do no harm

Laurence Crutchlow explores a complex dilemma

Primum non nocere. If like me you had no opportunity to learn Latin at school, you probably still recognise this phrase. Translated 'first do no harm', it is usually attributed to Hippocrates, though the famous oath contains only an approximation to these words. It has been a consistent principle in medical ethics, today usually expressed as 'non-maleficence'. It often comes to mind when thinking about euthanasia or abortion, or decisions over risky treatments. So what relevance has it to sexual ethics?

is sexuality relevant to medicine?

Sexuality often affects day-to-day medical work. This article focuses on one issue – prescribing hormones to patients with gender dysphoria. Though seemingly niche, it is likely to arise more frequently (we've already had queries from CMF members about it). Just as CMF is keen to encourage students to think practically about abortion or truth-telling, this is an area also worth consideration.

Problems with gender identity are not new, but normally have only involved the psychiatrist or specialist gender clinic. Discussing such difficulties has become more acceptable, meaning that virtually no doctor will avoid these questions. The 2010 Equality Act[1] names 'gender reassignment' as a protected characteristic, which may affect conscientious objection to gender reassignment treatments if such treatments are perceived as 'indirect discrimination' against transgender patients.[2] But might treatments harm our patients? Or could our attitudes be harmful if not carefully thought through?

case scenario

You are an FY2 in general practice. Your next patient, registered as John, appears in the notes to be a fit 28-year-old man.[3] When he arrives, you are slightly thrown by his female appearance. All soon becomes clearer as the patient explains that he has been buying oral oestrogen online for the last nine

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months, and has identified as female for some years. He is now having trouble obtaining supplies and would like a prescription on the NHS, which he believes he is legally entitled to after a discussion with friends online.

how do you respond?

Step back from the situation and think about your own feelings and reaction. You will be inexperienced as a GP FY2, and probably haven't come across anything like this before. You may be worried that you've shown embarrassment or surprise when the patient didn't look quite as you expected on entering your room and, quite aside from any ethical concerns, you are likely to be clinically uncertain of the position.

'Ask your trainer/supervisor' will form an important part of your answer, but your own learning will be much better served if you think through a plan to discuss, rather than simply ask what to do.

what about the patient?

Let's start with the patient. Before thinking about a diagnosis, consider John's feelings. It must have been very difficult to come to the doctor with this question, which is perhaps why he has done research online before consulting. It must be even trickier if he realises he is seeing someone quite junior. Whatever you actually do, you must take this into account, and ensure he feels listened to.

is there a diagnosis?

What is his diagnosis? This is controversial. ICD10 (the diagnostic manual usually used in the UK and Europe in psychiatry) still describes 'Gender Identity Disorders'.[4] The definition under code F64 is:

'A disorder characterised by a strong and persistent cross-gender identification (such as stating a desire to be the other sex or frequently passing as the other sex) coupled with persistent discomfort with his or her sex (manifested in adults, for example, as a preoccupation with altering primary and secondary sex characteristics through hormonal manipulation or surgery).'

However the phrase 'Gender Identity Disorder' has become controversial, as it implies that the cross-gender identification is abnormal or even pathological in and of itself. DSM-V (the psychiatric diagnostic manual most widely used in the USA) published in 2013, took a different approach, using the phrase 'Gender Dysphoria'. *Frontiers in* **Psychology** has a freely available review that describes the discussion leading to this.[5]

The DSM-V criteria are for adolescents and adults listed in the box above [the italics are mine].

The significant difference is clear. In the ICD10 definition, the fact of identifying as a different gender, and being uncomfortable with 'assigned' gender, is pathological in itself. In DSM, there must *also* be significant distress or problems functioning for this to be considered a disorder.

CRITERIA FOR ADOLESCENTS & ADULTS[6]

In adolescents and adults gender dysphoria diagnosis involves a difference between one's experienced/expressed gender and assigned gender, *and significant distress or problems functioning*. It lasts at least six months and is shown by at least two of the following:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics
2. A strong desire to be rid of one's primary and/or secondary sex characteristics
3. A strong desire for the primary and/or secondary sex characteristics of the other gender
4. A strong desire to be of the other gender
5. A strong desire to be treated as the other gender
6. A strong conviction that one has the typical feelings and reactions of the other gender

Even though the ICD10 is still the 'gold standard' in the UK, anecdotally 'gender dysphoria' has become the most commonly used term.

After you've asked more questions, it seems likely that John fits this definition. He has wanted to be a female for many years, and this is the second time that he has started taking oestrogen.

referral and treatment

If you think John is suffering from gender dysphoria, who should treat him? It is probably well beyond your experience and may be new to your trainer as well. So ideally you would ask a specialist clinic to see him. A number do exist in the UK, but are not easy to access. Waiting lists have increased markedly. A Freedom of Information request by a prominent newspaper[7] led to a report detailing exponential increases in referrals in the past few years, with an average adult waiting time of around nine months. You make a referral, but what will you do about his hormones until he is seen at the clinic sometime next year?

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Prescribing sex hormones *per se* isn't actually unusual in general practice. Oestrogen is widely used as part of contraceptive pills and in hormone replacement therapy. But prescribing oestrogen for gender reassignment isn't licensed (meaning that the prescriber takes full responsibility for any adverse effects), and has historically been the preserve of specialists – all very well when a patient can easily see one.

Long waits were one factor leading to controversial GMC guidance[8] suggesting that it is usually appropriate for GPs to prescribe while patients wait to see gender specialists. Given that GPs are very unlikely to have had much specific training in this area, there must be a risk of harm in such cases. The GMC suggests a one-hour online module to help GPs in this situation, but surely this is not adequate preparation for taking on a new and complex area of practice, and is unlikely to serve these patients well. Most prescribing guidance rightly emphasises that prescribers should only prescribe (and so take responsibility for) medicines which they are fully competent in using.

are hormone prescriptions harmful?

A 2015 summary[9] suggests that prescribing oestrogen in this situation increases thromboembolic risk. However these risks are also present with the combined contraceptive pill and hormone replacement therapy which are widely used, so will not normally stop doctors prescribing. There was no clear evidence of other risks, though the paper points out that there is very limited research to draw on currently.

Although we may logically see other possible harm from such prescribing (subsequent infertility, for example), we may not be able to support these with robust evidence. It is unlikely that we will be able to credibly use safety alone as a reason not to prescribe.

On the contrary side, a recent review suggests that there is some mental health benefit in such treatment, although acknowledges that the evidence is not unequivocal.[10]

Many Christians in the position of our hypothetical FY2 still feel very uneasy about issuing such a prescription. The remainder of this article will consider why that is the case, and whether we have any better alternative available.

the Bible says...

This may not be such a straightforward area as abortion or euthanasia, where we are dealing with the taking of innocent human life. There is no single 'proof text' to which we can easily go to say that prescribing hormones is wrong in these cases.

But a look at the wider story of scripture and the place of gender within it may leave us with a distinct unease about such a prescription. God created humans male and female, and intended them to form families.[11] We may not be surprised that in a fallen world this pattern is distorted. Rarely this is through 'intersex' conditions such

as androgen insensitivity syndrome that lead to physical changes and initial confusion over biological gender. More often it is through a struggle with biological sex not matching perceived gender identity, and experiencing dysphoria.

Yet there is more to God's decision to create two sexes than this. Revelation 19:7 uses the image of a wedding to describe the union that is to come between Jesus and the church. When a man and woman join in marriage, they reflect that union.[12] A far fuller exposition of these things is found in Vaughan Roberts' *Transgender* (review on page 38).

At minimum, scripture gives us a sense that our gender is from God, and is important; being part of what illustrates the climax of salvation history to us here on earth. We will naturally be uneasy at interfering with what he has designed, though there may not be the same firmness as over the making and taking of life.

is there a better way?

Providing oestrogen to John would deal with the immediate need that he perceives. Indeed it is probably safer that he uses a drug which is formulated properly, and known to be genuine. The current regulatory environment will make life very difficult for a doctor who does not prescribe, even though many without strong moral views on the subject might agree that it is no area for the generalist.

Those who cannot in all conscience issue a prescription may want to come to an arrangement with a colleague who could see these patients – which will be all the easier to do if we have already built good working relationships, though is not without its risks. Although it may feel good for us to 'keep our hands clean', the reality is that patients like John will obtain their hormones somewhere, even if not from us.

Whether we do or do not issue a prescription to this one patient will not in itself change society and its perceptions over gender issues, unless a large number of doctors do the same thing.

How might society change? The church has not always intervened well in these areas. Conversations with friends who hold different views on sexuality are difficult as any mention of Christianity usually founders on past negative impressions.

Whatever we do about prescribing, we must be compassionate and caring in our response. But we need to look more widely than our individual consultation. Culture tells us that sexuality is important, which Christians can affirm. Yet whilst our culture sees sexuality as a defining characteristic of our identity and something that's up for grabs, Christians find their identity in Christ. Our culture agrees with us that sexuality is very important, but differs first by seeing it as something only important for the individual, and second by making it the most important thing of all. More broadly, we need to tell the story of sex and gender in the much better way that points to God's salvation plan.

Although we have only looked at one specific example here, I hope that we've seen how the interface between medicine and sexuality can be complex, harder than a simple 'yes' or 'no' answer, however pleasing. We need to think through not only what we will and will not do, but on how we will practice in a way that tells something of the better story we have to tell. ■

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