people of color. *Id.* at 6. Transgender people had higher HIV rates, had to teach their healthcare providers about transgender care, and also delayed receiving care due to discrimination. *Id.*

[28] *See* Poteat, *supra* note 3, at 26 (describing the participants' overall expectations of their medical care providers). Medical care providers are documented in Poteat's study as saying transgender patients are "a lot harder to deal with," can't transgender people just "not . . . . get involved with hormones and stuff," and "can't you just dress as a woman?" *Id.* Transgender health care centered around the gatekeeper model "often included hefty amounts of transphobia." O'Reilley, *supra* note 24.

[29] *Access to Healthcare*, TRANSGENDER LEGAL DEF. & EDUC. FUND, http://www.transgenderlegal.org/work_show.php?id=2 (last visited Dec. 27, 2017) (describing the negative health outcomes of transgender people due to discrimination in health care settings). Transgender people have a "greater-than-average need to access health care" because "[t]ransition-related hormone treatments and surgical procedures require partnership with a

care providers, as a whole, failing the transgender community is the case of Robert Eads.[30] Robert Eads was a transgender man who was diagnosed with ovarian cancer in 1996 and over a dozen doctors refused to treat him "fearing taking him on might harm their practice," which ultimately led to his death.[31] The landscape of transgender medical care has expanded in America, but is still very limited in scope with very few surgeons specializing in gender affirming surgeries and many general medical practitioners still uncomfortable with treating transgender patients.[32] The lack of general provider knowledge on the treatment of transgender patients, and even the lack of specialized

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trustworthy health care provider." *Id.* When transgender people are unable to access healthcare in a "safe and non-discriminatory manner, they often will find what they need outside of the mainstream health care system." *Id.* Transgender people will seek out "unsafe and unclean" black market hormones with "little direction or medical supervision." *Id.* These black-market hormones can "seriously harm those who use them." *Id.*

[30] *See* Joshua Riverdale, *Robert Eads Day- January 17*, TRANSGUYS.COM (Jan. 12, 2015), http://transguys.com/features/robert-eads-day (discussing the life of Robert Eads, a transgender man who died from metastasized ovarian cancer). *See also Southern Comfort*, IMDB (2001), http://www.imdb.com/title/tt0276515/ (last visited Dec. 27, 2017) (describing *Southern Comfort*, a documentary about Robert Eads last year of life with ovarian cancer). When talking about his experiences with medical care discrimination Robert Eads said:

> I wish I could understand why they did what they did, why they had to feel that way. And I know in a way they've contributed to my dying here. But I can't hate them. I don't hate them. I feel sorry for them. What makes me most sad is they probably felt like they did the right thing.

Id.

[31] Riverdale, *supra* note 30. *See* HRC Staff & Beth Sherhouse, *Addressing Deficits in Healthcare for Transgender Men*, HUMAN RIGHTS CAMPAIGN (Sept. 11, 2014), http://www.hrc.org/blog/addressing-deficits-in-healthcare-for-transgender-men (discussing Robert Eads and the impact his death had on transgender healthcare). In honor of Robert Eads, Eads partner Lola founded the Robert Eads Health Partnership at the Southern Comfort Conference to provide "transgender men and transmasculine-identified people with free lower exams and consultations, medical attention that they might not otherwise receive because of anti-trans stigma and the marginalization and poverty that so often accompany it." *Id.*

[32] *See* Daphna Stroumsa, *The State of Transgender Health Care: Policy, Law, and Medical Framework*, 104 AM. J. PUB. HEALTH 31, 33 (Mar. 2014) (describing the state of transgender health care as of 2014). In 2014, only six surgeons in the United States were certified to perform genital reconstruction surgery. *Id. See also*, Grant *supra* note 27, at 6.

physicians, means the transgender community has a stake in the way substances are re- and descheduled in the CSA.[33]

III. DESCHEDULIZATION DEVELOPMENTS, DISCRIMINATION STATISTICS, SCHEDULIZATION CONCERNS, AND ADVERSE HEALTH RISKS

A. Developments in Re/Deschedulization and the Controlled Substance Act

Rescheduling a drug listed in the Controlled Substances Act means that the drug in question is moved to either a "less restrictive category" or a more restrictive category, which has an impact on criminal laws, accepted medical uses, and the study and distribution of the drug in question.[34] In contrast to rescheduling, descheduling means a drug is removed entirely from the Controlled Substance Act.[35] Descheduled drugs are

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[33] *See infra* Section III, A. and accompanying text (discussing how substances are categorized in the CSA and rescheduled or descheduled).

[34] Christopher Teague, *Rescheduling vs. Descheduling & the Future of Cannabis*, HERB (May 21, 2016), http://herb.co/2016/05/21/future-of-cannabis/ (describing the different implications rescheduling or descheduling marijuana would have on the marijuana industry). Rescheduling a Controlled Substance Act drug ("CSA drug") can create a less restrictive environment for studying the drug's effects and accessibility for medical patients. *Id.* Rescheduling marijuana to either Schedule II or Schedule III would have very different implications for regulation. Alex Halperin, *What Will Rescheduling Marijuana Mean for the Pot Industry?*, ROLLING STONE (Apr. 20, 2016), http://www.rollingstone.com/culture/news/what-will-rescheduling-marijuana-mean-for-the-pot-industry-20160420 (describing the impact different schedule designations would have on the pot industry). *See also* Jacob Sullum, *More Than Zero: Reclassifying Marijuana Could Have A Significant Impact On Drug Policy*, FORBES (Feb. 7, 2014, 7:00 AM), http://www.forbes.com/sites/jacobsullum/2014/02/07/more-than-zero-reclassifying-marijuana-would-have-a-significant-impact-on-drug-policy/#7b8861742eb1 (describing the impact rescheduling marijuana would have on nationwide drug policy).

[35] *See* 53 Fed. Reg. 17, 2225 (Jan. 27, 1988) (to be codified at 21 C.F.R. Pt. 1308) (descheduling methylenedioxymethamphetamine ("MDMA") and removing MDMA from the Controlled Substance Act); 53 Fed. Reg. 34, 5156 (Feb. 22, 1988) (to be codified at 21 C.F.R. Pt. 1308) (rescheduling MDMA as a Schedule I drug after its brief deschedulization). After extensive hearings, in 1988 the Drug Enforcement Administration ("D.E.A.") descheduled MDMA which removed it entirely from the C.S.A. before deciding to reschedule it less than one month later due to lack of scientific evidence that it was safe for human use. 53 Fed. Reg. 17, 2225; 53 Fed. Reg. 34, 5156. In advocacy work for descheduling different drugs the words descheduled and unscheduled are used interchangeably in most major publications. David Downs, *DEA's pot ruling slammed by lawmakers, doctors, advocates*, SFGATE: SMELL THE TRUTH (Aug. 15, 2016, 10:29 AM), http://blog.sfgate.com/smellthetruth/2016/08/15/deas-pot-ruling-slammed-by-lawmakers-doctors-advocates/ (discussing unfair targeting of marijuana by the D.E.A. despite

still subject to regulation under state law and states can create regulations for individual substances as they see fit, much like tobacco or alcohol.[36] In the history of the CSA only methylenedioxymethamphetamine, commonly known as MDMA, was descheduled, for it to be rescheduled the next month.[37] The Obama-era administration did not taken legal action against states that have legalized the sale of medical and recreational marijuana, but it still remains a federal crime.[38] However, there are significant lobbying efforts to reschedule marijuana despite the D.E.A.'s recent rejection of rescheduling after reviewing two separate petitions in 2016.[39] Due to the difficulty of rescheduling or descheduling

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intra-disciplinary leaders attesting to its safety). While many drugs are scheduled, there are drugs which are known to be addictive, such as inhalants and alcohol, that are not scheduled. *Commonly Abused Drugs Chart*, NAT'L INST. OF HEALTH: NAT'L INST. ON DRUG ABUSE (Jan. 2016), https://www.drugabuse.gov/drugs-abuse/commonly-abused-drugs-charts (discussing commonly abused drugs and how to identify signs of addiction). While some drugs that are addictive are not scheduled, other, more common drugs such as cough syrups are considered Schedule III controlled substances. *Schedule 3 (III) Drugs*, DRUGS.COM, https://www.drugs.com/schedule-3-drugs.html (last visited Dec. 27, 2017) (listing Schedule III controlled substances). States regulate the sale of cough syrup through legislation, but many advocates say age restrictions on the purchase of cough syrup would help curb drug abuse in teens. Christy, *Age Restrictions on Cough Medicine Purchases Can Help Us in Our Fight!*, STOP MED. ABUSE (Jul. 12, 2012), http://stopmedicineabuse.org/blog/details/age-restrictions-on-cough-medicine-purchases-can-help-us-in-our-fight (discussing the regulation of the purchasing age of cough syrup).

[36] *See* Teague, *supra* note 34. *See generally* Nat'l Minimum Drinking Age, 23 U.S.C. § 158 (2012) (designating the federal minimum drinking age requirements based on highway funding); Fed. Food, Drug, and Cosmetic Act, 21 U.S.C. §§ 387-387u (2009) (regulating tobacco products); Alcohol and Tobacco Tax and Trade Bureau, *Regulations and Rulings Division*, U.S. DEP'T OF THE TREASURY (Apr. 28, 2014), https://www.ttb.gov/rrd/federal_regulations.shtml (listing the federal regulations for the tax and trade of alcohol and tobacco).

[37] *See* sources cited *supra* note 35.

[38] *See* Monica Steiner, *Medical Marijuana and Federal Law*, NOLO: CRIM. DEF. LAW., http://www.criminaldefenselawyer.com/resources/criminal-defense/federal-crime/medical-marijuana-federal-laws.htm# (last visited Dec. 27, 2017) (describing the conflict between state and federal medical marijuana law). *See also* Ashley Southall & jack Healy, *U.S. Won't Sue to Reverse States' Legalization of Marijuana*, N.Y. TIMES (Aug. 29, 2013), http://www.nytimes.com/2013/08/30/us/politics/us-says-it-wont-sue-to-undo-state-marijuana-laws.html (describing a federal memo publicizing the federal government's low prosecutorial priority for states legalizing marijuana); John Hudack & Grace Wallace, *Clearing up misconceptions about marijuana rescheduling: What it means for existing state systems*, BROOKINGS INST.: FIXGOV (May 27, 2016), https://www.brookings.edu/blog/fixgov/2016/05/27/clearing-up-misconceptions-about-marijuana-rescheduling-what-it-means-for-existing-state-systems/ (discussing how federal drug law and policy interacts with state drug law and policy).

[39] *See* Paul M. Bessette, *DEA Rejects Petitions Seeking to Reschedule Marijuana*, MORGAN LEWIS (Aug. 15, 2016), https://www.morganlewis.com/pubs/dea-rejects-petitions-seeking-to-reschedule-

substances the transgender community is more at risk when trying to access testosterone and medical care; this trend is reflected in peer-reviewed studies performed over the last two decades.[40]

B. Discrimination Examined Through Statistics

In two different studies 25.4%-28% of transgender people postponed medical treatment "when they were sick or injured" due to discrimination and 48%-50.4% postponed medical treatment due to an "inability to afford" medical treatment combined with discrimination.[41] In one study of health care encounters 19% of transgender people were refused service "due to their transgender or gender non-conforming status," 28% were subject to harassment, 2% were "victims of violence in a doctor's office," and 50% had to "teach their medical providers about transgender care."[42] When the parameters were limited to transgender men, 20% of the study respondents who identified as transgender men were "refused [medical] treatment."[43] In a 2015 study of 1,711

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marijuana (describing the D.E.A.'s rejection of the two separate petitions to reschedule marijuana). The two pending petitions were to reschedule marijuana from Schedule I to Schedule II and have been pending since 2009 and 2011. *Id.* Marijuana's Schedule I status means the substance is deemed to have a "high potential for abuse" and "no currently accepted medical use," but despite this, the D.E.A. has increased access to marijuana for research purposes by relaxing supply restrictions. *Id. See also* Carrie Johnson, *DEA Rejects Attempt to Loosen Federal Restrictions on Marijuana*, NPR (Aug. 10, 2016, 9:30 PM), http://www.npr.org/2016/08/10/489509471/dea-rejects-attempt-to-loosen-federal-restrictions-on-marijuana (discussing interviews with multiple federal representatives following the rejection of the petitions). The D.E.A. cites to the lack of medical studies, international treaties, and marijuana's lack of FDA approval as some of the reasons for rejecting the petitions. Denial of Petition To Initiate Proceedings To Reschedule Marijuana, 81 Fed. Reg. 53687 (Aug. 12, 2016) (codified at 21 C.F.R. ch. II) (from this point forward "petition denial one"); Denial of Petition To Initiate Proceedings To Reschedule Marijuana, 81 Fed. Reg. 53767 (Aug. 12, 2016) (codified at 21 C.F.R. ch. II) (from this point forward "petition denial two"); *DEA Announces Actions Related to Marijuana and Industrial Hemp*, D.E.A. (Aug. 11, 2016), https://www.dea.gov/divisions/hq/2016/hq081116.shtml (discussing the D.E.A. decisions regarding recreational, medical, and industrial marijuana and hemp).

[40] *See infra* Section III, B. and accompanying text (detailing multiple studies which demonstrated anti-transgender discrimination and its impact on transgender health outcomes).

[41] *See* Grant, *supra* note 27, at 72; Shires, *supra* note 6, at 69.

[42] Shires, *supra* note 6, at 69.

[43] *Id.* at 73.

transgender men, one of the most comprehensive studies published on discrimination against transgender men in medical settings, it was reported that 41.8% of their total respondents experienced discrimination in health care settings.[44] The highest discrimination rates were experienced among transgender men who held one or more of the following identities or characteristics: identified as Native American, mixed race, or Hispanic/Latino, identified as queer or asexual, were on public insurance, had a graduate degree, currently lives as their gender identity (non-birth gender), or previously received transition related care.[45] Transgender men and transmasculine people are at risk even when seeking non-transitional medical care, yet the common need for access to testosterone leads this community to have specific concerns about its scheduled status.[46]

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[44] *See* Shires, *supra* note 6, at 137. This study examines intersectional identities and demonstrates "that certain minority subgroups of [FtM] people are at higher risk of discrimination." *Id.* at 139. These higher risk individuals are impacted by multiple identities that overlap, for example an individual might be impacted by racism, sexism, and anti-transgender discrimination simultaneously. *Id.* This means someone who is an African-American transgender woman is more at risk than a white transgender man because racism and sexism impact these individuals differently, though they both may be at risk for anti-transgender discrimination. *Id.*

[45] *Id.* at 137. In medical settings 62.7% of Native American transgender men, 50.9% of Multiracial/mixed race transgender men, and 43.6% of Hispanic/Latino transgender men experienced discrimination based on their gender identity. *Id.* Additionally, in medical settings 46.7% of queer transgender men and 44.1% of asexual/other transgender men experienced discrimination based on their gender identity. *See* Shires, *supra* note 6, at 137. In contrast, only 37.5% of gay/lesbian/bisexual transgender men and 36.7% of heterosexual transgender men experienced discrimination in medical settings due to their gender identity. *Id.* 55.5% of transgender men on public insurance experienced discrimination in health care settings and 42.8% of uninsured transgender men experienced that same discrimination. *Id.* 52.1% of transgender men who hold a graduate degree experienced discrimination in medical settings, which was the highest rates out of the educational break down. *Id.* Additionally, 46.4% of transgender people who live fulltime as their nonbirth gender and 47.2% of transgender men who have already received some medical care related to transitioning experience discrimination in healthcare settings. *Id.*

[46] *See infra* Section III, C. and accompanying text (discussing the concerns transgender men and transmasculine people have regarding testosterone's Schedule III status).

C. The Transmasculine Community's Concerns Regarding Schedulization

The transmasculine community is uniquely affected by testosterone being a Schedule III controlled substance.[47] While some cisgender men are seeking testosterone for hormonal deficiencies, many non-professional athletes are also seeking it for personal fitness and body aesthetics.[48] In contrast, the transmasculine community is seeking

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[47] *See generally FTM Testosterone Therapy Basics*, HUDSON'S FTM RESOURCE GUIDE, http://www.ftmguide.org/ttherapybasics.html (last visited Dec. 27, 2017) (describing testosterone therapy and the effects of testosterone therapy on female-bodied individuals). For those transgender men who want to medically transition the first steps are frequently therapy and a prescription for testosterone to "induce and maintain the presence of masculine secondary sex characteristics." *Id.* Transgender resource websites most frequently use the phrase "transitioning" to refer to hormonal and surgical treatments because that is the most commonly sought out gender affirming care, which highlights the necessity of hormones in the transmasculine community. *Information of Transitioning & Transgender Health*, REVEL & RIOT, http://www.revelandriot.com/resources/trans-health/ (last visited Dec. 27, 2017) (describing transition and using the word transition predominantly to refer to hormonal care). In order to receive gender affirming care a transgender person will have to interact with many different staff people at the doctor's office, from receptionists to their physician. *Who's Who in Your Doctor's Office*, CENTER FOR ADVANCING HEALTH, http://www.cfah.org/prepared-patient/communicate-with-your-doctors/whos-who-in-your-doctors-office (last visited Dec. 27, 2017) (describing the different staff who work in doctor's offices and medical centers).

[48] *See* Ingrid Strauch, *Treatment of Low Testosterone*, EVERYDAY HEALTH (Feb. 23, 2015), http://www.everydayhealth.com/low-testosterone/guide/treatment/ (discussing different treatments for low testosterone is cisgender men). Masculinity is placed at the center of our social interactions and manifests negative effects through the systemic demonization of femininity. Shannon Ridgway, *Patriarchy and How It Shows Up for Everyone*, EVERYDAY FEMINISM (May, 5, 2013), http://everydayfeminism.com/2013/05/patriarchy-and-how-it-shows-up-for-everyone/ (discussing how the patriarchy informs our interactions in social contexts). This is seen through cisgender men's fear of the feminine and not having enough testosterone to conform to "patriarchal expectations." *Id. See also* Collins, *supra* note 6, at 13. Most cisgender people who seek non-medical testosterone are "noncompetitive weight trainers seeking purely cosmetic physique enhancement." *Id.* They use testosterone in "calculated 'cycles' as part of an overall strategy including a high-protein diet, supplementation with vitamins and herbs, and high-intensity weight training to achieve physical improvements (increased muscle and decreased body fat) that might not be possible without them." *Id. See generally* Jacob Rajfer, *Decreased Testosterone in the Aging Male*, 5 Rev Urol. Supplement 1 S1-S2 (2003) (describing changes in testosterone levels over time for cisgender men); Thomas O'Connor, *The Top 5 Best Steroids for Raw Power*, MUSCULAR DEVELOPMENT (Apr. 25, 2016), http://www.musculardevelopment.com/articles/chemical-enhancement/2893-the-top-5-best-steroids-for-raw-power-by-the-anabolic-doc-thomas-oconnor-md.html#.WDISvvkrK00 (last visited Dec. 27, 2017) (detailing steroid options for those looking for performance enhancement in weight lifting); *Steroids vs. Natural: The Muscle Building Effects of Steroid Use*, A WORKOUT ROUTINE, http://www.aworkoutroutine.com/steroids-vs-natural/ (last visited Dec. 27, 2017) (describing the effects of steroids on the body, written by an unnamed fitness blogger); Paul Navar, *Optimizing Testosterone Levels in Aging Men*, LIFE EXTENSION (July, 2008),

testosterone to affirm their gender identities, gender expression, and to increase their personal safety.[49] Fourty-six percent of transmasculine people, and specifically transgender men, attempt to commit or commit suicide at some point during their lifetime.[50] Decreased suicide risk is anecdotally linked to transgender people transitioning, living as, and being perceived as their gender identity; however, there are no existing

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http://www.lifeextension.com/magazine/2008/7/optimizing-testosterone-levels-in-aging-men/Page-01 (discussing the use of testosterone to combat aging and health concerns for older men).

[49] *See generally* Patrick Strudwick, *This Trans Guy Took A Selfie Every Day For Three Years To Show How His Face Changed*, BUZZFEED (Oct. 7, 2016, 1:11 PM), https://www.buzzfeed.com/patrickstrudwick/this-trans-guy-took-a-selfie-every-day-for-3-years-to-show-h?utm_term=.vnZ9GjNN6#.qnk1mEooY (interviewing a transgender man who documented his transition every day for three years). When asked about his transition, Jamie Raines said that after taking hormones, "I'm very happy with what I see in the mirror and very grateful for how I look now." *Id.* Jaime was taking hormones because he wanted to "go through the correct puberty for [him]" and align his body with his gender identity and desired gender expression. *Id.* One transgender man in an interview said that taking hormones made him feel "balanced and free" and he could finally "see the me that used to be hidden." Lane Moore, *What It's Really Like to Transition From Female to Male*, COSMOPOLITAN (Jan. 15, 2016), http://www.cosmopolitan.com/sex-love/news/a52196/what-its-like-to-transition-transgender-man/ (interviewing three unnamed transgender men about their experiences transitioning). The changing of documents, which usually requires irreversible medical transition, means hormonal transition is directly linked to "social integration and personal safety." *WPATH Clarification of Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage for Transgender and Transsexual People Worldwide*, WORLD PROF'L ASS'N FOR TRANSGENDER HEALTH (Jun. 17, 2008), http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1352&pk_association_webpage=3947 (discussing the necessity of medical treatment/transition for transgender people's bodily comfort and personal safety).

[50] Ann P. Haas, Phillip L. Rodgers & Jody L. Herman, *Suicide Attempts among Transgender and Gender Non-Conforming Adults: Findings of the National Transgender Discrimination Survey*, AM. FOUND. FOR SUICIDE PREVENTION & THE WILLIAMS INST. 1, 2 (Jan. 2014), http://williamsinstitute.law.ucla.edu/wp-content/uploads/AFSP-Williams-Suicide-Report-Final.pdf (reporting the suicide rate outcomes for different transgender people across intersectional identities). Only 4.6% of the overall United States population attempts to commit, or commits, suicide, but the rate is much higher for transgender individuals. *Id.* at 2. Approximately 46% of transgender men attempt or commit suicide and 42% of transgender women attempt or commit suicide. *Id.* More importantly:

> [a]nalysis of other demographic variables found prevalence of suicide attempts was highest among those who are younger (18 to 24: 45%), multiracial (54%) and American Indian or Alaska Native (56%), have lower levels of educational attainment (high school or less: 48-49%), and have lower annual household income (less than $10,000: 54%).

Id. at 2.

studies that take into account transitionary medical care and when it was received in relation to suicide attempts.[51] Besides suicide risk, the transmasculine community is also generally concerned about being included on lists or registries of those receiving controlled substances for personal safety reasons and the possibility of being outed to employers or family.[52] While many medical conditions are stigmatized, specifically addiction and psychiatric diagnoses, gender dysphoria carries a particularly dangerous stigma due to it not being protected under the Americans with Disabilities act and the prevalence of anti-transgender discrimination.[53] Some transgender men and

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[51] *See* Moore, *supra* note 49. One transgender man who was interviewed by Moore, when asked why he decided to pursue hormones, responded:

> I wanted to stop feeling suicidal and start feeling worthy of love. I realized I could no longer make other people comfortable at the expense of my own life; I could no longer set myself on fire to keep others warm. Once I started recognizing myself by changing my name, pronouns, and clothing, I wanted to go further with hormones and surgery.

Id. However, the Williams Institute data compilation shows suicide risk doesn't seem to fall, and in some cases rises, after receiving transition related care. Haas, *supra* note 50, at 8. This study, which is an analysis of the most comprehensive study of transgender individuals performed in the United States, doesn't "provide information about the timing of reported suicide attempts in relation to receiving transition-related health care, which precluded investigation of transition-related explanations for these patterns." *Id.*

[52] *See* Or. Prescription Drug Monitoring Program v. U.S. DEA, 998 F. Supp. 2d 957 (D. Or. 2014). The Oregon prescription drug monitoring program required pharmacies dispensing Schedule II-IV drugs to record and "report certain information regarding that prescription to the PDMP including: the quantity and type of drug dispensed, identifying information about the patient, and identifying information about the practitioner who prescribed the drug." *Id.* at 960. While the intent of this program was to "'provide practitioners and pharmacists a tool to improve health care,' by providing health care providers with a means to identify and address problems related to the side effects of drugs, risks associated with the combined effects of prescription drugs with alcohol or other prescribed drugs, and overdose" it also violated the fourth amendment's protection of "searches and seizures of items or places in which a person has a reasonable expectation of privacy." *Id.* at 960, 963. The program specifically revealed significant portions of information about the patient's medical condition for which the scheduled substance was prescribed, such as a "AIDS, psychiatric disorders, chronic pain, drug or alcohol addiction, and gender identity disorder." *Id.* at 960. This means anyone who has access to this electronic database can see individuals who have "gender identity disorder and are treating it through hormone therapy," which outs transgender individuals and can compromise their safety. *Id.* at 966.

[53] *See Diagnostic and Statistical Manual of Mental Disorders*, AM. PSYCHOL. ASS'N, 451, 481 (Am. Psychol. Publishing, 5th ed. 2013) ("DSM-5") (discussing gender dysphoria and substance related

transmasculine people, due to reasons such as cost, discrimination, and health care access, choose to instead use illegally obtained hormones to transition.[54]

D. The Risks of Unmonitored Transition

"More than 50% of persons identified as transgender have used injected hormones that were obtained illegally or used outside of conventional medical settings."[55] For transmasculine people who cannot access transition related medical care and are

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and addictive disorders as psychiatric diagnoses). *See also* Kevin M. Barry, *Disabilityqueer: Federal Disability Rights Protection For Transgender People*, YALE HUM. RTS. & DEV. J.1, 1 (2013) (discussing the protections afforded to transgender people on a federal level). Gender identity disorder ("GID"), now known as gender dysphoria, is the clinical diagnosis for people who identify as transgender. *Id.* When the Americans with Disabilities Act was passed, GID was purposefully excluded:

> because, in 1989, a small handful of senators believed gender nonconformity – like pedophilia, pyromania, and kleptomania – was morally harmful to the community. In the eleventh hour of a marathon floor debate, and in the absence of an organized transgender lobby, the ADA's sponsors and disability rights advocates reluctantly sacrificed GID and nine other mental impairments in exchange for passage in the senate.

Id.

[54] *See infra* Section III, D. and accompanying text (discussing the different health and legal risks of using non-prescribed testosterone to transition).

[55] *See* Comm. on health Care for Underserved Women, *supra* note 6. The Committee on health care for underserved women also found that those who use non-prescribed or illegal hormones also "frequently resort to the illegal and dangerous use of self-administered silicone injections to spur masculine or feminine physiologic changes." *Id.* The self-injection of hormones and other substances in non-medical settings also "inevitably places them at higher risk for HIV and hepatitis from using shared needles." Nicholas Ray, *Lesbian, Gay, Bisexual and Transgender Youth: An Epidemic of Homelessness*, NAT'L GAY & LESBIAN TASK FORCE POLICY INST. & NAT'L COAL. FOR THE HOMELESS (2006), http://www.thetaskforce.org/static_html/downloads/HomelessYouth.pdf (providing statistics and analysis of data concerning homeless LGBTQ+ youth and their lives). Birth control is a commonly used pill for unmonitored transition in populations of transgender women, but it requires a prescription. *How Do I Get Birth Control Pills?*, PLANNED PARENTHOOD, https://www.plannedparenthood.org/learn/birth-control/birth-control-pill/how-do-i-get-birth-control-pills (last visited Dec. 27, 2017) (discussing how to obtain birth control). Through Planned Parenthood birth control prescriptions are easy to obtain, and they also offer low cost transition related care. *Birth Control Pills*, PLANNED PARENTHOOD, https://www.plannedparenthood.org/learn/birth-control/birth-control-pill (last visited Dec. 27, 2017) (discussing birth control options at Planned Parenthood). However, birth control is still a controversial topic in the U.S., despite access being a fundamental constitutional right. Cecile Richards, *The Only Controversy About Birth Control Is That We Are Still Fighting For It*, TIME (July 1, 2014), http://time.com/2945942/planned-parenthood-hobby-lobby/ (discussing the remaining controversy surrounding birth control).

seeking testosterone therapy, "[m]ost forms of testosterone are regulated as a steroid by both the Controlled Substances Act and the Anabolic Steroid Control Act of 1990—meaning most DIYers are transgender women."[56] However, there are transgender men who choose to self-medicate despite the Schedule III status of testosterone.[57] In addition to the standard risks that come with taking testosterone, some additional risks of taking black market hormones include injecting tainted hormones, HIV and hepatitis transmission due to shared needles, and liver damage due to unregulated dosages of testosterone.[58] Even for transmasculine people who are able to obtain testosterone

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[56] *See* Jillian Branstetter, *Sketchy Pharmacies Are Selling Hormones to Transgender People*, THE ATLANTIC (Aug. 31, 2016), http://www.theatlantic.com/health/archive/2016/08/diy-hormone-replacement-therapy/498044/ (describing transgender people who self-medicate to transition and the ways that is done). Some transgender women "In an effort to make their bodies more feminine, ... take unregulated doses of hormones bought on the black market and pump industrial silicone – the same stuff used in brake fluid – into their breasts." Russell Goldman, *Making Change: The Cost of Being Transgender*, ABC NEWS (May 10, 2007), http://abcnews.go.com/Health/story?id=3156598&page=1 (describing the journeys of transgender women who self-medicate and prostitute themselves to pay for hormones). "Very often, trans young people have to rely on sex work regardless of what other skills they have" in order to make ends meet and afford their hormones or other transition related care outside of a medical setting. *Id.*

[57] *See Some transgender youths look to black-market hormones*, NEWSDAY: NEW YORK NEWS, http://www.newsday.com/news/new-york/some-transgender-youths-look-to-black-market-hormones-1.2802396 (last visited Dec. 27, 2017) (discussing why transgender youth seek out black-market hormones). One young transgender man reported that he started to see a doctor for his testosterone prescriptions after his friend ended up "in the hospital for almost a year," due to self-administering black-market testosterone. *Id.* Xavier suspected his friend obtained testosterone that was somehow tainted." *Id.* There are many age-restricted members-only online groups of transgender men and transmasculine people where the primary topic of discussion is how to transition without medical supervision. *See T's Do It Yourself Hormones*, YAHOO! GROUPS, https://groups.yahoo.com/neo/groups/TsDoItYourselfHormones/files/m2f.htm (last visited Jan. 7, 2018) (showing a restricted group of transmasculine people who are looking to transition without medical supervision). This particular group has 20,962 members. *Id. See generally* Kelli Busey, *HRT Self medicating hormones resources*, PLANET TRANSGENDER (Sept. 15, 2014), http://planettransgender.com/hrt-self-medicating-hormone-resources/ (listing different resources for transgender people who are looking to self-medicate for their transition).

[58] *See* Ann Jones, *Testosterone Effects on Transgender*, LIVESTRONG (Jul. 22, 2015), http://www.livestrong.com/article/229467-testosterone-effects-on-transgender/ (describing effects on female-bodied people as well as negative side effects). Some side effects of taking testosterone include a risk of decreased liver functioning, osteoporosis, weight gain, acne, and mood swings. *Id. See also* Ray, *supra* note 55; *Some transgender youth look to black-market hormones*, *supra* note 57. Additionally in terms of liver health:

prescriptions, some compounds of testosterone, specifically dihydrotestosterone, are no longer available in the United States due to nationwide shortages and a lack of compounders, meaning the only ways to obtain it are illegal.[59] Transgender men and transmasculine people's access to testosterone is governed by the CSA, however, there are other impacts schedulization has on transgender individuals' medical care and on the lives and health case of cisgender men.[60]

> Testosterone therapy can cause alterations in liver function tests, cholestatic jaundice, hepatocellular neoplasms (rare), and peliosis hepatis. Specifically, the use of orally-administered C-17 alpha alkylated testosterone has been associated with such complications, in addition to being associated with hepatocellular carcinoma and hepatic adenomas. Oral use of C-17 alpha alkylated testosterone is therefore generally discouraged, as injectable, transdermal, buccal, and pellet delivery methods are thought to significantly lower such risks. No matter which testosterone delivery method is being used, it is prudent to screen the user with liver function tests to monitor the overall health of the liver.

FTM Testosterone Therapy and General Health, HUDSON'S FTM RESOURCE GUIDE, http://www.ftmguide.org/tandhealth.html (last visited Jan. 7, 2018) (describing necessary medical tests that physician's should perform to monitor potential testosterone side effects).

[59] *See* Joshua Riverdale, *DHT For Transgender Men*, TRANS GUYS (Oct. 4, 2009), http://transguys.com/features/dht-transgender-men (describing the effects of dihydrotestosterone ("DHT") and how to obtain it). Riverdale went on to state:

> In North America, DHT had been available to compounding pharmacies through the PCCA [Professional Compounding Centers of America]. In July 2009, the PCCA announced that they were out of stock and that the manufacturer had ceased production of DHT. It's unknown if there are other sources available. It's very difficult to get a prescription for DHT filled in North America at this time.

Id. So even if someone is prescribed DHT, there is no legal way to obtain it since it cannot be compounded in the United States or shipped in due to the CSA. *Id. See also Frequently Asked Questions About DHT*, DHT CREAM (2010), http://www.dhtcream.com/andractim/ (providing information about DHT and the different topical forms it can be compounded in); *DHT Gel – Andractim DHT Gel Online: What is Andractim DHT Gel?*, DHT GEL (2017), http://dhtgel.org/ (describing what DHT gel treats). Most websites that advertise DHT gel for online purchase are not American and it is illegal to have DHT, a controlled substance, shipped into the United States, even if it is with a prescription for personal use. *Andractim Testosterone Gel*, ALL SAINTS CLINIC (2016), http://www.allsaintsclinic.org/testosterone-gel.shtml (showing the costs of different amounts of DHT in British pounds).

[60] *See infra* Section IV and accompanying text (discussing the impact of testosterone being a Schedule III controlled substance).

IV. THE IMPACTS OF TESTOSTERONE'S SCHEDULIZATION

Testosterone's status as a Schedule III drug has an irrefutable impact on transgender men and the transmasculine community due to its usage in treating gender dysphoria.[61] However, the transgender community is not the only group of people affected by the schedulization of testosterone, and there may be compelling arguments for keeping testosterone listed at a Schedule III substance.[62] This section will explore the different impacts of testosterone's schedulization on the general United States community, the transgender community, and the legal implications of keeping testosterone scheduled versus de/rescheduling it.[63]

A. Testosterone and the United States' Community

Testosterone is not only sought by transgender men and transmasculine people, but also by cisgender men for a litany of reasons which include performance enhancement and hormonal deficiencies.[64] Professional athletes are prohibited from using performance enhancing drugs by all major sports' governing bodies, so the cisgender populations seeking testosterone are non-professional athletes and men with diagnosed medical conditions or ailments.[65] When cisgender men seek testosterone as a medical treatment

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[61] *See* WORLD PROF'L ASS'N FOR TRANSGENDER HEALTH, *supra* note 4, at 33-50 (discussing testosterone as the main form of gender affirmation for transgender men and transmasculine people).

[62] *See supra* note 12 and accompanying text (discussing the sports agencies that have banned testosterone as a performance enhancing drug).

[63] *See infra* subsections A-C and accompanying text (explaining the current medical climate that exists for such drugs and the difficulties with them).

[64] *See* Collins, *supra* note 6, at 13. As noted previously, the majority of cisgender men who are seeking testosterone for non-medical uses are "noncompetitive weight trainers" who use testosterone is "calculated 'cycles'" to achieve aesthetic goals. *Id.* Cisgender men who have different hormonal deficiencies, which may originate from different endocrine disorders or age, also are prescribed testosterone for their ailments. *Id.*

[65] *See supra* note 12 and accompanying text (discussing the banning of testosterone use by professional athletes). *See also* Collins, *supra* note 6, at 13 (discussing cisgender men's uses for supplemental testosterone).

they are met with understanding from their doctors due to the patriarchal centering of masculinity and low testosterone levels signaling a socially unacceptable loss of virility.[66] The schedulization of testosterone doesn't hinder cisgender men's ability to receive treatment for low testosterone, but for those who want testosterone for aesthetic or performance enhancing reasons must obtain it through the black market and illegal importing.[67]

Testosterone is considered a Schedule III controlled substance because it "has a potential for abuse less than the drugs or other substances in Schedules I and II," "has a currently accepted medical use in treatment in the United States," and "[a]buse of the drug or other substance may lead to moderate or low physical dependence or high psychological dependence."[68] One of the benefits of the CSA is its flexibility to include substances that are found to have a potential for abuse as we learn about different drugs effects on the body and psyche.[69] Testosterone for medical purposes is dispensed by

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[66] *See* Strauch, *supra* note 48 (discussing treatment of low testosterone). *See also* Ridgway, *supra* note 48 (discussing the patriarchy's effects on social behaviors). Ridgway identifies that for men to be successful in American culture they are "expected to conform to the patriarchal expectations within the good ole' boys' club." *Id.* This requirement means that they must "refrain from outward displays of emotion, and be completely reliable at all times." *Id.* This standard is one that requires one hundred percent compliance and is impossible for anyone, including cisgender men, to adhere to, which makes it more difficult "[f]or those who identify as homosexual, trans* or non-cisgender and who choose not to stay within these rigid gender boxes, [to break] out of the bounds of patriarchy." *Id.*

[67] *See* Collins, *supra* note 6, at 15 (discussing differences between testosterone/steroids and other "street" drugs). As pointed out by Collins, some testosterone that is shipped in from overseas has a "*minimum* quantity" of testosterone pills that can be ordered and requires other supplements be taken at the same time to combat testosterone's negative side effects, which would be better overseen by a doctor. *Id.*

[68] *See* Controlled Substances Act, 21 U.S.C. § 812 (amended 1990) (providing lists of controlled substances and their schedule classifications). There are three pieces of criteria considered when scheduling a substance for the CSA. *Id.* Every schedule of drug, I through V, discusses the likelihood for abuse, accepted medical uses in the United States, and what level of dependency abuse could have on an individual, physical and psychological. *Id.*

[69] *See* Controlled Substances Act, 21 U.S.C. § 811 (2015) (providing the right to add substances to the CSA or remove substances). The CSA gives the Attorney General the power to "add to such a schedule or transfer between such schedules" and "remove any drug or other substance from the schedules if he finds that the drug or other substance does not meet the requirements for

pharmacies and is overseen by physicians, but non-prescription testosterone is unregulated and only available through illegal means.[70] When testosterone is utilized by cisgender men to build muscle it is taken in "carefully measured amounts over time . . . . [for a] gradual effect," unlike many other drugs that are designated as Schedule I and Schedule II, possessed usually only in an "amount that can be consumed in a [single] sitting."[71] Additionally, testosterone is stereotyped as causing aggressive behavior, mood swings, and other physiological problems, such as liver damage.[72] For those reasons, with athletes in mind, the government sees a benefit in regulating testosterone because it can sometimes cause volatile behavior and dependency for physical body building effect,

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inclusion in any schedule." *Id.* §§ (a)(1)-(2). When scheduling, rescheduling, or removing drugs from the schedules the Attorney General, by statute, shall consider:

> (1) Its actual or relative potential for abuse; (2) Scientific evidence of its pharmacological effect, if known; (3) The state of current scientific knowledge regarding the drug or other substance; (4) Its history and current pattern of abuse; (5) The scope, duration, and significance of abuse; (6) What, if any, risk there is to the public health; (7) Its psychic or physiological dependence liability; (8) Whether the substance is an immediate precursor of a substance already controlled under this title.

Id. §§ (c)(1)-(8).

[70] *See* Collins, *supra* note 6, at 13 (discussing legal ways to obtain anabolic steroids as defined by the CSA). Under the CSA "it is unlawful for any person knowingly or intentionally to possess an anabolic steroid unless it was obtained directly, or pursuant to a valid prescription or order, from a practitioner, while acting in the course of his professional practice or except as otherwise authorized." *Id.* Possessing testosterone, an anabolic steroid, without a valid prescription could be punished by "a term of imprisonment up to one year and/or a minimum fine of $1,000, with higher penalties for repeat drug offenders." *Id.* Steroid arrests "commonly occur at U.S. land boarders" with people either driving steroids through customs for unauthorized personal use or to sell in the United States. *Id.* at 16.

[71] *Id.* at 15. Collins also notes that because testosterone cycles are taken over time frequently those using testosterone have large quantities in their possession and are "charged with intent to distribute for possessing but a single cycle of steroids." *Id.*

[72] *See* Collins, *supra* note 6, at 13-14. There have been a limited number of studies that have said testosterone actually causes "roid rage," the "descriptive term for steroid-induced spontaneous, highly aggressive, out-of-control behavior." *Id.* at 14. This is considered a "common side effect of steroid use" but "objective experts are dismissive" of these claims. *Id.* Experts claim that even if "roid rage" is a real side-effect of steroids it is "relatively rare (probably less than 1 percent) among steroid users." *Id.* Additionally, after intense scrutiny, "medical literature did not find consistent evidence for a direct causal relationship between steroid use and aggression even in those affected." *Id.*

without much reward in the case of non-medical use.[73] It is clearer how testosterone's Schedule III status effects cisgender athletes, but the connection between testosterone's Schedule III status and anti-transgender discrimination is slightly more attenuated, but nevertheless leads to insidious anti-transgender discrimination in medical settings.[74]

B. Testosterone's Schedulization Impact on the Transmasculine Community

When the CSA went into effect in 1970 and testosterone was scheduled, transgender men were not the group specifically targeted by Congress.[75] The impact of discrimination against transgender men and transmasculine people was not foreseen when the CSA went into effect in 1970.[76] However, testosterone's Schedule III status has directly contributed to discrimination against transgender men and transmasculine people due to the necessity of accessing testosterone with a prescription from a licensed physician.[77] As a whole, transgender people already struggle to access medical care and

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[73] *See id.* at 13 (discussing some subjective testimonies at the legislative hearings for scheduling testosterone). While there may be some public health concerns regarding testosterone:

> any 'psychologically addictive' properties of steroids or public health dangers seemed to be secondary considerations to Congress. The majority of witnesses at the hearings were representatives from competitive athletics whose testimony, and apparently Congress' main concern, focused on the purported need for legislative action to solve an athletic 'cheating' problem.

See Collins, *supra* note 6, at 13. Additionally, this demonstrates that transgender men and transmasculine people were not the group of people intended to be impacted by scheduling testosterone. *Id.*

[74] *See infra* Section IV, B. and accompanying text (discussing the impact testosterone's Schedule III status has on the transmasculine community).

[75] *See* Controlled Substances Act, 21 U.S.C. § 801 (2017). *See also* Collins, *supra* note 6, at 13 (discussing reasons for scheduling testosterone). Congress' main witnesses in the hearing regarding scheduling testosterone focused on the subjects of "athletic 'cheating'" and public health. *Id.*

[76] *See* Collins, *supra* note 6, at 13. Because transgender issues were not part of Congress' legislative hearings the effects the schedulization of testosterone would have on transgender men and the transmasculine community could not have been anticipated or foreseen by Congress. *Id.*

[77] *See Information of Transitioning & Transgender Health*, *supra* note 47 (discussing who can prescribe testosterone to transgender men and transmasculine people). Testosterone prescriptions may be obtained from "general practitioners, endocrinologists and gynecologists" meaning transgender

frequently forgo necessary medical treatment due to discrimination or a fear of facing discrimination from healthcare professionals.[78] Obtaining a testosterone prescription from a physicians' office that does not use informed consent requires months of therapy and office visits; during each office visit, the transgender patient will talk with at least two individuals, usually a receptionist or nurse and their physician, increasing the risk of anti-transgender discrimination.[79] This cycle of doctor's appointments creates an unnecessary barrier to accessing hormones for the transgender community, and more specifically transgender men and transmasculine people, who are not abusing testosterone, but rather using it for personal transition related purposes.[80]

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men and transmasculine people must interact with the healthcare system to hormonally transition using testosterone. *Id.*

[78] *See* Grant, *supra* note 27, at 76 (discussing postponement of necessary medical care due to discrimination). According to Grant and Tanis, 42% of transgender men referred as FtM, postponed medically necessary care due to discrimination by providers. *See id.* In addition, 48% of transgender men forgo preventative care, such as vaccinations or a Pap smear, due to discrimination by providers. *See id.* This increases the risks of transgender men having undetected cervical cancer or being afflicted with easily preventable illnesses. *See id.*

[79] *See supra* note 77 and accompanying text (discussing who can prescribe testosterone). Doctor's appointments typically involve checking in with a receptionist, being seen by a nurse, seeing your physician, and if your physician prescribed medication, speaking with pharmacy staff. *See Who's Who in Your Doctor's Office, supra* note 47 (describing the different staff who may be present in doctor's offices). At a minimum, a patient will talk to at least their physician, but most likely a receptionist and their physician. *See id.* Each interaction with an individual presents an opportunity for anti-transgender discrimination to occur. *See id.* Anti-transgender discrimination could manifest through inadvertently or purposefully misgendering a transgender person or being refused medical service by any person who is a part of the process from walking into the office to leaving. *Id.*

[80] *See* Cruz, *supra* note 3, at 71-72 (discussing how perception of trans-identities will change the frequency a transgender person seeks medical care). It is concluded that "[c]hanges in visibility and perception may change social expectations and behaviors" and "[in]visibility regarding trans status, traditionally referred to as 'passing,' may be connected to the use of hormones." *Id.* at 71. Those transgender people who are already on hormones are more likely to postpone care because of the higher likelihood of being perceived as transgender or gender non-conforming. *See id.* at 71-72. This is due to the changes associated with starting hormones and beginning the transition process. *See id.* Those transgender and gender non-conforming people who are not on hormones are more likely to go to the doctor's office, but once they start hormones their compliance with follow-up care decreases. *See id.*

The Report of the National Transgender Discrimination Survey and the Cruz *Assessing access to care for transgender and gender nonconforming people* study show that transgender people, for many reasons, avoid going to the doctor even in the direst of circumstances and despite this a reported 69% of transgender men take testosterone to hormonally transition at some point in their lifetimes.[81] Out of people who identify as transgender, 50% have used black market hormones during the course of their transition meaning that the other 50% have acquired their hormones lawfully through the prescription process.[82] This means that those transgender men and transmasculine people who have lawfully obtained testosterone have had at least one doctor's appointment, but likely many more.[83] In terms of overall health, the more discrimination a transgender person experiences in healthcare, the more likely they will have long-term negative health outcomes due to a lack of competent care.[84] These long term negative health outcomes may manifest in hypertension, diabetes, anxiety, depression, suicidality, substance abuse, elevated cardiometabolic risk, and death.[85] While discrimination in health care settings does occur during appointments that are not related to hormones, hormone-related appointments are the most common reason transgender people seek care.[86] Testosterone's status as a

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[81] *See* Grant, *supra* note 27, at 76, 78 (providing statistics regarding anti-transgender discrimination); Cruz, *supra* note 3, at 69 (discussing barriers to transgender healthcare and discriminatory behaviors in medical settings).

[82] *See* Comm. on Health Care for Underserved Women, *supra* note 6 (providing statistics about illegal hormone usage in the transgender community).

[83] *See* WORLD PROF'L ASS'N FOR TRANSGENDER HEALTH, *supra* note 4, at 104 (discussing criteria for hormone therapy). According to the widely-followed Standards of Care for transgender people, for a transgender person to be prescribed "masculinizing hormones" they must, from a psychosocial assessment, have "[p]ersistant, well-documented gender dysphoria," which cannot generally be established in only one therapy appointment, but usually is established over a three-month period. *See id.*

[84] *See* Hughto, *supra* note 6, at 226 (discussing negative long-term health outcomes associated with discrimination).

[85] *Id.*

[86] *See* Grant, *supra* note 27, at 78 (providing statistics regarding access to hormone therapy for transgender people). According to this study, 62% of transgender people have accessed hormone therapy, which increases with age, and another 23% would like to have hormone

Schedule III drug means that transgender men and transmasculine people are required to interact with healthcare professionals in a way which centers their transgender identity and puts them at risk, directly increasing the chances of those individuals facing discrimination.[87]

Testosterone's schedulization puts transgender men and transmasculine people at higher risk for discrimination, but the alternative to avoid discrimination risk in medical settings is illegally obtaining testosterone.[88] Additionally, the harms of unsupervised hormones and black market hormone contamination are part of what create negative health outcomes for both physical and mental health.[89] Descheduling testosterone would give transgender men and transmasculine people who were unable to access hormones through their doctor's office the ability to use non-contaminated and safe testosterone through legal means.[90] Additionally, attending doctor's appointments and paying for lab tests with, or without, insurance can be unrealistic for transgender people who are living

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therapy sometime in their future. *Id.* Additionally, 93% of transgender people who have received gender affirming surgery or transition-related surgery also received hormone therapy. *Id.*

[87] *See* Poteat, *supra* note 3, at 26-27 (discussing interactions with healthcare professionals). When transgender people disclose their transgender identity to medical providers they may respond in negative ways which include blaming the transgender person for prejudice they encounter, shaming the transgender person, othering the transgender person, and discriminating against a transgender person either explicitly or implicitly. *Id.* at 27.

[88] *See* Collins, *supra* note 6, at 13 (discussing necessity of a prescription to lawfully obtain testosterone); Poteat, *supra* note 3, at 26-27 (discussing physician reactions to transgender people disclosing their transgender identity).

[89] *See* Feeney, *supra* note 6 (discussing youth usage of black market hormones); *see* Hughto, *supra* note 6, at 226 (discussing the long-term stress discrimination causes on oppressed people). Transgender youth who are using black market hormones usually face discrimination that leads them to not hold health insurance or have access to traditional medical care. *See* Feeney, *supra* note 6. These stressors, including the uncertainty stress regarding the consistency and quality of the hormones they are taking, can create the stress seen in the Hughto, Reisner, and Pachankis study that leads to negative health outcomes, both in the short term and the long term. *See* Hughto, *supra* note 6, at 226.

[90] *See* Feeney, *supra* note 6 (discussing black market hormones used by transgender youth).

in poverty.[91] If testosterone were available over the counter, through descheduling, the high costs associated with traditional healthcare would no longer make testosterone cost-prohibitive.[92] Currently testosterone is not available without a prescription, so the deschedulization or reschedulization of testosterone would also likely decrease black market usage.[93]

C. Testosterone's Schedulization, De/Reschedulization, and Policy Alternatives

There are benefits for the transgender men and transmasculine community to keeping testosterone a Schedule III controlled substance which requires a prescription.[94] A physician being involved in a transgender person's transition ensures they are using the correct dose of hormones, injecting hormones correctly if using an injection method, and ensures general health oversight during their transition.[95] Ensuring a physician is involved

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[91] *See* Cruz, *supra* note 3, at 69 (providing statistics on postponement of medically necessary care based on cost). In Cruz's study, 25% of the study participants reported postponing medically necessary care based solely on cost. *Id.* When fears of discrimination are combined with the prohibitive cost of health care an additional 25.4% of study participants reported postponing care. *Id.*

[92] *Id.* at 69-70. Those who are unable to access primary care physicians and primarily use clinics and emergency rooms for basic care are more likely to postpone necessary medical care. *Id.* If affordability were not an issue up to an additional 25% of transgender people would be able to access health care and that number could be higher based on the additional 25.4% who said discrimination and cost prevented seeking care. *Id.* More transgender people would likely be accessing care as well due to a decrease in medical personal interactions and a lower cost. *See* Cruz, *supra* note 3, at 69.

[93] *See* Collins, *supra* note 6, at 12 (discussing the size of the anabolic black market steroid trade in 2002). Collins noted that:

> [i]n January 2001, federal law enforcement officials announced that they seized more than 3.25 million anabolic steroid tablets in the single-largest steroid seizure in U.S. history. In the past year, U.S. Customs agents made 8724 seizures, up 46 percent from 1999 and up eight-fold from 1994, and public health experts say the black market has grown larger – perhaps far larger—than the $ 300 million to $ 400 million estimated in 1988.

Id.

[94] *See supra* note 58 and accompanying text (discussing the dangers of unmonitored transition on the physical and mental well-being of transgender men).

[95] *See FTM Testosterone Therapy and General Health*, *supra* note 58 (describing different tests and oversight a physician should perform during a transgender man's hormonal transition).

would also help transgender men and transmasculine people avoid the risk of too much injected testosterone converting back into estrogen.[96] The current Schedule III status of testosterone means that those transgender men and transmasculine people who want testosterone as a part of their transition are doing so in the safest way, if they are obtaining their testosterone lawfully.[97] If testosterone no longer required a prescription and direct doctor oversight some transgender men, who would otherwise be under the care of a physician, may opt to use testosterone at their convenience and inconsistently, which would not be the most medically safe path of action.[98]

The Controlled Substance Act puts a lot of emphasis on the possibility of abuse, but the standards of schedulization, which are fairly uniform across the different schedules, are vague.[99] Due to the vague standards any substance has the possibility of being abused, yet not all substances are scheduled despite fitting the standards.[100] Substances like cough syrup are scheduled because they are used to make higher schedule

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[96] *See FTM Testosterone Therapy Basics*, *supra* note 47 (discussing testosterone converting back into estrogen with higher testosterone doses in transgender men). "[E]xcess testosterone in your body can be converted into estrogen by an enzyme called 'aromatase.' This conversion is part of the body's natural feedback system-- if there is an abundance of testosterone in the body, it is converted ('aromatized') to estrogen in order to maintain a 'normal' hormonal balance." *Id.* With a physician performing regular testosterone level checks through lab testing the hormonal balance in the body can be closely monitored, which might not otherwise happen if a physician is not overseeing testosterone dosages for transition. *Id.*

[97] *See* Jones, *supra* note 58 (discussing the beneficial effects and risks of testosterone on transgender men's physical health).

[98] *See* Comm. on health Care for Underserved Women, *supra* note 6 (discussing the dangerous effects of transgender people self-medicating for transitional care).

[99] *See* Controlled Substances Act, 21 U.S.C. § 812 (amended 1990) (providing the standards for substances to be considered for schedulization, reschedulization, or deschedulization).

[100] *See Commonly Abused Drugs Chart*, *supra* note 35 (discussing addictive drugs, including unscheduled drugs known to the U.S. government). The World Health Organization defines substance abuse as "refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs." *Substance Abuse*, WORLD HEALTH ORG. (2017), http://www.who.int/topics/substance_abuse/en/ (providing the definition of substance abuse). Under that definition there are scheduled substances, like anabolic steroids, that do not fit the definition of substance abuse, and unscheduled substance, like alcohol, which do. *Id.*

drugs, yet are still available to the public without a prescription.[101] Cough syrup, also referred to as pseudoephedrine, is considered a Schedule III controlled substance, yet in order to buy cough syrup in many states, stores only ask the purchaser for proof of identification showing the purchaser is over the age of eighteen.[102] Even if testosterone maintained its Schedule III status, its sale and use could be shifted to allow for over the counter use, similar to cough syrup.[103]

Rescheduling or descheduling testosterone would also open up the possibility of it being regulated similar to birth control.[104] Birth control requires a prescription, but many times a doctor will meet with the patient once a year, or just for the set-up appointment, and after that the patient can contact their doctor if complications arise.[105] Testosterone is taken in cycles regularly over time for gradual effect, which is very similar to birth control dose regimen.[106] However, regulating testosterone in a way that is similar to birth control, to which access is considered a fundamental right but is the subject of volatile debate, might invite unneeded controversy to shifting testosterone's schedulization.[107]

If testosterone was regulated like cough syrup or birth control it could still maintain its Schedule III status and instead the shift would be in how it is obtained and

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[101] *See Schedule 3 (III) Drugs*, *supra* note 35 (listing cough syrup as a Schedule III controlled substance by brand name and generic name).
[102] *See Schedule 3 (III) Drugs*, *supra* note 35; Christy, *supra* note 35.
[103] *See* Christy, *supra* note 35.
[104] *See How Do I Get Birth Control Pills?*, *supra* note 55 (explaining how birth control is obtained using a prescription).
[105] *Id.* Some states allow birth control to be prescribed online, but other states require you meet with a medical provider for at least one appointment. *See How Do I Get Birth Control Pills?*, *supra* note 55. At Planned Parenthood, those appointments can be made online and are entirely confidential, even for minors. *Id.*
[106] *See* Collins, *supra* note 6, at 15 (discussing testosterone's gradual effects).
[107] *See* Richards, *supra* note 55.

possibly less stringent prescription requirements.[108] However, a more extreme change would be to completely deschedule testosterone and no longer include it in the CSA.[109] In the United States we allow people to change their bodies in a multitude of ways, so the idea of allowing cisgender men access to testosterone who want to take the hormone for aesthetic reasons does not reach far outside of an American understanding of bodily autonomy.[110] However, transmasculine people having unfettered access to testosterone without the barrier of medical diagnosis is improbable and would likely be viewed as too self-determinative and freeing by society as a whole because transgender people are believed to be deceptive and unsure of their own identities.[111]

The benefits of changing how testosterone is regulated and scheduled for the transgender man and transmasculine community are increased access to hormones with less discriminatory encounters.[112] Cisgender men would also now have access to testosterone for aesthetic reasons, which would not impact the sports regulations regarding doping and performance enhancing drugs.[113] One of the goals of the alternative testosterone schemes would be increased safety of those who are using testosterone

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[108] *See Schedule 3 (III) Drugs*, *supra* note 35; Christy, *supra* note 35; *How Do I Get Birth Control Pills?*, *supra* note 55.

[109] *See* Controlled Substances Act, 21 U.S.C. §§ 811, 812 (amended 1990) (listing testosterone as a controlled substance and providing authority to deschedule substances).

[110] *See* Cha, *supra* note 19. In 2015, over fifteen million plastic surgeries were performed in the United States. *Id.* The most popular minimally invasive plastic surgery performed were Botox injections and the most popular non-minimally invasive plastic surgery was breast augmentation. *Id.* Additionally, for the first time, men made up more than 40% of breast reduction surgeries totaling 27,456 procedures. *Id.*

[111] *See* Jones, *supra* note 4; Violet, *supra* note 4. In order to be considered "trans enough," transgender people are held to gender role standards that even cisgender people cannot fulfill because they are unrealistic. Violet, *supra* note 4. One transgender woman talks about the "trans enough" myth and says, "[w]hen a person accuses someone of not being 'trans enough' it is elitist [and] self-entitled . . . . There is no benchmark of 'you must be this trans' to transition." *Id.* "Transition doesn't have to be a desperate last resort" and "the media perpetuates [this] damaging fallacy that keeps a lot of us sat in denial and ignorance for years." *Id.*

[112] *See* Poteat, *supra* note 3, at 26-27 (discussing the impact of disclosing trans identities to health care providers).

[113] *See* Collins, *supra* note 6, at 13.

illegally through the black market.[114] The United States government has an interest in preventing illicit drugs from entering the country and allowing non-prescription, or increased access, to testosterone would likely slow the flow of illegal testosterone.[115]

While cisgender men would benefit from non-prescription testosterone availability, the main reason for the shift in how testosterone is handled would be to combat systemic discrimination against transgender men and transmasculine people.[116] There are reasons the United States would want to regulate testosterone, however, there are ways to modify how testosterone is prescribed and scheduled that do not place transgender people at heightened risk for discrimination through repeated, unnecessary interactions with the healthcare industry.[117]

V. CONCLUSION

Testosterone was originally scheduled to prevent the use of performance enhancing steroids in athletes, and transgender men were not the intended targets of this legislation.[118] However, now that transgender men and transmasculine people are more commonly medically transitioning the prescription requirements for obtaining testosterone expose this community to unnecessary discrimination.[119] Every interaction a transgender person has with a healthcare professional is an opportunity for

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[114] *Id.* at 12 (discussing the testosterone black market). *See also* NEWSDAY, *supra* note 6 (discussing transgender youth using black market hormones).
[115] *See* Collins, *supra* note 6, at 13.
[116] *See supra* notes 48 & 49 and accompanying text.
[117] *See* Collins, *supra* note 6, at 12, 15 (providing information about the testosterone black market); *Who's Who in Your Doctor's Office supra* note 47 (discussing who might interact with an individual in a doctor's office visit); Grant, *supra* note 27, at 72-87 (discussing transgender health and discrimination).
[118] *See supra* note 73 and accompanying text (discussing the legislative hearings for scheduling testosterone).
[119] *See supra* note 24 and accompanying text (discussing cross-sex hormones and testosterone's different prescription requirements).

discrimination to occur, which is statistically more likely than not.[120] Changing the way testosterone is distributed and scheduled would decrease the number of discriminatory encounters transgender men and transmasculine people have to endure by lessening the number of overall interactions they must have the healthcare providers.[121] This would not only allow transgender men and transmasculine people access to life saving and gender affirming testosterone, but it would also allow cisgender men access to testosterone without impacting professional athletics.[122] The original intent of testosterone's schedulization was not discriminatory, however, over time the impact of the policy has created a demonstrable hardship for transgender men and the transmasculine community.[123]

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[120] *See supra* notes 41, 44, 45 and accompanying text (discussing multiple studies that show patterns of discrimination against transgender people in healthcare encounters).
[121] *See* Cruz, *supra* note 3 (discussing barriers to care and discrimination in medical settings against transgender people).
[122] *See* Poteat, *supra* note 3, at 26-27 (discussing the impact of disclosing trans identities to health care providers).
[123] *See* Grant, *supra* note 27, at 72; Shires, *supra* note 6, at 69 (providing statistics regarding transgender discrimination in healthcare).