

Comments on the Good Practice Guidelines for the Assessment & Treatment of Gender Dysphoria (v8.3b 06/11/2006)

In my opinion, the draft guidelines are a step in the right direction but do not go far enough to be considered truly patient centred. In commenting, below, I have included some information about my personal experiences to illustrate how these guidelines would not have helped me, even if they had been in use at the time I was undergoing treatment.

Page 8 – in final sentence (excluding disclaimer), it is unclear what is meant by “such ways of working” but I think it probably means ways of working that cause trans people to feel the “need or inclination to avoid seeking professional medical assistance”. I would suggest that most trans people only have an “inclination to avoid” some specific practitioners (mostly within the NHS) who have acquired a very poor reputation within the trans community. I speak from personal experience. I “avoided” the NHS treatment available to me because my conversations with many past and (at that time) current “patients”, both of NHS and non-NHS providers, convinced me that I would receive much better, and more humane, treatment from some individual practitioners only available to me in the private sector.

I firmly believe that an endocrinologist or GP (if s/he feels competent and has the patient’s agreement), not a psychiatrist, should lead any multi-disciplinary medical team treating transsexualism and that GPs should be able to refer their patients direct to that lead person (better still, also allow patients the option to refer themselves). I believe that this is the only way that NHS practitioners can hope to convince trans people that (a) they no longer regards gender dysphoria as a mental illness (b) their role is to help the patient; not to act as gatekeepers to services.

Para 8.2 – Shouldn’t all patients (whether trans or not) have access to local mental health services? I would suggest that making specific mention of this, in this document, only serves to reinforce the myth that transsexualism/gender dysphoria is, itself, a mental illness.

Para 9.4 – This is good, provided the service user agrees the choice of practitioner taking the lead role, rather than having someone imposed on him or her.

Counselling and psychotherapy – Para 17.3 says, “The intention of the service is to help people understand and appropriately accept responsibility”. However, I detect no willingness on the part of the Guideline’s authors to understand and accept that some service users do not need or want counselling or psychotherapy, no matter how well intentioned.

I accept that a psychiatrist should assess the mental health and competence of the person seeking treatment, early on. If all is well, counselling and psychotherapy should be available to the service user but should not be a compulsory part of further treatment.

When I was ready to seek treatment, I sought advice from other trans people (who had already transitioned successfully) to help me plan my own "pathway". I chose a private consultant psychiatrist to assess me. After satisfying himself that I was not suffering from any psychiatric condition, he agreed to issue me with a prescription for hormones and wrote to my GP to explain. The effect of the hormones on my sense of well-being was rapid and, after only six weeks, I had no remaining doubts that I was doing what was right for me. N.B. I do not believe that the effects of the hormones would have been irreversible, after such a short time, so I do not understand why many "gender specialist" practitioners refuse to prescribe them until after the service user has attempted to live full-time in role for a year or more, without hormones. Such behaviour is definitely not "patient-centred" but is inhumane, in my opinion.

I suggest that an endocrinologist should provide advice to the service user, including approximately how long hormones may be taken before there would be a likelihood of the effects becoming irreversible. Psychiatrists/psychotherapists should not be in control of access to hormones.

As I have said, six weeks of hormones was sufficient to reassure me, so I then simultaneously changed my name by statutory declaration and switched gender role (full-time and permanently). After about another 7 weeks, I saw my private consultant again. He arranged for me to start receiving speech therapy at my local NHS hospital, which I found very beneficial. I also started planning how I would best be able to fit in surgery without it affecting my earnings too much, as I was self-employed. I sought opinions from many people whose surgery had been performed by various surgeons. I chose an overseas surgeon about whom I had received the best reports regarding outcomes and aftercare. I was able to schedule my surgery to take place in late June of that year. That enabled me to convalesce during the summer months, which I knew were always my least busy, due to the nature of my work as a business consultant. Thus, I was able to minimise the disruption of service to my clients and my loss of earnings.

Only about 8 months had elapsed between my first consultation (and commencing hormones) and the date of my surgery, which would have been impossible in the UK due to the inflexibility of its medical practices.

Of course, I realise that this timescale would not be right for many people seeking treatment but I also know, personally, many others who have successfully transitioned within timescales similar to mine. I consider

myself very fortunate to be one of the few who could pay for private treatment but doing so inevitably had a serious negative impact on my financial situation, including my pension income when I retire in due course.

Unless the guidelines are made sufficiently flexible to accommodate people like me, and practitioners are willing to use that flexibility, the NHS will continue to fail us.

(name and address given on original document submitted to the Royal College of Psychiatrists on 3 January 2007)