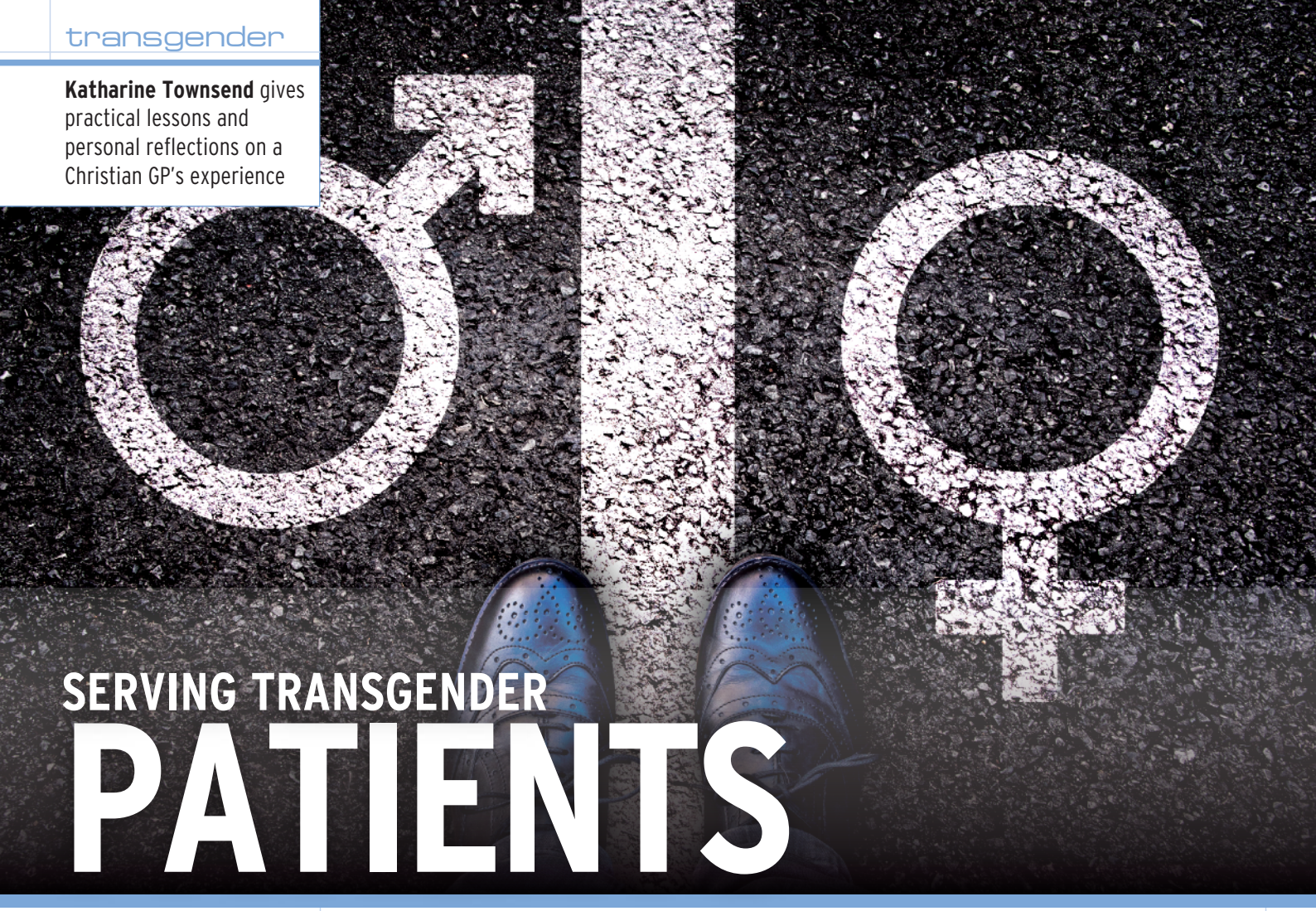
Katharine Townsend gives practical lessons and personal reflections on a Christian GP's experience



SERVING TRANSGENDER PATIENTS

key points

- The number of patients presenting as transgender has increased significantly in the last four years.
- Transgender covers a spectrum of gender identity issues, from non-clinical, alternative gender identities to those with severe distress and mental health issues.
- Care for transgender patients presents many challenges for GPs in particular but they do require compassion, non-judgmentalism and patience.

Background

I have worked as a salaried GP in a university town centre practice for 23 years. Until 2014, we could count on one hand the number of transgender patients on our list. Tragically, two of these (post-transition) have committed suicide. Since autumn 2014 we have experienced a sharp increase in the numbers of students asking for referral to a Gender Identity Clinic (GIC). Given our experience, it was essential we equipped ourselves to care for this growing group. This article summarises some of my lessons learned. I express views that may not be shared necessarily by my colleagues.

Time, time, time

It was truly heart-rending to hear the story of an individual who had, since they were six or seven, spent hours each day longing to be in the body of the opposite sex. They had hoped the feelings would settle with time, but realised with despair during puberty and after the teen years that this would not be the case.

However, for another group, who could be called 'gender variant', there was a less clear picture of long-term anguish. But they experienced a welter of complex issues and for a mixture of reasons had come to perceive medically supported adjustments in their gender appearance as a pathway to greater personal contentment and for some (though not all) to relieve distress.

Transgender is a catch-all term covering a diverse group of people who experience and/or live out their gender identities differently from people who feel comfortable with their biological sex. In contrast, Gender Dysphoria (GD) is characterised by experiencing distress with one's birth sex.

The GMC[1] strongly encourages swift referral to a GIC after presentation to GPs with GD, due to high rates of self-harm and suicidal behaviour. However, waiting times for GICs are upwards of two years. I now spend time getting to know my patient before referral (following suicide risk assessment). In practice several double appointments over several months at the end of a clinic (reducing time pressure) are necessary to get a thorough picture of their life, their emotional journey, when questions of gender occurred and how these have been expressed. Many have multiple comorbidities such as depression, autistic spectrum and personality disorders, and emotional turbulence from troubled family backgrounds.

Time with them helps me understand their complex issues and explore, and occasionally to challenge their thinking with respect to the wisdom of transitioning and the massive consequences that follow. Transitioning is a gradual process, not a single event. It may be simply name and attire that change, perhaps hormone treatment, perhaps 'top' surgery and/or 'bottom' surgery. A patient may choose some or all the possible options available. I explore the evidence base for medical treatment and impact on fertility.

On a foundation of a strong doctor/patient relationship a candid conversation is possible. Time at the outset enables a trusting relationship which will be a support along the difficult, and for many, lonely road ahead, as they face a host of complex decisions for years to come.

Vocabulary

Feelings of rejection, often justified, are commonplace among transgender patients. Using their preferred pronoun, I have found is an essential starting point: deliberately 'mis-gendering' is felt to be a form of rejection, insulting at worst and usually results in the patient seeing another GP.

Always remember the birth sex

There is a subtle, but elusive, difference in the way I interact with male and female patients. So, it took me a while to work out how to connect with my transgender patients. Internally, that is, in my core thinking and therefore subtly in my behaviour, I relate towards them as in their birth sex.

This is not articulated but I have consistently found this to be the most effective way of connecting, but they would never know my thoughts. I also recognise this may not work for everyone.

While obtaining a Gender Recognition Certificate for legal purposes takes a minimum of two years, changing gender on medical records[2] merely needs a letter of request signed and dated by the patient and takes weeks. Transgender patients requesting such a change come off all screening programmes associated with their birth sex and must take personal responsibility for having checks at appropriate times. Discussing gynaecological matters and breast issues is distressing for my trans-male patients.[3] Higher incidences of ovarian and cervical cancer occur in such patients due to their reluctance to be screened and fear of the physical examination, yet strong doctor/patient relationships can ease this.

It took me a while to grasp that a patient's gender identity has no bearing, whatsoever, on their sexual orientation or sexual practices. Many of our transgender patients have not had surgery and have heterosexual intercourse. Remember the birth sex and think; contraception, management of medical problems especially abdominal pain (could it be testicular torsion or an ectopic pregnancy?) and of disease prevalence.

Medicolegal issues

Adult GICs only accept a referral if the referrer agrees, at the outset, to prescribe any hormones the GIC may advise in the future after seeing the patient. However, with the exception of Sustanon, all hormones prescribed for gender dysphoria are unlicensed.

When I spoke to the MDU, they expressed surprise at the wording of the referral forms but added that GP prescribing, in this area, should follow written specialist advice. Since this advice would be deemed, 'best practice according to the knowledge and standards of the day,' GP prescribing, adhering to this, would be acceptable from a medicolegal perspective.

GICs give helpful and detailed guidance for monitoring those receiving hormones for adverse side effects, though quickly hand responsibility back to GPs for the initiation, administration of hormones and lifelong care.

The GMC[4] urges GPs to prescribe the GIC advised hormones but unlike other pharmaceutical products, there are few longitudinal studies demonstrating the effectiveness of treatment. Indeed, there is no agreed measure among GICs as to what constitutes successful medical treatment.[5]

My perception has been that some patients embarking on medical treatment reach a status quo and remain quietly contented. Others are delighted, at the outset, with the physical changes, but after six months to a year their mood deteriorates back to pre-treatment status occasionally becoming worse. These patients need much support in navigating the difficult road ahead.

Children

What of the capacity of children in early puberty to make life impacting decisions with respect to puberty blockers? I have many reservations concerning the impact on psychosocial development and fertility, but little experience at present. This is a relatively new treatment and in need of systematic research.[6]

Theological

I have tried to think about these issues from a theological perspective. Jesus teaches in Matthew 19 that we are created male and female: The Creator's basic pattern for humans is fundamental. However, Jesus goes on to talk about eunuchs (some born that way, some made that way by men) expressing a recognition that in a fallen world, people may not fit straightforwardly into the binary pattern of gender. The wonderful account of Philip and the Ethiopian eunuch[7] (the first Gentile convert after the resurrection) reminds us of Jesus's reaching out to all people whether or not their physical characteristics, or the cultural space inhabited by them, matches typical male or female patterns.

Jesus treats with absolute respect and kindness those rejected by society, people with leprosy, tax collectors, a woman with menorrhagia, a woman of ill repute, to name a few.[8] Many transgender patients feel rejected; I do not want to add to this.

Jesus urged his disciples, 'Do to others as you would have them do to you';[9] all medics embrace the principle 'Do no harm'. I am concerned that there has been a wholesale acceptance of medical treatments and protocols by the medical profession without adequate evidence to support such changes.

We have a duty of care to transgender patients to ensure that there are dispassionate long-term studies exploring the physical and psychological pros and cons of medical treatment. We must care for the needs of our transgender patients to the very best of our abilities. How that is done should vary from person to person but also as the medical evidence emerges.

***Katharine Townsend** is a GP in East Anglia*

Jesus treats with absolute respect and kindness those rejected by society... Many transgender patients feel rejected; I do not want to add to this

further reading

- CMF File 59 (2016) Gender Dysphoria *bit.ly/2OWFBgP*
- *God and the Transgender Debate* by Andrew Walker. The Good Book Company 2017

references

1. Trans-healthcare *General Medical Council bit.ly/2CbfvQq*
2. Gender construction kit: updating patients details *bit.ly/2A6cory*
3. Ovarian cancer in transgender men. *National LBGT Cancer Network bit.ly/2QM7lll*
4. Trans-healthcare (prescribing) *General Medical Council bit.ly/2EhNvgz*
5. See: Operational research report following visits and analysis of Gender Identity Clinics in England. *NHS England* November 2015 (p38) *bit.ly/2PrrgpH*
6. Kreukels BP, Cohen-Kettenis PT. Puberty suppression in gender identity disorder: the Amsterdam experience. *Nature Reviews Endocrinology* 2011; May 17;7(8):466-72 *bit.ly/2IT10ls*
7. Acts 8:27
8. Mark 5:25; Luke 5:13,27; Luke 7:37-38;
9. Luke 6:31