

Written evidence submitted by British Association of Gender Identity Specialists to the Transgender Equality Inquiry

Dear Mrs Miller,

I write in my capacity as the President of the British Association of Gender Identity Specialists.

The Association numbers over a hundred members and comprises the overwhelming majority of all clinicians working in every Gender Identity Clinic in the British Isles. The membership is drawn from all the involved disciplines and includes Speech Therapists, Psychologists, Psychiatrists, Surgeons, Psychosexual Counsellors, Nurses, Occupational Therapists, Endocrinologists, General Practitioners and Social Workers.

Firstly, the Association members who deal with Transyouth almost all work at the Tavistock NHS Trust. These members, with decades of experience and working in the only major Child and Adolescent clinic in the UK are, as I understand it, separately writing to the Committee. The Association advises that their separate communication summarises matters.

Secondly, considering proper terminology and definitions, it should be noted that anybody working for the NHS is obliged to record their diagnoses in International Classification of Diseases version 10 (ICD) format, as are all other health institutions, private or state, in every other country in the world. In the USA, where psychiatric diagnoses are often made in the locally based Diagnostic and Statistical Manual (DSM) the state has to translate its DSM diagnoses into ICD before submitting them to the World Health Organisation.

The current ICD diagnoses applicable to people with gender dysphoria don't sit particularly comfortably with contemporary UK clinicians, truth be told, but we are obliged to use them. They are due for revision fairly shortly, in any case, and are likely to be changed to something both more palatable and more clinically useful, as has already happened with DSM.

Considering looser, day to day, terminology there is, at all times, an ever shifting set of terms for the broad spectrum of gender identities (particularly non-binary) and no doubt with the passing of the years some currently used terms will flourish and become permanent features of language whilst others will fall by the wayside. It is not possible at this point to say which will burgeon and which will die away, as is ever the case with the evolution of language.

The provision of data in this field is indeed less good than one would wish. Estimates of population prevalence have varied wildly, this variation probably reflecting sampling bias, leading questions or a combination of the two. What certainly doesn't seem to be in question is the unvarying increase the numbers of people referred to UK gender identity clinics, this having steadily increased at a rate of about twenty per cent a year since 1966. There is every suggestion that this is a global phenomenon. Over the years the proportion of patients assigned male at birth has decreased from about ninety percent to more like sixty.

The only other really solid, near to real-time and big volume data is that which comes from the patient satisfaction studies done in all English clinics over the last year, and which would be available from NHS England Specialised Commissioning. These data are collected anonymously from every patient attending every appointment at every clinic and would accordingly accurately reflect the experiences of those who actually attended the clinics and filled them out. It is suggested that this should consequently be the most relevant and accurate source of such information.

From a clinician's point of view one of the most troubling aspects is the lack of really long-term follow-up data on patients discharged from treatment to detect any long-term adverse effects of treatment. It would be very helpful to know the subsequent history of these people but it is almost impossible to maintain people in long-term follow-up when they are, essentially, well. The UK is in an almost unique position to provide this data because nearly everyone gets healthcare of every sort from the NHS and the nature of every episode treatment is centrally recorded; further every death is certified. Cross referencing from the databases that are currently kept would enable the recording of the subsequent health career and eventual cause of death of every discharged patient, without disclosing any patient's identity to the researchers. This would not be a very expensive exercise and would allow current treatments to be refined to afford even greater long-term safety. It is hoped that the Committee can recommend this.

The Association doesn't find itself able to pass comment on the relationship between various government departments. It can be said that it is difficult at any one time to find out who is in charge of what. Even within the Department of Health there doesn't seem to be any readily available Directory of who is who and who relates to whom. Importantly, as will be described below, some parts of NHS England make statements about what other parts of NHS England will be responsible for and provide, the 'responsible' part later denying any duty to do so, instead suggesting that the first part is, in fact, responsible.

The Association's view is that the Gender Recognition Act doesn't work particularly well and could do with some amending:

Regarding disclosure of trans status for incapacitated persons under the Gender Recognition (Disclosure of Information) (England, Wales and Northern Ireland) Order 2005, at present Psychologists are not included under the *Disclosure for medical purposes* section of this Order which does allow disclosure (outlined elsewhere) by a Health Professional including: a registered medical practitioner; a registered dentist; a registered pharmaceutical chemist; a registered nurse; a paramedic or operating department practitioner; or a trainee for the above.

We echo the submission we understand has been given by the British Psychological Society to your committee; in that we contend that Applied Psychologists who are registered with the Health and Care Professions Council (HCPC) should be included in this list. We note that several of the professions who are included in the list are also accredited by the HCPC.

The Association acknowledges that some members of the trans communities feel that the restrictions on disclosure should be tightened. Indeed we are aware that the spirit of the restrictions has not always been respected within the healthcare sphere.

Notwithstanding this, the understandable wish to tighten such restrictions must be balanced against the need for appropriate care for trans people who lack capacity to consent — care which may be provided by Psychologists in cases where the person lacks capacity under the Mental Capacity Act 2005 or the revision to the Mental Health Act in 2007. The Association considers that the original Gender Recognition Act 2004 only foresaw times when people were physically unconscious — rather than lacking in capacity in other ways. While the Association wholeheartedly supports the feelings of the trans communities with respect to a general expectation for the right to privacy, this would, of course, not be pertinent to the case of severely disabled trans people with a significant intellectual or psychological disability who do not have capacity to consent; and therefore necessarily required their responsible Psychologist to make decisions on their behalf.

In addition, we note that the Gender Recognition Act 2004 and the Order 2005 predate the Mental Capacity Act 2005 and the Mental Health Act 2007. These pieces of legislation, alongside the move of applied psychologist accreditation to the Health and Care Professions Council from the British Psychological Society, radically increased the amount of responsibility afforded to registered Psychologists - not least that of being an Approved Mental Health Professional, which at the time of the Gender Recognition Act 2004 and the Order 2005 was assumed to be the province of Medical Practitioners and Approved Social Workers. The law as it stands therefore fails to take all this into account - In effect it makes Psychologists legally responsible for roles it would then be illegal for them to fulfil. The Association urgently seeks to see this addressed.

Another persistent source of difficulty is that NHS rules require patient files too be kept for at least thirty years whilst the GRA requires us to destroy any records which link the patient's old identity with the new identity. It isn't clear which legislation takes precedence.

Another difficulty is the interaction with the Companies Act, that Act requiring a list of all previous Directors of Companies. If a patient changes social gender role their previous identity will be listed as an earlier director and the often similar name and identical date of birth and address do rather give the game away.

End of life might be an issue, also. If the patient dies of an illness associated with only one sex (endometrial or ovarian cancer, for example) recording this upon the death certificate of somebody who is legally male would clearly expose a change of role that might have happened many years earlier and be known to very few people still living. Whilst the patient is no longer alive to be offended, this does seem to lie counter to the spirit of the Act.

The Association thinks it would be very useful to ask the Gender Recognition Panel to contribute information on these points. That Panel doubtless has observations of its own that the Committee would like to consider.

Considering the aspect of the Marriage (Same Sex Couples) Act 2013 which is referred to as the “spousal veto” this seems greatly to exercise those of a legalistic turn of mind but has not, to the knowledge of anyone in the Association, ever been successfully legally exercised. This is not to say that this aspect shouldn’t be dealt with; in the end, someone is bound to try to exercise it, if only because they can.

A separate issue is wording at a marriage ceremony. It does seem that if either or both parties at an apparently opposite sex wedding is/are someone who has changed social gender role and who does not possess a Gender Recognition Certificate it might be more seemly to use a form of words along the lines of “do you [name of first marriage partner] take [name of second marriage partner] as your lawfully wedded spouse ?” Followed by the same question asked to the other party, the order of the names reversed. This avoids the difficulties caused by the use of “husband” and “wife” altogether and might, indeed, be a form of words preferred by other sorts of marrying couples.

The Equality Act seems to cover gender identity fairly well in the sense of the words on the paper. The difficulty, it seems to working clinicians, is the implementation in practice. There have been few successful challenges using this piece of legislation that any of us have heard of, despite a considerable degree of discrimination we have heard about in clinical settings. It seems to that a major difficulty is the very small number of lawyers who are experienced in using the Act in this way. Those patients who have mounted successful challenges have often been represented by Trades Unions.

Employment and workplace issues seem, from patient reports in a clinical setting, to hinge particularly on the attitude of the employing organisation and, more particularly, the direct line management the person concerned. A positive attitude on the part of both of these is almost always accompanied by success — often very dramatic success. A negative attitude from either makes it a much more uncertain process and a negative attitude from both carries a grave prognosis, in our experience. We can be pretty sure that the problem isn’t the patient in that many people who have had difficult workplace experiences in the light of negativity from employers and line managers have gone on to thrive in a subsequent, similar, work placement where attitudes were more positive.

We would not describe transphobia as very widespread; on the other hand, its very presence is saddening and regrettable. On the whole, in our experience, non-fiction broadcast radio and televisual representations have varied between moderately poor and moderately good whilst print journalism has been moderately poor at best. There appears to be a persisting inability to distinguish between homosexuality, people who cross dress for any one of a large number of reasons including fetishistic and people for whom gender is the core issue. This difficulty in distinguishing one thing from another seems most marked in print journalism and low-end television.

With regard to fictional portrayals there seems to be a parallel with the casting of actors playing gay characters. There is a tendency in the media to cast straight/non-gay actors in gay roles because it somehow makes it a little more palatable for the audience; the exception this being when a gay character is particularly and deliberately put out as camp or ‘queeny’. There is a sense that the media profile of

trans story lines tend to use non trans people to play trans roles for similar, unconsciously transphobic reasons. An interesting practical commentary is that of actress Rebecca Root, shortly to appear in a lead role as a transwoman in 'Boy meets Girl' on BBC TV. It is striking that she was hired to play a transwoman in the BBC series 'Casualty' in about 2005 and that after all her scenes had been shot there was a decision to re-shoot all those scenes with a cisgendered actor playing her role and any trans references dropped. The Association feels that Trans Media Watch is a sound organisation and has done much to support trans narratives away from the voyeuristic and lurid documentary approaches that tend to obsess about genital reconstructions and promote confusion between gender and sexuality.

The criminal justice system merits quite a bit of thinking about. On the one hand, many of us can remember patients who were charged with crimes, convicted and who ended up on the sex offenders register when we thought that the same thing wouldn't have happened if they weren't a trans person. A good example would be the transwoman charged with sexual assault after some brief fellatio with two males who were two and three years younger than her own age at the time (she was eighteen). They were visitors to the area and boasted to their cousin of their recent sexual encounter. The cousin, enlightening them as to the nature of the person they had had a sexual encounter with, caused them to feel embarrassed. One thing led to another and the patient was charged with sexual assault. Given that she was in a kneeling position at the time and that it would have been perfectly possible for either one of the males concerned to run away this seemed a bit implausible. In the end, she was convicted of being reckless as regard to age. This does place her on the sex offenders register, though. One suspects that she would never have been charged at all if she had been a born female.

The converse is the ever-increasing tide of referrals of patients in prison serving long or indeterminate sentences for serious sexual offences. These vastly outnumber the number of prisoners incarcerated for more ordinary, non-sexual, offences. It has been rather naïvely suggested that nobody would seek to pretend transsexual status in prison if this were not actually the case. There are, to those of us who actually interview the prisoners, in fact very many reasons why people might pretend this. These vary from the opportunity to have trips out of prison through to a desire for a transfer to the female estate (to the same prison as a co-defendant) through to the idea that a parole board will perceive somebody who is female as being less dangerous through to a [false] belief that hormone treatment will actually render one less dangerous through to wanting a special or protected status within the prison system and even (in one very well evidenced case that a highly concerned Prison Governor brought particularly to my attention) a plethora of prison intelligence information suggesting that the driving force was a desire to make subsequent sexual offending very much easier, females being generally perceived as low risk in this regard. I am sure that the Governor concerned would be happy to talk about this.

There has been much talk recently of an "informed consent" approach being adopted. The difficulty is that this phrase is much used in medical practice at the same two word phrase holds a wholly different meaning in the context being suggested.

In routine medical practice in this and other countries the phrase “informed consent” means that patients can only be felt to have consented to any medical procedure if they have been fully informed, and understood, the likely consequences, both positive and negative, of the treatment being suggested, advised of alternative treatments that might be available, (including no treatment at all) and the likely positive and negative consequences of those alternatives. It is assumed in advance that the treatment suggestion is that being advanced by the practitioner concerned, the question being whether the patient is consenting to that treatment in a fully informed way.

The same phrase — “informed consent” — seems to the Association to have been borrowed by those suggesting very radical and negative shift in medical practice. It is suggested that provided patients are of sound mind (this amounts to the exclusion of serious mental illness) and understand the nature and consequences of what they request it should, essentially, be the role of the practitioner to fulfil that request. Crucially, there seems to be no recognition or acknowledgement of the view of the practitioner concerned about the merit of the suggested procedure. If actually implemented, this arrangement would leave medical practitioners in the position of having to make diagnoses they do not believe in, prescribe drugs they personally believe will not benefit the patient and undertake surgical procedures that they themselves believe will confer no benefit or cause harm. This is incompatible with medical practice, the first tenet of which is that one should “first, do no harm”.

In practical application, the worrying prisoner described in the paragraph above would be in a position to oblige medical practitioners to advance a plan the basis of which is the facilitation of subsequent sexual assault. If extended to other areas of medical practice this arrangement would leave General Practitioners obliged to prescribe antibiotics for viral conditions (something frequently demanded by patients and a leading cause escalating antibiotic resistance) even though they knew it to be wrong.

It has been suggested by those who promote this change in practice that this is what pertains in general medicine and surgery. This is absolutely not the case, the surgeons and physicians in the Association having confirmed that in general surgical and medical practice doctors do not undertake treatment which they don't think will confer benefit, even if it is the request of a patient with full capacity. Those members of the Association who undertake non-gender cosmetic surgery confirm that this is the case. Association surgeons report that the Health and Social Care Act restructuring of the NHS was immensely successful in ending the “postcode lottery” that seemed previously to apply but do make it clear that “whilst surgeons are independent of gender clinics we could not offer surgery other than as part of pathway managed by those clinics”.

In general medical and surgical practice almost 100% of the time the patient and the clinician, after discussion, find themselves in agreement and there is not an issue. In a very small proportion of cases the clinician recommends a particular line of treatment and the patient does not want to go along with it. Provided the patient is of sound mind that patient has every right *not* to go along with the treatment. Interestingly, in my long experience as a Liaison Psychiatrist, the usual response of the clinician in this scenario has been to call me ! Needless to say, almost always (provided the patient has properly grasped what the clinician is suggesting) it's simply been a case

of the patient not fancying the clinician's plan and my role has been to gently break it to the clinician that the patient has every right to refuse treatment.

Very rarely in general medicine the reverse is the case, which is to say that the patient wants some particular mode of treatment that the clinician cannot, in all honesty, support. In these circumstances it is usual to suggest a second opinion be sought. If the provider of the second opinion does support that line of treatment, they are usually then welcome to assume the care of the patient. If there isn't anybody else willing to support that line of treatment it does tend to suggest that it's probably not a great idea that it be undertaken.

It seems to the Association that gender medicine is no different from the other scenarios outlined above. There are no other aspects of the National Health Service in which patients need only to have their lack of insanity confirmed before being in a position to decide exactly what professionals will be obliged to prescribe to them and what surgical procedures they will be obliged to perform upon them.

An Association member has travelled to North America (home of the World Professional Association for Transgender Health, originators of the proposed way of working) and observed a large gender identity clinic in action. It seemed that, in practice, clinical work proceeds very much as it does in this country. It seems this situation is one in which the stated Guidelines bear no relation to what actually happens. It would be a bit like somebody in a foreign country, with an axe to grind about some aspect of transport policy, reporting to their own Department of Transport that every vehicle on a British motorway travels at no greater a speed than 70 miles an hour on the basis that the British legislation says that this ought to be so, and attempting to influence the governmental arrangements in their own country by citing the British law as if it actually reflected what happened on British motorways.

This mooted change aside, there is a very great deal that can be said about transpeople and wider NHS services as they actually currently operate. The commendable desire to have the same services on the 'menu' at every English gender identity clinic has been the aim and in some regards has been achieved (illustrated by the remark about the end of the 'postcode lottery, above) but in others only partially implemented — for example, it is notable that one gender identity clinic is unique in that it doesn't pay travelling expenses for patients on out of work benefits, that clinic being amongst the most remotely located and one that has more frequent appointments than average.

The casual, sometimes unthinking trans-phobia of primary care, accident and emergency services and inpatient surgical admissions continue to be striking. A matter of serious day-to-day importance at a primary care level is the persistent refusal of some General Practitioners to even make referrals to gender identity clinics.

Only last month there were reports of the death of Synestra DeCourcy. The account from her mother suggests that her General Practitioner steadfastly refused to refer her to a Gender Identity Clinic when she first requested this in early 2013. These refusals were said to have persisted and the patient to have commenced self-medicating with illicit hormones, prostituting herself to pay for these. Eventually, with the assistance of a transman who transitioned many years earlier, the referral was made, being received in February this year. An inquest is yet to be held but there is every

suggestion that her death might have been avoided if prompt referral had been made. Her mother sadly, correctly, said that if this had been the case she would, at the time of her death, probably have been well established on safe hormone treatment and about to be referred for gender reassignment surgery. Her mother has confirmed that she would be very happy to speak to the Committee.

In these circumstances, Association members have sometimes sought the help of secondary care endocrine services (itself a wildly wasteful use of this scarce resource) but on this occasion consultant endocrinologists are said to have declared that they are “too busy” to do this and that they lack the necessary expertise. This situation remains unresolved. It does not seem reasonable to expect Association members to prescribe for patients for the rest of their lives as the number of people involved would be vast and ever growing and it is the view of the Association that primary and secondary care should see it as a priority to acquire the quite manageable additional skills required to prescribe for this patient group rather than dismiss their needs.

The core of the current administrative arrangement is that NHS England Specialised Commissioning has published an Interim Protocol outlining what all English gender identity clinics are funded to provide, although it is silent on issues like funding travel allowing inequities to persist. It has been made clear from the outset that prescribing should be done at a primary care level, and a Circular was subsequently published to reiterate this. It also is made clear that gamete storage is not arranged through gender identity clinics and will be a matter for the patients’ local Clinical Commissioning Group. In a related vein, it is made clear that hysterectomy and oophorectomy should be provided by local gynaecological services, a separate tariff being drawn up for when this service is provided. It is implied that Speech and Language Therapy would be best provided on a local basis, in settings associated with the patients’ local Clinical Commissioning Group.

The problem is that these services either are not aware of this arrangement, or don’t accept them as their responsibility if they are.

An ongoing concern is the unwillingness of General Practitioners to prescribe hormones to patients, as NHS England Specialised Commissioning suggests they will, even when the patients are established at an NHS Gender Identity Clinic. This is most disastrous when the General Practitioner concerned sits on an important committee and sets the policy for a wider area. One such General Practitioner sat on the committee covering all of one of the Home Counties and as a consequence not a single General Practitioner across the entire county Buckinghamshire is “allowed” to prescribe for any trans person, ever, including after discharge and into old age. The individual, personal, General Practitioner of one of the patients affected by this rang me in some distress. He said he was perfectly willing to prescribe on a personal basis but felt he was not “allowed” to do so because of this. I am sure that he would be happy to give evidence, as would the patient concerned.

Clinical Commissioning Group fertility services occasionally do offer prompt gamete storage but mainly claim that they are ‘not funded’ to offer this service or that the patients are ‘not eligible’. Lengthy appeals are possible, of course, and a few patients pay privately but most, understandably, cannot face an indeterminate wait and forgo gamete storage — a decision they may well deeply regret having been forced into.

Clinical Commissioning Group gynaecological services might, in theory, have a tariff for undertaking hysterectomies but in actuality they won't do so. Yesterday, an Association member was contacted about a patient who was discharged from the London gender identity clinic in 2013 and whose General Practitioner requested a local hysterectomy (with a referral letter from the London clinic). At least three gynaecology departments in district hospitals have said that they 'cannot' offer this surgery and the patient and his General Practitioner are growing somewhat desperate. [For the avoidance of doubt it should be made clear to the Committee that the operation is no different from any other hysterectomy and is one that could be carried out by any gynaecologist.]

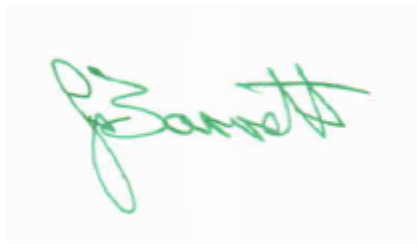
Attempts to refer for Speech and Language Therapy on a local basis, as is suggested by the Interim Protocol, are very often rebuffed with the statement that the local department is 'not funded' to do that sort of work. Sometimes the provision of care is refused with the slightly more reasonable statement that the local department lacks the necessary skills and the therapy would be better delivered by someone with much experience and a busier caseload to keep that experience up to date. There is some merit in this latter statement, as it is felt by the Royal College of Speech and Language Therapists that a poor service will be offered by a Therapist with only a few patients year, if that — such a therapist being what is suggested by the interim Protocol.

These persisting, seemingly growing problems with primary and secondary care suggest that any devolution of the management of gender dysphoria to these tiers of the NHS, even were it to be desirable, is currently a very distant prospect.

Gender medicine, which can be defined as clinical practice aimed at the safe and sustained relief of gender dysphoria, involves a wider range of clinical disciplines than almost any other part of medical practice. There is routine and ongoing involvement from psychiatrists, psychologists, endocrinologists, surgeons, nurses, speech therapists, psychosexual therapists, counsellors, occupational therapists and primary care. None of these disciplines is or should be pre-eminent and the professional body of each of them will only ever contain a very small number of members involved in this work, leaving their interests and those of their patients easily ignored. Consequently, the Association was formed to create an adequate collective voice for those of us working in this field, the better to advance the field and the welfare of the gender dysphoric patients we all try to help. The considerable difficulties experienced by the World Health Organisation and American Psychiatric Association when they attempted to reclassify gender dysphoria in diagnostic terms is reflected by the difficulties in trying to decide which part of the NHS should be responsible for gender medicine. For reasons more related to history than clear eyed thinking this has in the past been psychiatric services and the psychiatric part of NHS higher administration. The most truthful, if messy, analysis suggests that gender medicine doesn't easily fit into any professional or administrative category and that the best care for patients will always involve a close-knit and very multidisciplinary team. Such teams already exist in Gender Identity Clinics and the extremely large dataset from those actually attending such clinics makes it clear that satisfaction levels are extraordinarily high; chief patient concerns appear to be long waiting lists to access clinics and other parts of the NHS preventing referral to those clinics or

failing to cooperate with the advice given by the clinics. Recent, very welcome, if somewhat belated higher administrative action has been taken to address the problems of waiting lists. The Association does feel, though, that attention should be directed at strongly encouraging primary and secondary care providers to heed and adhere to the plans issued by NHS England and to grasp that gender dysphoric people as equally deserving patients in whose care they decidedly can and should play their part.

Sincerely,

A handwritten signature in green ink, appearing to read 'J Barrett', is enclosed in a rectangular box with a dotted border.

Dr. James Barrett
President, British Association of Gender Identity Specialists

20 August 2015