Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

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Mr Niall Dickson
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Dear Mr Dixon,

You are likely not the correct person to address this letter to; I would appreciate it if you could forward it within GMC to the person best placed to help.

I am writing on the basis of a feature by Dr James Barrett that recently appeared in the BMJ on services for Gender Identity Disorders (attached); this article with its associated correspondence refers to GMC Guidance on the management of this condition. Until then I had not been aware of this GMC Guidance even though I have been working with people with gender identity issues for 26 years and have been a local point of contact for patients with issues in North Wales during this time.

I am also an active historian in the field of medicine and am currently writing on aspects on the recent history of medicine in which gender identity issues feature.

I also lecture on gender identity issues to colleagues across a range of disciplines in North Wales and would envisage doing so in the future and want to ensure that my presentations are in line with GMC guidance and also to be able to caution colleagues about reactions they may have that might be viewed as problematic.

I am therefore interested in the GMC guidance both in terms of the care of patients I see, the education of colleagues and also from the point of view of ensuring I get the history of this condition right.

I have copied Simon Wessely, the President of the Royal College of Psychiatrists, into this letter, given that a Royal College of Psychiatrists' paper appears to form the basis of the GMC guidance. The College document is due for review in 2018. Given how febrile this issue has become, it would be no surprise if this review were brought forward. There are also aspects of this issue, detailed below, on which Dr Wessely is an expert.

I have a number of questions, but will try to indicate where these questions come from.

Provenance of the Guideline

For historical reasons, I am interested to find out exactly where the GMC Guidance came from. It appears that the RCP document was the primary source but were there others? I

would appreciate knowing whether there was a working party within GMC, a list of the materials consulted, and any details you can offer on the parties involved. My concern is to establish the provenance of the Guidance.

The Guidance states that it is generally accepted that the correct treatment approach for gender identity issues is a referral to a gender specialist service rather than through a mental health team, as still happens here in Wales. The GMC Guidance gives extensive references on how to access gender identity services

There is no reference in the Guidance to the extensive body of evidence for other approaches. Where the RCP document makes clear that the view being offered was not a uniformly accepted view within the working party, and there is scant evidence for some of the points being made, the GMC Guidance offers no such nuance. Dr Barrett's BMJ feature also lacks nuance but he is a clinician who runs a gender identity service.

Until recently, I saw patients from across North Wales because many of my colleagues were unwilling to see these patients. My estimate, based on surveys at case conferences or in lectures, is that 75% of my colleagues believe that going down the route of treatments generally supported by gender identity clinics is not appropriate. They will refuse to see patients entirely in order to forestall such options. As a result I see patients out of area because of my interest in them as people and willingness to engage without closing off the possibility of a referral down an endocrine or surgical pathway.

But my ability to engage with patients more broadly has been increasingly compromised by pressure to refer down a specific route. I did not expect GMC to increase this pressure and am intrigued to know how this came about.

I have to accept that my general psychiatry colleagues are as a body the experts on identity disorders of which gender identity disorder is a subset. Their response has been to ask questions such as how gender identity disorder differs from apotemnophilia for instance. Or from ethnic dysphoria disorder, as in the recent case of Rachel Dolezal in the US, who claimed to be black but to whom the black community have responded by denying there is a physiological or other basis to such claims.

Superficially gender dysphoria and ethnic dysphoria appear similar. I would appreciate any evidence you have to the contrary or comments or insights on how to handle these issues when they come up.

Safety of Treatment

In its guidance on prescribing, GMC introduces a very helpful paragraph on the meaning of unlicensed medications. I agree fully. This will be tremendously useful in other contexts.

The same point is made in Dr Barrett's BMJ feature which states there is no evidence of any harm from endocrine treatments being given to patients with gender dysphoria.

I appreciate the GMC haven't quite made this latter point and have noted safety issues but while these treatments remain unlicensed, there can by definition be no controlled trial evidence for harms because clinical trials and epidemiological studies have not been and will not be undertaken for this indication.

Stating assertively that there is no evidence of harms as the BMJ article states runs smack up against the perception that most doctors, and many in professions allied to medicine, will correctly have that of course there will be harms from giving sustained courses of high dose hormone treatments for an indication like this. Given to normal healthy women in relatively

low doses and not sustained over the periods of time that would be necessary in this case is generally accepted as producing significant harms.

Dr Barrett's article states that some doctors appear to have ethical or religious objections to prescribing hormones off-label for this indication. I can see the temptation to make a statement like this in the case of someone marketing a service, but it is difficult to support the idea that doctors if they did go ahead to prescribe should not be free to say to patients that there is a high likelihood of significant harms. And I would imagine a majority of the profession would not regard it as unreasonable if a doctor were to refuse to support such prescribing initiated by another.

The GMC guidance offers little support to doctors in this area. It states doctors should continue prescriptions initiated by a gender specialist even when the patient has been discharged from the care of gender identity clinic. It would be ironic if the doctor's defence was to fall back on GMC guidance in the event of a negligence case. Are GMC insured in the event of an action against them by the doctor? There is a legal precedent for a body like GMC to be sued successfully by doctors found guilty of negligence in a situation like this.

Whatever about the role of oestrogen and testosterone in adults, there is another prescribing issue that the GMC Guidance doesn't mention but is likely to be taken to endorse, as currently framed. This is the use of leuprolide (Lupron) and other GnRH analogues in children to prevent puberty. I want if possible to retain a middle ground on these gender identity issues but it is difficult to do so on this specific issue. I personally would take my chances with a month's course of Nitrogen Mustard over a month on Lupron.

With off-label use of oestrogen and testosterone there is decades of experience. In the case of Lupron not only is there no data on this particular indication, but it is made by a company that has spearheaded the drive to block access to clinical trial data for all drugs for all indications. If we add to this the fact that it is difficult to think of a less pharmacologically savvy group of clinicians than those involved in Gender Identity services, it might be possible to explain how the idea of using Lupron in children arose.

There is a further group who concern me in this mix – people who designate themselves as asexual. There is a growing community of such people. Some get sucked into the gender identity whirlpool.

I may know more about asexuality than anyone in GMC or RCP. There is a growing body of evidence that links asexuality in animals and humans to maternal and early developmental intake of SSRI antidepressants. This factor is not the cause of all asexuality but it is likely to be a significant factor. It is difficult to know how someone might react in due course who, after being persuaded the reason they show no interest in sex is because they are in the wrong gender, stumbles on the link to antidepressant intake.

Transition Pressure

A further feature of this field at the moment is the tremendous pressure that patients are under 'to transition'. Once a person begins to think of themselves in these terms pretty well all the material they can access online or elsewhere including that produced by the NHS heavily promotes one view of the condition and one treatment pathway. Many are made uncomfortable by this.

The GMC guidance says that 'every patient's treatment journey will be different, that gender identity clinics aim to provide care packages tailored to individual need by focussing on your patient's priorities and concerns and exploring with them the options available, you can

collaborate with gender identity clinics to provide effective care and a positive experience for your patient'.

If gender identity clinics don't have the time to prescribe, as the BMJ feature states, they aren't going to spend months or years engaging patients. There is no evidence from the Barrett article that gender identity clinics offer any exploration of the condition or suggest that this is an identity disorder and that patients should be engaged in those terms and potentially for a considerable period of time before endocrine options or surgery are adopted.

A general practitioner or a psychiatrist in the meantime attempting to engage in the way that was standard until very recently will find themselves up against a hostile gender identity service that feeds through to increasing hostility from patients who perceive any such efforts as an effort to frustrate them and as disrespectful rather than caring.

No Platforming

One of the striking features of the Gender Identity story since the publication of the RCP paper is the link to No Platforming. When feminist icons like Germaine Greer, and Gay activists like Peter Tatchell are hounded in public with efforts to block presentations in university settings after they express sceptical views, there have to be concerns about freedom of speech.

I come at this issue as someone with a link to Ryerson University's Centre for Free Expression.

Ryerson University is based in Toronto, where Toronto University's Centre for Addiction and Mental Health has a distinguished track record in limiting academics abilities to speak on issues that later become prominent. Earlier this year CAMH fired Kenneth Zucker, the University's lead transgender clinician and researcher because he was too middle of the road on these issues – i.e. closer to me than many of my colleagues here are on one side or gender identity clinicians are on the other.

The GMC guidance appears to push us closer to an academic 'No Platforming'. I can accept that a feature in the BMJ from someone who runs a gender identity clinic will take an uncompromising position but it appears to me that the GMC's guidance does even more to close down debate between doctor and patient and amongst colleagues. I say this as someone who is more committed to the possibility of a referral for endocrine and surgical treatment than most. I was concerned about the climate in which these issues can get discussed even before the GMC guidance and am more concerned now.

I regularly get emails from colleagues concerned about where the transgender trajectory is headed. They disguise their identity. There is a palpable fear in many quarters about the nastiness that may ensue if opinions that are still the opinions of a reasonable majority are expressed in public.

An academic colleague who has written more on the history of sex and perversion than anyone else alive, refuses to go near the transgender issue because of the firestorm likely to be triggered. He prefers to stick with pornography industry rules that enforce a total ban on anything sexual linked to anyone under 18.

Meanwhile, I work in a Health Board that has just shot up from 199th to 72nd on Stonewall's list of LGBT friendly institutions. This is one of the few things the Board can promote – it is otherwise in Special Measures. I doubt if the Health Board would be amused at ongoing debate on these issues in N Wales and they can now appeal to GMC Guidance.

One of the reasons for copying Dr Wessely in, aside from the RCP Guidance, is his personal role in debates about Chronic Fatigue Syndrome. He has extensive experience on the threats from activists in health care on topics of concern to them – an early form of No Platforming.

Patient Distress

GMC guidance states that it may well be that the risk to your patient of continuing to self-medicate with hormones is greater than the risk to them if you initiate hormone therapy before they are assessed by a specialist.

This advice I imagine stems from policies aimed at harm minimisation in the drugs and AIDS arena – policies I support. Applied in other areas however it risks harm maximization.

It is a psychiatric truism that admitting patients with identity issues threatening suicide will in general increase the risk of self-harm and suicide.

If patient distress at a doctor's refusal to prescribe what they want, and awareness grows that attributing unwise actions on their part to this refusal puts the doctor in an awkward place vis-à-vis GMC guidance, we open the door to patients who insist on the prescription of skin bleaching agents, vaginal bleaching agents, Botox and other cosmetic interventions.

This will be particularly tricky and problematic in the case of pre-pubertal children where, given the climate currently being created about transgender issues, there are likely to be some parents putting pressure on some doctors to delay or prevent puberty in their children with treatments that are dangerous and citing this GMC guidance in support of their position.

This is another area where Dr Wessely may have something to offer. In the case of chronic fatigue syndromes, one of recognized features is that having an overly supportive family member may make for chronicity.

In fatigue and gender identity syndromes, it has been recognized for over fifty years that circling around a core disorder is an area into which vulnerable people can get sucked. It is these latter patients who may benefit from a degree of scepticism rather than agreement with their assessment of the issues.

GMC – Extended Regulatory Role

I was at a lecture recently where David Haslam, Chair of NICE, mentioned that GMC were extending their regulatory role. Does GMC's transgender Guidance fit with GMC's vision of an extended regulatory role?

I am sure everyone in GMC knows these issues are complex. Part of the problem I have with the Guidance is that there is no concession to this complexity and no indication that it might be legitimate for doctors on the basis of this complexity to step back from treatment approaches dictated by the patient. Where is the room for professional opinion here?

Is there any room for the kind of wisdom that comes at the end of a longish career which takes into account that many health related issues can become intensely fashionable before vanishing soon after?

GMC's guidance states 'you must cooperate with gender identity clinics and general specialists in the same way that you would cooperate 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'.

I cover a mental health catchment area. Many of my general practice colleagues who have been around for some time do not follow the psychopharmacological advice I offer on patients they refer. A generalist is often better placed in terms of knowing the other treatments a patient is on, and knowing more about the patient and their circumstances than a specialist, and as a result I have never quibbled when colleagues have not followed my recommendations. Many colleagues are interested to get a view and then take their own position based on the range of options they have. This is appropriate.

However we are in a changing medical world where many doctors new to the field regard guidelines as mandatory rather than guidance. I would imagine many younger doctors would find themselves in a more difficult position reading the text of the GMC guidance than older doctors would.

Extraneous Factors

Gender Identity issues in the United States now come wrapped in Title IX issues and the actions of the Office of Civil Rights. Over the weekend, there have been developments with the White House wading into the issue. They may have set up an open goal for Donald Trump to shoot into later this year. The issues are this big.

So big that it would be helpful to hear back from GMC and Dr Wessely before taking any of these aspects of the problem to other audiences. So big that refusing engagement is not an option either.

It may be too late to maintain a beachhead patients with gender identity disorders and clinicians interested in their care had taken some years ago. Recent developments might suggest we are making progress beyond this beachhead but I worry that by the end of this year we may have even lost the prior beachhead.

Yours sincerely

Professor David Healy MD FRCPsych

cc. Professor S Wessely