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Trans People in the New NHS

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Introduction

Ladies and gentlemen, colleagues: thank you for inviting me to speak at this conference, and thanks to your Chair for providing me with such a challenging topic. My presentation was put together in consultation with the major organisations representing trans people in the UK and I am pleased to speak on their behalf. As you may be aware, this meeting has raised some anxieties in the trans community, which now has a sophisticated and professional understanding of this conference's issues, firmly grounded in the real life experiences of trans people. It is important, therefore, for the community's voice to be heard today, to ensure that any new practices proposed are considered in consultation with that community, not only by healthcare teams listening to individual patients but also through clinicians working with the community leaders, who daily deal with the real-life issues which affect trans people.

Accordingly, then, I am going to set out the main contexts from which it is important to consider the quality of care for trans people in the UK, and then to indicate some possibilities that those contexts suggest. I shall speak for thirty minutes and leave fifteen minutes for questions at the end.

Contexts

Three important contexts need to be considered in planning future healthcare for trans people:

- 1 the requirements of government, the Department of Health, and the various regulatory and statutory bodies which affect UK healthcare;
- 2 the history of the medico-legal treatment of trans people in relation to the treatment of lesbians and gay men;
- 3 the increasing move by trans people themselves to participate as a community in their medical, social and legal treatment

These contexts combine to reflect changes of the last ten years, such as the development of new practices in medicine and new moves in the law and social positioning of trans people; they combine to identify what constitutes best patient care, at present and for the future, and to indicate the importance of the patient's voice and the community's views: trans people are, after all, the individuals who have to live with the condition, and who benefit directly from treatment.

The New NHS

Everyone in the UK, perhaps, is now familiar with government's vision for a New NHS, introduced resoundingly with the landmark *The New NHS* and *Our Healthier Nation*, which set out the main principles that other policy and strategy documents have elaborated, culminating in the *NHS Plan*, and the key documents which have followed that:

Department of Health (1997) *The New NHS*
Secretary of State (1998) *Our Healthier Nation*
Department of Health (1998) *A First Class Service*
Department of Health (2000) *A Health Service of All the Talents*
Secretary of State (2000) *The NHS Plan*
Department of Health (2002) *The Medical Education Standards Board*

These documents suggest six key principles:

- taking account of social and economic factors in health, removing medicine from its isolation in a set of purely clinical definitions, and insisting that it connects with the social sciences;
- insisting equally strongly on patient empowerment, with patient consultation on the development of clinical services, and their provision, being established as the norm, rather than the exception;
- the introduction of Evidence Based Medicine and Clinical Governance, so that clinical decision-making should become open and accountable;
- a reorganisation of responsibilities, with the creation of the Statutory Training Authority, the establishment of the postgraduate Deans to control the funding for postgraduate doctors, and the establishment of a Medical Education Standards Board;
- an emphasis on consultants as members of a team of healthcare professionals, in which respect is earned through expertise in working together and learning together, to provide best patient care, and a consequent emphasis on consultant CPD (Continuing Professional Development);
- an insistence on public *and* private partnerships in the delivery of healthcare to the nation, in which the NHS learns from and utilises the processes and policies in place in private practices and hospitals, as part of its recognition that many NHS consultants work 'on both sides of the fence'.

These six principles provide the touchstones for development and progress in the new NHS, and are reiterated time and time again, not only in the policy documents of the Department of Health, but by the GMC, the BMA, the Academy of Royal Colleges and the new Commission for Health Improvement (CHI) and National Institute for Clinical Excellence (NICE).

By contrast, everyone in the UK is well-versed in old medicine and the old NHS: the consultant-god, surrounded by acquiescent juniors and humble nurses, ruling by fear, condescending to treat grateful and uncomprehending patients. That image (whether Sir Lancelot Spry, or Mr Rodney Ledward, or, in this context, the distressing one recently shown again on television, of Dr John Randall humiliating Julia Grant) is a kind of medicine against which government and the profession has turned its faces, and which everyone in the UK now knows to be unacceptable.

There is, therefore, a new spirit abroad in medicine, in the NHS and in the country at large, and it is in this perspective that the treatment of trans people must be viewed. To make a small but crucial point: it is generally considered to be the right of any minority group to determine the name by which it is known, so that, for example, it is no longer acceptable to call black people, 'coloured'. In the same way, while the medical condition of 'transsexualism' stands as the name of a clinical condition, it is not acceptable to call people treated for that condition, 'transsexuals': the name which the community demands is 'trans people', or 'trans man' or 'trans woman' or, simply, 'people', 'woman', 'man'. This, perhaps, is the first influence of the social sciences on medicine, that there are new and different standards for assuring the dignity of patients while they are receiving medical care, and the starting point for nomenclature is the patient. This means that if in doubt, about how to address individuals, you should ask them how they wish you to refer to them. Very importantly, it means that patients, including trans people, are individuals, so that no one care pathway can address the needs of the whole group.

These considerations indicate the range and complexity of changes that the new NHS needs to deal with, in order to provide best patient care. A first stage in dealing with these complexities, it seems to me, is to have them laid out before us, so that we can see the implications of change, and act in a judicious and caring fashion. For at the end of the day, we are all gathered here with a single aim in mind, to do the best medicine that it is possible to do, to help and not to harm the person who needs clinical care, and to do that in a fashion which is timely, resource-efficient, and clinically effective.¹

Clinicians are, of course, experts in clinical matters, just as other healthcare professionals have their expertise, and all come together in the provision of best patient care. But patients, too, have their own expertise, in what it is like to be a person experiencing a particular condition, how the various clinical possibilities are likely to affect them, adversely or otherwise, and it is for this reason that patient consultation is so high on government's agenda. That is particularly the case for minority groups, whose special circumstances may be considered to disempower them in ways that are more extreme than those who live in the mainstream. It is even more the case when it is psychiatry that is dealing with those minority groups, since only by careful attention to the patient's personal narrative is it possible to distinguish those features of their circumstances that are the product of social disenfranchisement – unemployment, poor housing, poor education, and in particular in the case of trans people, social stigmatisation² – and those which are the product of a medical condition which may be amenable to a clinical intervention. This in turn would lead to planning with and for the individual, not the group. In the case of the trans community, there are particular difficulties to be faced, because of the history which surrounds it, and the second context, therefore, is the historical one.

Historical context³

From the 1930s to the 1960s, trans people were understood to experience a congenital physical condition, and after appropriate clinical intervention, they had full civil liberties in their real sex. Their birth certificates could be corrected, they could marry

if they wished, and live otherwise ordinary lives. In the late 1960s, however, two events contributed to a massive change in that status. First – and ironically at the point at which gay men were decriminalised in the UK, in 1967 – in the USA, John Money announced that he had solved the dilemma of whether nature or nurture decide our gender.⁴ One of a pair of twin boy babies had accidentally been penectomised during circumcision, had been reassigned as female, never told of his reassignment, and brought up as a girl. Money, a self-styled ‘missionary of sex’⁵ announced that, after long-term follow up, the girl had successfully adjusted to her new role and that it was, therefore, nurture and not nature that decided the gender of people. Incredibly, on the basis of one single case, that view became the dominant one. It was clear by analogy that transsexualism was not congenital, and that trans people should respond to nurture if it was persistent enough and firm enough. Second, in 1970, the case of *Corbett v Corbett* ‘criminalised’ trans people by removing civil status recognition from them.⁶ The effect of that trial was comparable to the effect of the trials of Oscar Wilde and of Radclyffe Hall: it produced ‘a brilliantly precise image’ of the trans community, a ‘grafting of a narrow set of cultural signifiers’ onto an ostensibly homogenous body of trans people.⁷ In the public imagination, trans people would always be trans women [so that trans men became invisible] and trans women would always be, in the judge’s terms, ‘a pastiche of femininity’,⁸ a sort of piss-elegant drag-queen, a kind of figure of fun. Equally seriously, trans people were no longer allowed to correct their birth certificates, could not marry, could not adopt, were sent to the wrong sex prison [where trans women at least were routinely raped by male inmates and warders alike] and it became the norm for them to be dismissed from employment as soon as their condition was disclosed, whether at diagnosis or later. With further irony, in 1980, as homosexuality was removed from the American Psychiatric Association’s Diagnostic and Statistical Manual of Registered Mental Illnesses (DSM), transsexualism was placed in it, to confirm by medicine this new edict of the law.

The first response of the UK trans community was to feel crushed, and the second was to organise. In 1986, the first attempt to gain correction of the Birth Certificate in the European Court of Human Rights failed,⁹ as did the second in 1990,¹⁰ the third [in the High Court] in 1998¹¹ and the fourth in 1998¹². But in the early 1990s, the existing self-help groups collaborated to form an over-arching lobbying group, Press For Change,¹³ and shortly afterwards, the Parliamentary Forum on Transsexualism was established. These two bodies brought together legal, medical, and other experts, and sympathetic Parliamentarians, and between them produced a strong pressure for change. The first victory came in 1996, when two successful cases meant that trans people had employment rights for the first time for almost thirty years.¹⁴ In 1996, the Gender and Sexuality Alliance produced Guidelines for the Prison Service on the treatment of trans prisoners, and in 1998, a High Court case decided that Health Authorities had to make appropriate provision for treatment for transsexualism on the NHS:¹⁵ until then, the norm was for people to pay privately for treatment, something made particularly difficult by their generally unemployed status. Coincidentally, in 1998, in the USA, Professor Milton Diamond discovered the real outcome of John Money’s iconoclastic research:¹⁶ the child who had been reassigned as a girl had never been happy in the female gender role; he had always experienced his gender as male, despite his female rearing, and female hormone treatment, and as soon as he was able he had reassigned to his male identity. John Money’s findings for his research were revealed as being grossly inaccurate at best, but not before a generation

of tertiary specialists had been at least misdirected by someone who, for many of them, had been their mentor and pre-eminent amongst them. From the point of view of trans people, of course, a generation of patients had been inadequately and inhumanely treated.

There has been a real need for rapid re-evaluation of the provision of care for trans people, therefore. In Europe, there had already been a ground-swell of changing medical viewpoint. The idea that transsexualism is a mental illness, amenable to psychotherapy, was no longer applicable; rather, 'transsexualism . . . imposes itself on the subject by a pathological determinism . . . [it] is a medical problem'.¹⁷ Public attitudes have changed dramatically: the defining image of trans women is no longer April Ashley but Coronation Street's Hayley Cropper, an ordinary, sensible, kind-hearted woman who just wants to get on with her life. The FTM network, and Dr Stephen Whittle in particular, has done a tremendous amount of work to end the invisibility of trans men, although it is still common for medical and legal discussions to omit men. The UK trans community has changed, so that with the gaining of employment rights, it has become very much a professionally successful, articulate, politically aware and legally experienced group of people, committed to working with government and medicine to find mutual ways ahead. In both the USA and the UK, there has been a burgeoning of research into trans issues, so that now the naive brutality of works such as Janice Raymond's *The Transsexual Empire*,¹⁸ which sought to exclude trans women from the women's movement, can be understood as similar to earlier, equally mistaken, attempts to exclude lesbians from the women's movement.¹⁹ One measure of this progress is a headline in the *Independent* national newspaper, on 22 January 2002, which said 'Transsexuals [sic] set to win the legal right to marry' which, although wrong in fact (at least for the moment), produced no public backlash of anxiety as a response.²⁰

Current trans issues

One important set of trans issues, therefore, focuses on personal identity: in medical terms, some recent research supports the view that transsexualism is an intersex condition which involves the prenatal organisation of the brain.²¹ The research is small scale and cannot be easily replicated; on the other hand, it has not been refuted and is reinforced by a wealth of animal experimentation; and it certainly accords with many trans people's own experience. Thus, some trans people may choose to claim a third gender; others choose a trans position; while others view themselves as simply just another person, for whom a mistake was made in identification at birth: an inevitable mistake, given that sex at birth is decided by external genitalia, but a mistake nonetheless. But standards of treatment should not depend on any conclusions about aetiology. Trans people exist and as individuals are deserving of the same standards of health care as other people.

As far as terminology is concerned, or needed, to reiterate my earlier point, there is a general rejection of terms such as 'a transsexual' or 'transsexuals' or 'male transsexual' or 'female transsexual', as completely unacceptable. They pervade the medical literature and this must change. Further, unless anyone tells you that they are trans and identify as trans, you should not assume that they are, or identify them in that way.

The intersections between trans and lesbian and gay histories point to another important set of issues. The inappropriate medical interventions used for gay men and lesbians were, in effect, transferred to trans people, where some of them still remain: what place does a rectal or a vaginal examination have in a psychiatric assessment? What do the enforced standards of appearance and behaviour 'like a woman' which are used on trans women now as they were used on lesbians formerly, really mean? In particular, the notion that trans people are an homogenous group is inappropriate to high quality clinical care, since in effect it obliges 'a standard of care' to become 'a standard of compliance'. History is full of lesbians and gay men who had such a standard of care enforced on them and it is important that this unacceptable medicine is not repeated.

The objections to particular clinical attitudes, procedures and practices, which may be made by the trans community, are not new objections, therefore: generally, they all represent practices which have already been discredited, a generation ago. These objections include the inference that transsexualism is a mental illness, implied by its presence in the DSM; and a persistent, though unfounded association between transsexualism and paedophilia, as previously there was a similarly unfounded association between homosexuality and paedophilia.²² Trans people are engaged in the project of reclaiming dignity for their community, and in rewriting a history which has systematically excluded or humiliated them.

Regardless however of any aetiological or clinical issues, it is clear that the vast majority of trans people are undoubtedly well balanced individuals, as demonstrated by how well they deal with the social stigma and legal problems of being trans. This does not mean that all is well. Social stigma still surrounds the trans person, causing social problems that at worst can even lead to violent death or attempted or successful suicide, or at best, to simple withdrawal from society. Further, it is particularly difficult for those trans people who have other disenfranchisement, such as physical or mental disability, to gain access to treatment, never mind social acceptance.

That anyone succeeds in their new life against these odds is in itself astonishing, that so many go on to have successful careers and jobs, form families, and become part of their local communities is indicative of their capabilities. It is easy to forget, but in fact the trans person spends far more of their life outside of clinical settings than in them, and success is judged not by doctors but by friends, families, work colleagues and the locals in the pub.

Perspectives

I advise, therefore, that there is a series of perspectives from which you may wish to consider the quality of care for trans people in the UK. First, of course, must be the perspective of the new NHS. In this context, the implications of the new NHS are that, in order to inform decision making, you should:

- fully involve patients and patient groups in extensive, national consultation before defining any new standards;
- draw on the trans community's expertise in social sciences in this specialist area;
- operate to the principle of informed consent and offer choices in clinical care;

- recognise that what evidence there is points to transsexualism as ‘an intersex condition of the brain’ and not a mental illness;
- work in collaboration with all of the agencies that regulate medicine and medical education in order to provide a supply of appropriately qualified and experienced healthcare practitioners for this minority area;
- carry out consultation with your clinical teams and with your extended teams, such as social services, in order to improve your services;
- learn lessons from private practitioners about what is acceptable and appropriate in patient care.

Second, it will be important to take into account the changing legal and social status of trans people. There is now an increased political concern that trans people should be well-treated and a strongly changed public perception of them. So, for example:

- Government has a cross-departmental working party concerned to take forward issues of trans citizenship;
- appropriate provision of health care services must now be made available via the NHS;
- public service, including the Armed Forces, have increasingly high expectations of dignity at work for trans people.
- there have been changes in practice in the Prison Service;
- in Northern Ireland, the ‘Good Friday Agreement’ has shown that minority needs, including those of trans people, can be incorporated into community requirements with success;
- DfES Citizenship initiatives can include specific consideration of trans issues and increasingly this area is being taught in schools;

Third, it will be necessary to take into account a European dimension, rather than a US one, following the introduction of the Human Rights Act (HRA). There are crucial differences between Europe and the US, which mean that a Standard of Care which is more liberal than the US Harry Benjamin Standard is required:

- classification: where the US relies on the DSM, Europe tends to prefer the ICD; WHO have indicated that they are open to reclassification of transsexualism as a physiological condition rather than a mental illness;
- healthcare: the UK has a national health system, supported by uniform clinical criteria which provides important legal protections to medical practitioners which are not present in the USA;
- medical education: the new Medical Education Standards Board will require clearer standards and curricula for training doctors, including sub-specialties such as transsexualism;
- legislation: the UK has uniform national legislation, unlike the state by state legislation of the USA where one state may have radically different law from another;
- scale: since there are thought to be only approximately 5,000 trans people in the UK, it is possible for all of the various organisations representing the trans communities to be involved in consultation.

Finally, it is important to recognise that there is already a developed viewpoint within the trans communities, about what constitutes appropriate clinical care. The new NHS requires that the patient’s General Practitioner must be in the driving seat of the

clinical process, working collaboratively with the individual patient to find the care pathway which will suit them best. It is the GP who will be the commissioner of services from secondary and tertiary specialists and who will evaluate their effectiveness and appropriateness in consultation with their patient. At present, then, the developing view of the various support groups of the trans community, their members and their GPs, is that:

- there should be no single or uniform route through but rather a variety of routes depending on the individual circumstances and preferences of the patient;
- there must be diversity in treatment programmes. Just as maternity care has offered choice, trans people need real choices to make about treatment routes and the power to assert those choices;
- individuals may not always choose surgical reconstruction but may prefer to end clinical intervention at an earlier point which better suits their emotional and personal needs;
- physical examinations as part of a psychiatric assessment are inappropriate. If, for example, it might be advisable for a trans man to have a vaginal examination [to be sure that they were not at risk for cervical cancer, for example] then it should be their GP who offers that procedure, which may in any event be turned down on the basis of informed consent;
- a Real Life Experience in advance of hormone therapy will generally be inappropriate, may not be appropriate at all in a number of cases, and should always be under the control of the individual concerned;
- patients should have access to a consultant endocrinologist for advice on the prescription and management of hormone therapy;
- it is not acceptable for practitioners to insist on the agreement of the patient's spouse or that the patient divorce their spouse in order to obtain the hormonal and surgical treatment they require;
- it is not acceptable for surgeons to require patients to sign a form of consent stating that they accept that surgery will not change their sex and that it is being done to prevent deterioration in their mental health;
- it is not acceptable for pharmaceutical companies not to list their hormone treatments as being used for transsexualism, and thus to deny appropriate clinical information to GPs prescribing those medications;
- where multi-disciplinary teams, including lay people work, with trans people it is necessary to recognise that most members of such teams are facilitators. They are not clinicians with diagnostic or assessment roles and must not be used to 'gate-keep' access to aspects of gender reassignment treatment;
- as the NHS reorganises into Strategic Health Authorities (SHAs) and new regional structures it will be important to ensure that: there is an even distribution of access to care across all regions; that there is a robust programme to supply the clinicians required to provide that; and that there are appropriate means for ensuring a high standard of patient care.

All of these are changes which would bring transsexualism into the mainstream of medicine with the benefits of:

- an increased role for liaison psychiatry;
- potential access to funding for research in this area, especially into the long-term effects of pharmaceuticals;

- better risk management from litigation against individuals and against government under the HRA;
- patient participation in best treatment choice for their individual need
- community participation in promoting group best-health practices

and accordingly, I recommend them to you.

Thank you. If there are any questions or comments, could they please be addressed to the entire gathering, rather than just myself, since there may be people present who are better equipped to answer than am I.

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Birth Certificate Campaign
FTM Network
Gender Identity Research & Education Society - GIRES
Gender Trust
Gendys Network
Mermaids
Parliamentary Forum on Transsexualism
Press For Change
Trans People in Northern Ireland
Trans People in Scotland

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- ³ Historically, the process of social exclusion for any group is, first of all, a moral condemnation on religious grounds; secondly, criminalisation by the law; and thirdly, their pathologisation by medicine. For a longer discussion of this process, see Playdon, Z. J. (2002) *Mad, Bad and Dangerous to Know: ending discrimination against lesbians, gay men and trans people in the new NHS*. London: Gay and Lesbian Association of Doctors and Dentists. www.gladd.dircon.co.uk/news.htm#StGeo
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- ⁹ *Rees v UK*, 1986.
- ¹⁰ *Cossey v UK*, 1990.
- ¹¹ *Regina v Registrar General for England and Wales ex parte P & G*, 1996.
- ¹² *Sheffield & Horsham v UK*, 1998.
- ¹³ www.pfc.org.uk
- ¹⁴ *P v S & Cornwall County Council*, 1996; *R v Chessington World of Adventure*, 1997.
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- ¹⁹ See, for example, Bunch, C. (1972) 'Lesbians in Revolt', *The Furies: Lesbian/Feminist Monthly*, vol 1 (January 1972), pp. 8-9; Radicalesbians (c.1970) *The Woman Identified Woman*. Pittsburgh: Know.
- ²⁰ Verkaik, R. (2002) 'Transsexuals set to win the legal right to marry', *Independent*, 22 January 2002.
- ²¹ Kruijver F.P.M., Zhou J-N, Pool C.W., Hofman M.A., Gooren L. J.G., & Swaab, D.F. (2000) 'Male to female transsexuals have female neuron numbers in a limbic nucleus', *The Journal of Endocrinology & Metabolism*, 2034.
- ²² For a discussion of the unfounded nature of the relationship between homosexuality and paedophilia, see David, H. (1997) *On Queer Street: a social history of British homosexuality 1895-1995*. London: Harper Collins. David points out that the so-called 'boys' and 'ladloves' of Wilde and Housman respectively were all in their late teens or early adulthood.