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10 February 2007

Dear Sirs,

I write in connection with your recently published Draft Guidelines on the treatment of transsexual people, and in response to your request for comments on this draft. Thank you for publishing them in draft format and also opening them up for comments.

It may be helpful if I give some background. I:

- am in my early 40s,
- started living full-time in a female role around 2 and a half years ago,
- have no current intentions to pursue genital surgery,
- have experience of both the private and the NHS treatment paths,
- received a lot of specialist "gender counselling" over the period of a year,
- started my own IT business about 3 years ago after losing my job largely because of my "trans-status",
- am still married and live with my very supportive wife and children.

I have read your draft proposals a few times since they were published. I agree with the broad thrust of a patient-centric approach, mainly highlighted in section 11. However there are some inconsistencies within your document in the way this approach appears to be promoted.

### ***Patient Autonomy***

Section 11.1 states "Care should be taken to respect the patient's autonomy for decision making at all times", and section 11.3 states "It is imperative that those experiencing this condition are accorded a substantial role in determining the kind of treatments that are appropriate for them, the pace at which treatment should progress and the duration and sequencing and, where practicable, providers of its individual elements". However, section 10.1 states that "Service providers should take all reasonable steps to provide the service user with a realistic understanding of the timescales involved"; *ie.* it doesn't really matter how quickly "patients" feel they should be progressing because anything that differs from the specialist's viewpoint can be labelled as unrealistic.

You further insist in section 17.1 that "Effective psychotherapy should be seen as an essential intervention...", even if the "patient" feels it is not required, further comprising sections 11.1 and 11.3.

This insistence on gender specialist psychotherapy, which is generally not currently offered under the NHS, will also create delays. When I was first assessed at Charing Cross in September 2003, Prof Green knew of no such facility that was available under the NHS. Where are all the psychologists and psychotherapists who specialise in gender issues that will be required under your proposals going to come from, especially if such services are to be provided on a more local basis? Please note that I do think psychotherapy and counselling is important, but I don't think it is appropriate for all – the service user needs to think there will be benefit for it to be effective, forcing people into psychotherapy is generally counter-productive.

Section 19.3 states that "The quality of the RLE is assessed ... [by] the patient's ability to consolidate their gender role in areas such as employment, education and training or some other stable, social and domestic lifestyle, formally adopt a gender-appropriate first name and to demonstrate that society is aware that they are living in their new role." Personally I find this approach somewhat discriminatory and intrusive. If the "patient" finds it difficult to get a job or placement on a training course, your proposal implies that treatment would be withheld. Also many trans women find themselves in a situation where they are a home-maker, but this wouldn't be independently verifiable. I don't know of any other area of public medicine where treatment is dependent upon the patient's social or economic status.

Section 19.4 states that "There may be some occasions when clinicians request verifiable documentation or evidence of the gender change". These occasions should be clarified, together with the types of documentation that may be asked for. What would happen if the "patient" refuses to supply such documentation on the grounds of confidentiality? I know some trans women who are self-employed and have recently been asked by NHS psychiatrists to provide verification of their gender role from some of their clients together with their tax return as "verifiable documentation". Personally I would be extremely unwilling to approach my clients to ask them to provide such documentation, and feel strongly that my tax affairs are my own and not the domain of any medic. Section 19.4 indicates a lack of trust either in the "patient" themselves or in the "patient's" ability to accept such responsibility, as defined in section 17.3.

### **Referrals**

Introducing the requirement for a written opinion and a peer review before hormones are prescribed (section 20a) would rule out any gender clinic that has sole clinicians, as well as introducing further delays in the process.

The introduction of the requirement for a medical practitioner to also provide an opinion before "surgery" (section 20d) means that three separate opinions are required before the "patient" even sees the surgeon, incurring yet more delays. Do you not trust urologists to make their own medical assessments?

There appears to be a contradiction between section 20b, where you state that a "Second opinion for surgery should normally be obtained after completion of RLE", and section 19.6 where you state "During RLE there should be early consideration of obtaining a second opinion".

I note with disappointment that you also propose introducing the requirement for two opinions for other surgical procedures such as breast augmentation or orchidectomy that currently require none. I find myself wondering why this is, then I remember the televisual image from the 70s of Dr Randall berating Julia Grant for having breast augmentation without his approval. This leads me to the conclusion that, far from wanting transsexual people to have "autonomy for decision making at all times"

(section 11.1) and “appropriately accept responsibility” (section 17.3), the Royal College wants to extend the gatekeeping role of psychiatrists beyond the remit they already have. Would you expect all women to require two psychiatric assessments before having breast augmentation surgery? If not, then this is another example of discrimination in your proposals. It appears that the Royal Society does not appreciate the stresses of having the “wrong” body shape and the difficulties in fitting into society with an unusual appearance.

Moreover the requirement for further assessments will incur further delays in an already notoriously slow NHS system. If GIC’s are already stretched to supply appropriate psychiatric cover, then how are the additional appointments that will be required at each stage of the process going to be resourced?

### ***Shared Care Arrangements***

Section 8.1 states that “Support of a GP who is prepared to enter into shared care arrangements is essential”. My GP has explained the reasons to me and my wife why he and all others in his practice will not enter into a shared care arrangement; basically the hormone treatment is unlicensed and they are not prepared to take the legal risk. They have taken the same line over other medical issues with other patients. Given the increasing likelihood of litigation should things go wrong with prescribed treatment, I fully anticipate that this will become a standard approach within GP practices before too long.

Your proposals would force me to move to a different area in order to find a GP who is willing to enter into a shared care arrangement, even though I am thoroughly satisfied with the professionalism and diagnostic ability of my current GP. Fortunately my PCT made arrangements for my medication to be prescribed by a local endocrinologist, an approach that is not covered by your guidelines – your expectation appears to be that a GIC would remain an assessment centre rather than a treatment centre. The endocrinologist who looks after me also prescribes for a handful of other local trans women in the same situation.

I feel you should be aware of my experience of a PCT’s expectation. They are forwarding people to specialist centres to have treatment provided on their behalf. They do not expect a GP to be required by such centres to prescribe off-licence medication. My PCT was shocked when they realised that this was the current situation. They couldn’t identify any other area where specialists merely assess people. Your proposals merely reinforce the current situation while not recognising the changes in what GPs are and are not prepared to prescribe.

I also note that your proposals’ insistence on a GP’s involvement will continually penalise me. For example, under section 27.1.7 (“appropriate hormonal treatment should continue to be offered providing that the patient has had this prescribed from a bone fide GP”), should I move I would be denied medication under your proposals because my current GP has refused to prescribe.

### ***General Observations***

I am surprised that in sections F1.1 and H, 4mg of estradiol per day is deemed to be the standard dose, while almost every pre-operative transsexual woman I know is receiving 6mg per day – even those being treated by the Gender Identity Clinic at Charing Cross.

Similarly, section 23 states only that "hair removal ... may help a trans woman live more successfully". I would have said this was usually essential treatment. I don't know of any trans women who have not undergone some programme of hair removal.

The lack of definition of "surgery" in section 20d reinforces the implication that the only necessary surgery is "Gender Reassignment Surgery". Personally I prefer the term "Gender Confirmation Surgery" as the intervention aligns the genitalia with the gender the person already has. Indeed, section A6 uses this term.

Section 2.1 states that transsexualism should be viewed "not [as] mental illness ... [but] a rare but nonetheless valid variation in the human condition", yet the consistent referral to "patients" throughout your document indicates that you continue to pathologise transsexualism. Would you consider pregnant women as "patients"? I would be grateful if you change this to a less offensive term, such as "service user" which is already used in some parts of your document.

Nowhere in this document does it make explicitly clear what the psychiatrist is actually expected to do in the process, and why this differs from a psychotherapist, an endocrinologist or a urologist. I welcome the removal of a reliance on a psychiatrist for all aspects of care, which seems to be commonplace at the moment. My experience so far has been that, once an initial psychiatric assessment has taken place, there is little need for psychiatric input afterwards. I think your proposals should explain why and when each of the roles are important.

I was looking forward to a set of proposals that took into full consideration the differing requirements of each transsexual person, that removed a systemised process that allowed no variance; a set of proposals that were truly patient-centric. The more I read your proposals, the more disappointed I am. If this truly represents the best that the Royal College can offer, I would rather they offered nothing, as the proposals as they are currently written, represent steps backwards in many, many areas.

I understand that GICs see many people who live in some kind of fantasy world. I understand that lots of transgendered people have focused on genital confirmation surgery as the only way to make them "better" people while having no awareness of the implications on those around them. I also understand that the current systems lead many people into lying about their intentions, or giving the answers they expect the psychiatrists to hear rather than what they actually think or feel; a situation that cannot change while psychiatrists are seen to be gatekeepers to treatment. These proposals appear to confirm that protecting either the medics or fantasists is deemed to be more important than progressing the treatment of and empowering transsexual people. If so, the current situation, where transsexual people tend not to trust their medics and many commit suicide because of the difficulties involved on obtaining appropriate treatment, will at best continue and probably get worse.

If the Royal Society truly believed in patient-centric care, and truly believed that transsexual people were not mentally ill and were fully capable of accepting responsibility for their treatment, then the proposals would be substantially different.

Respectfully yours,

Helen Belcher