AMRCW

Academy of Medical Royal Colleges Wales

Responding to individuals with Gender Identity issues

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A Positional Statement from the Academy of Medical Royal Colleges Wales

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General Statement

There is a growing awareness amongst health professionals of the difficulties faced by individuals who are uncomfortable or distressed by the gender assumptions and expectations of family and society based on the sex assignment at birth. The level of distress varies from individual to individual and the desire or need to adapt their gender expression perhaps with medical assistance, also varies. Many in this situation do, at some point, seek help from a medical professional. It is important that we, as doctors, are receptive to their issues and that we respond appropriately. Patients will need to be assured that doctors will seek to understand their needs without judgement, maintain confidence and guide them towards appropriate services. A relationship of mutual trust is fundamental. Currently good anecdotal evidence suggests that is not always the case, arising from a mixture of ignorance, misunderstanding or, occasionally, prejudice and sometimes from a lack of a service to specifically help. As with all interactions between doctors and members of the public the principles of GMC's Good Medical Practice must apply.

Doctors are professionally obliged to respond helpfully to those with a real or perceived health or wellbeing need. As always doctors should act within their limits of competence but are also expected to have the competences normally demonstrated by colleagues in their specialty and demanded by their royal College or Faculty standards.

It has been suggested by the Gender Identity Research and Education Society (GIRES) that about 1% of the population may experience gender incongruence (c30,000 individuals in Wales) to an extreme degree: these are 'trans' people who identify socially as men, despite female sex assignment; or as women, despite male sex assignment, at birth. They are likely to need medical assistance to align their sex characteristics with their gender identity. A larger population, possibly 3%-4% of the population, are those who are non-binary, that is, their identities lie somewhere between man or woman; occasionally an individual who has no sense of gender at all, may be described as non-gender. All of these groups may seek medical assistance.

This document is a statement of the position of the Academy (MRCW) with respect to the doctor's role in helping individuals with atypical gender identity development and is a consensus of opinion from member colleges in Wales. It is not a guidance document and draws on statements from other professional organisations which it is recommended members refer to for more detail. This document applies to the management of adults with gender identity issues. Most of the principles will apply for managing children and young adolescents with gender identity issues. However treatment of such individuals should be directed and provided by specialists and expertise in such problems. These services are not currently provided by Welsh services but there is an outreach clinic in Llandough.

Good Medical Practice

The General Medical Council's "Good Medical Practice" principles direct standards of care to promote fair, safe and effective care for all who need it. Medical practitioners are reminded of the following statements

46. You must be polite and considerate

47. You must treat patients as individuals and respect their dignity and privacy

48. You must treat patients fairly and with respect whatever their life choices and beliefs

50. You must treat patient information as confidential

54. You must not express your personal beliefs to patients in ways which exploit their vulnerability or may cause distress

59. You must not allow your views about a patient to adversely affect your professional relationships or the treatment you provide or arrange.

Some definitions

1. Sex refers to biological development (male/ female / intersex) (equivalent to phenotype). It is usually determined by the genital appearance at birth.
2. Gender identity is a person's internal psychological identification as a man or woman, both or neither, that is, non-binary and non-gender. Gender fluid people have fluctuating identities.
3. Gender expression is the outward manifestation of a person's gender identity.
4. Sexual orientation refers to the sex and gender to whom a person feels sexually attracted: sometimes androphylic (attracted to male/men), gynaephylic (attracted to female/women), or people may be bisexual(attracted to both men and women), or asexual (no sexual attraction).
5. Transgender or trans people are those whose gender identity is not congruent with the sex assigned to them, usually at birth, on the basis of genital appearance.
6. Transsexual is a term that is scarcely used now, but still appears in legislation and some medical literature. It refers to people who identity is the opposite of that which is typically associated with their sex assignment.
7. Gender Incongruence refers to the mismatch between genital appearance and gender identity; Gender Dysphoria is the discomfort that may arise in the presence of such incongruence: primary and secondary sex characteristics, as well as inappropriate social interactions cause this distress.
8. Transition describes the point at which a trans person will publicly adopt the gender expression that reflects their gender identity. Social transition may be supported by medical interventions undertaken over time. Social changes include name, pronoun, title, gender expression (clothing, hairstyle etc) Physical changes may involve use of hormones and/or surgery.

General principles for clinicians and support staff

See e-learning on Royal College GPs' website

Principles applied to the treatment of trans people must take account of the current understanding of these conditions.

The WHO is in the process of moving 'transsexualism' – renamed 'gender incongruence' out of its present position under Mental and Behavioural Disorders and into a non-psychopathologising section. The advice to the WHO Executive Committee was to "abandon the psychopathological model, in favour of a model that reflects current scientific evidence and best practice". A short review of the "Biological Correlations in the development of Gender Dysphoria" is published in the Lancet (2016 June) (Reed T., and Diamond M.) The NHS specifically says that gender dysphoria is not a mental illness.

1. Listen and understand the issues from the point of view of the individual consulting. A negative reaction may cause harm. Engage in an open non-judgemental way.

2. Patients should be recognised as the gender with which they identify and have the same rights, including to physical and mental health services as any other patient. Support staff must be aware of this and apply these general principles as appropriate to their role.

3. Check and use the individual's current name and ensure you use the right pronoun. This might be 'they' for a non-binary person.

4. Assure and maintain confidentiality. It is unlawful to disclose a patient's gender history without consent. This includes not making reference to a patient's gender past to anyone (including clinical colleagues outside your team) without specific consent in any form of communication unless directly relevant to the condition being reviewed.

5. Establish what the individual is expecting from their consultation with you.

6. Be aware that co-existing health issues may not be directly linked to the gender issues and respond accordingly.

7. Provide care that is within your competency.

8. If relevant for your role, refer to the appropriate gender identity (or other) service.

9. Support the management plan set out by the gender service. This may involve shared care.

10. Whilst many trans people have mental health problems, arising, for example, from social, family, or employment difficulties, and/or delays in treatment, gender incongruence and the dysphoria it causes is a somatic condition, not a mental illness. (See The Lancet, June 2016)

11. If the individual has transitioned, be aware of what organs may be present and the implications for screening or risk (eg prostate, breast, cervix, uterus, osteoporosis). Disease prevention and screening should be organ specific rather than gender specific.

Initial response to requests for hormone treatment

Many trans people will self medicate with hormones or anti-androgens so it is important to ask directly about this. There are risks of non standardised dose and potency or indeed quality assurance with drugs obtained privately. Patients may request blood tests to check levels. Some trans people will take high doses in the mistaken belief it will speed up transition. If patients suddenly withdraw from hormones they are at high risk of depression. If those assigned male seek to transition to live as women start at a low dose of oestrogen and gradually increase they are “mimicking puberty” and will have an easier transition. If those assigned female transitioning to live as men take very high doses of testosterone they may become aggressive. On the other hand, those who have become distressed by delays in providing appropriate testosterone treatment, may become much calmer upon receiving it.

When faced with a request to prescribe hormones by a “new” patient, the doctor should assess the motivation, current treatment and balance the risks of prescribing hormone treatment before or whilst waiting for full assessment against the risks of non treatment (including continued self purchase or possible withdrawal and exacerbation of mental health problems). The doctor must also consider their responsibilities to act within their competency making use of appropriate guidelines and the medico – legal implications that may arise if an adverse event occurs either through treatment or non treatment. Many transgender patients improve mentally with safe access to appropriate hormone treatment.

The GMC advises that GPs should only consider a “bridging” prescription for an individual patient if all the following criteria are met:

1. The patient is already self prescribing with hormones obtained from an unregulated source

2. The bridging prescription is intended to mitigate a risk of self harm or suicide

3. The doctor has, if possible, sought the advice of a gender specialist and prescribes the lowest acceptable dose in the circumstances.

Responding to the needs of individuals with gender incongruence

All clinicians should apply the general principles mentioned above. It is important to establish the understanding and needs of the individual and if they are in any immediate danger. A referral is usually required. At present in Wales initial referral is to the mental health services to exclude significant mental health disorder and confirm there is a gender identity issue. There are plans to change this practice to bring it in line with the rest of the UK, at which point GPs should refer directly to a GP with an extended role or specialist service for a holistic assessment. At the same time, they should consider the need for hormone monitoring in the presence of self-medicating, and consider replacing medication with safer products and dosages where necessary to reduce risk of harm. Many will not wish or require surgery but may require medical treatments or other support.

The Academy recommends all patients with gender incongruence should have access to a care pathway which should include the actions taken in primary, secondary and tertiary care. Such a pathway must provide an holistic approach addressing psychological, mental health and physical needs. Social support may also be needed.

All GPs should offer basic care and referral to a dedicated gender identity service. Basic care will include initial holistic assessment, signposting to support services in the community, dealing with coexisting health and wellbeing issues taking account of the patient's preferences. It may or may not include immediate prescription of hormone treatments depending on the expertise of the GP and the patient's needs. In the presence of self-medicating patients, the risk of not regulating the medication must be taken into account. Failure to support harm reduction strategies can lead to mental health deterioration. Suicide rates are significantly higher in this population.

Moving forward, first level gender identity service should be available promptly and may be provided by a GP with an extended role or a mental health practitioner, a paediatrician or an endocrinologist with a special interest and training. These may be part of a multidisciplinary team. Such individuals will need to have undertaken appropriate CPD to gain expertise in gender identity issues. The first level should confirm that the individual has gender identity issues or "gender incongruence" and establish the agreed way forward with the individual.

On - going medication and monitoring can be provided through primary care under a shared care agreement.

Stable long term support of adults may be delivered solely through primary care with appropriate safeguard to return to the specialist service if problems arise.

The GMC advice states that “you must co-operate with Gender Identity clinics and gender specialists in the same way that you would co-operate with other specialists, collaborating with them to provide effective and timely treatment for trans and non binary people”. This includes prescribing medicines recommended by a gender specialist, following recommendations for safety and treatment monitoring.

The first level special service should be available in all locality areas. If staffed by GPs, they should have access to specialist advice. Individuals requiring more complex treatment including surgery may need to be managed by a tertiary centre. Although we accept that there will not be sufficient numbers in Wales to maintain expertise within country and therefore surgery will need to be undertaken by super specialists outside Wales, ongoing care should be available within Wales (or NW England for the North Wales population).

This statement is produced following discussions at the AMRCW council and has made reference to the following publications/reports. Individual clinicians are advised to make reference to these for further information and guidance:

GMC: Trans healthcare: Respect, confidentiality and the law. 2016

GMC: Trans healthcare: Prescribing. 2016

GMC: Good Medical Practice. 2013

RCGP Northern Ireland: Guidelines for the care of Trans patients in Primary Care. 2015

RCPsychiatry: UK good Practice Guidelines for the Assessment and Treatment of adults with Gender Dysphoria. 2013

Welsh Government: Action plan to advance equality for transgender people. 2016

BMA: Gender incongruence in primary care. 2016.

BMJ 2017;357;j2886 Gender dysphoria: assessment and management for non-specialists. Barrett J and BMJ 2017;357;j2963 I am your trans patient.

Gender definitions have been updated by the Gender Identity Research and Education Society (GIRES) (November 2017)

Be aware of a useful CPD resource for GPs by the RCGP in association with Gender Identity Research and Education Society

The Academy of Medical Royal Colleges Wales brings together the voices of its member colleges and Faculties for overarching generic issues around healthcare.

The Academy comprises of representatives of the Medical Royal Colleges and Faculties who meet regularly to agree direction; providing a collective, independent medical voice to promote College and Faculty standards through influence, collaboration and advice in Wales.

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