



Press For Change *BM Network, London WC1N 3XX*

Response to draft Good Practice Guidelines for the Assessment & Treatment of Gender Dysphoria

In December 2004 Press For Change (PFC) produced a skeleton consultation document intended to procure feedback from respondents on the principles to be built into these Treatment Guidelines. This document – and the very concept of an initial consultation, was rejected by the Working Group. For this reason, PFC produced its own list of principles by which to judge the resultant document. This is similar to the process we undertook with regard to Government legislation.¹

In this case, we were looking for a wider range of changes to the way that trans people are treated by clinicians than the few requirements we had for legislative change. Our process therefore resulted in fifteen points which we needed to consider.

1. Are the Guidelines formulated from a viewpoint that being trans is a defect or illness?

Yes. Although section 11 talks at great length of the need for a client led approach, at paragraph 17.1, the guidelines state that “effective psychotherapy should be seen as an essential intervention”. Not every client requires, needs or will benefit from psychotherapy and the guidelines should not suggest an insistence or requirement.

2. Do the Guidelines presume trans people to be incapable of responsibility for decisions about the steps to be taken?

In many ways, yes. While the guidelines are worded to give the clients some say in their treatments, they also disempower indirectly. For example, requiring multiple psychiatric / psychological referrals for treatments that would not require any such referral for non-trans clients shows that the clinicians do not accept the principle that their clients are competent to make their own decisions on their own treatment. This is most notable as regards breast reduction or breast enhancement.

3. Do the Guidelines disempower or demand compliance from trans people in any way?

Yes. At paragraph 19.4, the guidelines give the clinician the ability to require sight of personal documents which non-trans people would never be required to disclose to obtain other medical treatment. This is access to treatment through social policing.

¹ PFC's Five Guiding Principles for Negotiation: <http://www.pfc.org.uk/node/53>

4. Do the Guidelines seek to "normalise" people and/or embody contemporary cultural stereotypes?

Yes. At paragraph 19.3, the guidelines talks of the patient's ability to consolidate their gender role in area's such as employment, voluntary work, education and training or some other stable social and domestic lifestyle. These things must never be a condition for progressing with treatment. No account seems to have been taken of people that may have disabilities that preclude such activities. Patients must never be penalised in access to treatment on the basis their employment status.

Why should trans people have to have a "stable, social and domestic lifestyle" when it seems the rest of the world don't ever have one. Furthermore, the process of transition is pretty overwhelming to family life, and it is highly unlikely people can achieve a "stable social and domestic lifestyle" during transition.

5. Do the Guidelines directly or indirectly restrict service user choice?

Yes. The guidelines, while accepting the premise of a network, continually refer to 'clinics' on the assumption that, because most existing services are provided in all encompassing clinics, that this is desirable. In fact, the bringing together of service providers into the monolithic structure of a clinic removes from the service user the ability to pick and choose the clinicians they wish to deal with. The hub of treatment should be the primary carer – the GP. All that is being created is a few monolithic clinics – jobs for the boys.

6. Do the Guidelines directly or indirectly discourage diversity in approaches?

Yes. Many people who need assistance from a gender service will not be transsexual but have other experiences of gender dysphoria. A proportion will need some support for extended periods, many will not intend to transition (i.e. start RLE), some will need some form of hormonal therapy without transition as a support measure. Progression to RLE should not be assumed.

7. Do the Guidelines employ language which pathologises trans people?

Yes. The use of the term Gender Reassignment Surgery (at page 8 and throughout the document) shows that the authors do not understand the subject at all. Surgery to change a person's gender is not possible – it is a function of the brain, not the genitals. We would suggest Gender Confirmation Surgery as a term that is acceptable to most people.

8. Do the Guidelines assume surgery to be the primary goal?

Yes. There is no provision in the guidelines for those that require hormones but not surgery – or even to transition.

9. Do the Guidelines impose inappropriate requirements for second opinions?

Yes. Paragraph 20e requires that a trans person obtain a second opinion in order to receive surgical treatments that non-trans people do not require any psychiatric assessment at all to obtain. This is pure discrimination against trans people and will be made illegal by European Council Directive 2004/113/EC² which makes discrimination on the grounds of transsexualism in the provision of Goods, Services & Facilities unlawful. This directive must come into effect by 21st December 2007.

Despite the requirement for two psychiatric opinions, the guidelines still rightly place the onus on the surgeon to judge their patient's mental as well as physical wellbeing before agreeing to undertake procedures. That makes three opinions for surgery to take place.

10. Do the Guidelines address issues of accessibility?

No. The single sentence on the subject (paragraph 5.1) speaks of reasonable travelling time to access a gender identity service – but makes no suggestion as to what is considered reasonable.

11. Do the Guidelines encourage multiple entry points to services?

No. The guidelines, particularly at paragraph 19.1, assume that clients will enter the service pre-transition. It must be understood that some trans people will have transitioned independently, others will have obtained hormones via the internet. Some will require surgery while others will not. While the preface pays lip service to the concept of a client centred service, the guideline themselves are not based on choice and wellness in accordance with national NHS policy.

12. Do the Guidelines address waiting times for stages in care delivery? (Time to first appointment; time between follow-up appointments)

No. The single sentence (paragraph 5.1) on accessibility says little on the subject. It suggests that waiting times should be in line with those of other tertiary services. However, we do not believe that gender identity services should be tertiary services – and therefore waiting times should be in line with national targets for referral to secondary services.

There is no mention of the timing of follow-up appointments.

Paragraph 10, which is titled 'Waiting Times' is more concerned that clients will be informed how long they'll have to wait than to ensure they adhere to any particular target. It is important that service users receive timely treatment, in line with government requirements on waiting times for other clinical assessments and procedures including surgery.

² European Council Directive 2004/113/EC:
http://europa.eu.int/eur-lex/lex/LexUriServ/site/en/oj/2004/l_373/l_37320041221en00370043.pdf

13. Do the Guidelines impose inflexible requirements for waiting within a care programme? (eg minimum 12 months to surgical referral)

Yes. At paragraph 19.2, RLE is stated to last a minimum of 12 months. This is simply a setting in stone of current practice without any evidence being provided that shows it to be of any benefit. There is no clinical evidence of any relationship between RLE length and outcome, in fact there is much “community” evidence that RLE in excess of 12 months can be seriously damaging and as little as a 3-6 month RLE may be best for some people.

14. Do the Guidelines impose inflexible rules for the ordering of care stages? (eg no hormones before RLE)

Yes. There is an inherent assumption of an RLE => Hormones => Surgery pathway.

15. Do the Guidelines encourage independent auditing?

No. Suggestions that services should be subject to independent auditing were rejected by clinical members of the Working Group.

In conclusion, we consider that the Working Group have failed to make use of the opportunity afforded to them of considering ways forward in developing new models of treatment and have, instead, attempted to set in stone existing practice while using language that appears to pay lip service to the sensibilities of trans people.