



**A Written Submission by TransLondon on behalf of its members to the Panel Members participating in the public debate on “Gender Reassignment Services in the Capital” To be held on 1 May 2007 at City Hall, London.**

# **Gender Reassignment services in the Capital - a public debate**



A public discussion on NHS gender reassignment services for transgender people living in London, hosted at City Hall on

Tuesday 1st May from 1830 to 2000  
To register email [LGBTHealthUK@aol.com](mailto:LGBTHealthUK@aol.com)



**MAYOR OF LONDON**

## **Introduction**

TransLondon is a discussion / support group for all members of the 'trans' community, whatever their gender identity (or identities) and whatever stage in their 'transition' they have reached (if at all). However, all members must themselves be trans-identified or 'questioning'. The TransLondon group meets on the third Tuesday of every month.

In preparation for the public debate to be held on 1 May 2007 concerning Gender Reassignment Services in the Capitol, the topic for discussion at the TransLondon meeting, held on 17 April 2007, centred on health care provision within the NHS for trans people in London.

Those attending the meeting were encouraged to be present at the public debate on 1 May. However, several members are unable to come to the meeting and the TransLondon organisers offered to present a written submission highlighting the areas of main concern to Trans people in London.

The following submission is intended to be positive and constructive in its nature, whilst highlighting some needs that should be considered and addressed.

The overall consensus at the TransLondon meeting regarding health care provision for trans people was positive in nature. The perceived notion (gained from anecdotal discussion via online trans groups) that trans people attending the Charing Cross Gender Identity Clinic were treated with a lack of dignity, choice and inclusion did not, generally, hold true. In fact, it was expressed that the levels of commitment and professionalism of the staff at Charing Cross was high and the main problems people experienced were due to long waiting times and inflexible bureaucracy. Where people had expressed experiences regarding lack of dignity etc, it was found that such incidents tended to be historical in nature and were not ones which generally are experienced today. However, the perception of "significant dissatisfaction" and "Concerns about the standard of UK surgeons" remain and people are seeking treatment through the private sector as a first choice because they fear being treated in the negative ways described above. It should be the onus of the institution to dispel such fears especially so in light of the new Gender Equality Duty legislation which comes into effect this month.

### **Points of concern include:**

#### ***From a Primary Care perspective:***

Those seeking treatment for gender dysphoria often found their GP to be lacking in knowledge in how to proceed in the referral pathway. In many cases, this resulted in cumulative delay for referral to a local psychiatrist before being referred on to the Gender Identity Clinic.

In some cases, people perceived reluctance by their GP to facilitate treatment on grounds of prejudice or because the GP was unwilling to participate in a shared care arrangement (These accounts of unwillingness for shared care arrangements tended to come from people who had sought initial treatment privately)

There was also a perception that in some GP practices, staff were not adhering to the Data Protection Act and that confidentiality was possibly being breached. Concerns were also raised about the new medical record database in regard to information about an individual's gender issues being available to all personnel, including medical personnel on the European continent without explicit patient consent.

In regard to changing the gender signifiers on medical records, again, there seems to be a lack of knowledge on the procedures for this. However, where medical records had been changed accordingly, transwomen found themselves being requested to attend for cervical smear testing. It has been the same for some transmen who have undergone hysterectomy; if the gender is listed as Male (for transmen), then GPs are sometimes reluctant to alter the patients record as it means that they would be removed off the list for smear tests when in fact there would still be a risk of cervical cancer.

In regard to the above, it was felt that this could cause undue embarrassment as well as being an unnecessary waste of precious NHS resources.

Accessing Sexual Health Care was also found to be problematic for trans people. Where GUM clinics have designated male and female areas, confusion arises as to where a transman or transwoman should go.

Concern was also expressed about GUM screening being cascaded down to GP practices. The current system allows for the individual to decide whether or not his / her GP should be made aware of any sexual health issues. If such a proposal is implemented, how will the status quo (re: confidentiality arrangements) be maintained?

### ***Moving onto the Specialist Care Setting:***

Whilst it is understood that Gender Specialist Clinics aim to be absolutely sure in providing the appropriate treatment for a gender dysphoric individual, the question does arise as to why treatment protocols within the NHS differ from internationally recognised standards of care guidelines (The World Professional Association for Transgender Health (WPATH - formerly known as the Harry Benjamin International Gender Dysphoria Association, Inc.)). It could be argued that these international standards of care guidelines are just that, merely guidelines and that a more rigid protocol should be in place to ensure appropriate treatment. However, some individuals have been informed, possibly quite appropriately, that the next stage of treatment cannot take place until the WPATH guidelines have been met. This apparent inconsistency, has also been noted in the way in which the NHS offers its treatment when compared to the private sector, especially so when it can be seen that the same medical professionals are working in both sectors.

It is felt that there should be more harmony between the NHS and Private Sector in the approach to providing treatment for gender dysphoria and having access to surgical interventions. For example, a transman seeking bilateral mastectomy in the NHS would require two referrals for surgery, whilst in the Private sector, he would only require one. In the private sector, one year of Real Life Experience is deemed appropriate before a referral is made for gender reassignment surgery; the NHS insists on two years. In addition, it was suggested that it was unreasonable for a transman having to do RLE when they have big breasts that are too big to bind. Instead surgery should be considered in these cases at a much earlier phase, perhaps within three months. Forcing them to have a male name and to try to present

as male is inviting ridicule and harassment. However harmonising the two sectors does not mean that one should initiate "a levelling down to the lowest common denominator..."; rather one should aim forward to best practice, namely the WPATH guidelines.

It is recognised that there is only one NHS Gender Identity Clinic in London, which also serves as a National Centre of Clinical Excellence, and therefore a significant number of referrals to the clinic come from outside the London Strategic Health Authority. There is concern that the Extra- Strategic Health Authority referrals impact on the waiting times to be seen for London residents. The question raised in this regard is, is the London Strategic Health Authority willing to advise its PCTs to refer to privately operated Gender Clinics in London and the South East? Setting up a national frame work and formulating a nationwide strategy, along similar lines as proposed (but never implemented) in 2004 / 5 to create GICs in Brighton and Hove, would be a promising solution.

Another point raised at the TransLondon meeting concerned the scope of treatment available on the NHS to trans individuals. Apart from offering an initial diagnosis confirming gender dysphoria and / or transsexualism, speech therapy and gender reassignment surgery, there is a view that treatment for trans people should also include a more holistic approach with access to gender specialist counselling and Laser / IPL / electrolysis depilation treatments. In addition, a greater choice of choice of phalloplasty surgeons (there is only one established surgical team in the UK at present) and a wider range of surgical phalloplasty techniques should be made available to transmen.

There should be access into the NHS system at different stages of the transition - e.g. post gender reassignment surgery for speech / surgery, or post operatively for medical issues outside the psychiatric domain - e.g. for remedial work for SRS conducted elsewhere, even if this has been undertaken on a private basis. It is worth bearing in mind how much an individual will have saved on NHS resources by entering into the system at a later stage and they should not be penalised for doing so.

In a similar vein, it was noted that people with gender dysphoria who may not necessarily be transsexual are having difficulty in obtaining surgical procedures to help resolve their gender dysphoria. Having gender dysphoria does not necessarily mean one will be diagnosed as a transsexual person requiring gender reassignment surgery. However, it may be appropriate for somebody who does not identify as transsexual to have surgical intervention such as breast augmentation, bilateral mastectomy or orchidectomy in order to alleviate their gender dysphoria. There is a perceived notion of an "all or nothing approach" in this regard. This can result in some transgendered people seeking surgical intervention in the private sector and sometimes from surgeons abroad who have questionable expertise (Any resulting complications are sometimes left with the NHS to resolve).

Another highlighted issue concerned people who feel they do not conform to the perceived stereotype and have to "play the system" in order to achieve the outcomes they need. This may result in achieving the surgical outcome they desire but at the expense of engendering trust and potentially wasting valuable NHS resources i.e. assigning a place for gender reassignment surgery but withdrawing once that person's aims have been met; hence funding being lost or delayed for another individual. Ideally, a truly patient centred approach for transgendered people is what is required.

Finally, attention was drawn to the debatable issue of treating young trans people with hormone blockers, thus delaying the onset of what could be a traumatic and unwanted puberty. Whilst it was recognised that clinicians in the UK are reluctant to initiate such treatment on young trans individuals on the grounds that the experienced gender dysphoria may be temporary and resolve at a later date, perhaps an evidence-based approach should be taken in offering such treatment, i.e. consultation with other GICs e.g. in Holland, where there is an established protocol for this type of treatment with known outcomes of success.

### ***In Summary***

The provision of health care to trans people has certainly improved leaps and bounds over the past decade and the understanding of the condition of gender dysphoria has become more widespread and understood. This does not mean, however, that NHS service providers should rest on their laurels and not strive in continuing to improve health care for trans people.

In the current political climate where the NHS is under considerable pressure to reform and become cost efficient to the Tax Payer, there is a real fear that trans people will once again become marginalised and their access to health care provision, instead of being enhanced further, will be cut back in the face of prioritising needs. This has already been witnessed in Wales and in other Strategic Health Authorities. There has been recent media coverage concerning an individual in the North of England who has to have a psychiatric assessment before she can have a urological problem resolved. To most, this is blatant discrimination against a trans person seeking medical care through the NHS. Trans people are determined this should not happen in London or continue elsewhere.

In regard to Primary Health Care, the issues raised above can be addressed through education of GPs and NHS staff in all quarters. Trans people often encounter, prejudice and ignorance of gender issues within the NHS system. A proactive culture of respect, understanding and awareness of the issues trans people face when accessing health care should be fostered. Perhaps such a proactive approach would include identifying to staff their legal obligations and duty of care in providing non-discriminatory care to trans people. Consultation with trans people, such as is happening with this meeting on 1 May and the implementation of ideas discussed, will go a long way to alleviating these concerns.

Adopting a national framework approach rather than a Strategic Health Authority approach would be beneficial for trans people nationally and thus provide an environment where the specialist services in London are not so pressurised.

It is hoped this submission from the members of TransLondon will provide the panel members with a useful summary of the experiences faced by a cross section of trans people in London.

Many thanks for taking time to consider this document which the members of TransLondon hope will inform and direct the panel on the up and coming debate.

If panel members would like to discuss any points raised in the submission before the meeting, please contact, Christina, Tessa or Michael via email at [admin@translondon.org.uk](mailto:admin@translondon.org.uk)