Donor eligibility of a man who dresses as a woman in anticipation of sex change surgery

A transfusion medicine colleague in Ohio wonders what other colleagues would do about acceptance or deferral of a regular blood donor who has recently disclosed that he intends to have a sex change operation in a year or so to become a female. Although he has NOT yet had the sex change operation, he is in the stage of dressing like a woman and taking female hormones. In fact, at his most recent donation, he wore a dress and actually passed for a woman during a pre-donation interview with a newly hired interviewer. Because the interviewer thought that the donor was a woman, it is unlikely that the male gender-specific questions were asked at the most recent donation. However, in the past this donor (when dressed like a male) denied having male-male sex since 1977. A unit of blood was collected, but eventually, some of the veteran donor room staff noted that in spite of his 'female' attire, that he was a regular donor, and really a male. The collected blood was discarded. The staff is uncomfortable with the situation and believes that this individual should no longer be allowed to donate blood. The medical director has talked to several other blood bank experts and has received conflicting recommendations. Please share your opinions, but base them on a scientific foundation, not merely gut reaction.

The following responses were received.

ADDENDA June 9, 2003

1. **A colleague in Kentucky** reports that his first-hand experience in dealing with the same donor situation when he was at his regional blood center was that the male-gendered individual was **accepted/rejected based on the male gender health history questions**. This individual had always denied any high-risk activity and was accepted for donation. The biological gender of the donor will always be male and was so treated in health history. The donor understood why we were asking the "male" questions and there was never an issue with the staff or donor.

2. **A colleague in California** reports that his regional blood collection center would approach such a potential donor by **applying the regulations and standards very literally**. In other words, he believes that all FDA regulations and AABB standards should apply **according to his gender at the time the individual comes in to donate**. If such a donor answers all of their questions appropriately, the responding colleague would accept the donation. **Two caveats**: (i) in a case like this, if the donor interviewer **does not ask** about direct, male-to-male sexual contact since 1977, they also will discard the unit (but not defer the donor) - not because the donor wears female clothes or is preparing for transgender surgery, but because the answer to this "high-risk" question has been omitted (i.e., after a donor has left their collection site, they generally will not allow their staff to call him/her asking a high-risk question they previously forgot to ask); and (ii) if he were to have **had sex with another male prior to** his sex change procedure (i.e., while he was still male), then the responding blood banker believes the resultant deferral would have to remain in effect indefinitely, even after the donor changes gender and becomes a woman.

ADDENDA June 10, 2003

3. **A colleague in New York** reports that at her regional blood center they have had this situation from time to time. **They treat male donors according to their native gender**. For example, if the donor starts out as male, the center records the donor's gender as male in their record, even after a sex change operation. If the gender changing donor reports having sex with a man, the donor is out. If the donor denies sex with a man (there are trans-sexuals who do not have sex), the donor can be accepted (provided other reasons for deferral are absent). The donor center explains all this to the donor and requests his cooperation. If there is concern that the donor will not be honest or cooperative, the donor is deferred.

ADDENDA June 11, 2003

4. **A transfusion medicine physician in Maryland** reports that a question involving a very similar

case was posed to him recently. He answered that he would **defer the donor**, but admits that his answer may be based mostly on an instinct that he would not want his family member to receive this donor's blood. He also attempted to provide a 'scientific' reason to give to the donor when refusing him. He would tell the donor he was deferred **based on his history of hormone therapy as part of the sex conversion**. The Maryland physician does not believe that the medications being used to induce the sex change have been licensed for that indication or even adequately studied in this setting. He performed a Medline search using the Mesh headings 'sex reversal' and 'estrogens' and found that there are very few references on the effect of female hormones on human male physiology, but many animal studies that show a change in the expression of many enzymes. Because of this, the Maryland physician would be concerned that this donor's blood is not 'normal' and may not have the expected levels of various factors involved in the clotting cascade. Although this has not been studied, there is evidence that the levels of other plasma constituents are abnormal in males taking female hormones (Morbidity in transsexual patients with cross-gender hormone self-treatment: Med Clin (Barc). 1999 Oct 23; 113(13):484-7). Also, he would be concerned about the effect of the donor's plasma, which would be expected to contain supra-physiologic levels of estrogen, on the embryos of pregnant females. (No threshold dose for estradiol-induced sex reversal of turtle embryos: how little is too much?: Environ Health Perspect. 1999 Feb; 107(2):155-9)

5. **A colleague in Pennsylvania** would **treat this donor based on his biological gender** (i.e., as a male) and continue to ask him/her the male high-risk questions. Of course, the staff would have to be alerted each time she/he comes in to donate, but the Pennsylvanian sees no reason why this person should not be otherwise acceptable as a blood donor.

ADDENDA June 12, 2003

6. **A colleague in Southern California** reports that she and the facility Medical Director agreed that they shall apply all applicable regulations, standards and hospital SOP's very literally to the question of a gender-changing donor. In other words, they believe that this donor shall be excluded pre-surgically due to the excessive dose of hormones being ingested and excluded post-surgically due to the fact that this donor shall remain genetically male. Post-surgery he will be excluded because of the question regarding male-to-male sexual contact since 1977.

Please submit comments to the e-Network Forum.

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Posted: June 8, 2003

Addenda: June 9, 10, 11 & 12, 2003; Feb. 27 & Mar. 10, 2004; Apr. 28 & May 22, 2007

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ADDENDA Feb. 27, 2004

7. **A concerned prospective blood donor,** who is not a professional in blood banking, has submitted the following response:

"**There is a great deal of confusion, it seems, with your reporting medical professionals on just what transsexuality is and whether this is a cause for concern for blood banks**. I would encourage you to first of all discover that transsexuality is, like inter-sexuality, a biological condition. So, a transsexual woman is *not* a "man who wants to be a woman." **A transsexual woman *is* a woman in a neurologically phenotypic sense, and vice versa**. Gender-wise, only "late onset" transsexual women have interacted much in an imposed masculine gender role and few would have sexually interacted with men as "men", and hence would be a concern for the (in my opinion bigoted) blood donation injunction against those who have had "homosexual male" sex.

Most transsexual women, both pre- and post-op have sexual histories not too different from women at large. In fact, as lesbianism is, both anecdotally and by study (Anne Bolin, 1988) a disposition of a large minority of transsexual women, there should be less concern for exposure to HIV in this population. As most transsexual women have no sexual contact with the gay male community, this assessment of risk in the sector is proportionally small and hence invalid (not to mention spurious to begin with). In other words, **the comments of some of your members to the effect of limiting access of donations to transsexual women are based entirely on false and bigoted impressions**. Once identified as women (socially as well as internally) in the feminine role, transsexual women usually date men, or often women, in monogamous situations according to societal "norms". As such, heterosexual non-transgendered women provide a higher risk for HIV and STD transmission.

Regarding **the effects of exogenous estrogens on blood**, it is very well established that these conjugated estrogens are of healthy benefit to transsexual women. Taken in large doses pre-op over time periods exceeding 3 years, there is risk to the liver of such patients, but this is due to metabolism of oral estrogens over long periods of time. Post-operatively, transsexual women take hormone replacement therapy (HRT) in line with that of post-ovariectomy women. These estrogens are metabolized in practically similar ways to endogenous estrogens. Such hormone therapy can hardly be called "experimental", having been prescribed by thousands of doctors for 50 years. As the Red Cross itself does not restrict women on HRT from donation, this "risk" seems to be quite invalid, and probably fascetious.

Respondent number 4 would do well to use proper clinical nomenclature in his search parameters - it is "sex reassignment surgery", not "sex reversal". Try looking for "transsexuality" or "Gender Dysphoria" or "Gender Identity Disorder" and one might have more winnings.

Any reasonable analysis would find the effect of a very few transsexual women donating to be on the balance a good, adding to the total blood supply, which your organizations continually trumpet to be in crisis. An analysis based on subjective impressions of risk is unprofessional, unethical, and counterproductive to the needful work of finding able volunteers for blood donation. Any cursory examination of mainstream literature on transsexuality provides a contrast to such undeserved bigotries. As such donation is widely pushed as an act of civic virtue, such biases maintain illiberal constraints upon a phenotypically (and quite probably) genetically predisposed sexual minority. (As an aside, just how does one define "male" and "female" biology? Intersexual conditions are fairly common, both phenotypically and genotypically. Transsexuality is sometimes viewed by sympathetic, educated professionals as a highly dichotomous variant of intersex. Are you willing to write off entire sectors of the populace because they aren't "textbook"? Even though their blood may save lives?) I hope your members revisit and reappraise this discussion, hopefully with more consideration and educated opinions.

The psychologies of transsexual (TS) women reflect very much those of women in general for

their societies, despite your ill-informed and medically unlearned impressions of them as "cross-dressed men." I can personally guarantee that many blood banks receive massive amounts of blood from TS women every year (as well as TS men, who you seem strangely unconcerned about as a vector). They do not take kindly to unscientific and patronizing dismissals of their persons as displayed on your website, any more than anyone else. Transsexuality is not an "at risk behavior," but rather a complex physiological condition which, thankfully for you, poses no reasonable threat to blood donation.

On a personal note I would ask you to consider that, at the very least, social gender should be respected in presentation (which is usually contrasted with "natal sex", not "biological gender" as you malapropically presume.) That is, your constant referral to transsexual women as "he" and "him" shows no science, only moralistic bias, and reveals you as completely disrespectful. It would behoove you to change such uses to be in line with a volunteer's presentation, at the very least from a self-interested perspective of good public relations. As your "colleagues" show little understanding of transsexuality as a condition, this may be a futile request, but a needful one. Some of the anonymous addenda in your article relate unethical and arbitrarily discriminatory behavior which could open up such blood banks to litigation. Transsexuals do, believe it or not, at times hold positions of power. Some are even doctors and healthcare professionals. Some even read your own journals. It's obvious to this transsexual woman that **some reform is necessary in the blood banking world**."

ADDENDA Mar. 10, 2004

8. **A medical director at a blood collection center** in the Pacific Time Zone of the United States reports that they had a similar situation with a prospective blood donor and **consulted CBER** for the FDA's interpretation. The blood center was told that if the donor was **legally accepted as a specific gender then that is the gender they should use** for the sake of donor eligibility screening. It was emphasized that there is no reason to consider the history given by a transsexual or a "cross-dresser" to be any less reliable than that of any other donor. It appeared to the Medical Director that this was not a medical issue, but rather a regulatory one, and CBER dealt with the regulatory aspects, as stated above.

ADDENDA April 28, 2007

9. **A director of donor collections** wonders if her donor center should accept or defer a prospective blood donor who is a **biological male, but in the initial stages of a transgender process**. The donor **presented** to the donor center **dressed as a female**; the 'high risk history' and 'health history' were otherwise essentially unremarkable. The prospective blood donor **will begin hormone therapy** and psychological counseling shortly. The donor has been married twice and has several children.

ADDENDA May 22, 2007

10. **A transfusion medicine physician at an academic center on the East Coast** reports that when she was the Medical Director of a blood center **in the late 80s**, a member of her donor room staff became suspicious upon noticing a prominent Adam's apple on a well dressed, attractive female who was donating a unit of whole blood. Upon further investigation it was disclosed that the donor had undergone a sex change surgery and hormone therapy. Before the sex change surgery, the individual had been a frequent, extremely devoted male donor with no risk factors including denial of male/male sex. Upon being informed about the aforementioned situation, the East Coast physician decided to discard the donated unit and to place the donor on an **indefinite deferral**. Now, two decades later, the East Coast physician wonders **if there is enough knowledge and reliable testing to take a fresh look at the risks** of collecting blood from an individual who has undergone (or who is in the process of undergoing) a sex change, **if there are no other risk factors**.

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