

**Collected Essays in Trans Healthcare Politics**

**Documenting the Scandal of**

**How Medicine Lost The Trust Of Trans People**

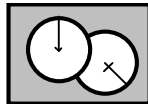
**Prepared on behalf of transsexual people in the United Kingdom**

**by**

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# COLLECTED ESSAYS IN TRANS HEALTHCARE POLITICS

CHRISTINE BURNS ~ MAY 2005

*A collection of essays previously written and published by the author and her associates in Press for Change – the UK’s only political campaign organisation working specifically on behalf of all trans people.*

*Unless otherwise stated the articles featured here were previously published in “Press for Change News” – the email based news service for trans people and their allies working towards the goals of care, equality and social integration in the UK*

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# Trans People and Medicine – A Recap

By Christine Burns

First Published 29<sup>th</sup> January 2006

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## Introduction

From time to time I am approached by journalists, civil servants, academic researchers and others writing about trans health care to explain the historical and political background to how and why trans people are now increasingly questioning and challenging healthcare arrangements in the UK and beyond.

Over time I evolved a form of guided tour through some of the material that I and some of my colleagues have written and published over the last few years.

The purpose of all my writing is educational – either to advance a campaigning objective or to build the level of community awareness which is the first pre-requisite of mobilising ordinary people to campaign coherently on their own behalf. Yet the audience for our work is constantly evolving. People join us all the time and not everyone has read all that went before. To begin a new year in which important events were expected to occur, I decided to put my rough “guided tour” into a more complete form that would summarise the story so far for late arrivals. The result forms a convenient introduction to the rest of the articles making up this assembled collection.

**Christine Burns – May 2006**

**From:** Christine Burns

**Sent:** 29 January 2006 15:56

**To:** 'Press for Change News Distribution'

**Subject:** UK: Trans People and Medicine - A Recap

Dear Readers

**LAST WEEK**, on Friday 20th January, the committee of practitioners and trans stakeholders that has been working on proposed guidelines for the care of trans people undertaking transition met for the last time to discuss the actual content of the document they've been producing.

The Chair of the Committee, Dr Kevan Wylie of the Porterbrook Clinic in Sheffield, tells me that he is now spending two weeks on simply tidying up the presentation of the text; after that, medical contributors will meet once to check for technical accuracy before the manuscript goes to the Registrar of the Royal College of Psychiatrists (RCPsych). Once the RCPsych is happy to put the material out in its name, a true period of wider consultation will then take place -- with feedback being sought from the Royal Colleges representing all the disciplines involved plus, of course, the trans community itself.

It's all a rather far cry from the events that gave birth to this process, on the streets outside the Royal Society of Medicine in April 2002, fondly recalled in this historical vignette by Stephen Whittle:

See : <http://www.lgbthistorymonth.org.uk/history/transout.htm>

*(For more of the historical background, including Claire McNab's blow-by blow updates on telephone conversations with Dr Brian Ferguson, see the PFC News Archive online at :*

<http://www.pfc.org.uk/pfclists/news-arc/2002q1/index.htm>

**FAST FORWARD TO THIS WEEK** and we see the close of another more international consultation process, begun (again rather hamfistedly) by the American Psychological Association, trying to find out how psychologists can collectively change their ways to be more respectful and responsive towards their clients' (and their trans colleagues') feelings.

My own advice was that Psychologists should drop the idea that trans people are "sick", accept that we are simply part of nature's diversity, and recognise the unequalled insight and expertise which trans people bring to the understanding of the gendered aspect of human existence. I ended by inviting Psychologists to take a historic part in achieving that paradigm shift for medicine as a whole, by supporting calls to remove healthy and happy transsexual people altogether from Psychiatric classification, and by concentrating their skills on helping rather than hindering us.

Maybe, in fact, they could begin by studying the remarks that continue to collect in a petition about the abusive nature of NHS treatment in the UK, which continues to grow at :

[http://www.petitiononline.com/mod\\_perl/signed.cgi?nhsgidsp&1](http://www.petitiononline.com/mod_perl/signed.cgi?nhsgidsp&1)

Today I see that the signature count has reached the remarkable level of 533 signatures .. And what a terrible indictment it contains.

**LATER THIS WEEK**, on Channel Five at 11pm on Thursday night (2nd Feb), a new TV documentary looks at medical treatment in the UK, through the eyes of that tiny handful of people whose wish for reversal provides the excuse for repression of the rest. I hope to write more about this later in the week, having filmed several hours of contributions towards it myself back in November 2004.

However, in case the existing follow-up studies over the last 20 years are not good enough in themselves, the most compelling proof of the long term success of gender reassignment for the majority lies in the sheer numbers of people who've already applied to the Gender Recognition Panel for legal recognition - 1229 applications as of four days ago ... almost 25% of the estimated trans population in the UK.

960 of those applications have been under the fast track - from people who had already completed more than six years of documented transition at the time the Act came into force. Analysis of people's intentions gleaned from the survey we've undertaken this month suggests that another 35% of the UK's trans population are planning to apply over the course of 2006 .. with a further 17% thinking about it for 2007-8, when they are able to qualify.

Put those numbers together overall and it suggests that over 77% of the UK's trans population are quite sure about how they intend to remain for the rest of their lives. As the gender recognition process continues to grind through applications I think we will only see that most definite of all outcome studies continue to bear out the truth that reassignment is overwhelmingly successful -- and would be a lot better were it not for the abuses inflicted by the NHS.

All of this sets the scene on 2006 as the year when the debate about trans people and medicine really gathers momentum -- and starts to at last be debated on the facts rather than hysterical lies. To make sure that debate reflects reality, more of you are going to need to stand up for yourselves and complain. Because it is your stories .. hinted at through the comments in that online petition .. which are really needed in order to reveal the true extent of the abuse that takes place in the name of medicine.

As we work up to all this revelation and debate, however, I thought it would be useful to reflect on aspects we've covered before on PFC-News, over the last 18 months or so -- especially for those who've only recently subscribed. The rest of this item is therefore just a reminder of all that, with links so that you can catch up on what you've missed ...

## **THE STORY SO FAR**

Our tour of the PFC-News archives starts in November 2004 when I announced the publication of Persia West's report about the Charing Cross GIC, through the article : "Something Rotten in the State of the Profession".

The "something rotten" feature (page 5) highlighted the state of enmity which exists between the psychiatrists at Charing Cross and Dr Russell Reid, and refers to the now famous internal memo by Dr James Barrett, exposing some remarkable attitudes on his part.

My second feature from around that time, "Echoes of a Bygone Age" (page 8), goes into more detail, with some wider historical perspectives on the way in which both homosexual and trans people have grappled with pathologisation by psychiatry over the years.

For more political background to the pathologisation of trans people, my next piece a few days later provided a look at an article by Paul McHugh, the man who once succeeded in halting virtually all gender reassignment work in the United States, and whose views account for the current attitude of the Vatican towards trans people. See page 12.

Later the same month, we then looked at the outcome of the controversy surrounding the book "The Man Who Would Be Queen", by academic psychologist J Michael Bailey, who most memorably labelled transsexual women as "eminently suited to prostitution". See page 19.

In February 2005 we then featured news of a formal complaint about the attitudes displayed by Dr James Barrett in his leaked memo .. including his remarkable dismissal of "Patient Centred Care". (Page 22)

The same day I also reported on the rather more direct way in which our French counterparts deal with controversial medical views... see page 26. Collette Chiland subsequently cancelled her plans to talk in London.

In May we reported that trans campaigners in Belgium had initiated an online petition seeking changes in the way they are treated by the medical profession there... Page 30.

Two weeks later our attention was also drawn to the launch of the UK petition mentioned above ... Page 32

Chris Pearse, the creator of the petition, turned out to be experiencing some truly awful obstruction by Health Commission Wales in even getting referred to a gender clinic, which I later reported in the feature "No Welcome in the Hillside" (page 36). Rhia had been told that she won't be funded to see a proper gender specialist unless psychiatrists diagnose a significant risk that she'll commit suicide. Yet if Rhia were to be diagnosed as suicidal then gender therapists wouldn't treat her gender dysphoria --revealing the dreadful kind of "Catch 22" cynicism trans people have to face.

With a number of other distractions in the Summer we then came back to the core issue of quality and choice by publishing what I dubbed "A Manifesto for Care" in July 2005.

This is separately available online in PDF form at:

<http://www.pfc.org.uk/medical/cb-eval1.pdf>

We then followed the launch of the Manifesto with an article examining whether change in this area is a pipedream or something that trans people should seriously expect as their right, like everyone else who uses the health service. (See "Pipedream or Prelude" – Page 44).

In that article I also looked at alternative models for care, which some psychiatrists working in the UK appeared determined to outlaw during through the new RCPsych care guidelines now nearing completion.

Later in August a well known gender specialist, Walter Bockting, published a paper reviewing the J M Bailey case, providing a useful cue to examine the souring of the relationship between the medical profession and their trans clients world wide. (Page 52). I asked rhetorically whether it was time for a divorce .. for trans people to reject the pathologising model outright and seek treatment approaches which take controlling psychiatrists and psychologists out of the loop, except where people seek help with particular issues of adjustment.

Then, in October, the Big Issue published quite a good feature covering the way in which trans people in the UK are driven into the use of private treatment (and surgery abroad) as a result of the status quo in the UK. (For the text see page 61).

All in all, the scene is therefore set for a year in which there may be a real prospect of change – but also a real threat from some quarters determined to resist it. Expect the year to be marked by more attempts to defame us and impose control over the expression of our identities by medical means. In turn I hope more and more trans people will take comfort from the sheer strength of evidence now available to combat the lies, and to go on the offensive against a system which is turning into 21st century medicine's guilty shame.

Christine Burns

29th Jan 2006

# Something Rotten in the State of the Profession

By Christine Burns

First Published 18<sup>th</sup> November 2004

**From:** Christine Burns  
**Sent:** 18 November 2004 20:42  
**To:** Press for Change News Distribution  
**Subject:** UK: Report Criticises Charing Cross GIC [B&H PCT]

A new report, "The Medical and Related Needs of Transgender People in Brighton and Hove" pulls no punches in criticising Charing Cross GIC and recommends that the Primary Care Trust should set up its own local service for the many trans people living in the Brighton and Hove area.

The report is now available in PDF format on the Press for Change web site and is bound to fuel controversy on the state of trans care on the NHS. Read it at :

<http://www.pfc.org.uk/medical/spectrum.pdf>

And, below, we explain a part of the controversy which the evidence and conclusions of this report are bound to fuel.

If you wish to contact the author, Persia West, to discuss your reactions or your personal experiences of treatment by Charing Cross then her email is [persia.west@aplaceatthetable.co.uk](mailto:persia.west@aplaceatthetable.co.uk). She is expecting reactions in quantity .. and any accounts which you can give her yourselves will strengthen her case, as she will no doubt be called to justify her conclusions.

## *Something Rotten in the State of the Profession*

2004 has been an extremely controversial year when it comes to the question of treatment for trans people in the UK...

In mid January the news broke that four Charing Cross psychiatrists (including Don Montgomery, James Barrett and Richard Green) had lodged a series of eleven professional misconduct complaints against Dr Russell Reid with the General Medical Council (GMC).

See <http://www.pfc.org.uk/pfclists/news-arc/2004q1/msg00027.htm>

The same day we were fortunately in the position to announce that the GMC's Interim Orders committee had decided not to immediately suspend Dr Reid as, in their view, there was no cogent evidence to do so. It also later turned out that many of the original eleven complaints were subsequently dropped when the patients themselves refused to permit their notes to be released. See <http://www.pfc.org.uk/pfclists/news-arc/2004q1/msg00030.htm>

About a month later, the Guardian's Social Care Correspondent (David Batty) was back on the case again, announcing that a former MtF patient of Russell Reid (Charles / Samantha Kane) was attempting to sue Dr Reid for damages in the civil court, claiming he was misdiagnosed and hurried through the transition process which he had claimed in a book (shortly afterwards) to be something (s)he "would never regret"

See <http://www.pfc.org.uk/pfclists/news-arc/2004q1/msg00123.htm>

Batty and his associates in a TV documentary company have subsequently dismissed Charles Kane as something of a Walter Mitty character, although Kane continues to press his case for substantial damages against Reid and to try every available avenue to sell his contradictory story through the tabloid press ... surfacing now and then throughout the year to maintain interest in his story. See <http://www.pfc.org.uk/pfclists/news-arc/2004q1/msg00129.htm>

Throughout the year, in fact, the GMC case has rumbled on .. though in some cases we've decided to spare Dr Reid further anguish by printing allegations or rehashes of the news that he is professionally constrained from commenting upon.

Just as quietly, another process has been going on in the background too ... as a committee established last Autumn by the Royal College of Psychiatrists began work to develop a new set of UK-based guidelines for trans people's treatment, under the chairmanship of Dr Kevan Wylie.

In September, this quiet process itself came into the news, when it was revealed by the Guardian's David Batty that Dr Reid (himself a member of the RCPsych committee), had been obliged to stand down and adopt an advisory-only role within the standards of care committee, following a challenge from James Barrett relating to the outstanding GMC hearing. See <http://www.pfc.org.uk/pfclists/news-arc/2004q4/msg00000.htm>

Unanswered questions still exist concerning the way in which this news was leaked to the press, as the proceedings of the committee where all this happened were supposed to be confidential at that time. Indeed, only NOW is Kevan Wylie's committee gearing up to consult more widely with stakeholders over what the committee has been doing for the last year. This will doubtless be a massive topic for debate in the weeks and months ahead.

Observers are certainly already asking questions about exactly what is wrong about the state of trans care in the UK, when one group of NHS doctors seem to have dedicated so much of their efforts to attacking a private practitioner who (prior to these allegations) was better known for the huge respect and popularity he enjoys.

There are clues contained in some of the 60 responses which PFC News readers sent in response to a small survey which I ran here during the Spring (and which I'm still working to collate). The most disturbing element of that survey was the things which many Charing Cross patients indicated that they were afraid to have attributed to them, owing to the climate of fear which seems to exist among many of them.

The responses from those who had recently completed their treatment (and therefore had less to fear) revealed some of the areas for concern though: Aggressive and rude handling, punitive rules, threats to withdraw treatment, appointments cancelled without notice, different therapists at each appointment, notes getting lost – a catalogue of complaint in fact. It was also clear from a first analysis of the results that, for all the hype about standards, patients at Charing Cross are not in practice seen any more times before RLE, hormones or surgical referral than at other centres, NHS or private .. they just take longer to chalk up those appointments.

An internal Charing Cross memo penned by James Barrett in August and seen by several observers of this controversy also reveals some of the mindset within the centre. In a blow by blow tirade aimed at the latest draft of a document being prepared by the Parliamentary Forum, Barrett shows distinct contempt for trans people as a whole (and trans campaigners in particular). He dismisses the modern day self-descriptive language of the trans community, angrily asserts that transsexualism is a mental illness and takes "extreme exception" to a section saying that 'patient satisfaction audits should be undertaken'. He reckons instead that



"a more independent measure of outcome than patient satisfaction audits should be applied"  
... presumably meaning that the patient's view is secondary.

It is therefore extremely timely that a brand new and detailed report has now been published, lifting the curtain of silence around the state of Charing Cross GIC and reporting on what referring doctors as well as patients actually think about the service.

The new report, entitled "The Medical and Related Needs of Transgender People in Brighton and Hove" has been researched and written by Brighton trans campaigner Persia West, and was funded through the local LGBT community forum, "Spectrum", by the Brighton and Hove City NHS Teaching Primary Care Trust.

The report, which is now available to read at <http://www.pfc.org.uk/medical/spectrum.pdf> spares no punches in its critique of a service which is coming under increasing scrutiny from many quarters.

Rather than steal any of its' thunder, however, I recommend that you read it and that you make sure everyone you know reads it too and starts asking the questions that it poses.

Needless to say, this is a story which will be continued...

Christine Burns

18th November 2004

# Echoes of a Bygone Age

By Christine Burns

First Published 20<sup>th</sup> November 2004

**From:** Christine Burns  
**Sent:** 20 November 2004 16:34  
**To:** 'Press for Change News Distribution'  
**Subject:** : Echoes of a Bygone Age [PFC]

In August of this year Dr James Barrett of Charing Cross GIC wrote an angry memo to Professor Richard Green which he may (by now) thoroughly regret.

The target of his three page apoplectic tirade was a draft document which, quite ironically, has taken longer to get agreed than almost anything I can ever remember working on.

The Parliamentary Forum's guidelines for health authorities are NOT any sort of recipe for standards of care. That was never the intention when a meeting chaired by Lynne Jones MP first agreed to initiate such a project more than three years ago.

The original idea was actually quite practical - to provide health authorities with an authoritative review of the background to gender reassignment counselling, surgery, and other care topics so that (in a fair and honest world) purchasers could consider their funding obligations from a clinically informed perspective... rather than using knowledge below the standard of the school bicycle sheds, as most seem to have done with trans policy making until now.

In practice, agreeing such a document to everyone's collective satisfaction has been an absolute nightmare... though perhaps for the best of reasons.

The Parliamentary Forum only meets 2 or 3 times every year. Its strength, however, is that it provides a uniquely strong forum for expert stakeholders from all sides in this field.

Meetings are regularly attended by a healthy contingent of well known practitioners... people like Russell Reid, Kevan Wylie, Domenico de Ceglie and Richard Green are regulars... along with Dr Joyce Martin, a retired GP who is also a trans woman.

Alongside them sit the leading faces in trans campaigning and support .. including Stephen Whittle, Claire McNab, Tracy Dean, people from groups such as the Gender Trust, GIRES... and myself.

Then there are specialists in particular areas, such as equal opportunities, policing and nursing.

Last, but not least, there are the MPs who get along regularly too... with Dr Lynne Jones MP in the chair. Very often Dr Evan Harris MP manages to attend too... or sends one of his researchers.

(Evan Harris is a significant figure in this, as he was Liberal Democrat Health Spokesman until recently, when personal circumstances forced him to scale down his commitments).

To get such a broad church to agree on a very detailed document is no mean feat. It has taken literally years... and has come down to a sentence by sentence reading ordeal over the last few meetings of the forum, as all sides managed to agree forms of words to describe the detail and aspirations of trans people's care to mutual satisfaction.

Happily, after all this time, the degree of consensus on many parts of the main document now seems to be encouragingly high. An end COULD be in sight! There does admittedly remain an area of conflict; however this is not now about the description of the care pathway or options within that... but about the way in which the background theory of transsexuality's etiology is described and presented.

The sticking point is an argument about whether brain sex theories should be accorded prominence in explaining the nature of our existence to purchasers, or whether one should adopt a human rights-based stance and just say, in essence, "Trans people self evidently exist, ergo they deserve access to treatment services on the same basis as any other minority with a problem requiring medical assistance".

You don't have to know what causes something to treat it. Nor does ethical medicine normally demand proof that you "can't help" your condition as a precondition for treating the bearer with respect and the fullest standard of care. So, I'm on the side of those who would rather NOT promote one small set of research findings further than necessary just to try and persuade a few more ignorant NHS administrators to pay up for our care.

Still... that's an argument still going on... mostly between trans people I should add!

Rather than pursue that topic, I want to step back to the previous point though... because it is vitally important to emphasise...

The cross section of doctors and service users in the Parliamentary Forum now largely agree on the part of the purchasing guidelines describing the existing care pathway and options for people seeking gender reassignment.

This doesn't mean that all sides agree on the philosophy of how caring services should be improved and restructured and reoriented in the future... questions of who has POWER, and who has CHOICES...

No ... THAT's a separate debate which I think we are about to have when consulting over the RCPsych UK standards of care proposals. (And that is the level at which I think that consultation will need to start from).

In contrast, the Parliamentary Forum's aim has essentially been to describe how the PRESENT way of delivering gender reassignment care should best be done, so long as it is done that way.

And what this long and passionately debated process shows is that it is possible for trans people and those most closely associated with existing care processes to work pragmatically together and agree on SOME things whilst clearly still needing to work at our immense differences on others.

...All of which makes Dr Barrett's blistering point by point tirade against the Parliamentary Forum's efforts seem rather strange... indeed putting him very much out of line with his peers.

Which brings us back to where we came in...

There are many aspects of James Barrett's apparent clinical philosophy which one could choose to write about. However, on this occasion I want to focus on just one... and to put that one aspect of his apparent views into a historical perspective.

In the middle of his leaked memo Dr Barrett takes issue with a statement in the Funding Guidelines draft which says quite clearly that "Transsexualism is not a Mental Illness".

This is quite a significant point to get clear of course... principally because if the condition *were* a mental illness then surgery, whilst perhaps mitigating the symptoms, would not be expected to effect a "cure". We would all still be, to put it bluntly, mentally ill... and potentially unfit to hold our jobs and roles in society as a result.

Fortunately the Government doesn't think we are mentally ill. It has said so in its policies ... after getting to know some of us in far more depth than the average psychiatrist!

In fact the Government is quite unequivocal. It says,

*[Transsexualism] "is not a mental illness. It is a condition considered in itself to be free of other pathology (though transsexual people can suffer depression or illnesses like anyone else)." [See <http://www.dca.gov.uk/constitution/transsex/policy.htm> ]*

Dr Barrett thinks differently though. He says in his leaked memo,

*"It would seem to me that it is by definition a mental illness since it is a diagnosis currently appearing in the ICD 10 in the Mental Illness Section"*

This is of course a classically circular kind of justification: Psychiatrists put transsexual people in the handbook of mental illness because they think we are mentally ill. They think we are mentally ill because we are in the handbook of mental illness. Joseph Heller, author of "Catch 22", would be proud!

It's good to know we are pathologised by such incisive thinkers.

But does this ring any bells?

A few weeks ago I asked an audience of several hundred gay and lesbian civil servants to put their hands up if they were mentally ill. None did of course. However, there was a serious side to my mischievous question.

It is now almost 38 years since homosexuality was decriminalised in Britain, with the passage of the Sexual Offences Act in 1967.

The decriminalisation of their existence marked a watershed for gay and lesbian folk... a watershed which has only just been equalled by our own community with the passing of the Gender Recognition Act.

It may not have been a criminal offence to be transsexual during all those intervening years, but the punishments meted out by society between those two Acts of Parliament were no less severe.

People maybe know about the decriminalisation of homosexuality; but fewer will recall that, in those days, psychiatry still regarded gay and lesbian folk as mentally ill .. and fit subjects for "aversion therapy".

The state couldn't lock you up... but the Psychiatrists were undeterred from trying!

The following article by the famous Gay activist Peter Tatchell paints a very clear picture of the world... and psychiatry... as it was then.

Writing in a very young "Gay News" in 1972 he began ...

*"Professor Eysenck is one of the world's leading "psycho-Nazis", advocating theories on the nature and treatment of homosexuality that sometimes came close to echoing those of Nazi leaders, such as Heinrich Himmler. Much favoured in establishment and psychiatric circles, he is a leading exponent of aversion therapy. In the numerous books he has written, homosexuality is variously associated with perverse, abnormal,*

*unnatural, neurotic and criminal behaviour. He has consistently advocated the use of aversion therapy to cure what he sees as sexual perversion."*

See: "Aversion Therapy is 'Like a trip to the dentist' "  
<http://www.petertatchell.net/psychiatry/dentist.htm>

As I've explained before, it took several years (and two goes) for gay and lesbian people to extract themselves from the psychiatrists' grasp.

In 1973 the process began when a proposal to remove homosexuality from the DSM II was passed by the Board of the American Psychological Society (APA).

That wasn't the end, however...

Following the necessary ratification by the APA's membership in 1974, the seventh printing of the DSM II dropped "homosexuality" but hung on in there for another 13 years, first with "sexual orientation disturbance" and then later with a brand new expression "Ego-dystonic homosexuality".

These successive attempts to define a niche market for hard up psychiatrists only finally came to an undistinguished end in 1987, when the men in white coats finally gave up the fight and turned their full attention to terrorising trans people instead.

Surprisingly, transsexual people had not interested psychiatrists enough to be listed in the DSM until 1980. One can only speculate that if James Barrett had been asked for a view on us prior to that, he might have had a different answer.

But that's the difference between psychiatry and a real hard science like physics of course... Once a gravitational constant, always a gravitational constant.

In contrast, for psychiatry, it's rather like that annoying strapline from Microsoft's marketing department.

*"How would you like to be pathologised today?"*

Since our first appearance in the DSM, we've been through more labels than a demented Supermarket shelf stacker. They can't agree how to categorise us, but they sure as heck want to carry on trying.

Looking back on the history, it is quite a daunting thought. The idea that it might take us twenty years to get from a legalised existence to removal from psychiatric handbooks is too dire to contemplate.

History, and Peter Tatchell's 1972 article teach us one thing though: It probably won't happen without a struggle.

However, whether it's dealing with the likes of J Michael Bailey in Chicago or James Barrett and friends at Charing Cross, I have a feeling that these first few years of the new millenium will be remembered as the point where, for trans people around the world, the gloves started coming off.

Christine Burns

19th November, 2004

**PLEASE NOTE :** *The views expressed in this article are those of the author personally and do not necessarily reflect the collective or individual positions of Press for Change or its' vice presidents.*

# Surgical Sex (Paul McHugh)

By Christine Burns

First Published 24<sup>th</sup> November 2004

**From:** Christine Burns  
**Sent:** 24 November 2004 20:00  
**To:** 'Press for Change News Distribution'  
**Subject:** US: Surgical Sex [Paul McHugh]

## *Introduction*

I apologise and know in advance that many people reading the feature which follows will find it a mixture of intensely annoying and profoundly depressing. However, the steadily growing archives of PFC-News have an important role for the future, in charting the zeitgeist of the age in which many far more positive things continue to occur. It seems to me that it would therefore be wrong to miss out this item.

Those who know a bit of trans history will already know Paul McHugh. He is the man who at one time shut down the gender reassignment programme at the famous Johns Hopkins Hospital in Baltimore .. an event which has often been cited since as some sort of "proof" that "sex changes don't work". What was less reported was the very deep right wing Catholic orthodoxy behind the man's views on everything, and the fact that the termination of that programme, and all of his pronouncements since then, are rooted in that ideology, rather than the open-minded pursuit of knowledge.

It has been pointed out to me that this brand new essay of his, published by a body "whose purpose is to advance a religiously informed public philosophy for the ordering of society", constitutes a part of his career swansong .. in which he is seemingly determined to assert ownership of ideas which, until now, have been credited to (or blamed on) others.

J Michael Bailey briefly tried to claim credit for inventing the "two types" categorisation of transsexual people into primary (ultra "homosexual") and secondary (ultra perverted) boxes. On being challenged over this, Bailey transferred praise to his mentor Ray Blanchard, who has generally in the past been regarded as the man responsible for cooking up such an ill-fitting classification, and then spending the rest of his career bending any data he could find to fit the model. Now, in the twilight of his life, McHugh wishes nobody to be in any doubt that the whole thing was his idea from the start... and anyone else was just a bit-player. As Ray Blanchard is also nearing the end of his career too, it will be interesting to see just what he makes of having his life's "contribution" whipped out from under his feet in this way. The scene could be set for an interesting cat fight!

McHugh has done immeasurable damage to unknown numbers of transsexual people around the world... most notably as the force behind the Roman Catholic Church's unequivocally nasty position on the whole topic in 2000. Some also suspect that his influence may go a long way to explain the absolutely remarkable refusal by the US National Academy of Science to even engage with transsexual people when the controversy first broke over the J Michael Bailey book.

One day the truth will out. In the meantime, Paul McHugh portrays himself as a particularly unpleasant human being without any editorial help from anyone else.

-Christine Burns

*Surgical Sex – By Paul McHugh*

From: <http://www.firstthings.com/ftissues/ft0411/articles/mchugh.htm>

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When the practice of sex-change surgery first emerged back in the early 1970s, I would often remind its advocating psychiatrists that with other patients, alcoholics in particular, they would quote the Serenity Prayer, "God, give me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference." Where did they get the idea that our sexual identity ("gender" was the term they preferred) as men or women was in the category of things that could be changed?

Their regular response was to show me their patients. Men (and until recently they were all men) with whom I spoke before their surgery would tell me that their bodies and sexual identities were at variance. Those I met after surgery would tell me that the surgery and hormone treatments that had made them "women" had also made them happy and contented. None of these encounters were persuasive, however. The post-surgical subjects struck me as caricatures of women. They wore high heels, copious makeup, and flamboyant clothing; they spoke about how they found themselves able to give vent to their natural inclinations for peace, domesticity, and gentleness-but their large hands, prominent Adam's apples, and thick facial features were incongruous (and would become more so as they aged). Women psychiatrists whom I sent to talk with them would intuitively see through the disguise and the exaggerated postures. "Gals know gals," one said to me, "and that's a guy."

The subjects before the surgery struck me as even more strange, as they struggled to convince anyone who might influence the decision for their surgery. First, they spent an unusual amount of time thinking and talking about sex and their sexual experiences; their sexual hungers and adventures seemed to preoccupy them. Second, discussion of babies or children provoked little interest from them; indeed, they seemed indifferent to children. But third, and most remarkable, many of these men-who-claimed-to-be-women reported that they found women sexually attractive and that they saw themselves as "lesbians." When I noted to their champions that their psychological leanings seemed more like those of men than of women, I would get various replies, mostly to the effect that in making such judgments I was drawing on sexual stereotypes.

Until 1975, when I became psychiatrist-in-chief at Johns Hopkins Hospital, I could usually keep my own counsel on these matters. But once I was given authority over all the practices in the psychiatry department I realized that if I were passive I would be tacitly co-opted in encouraging sex-change surgery in the very department that had originally proposed and still defended it. I decided to challenge what I considered to be a misdirection of psychiatry and to demand more information both before and after their operations.

Two issues presented themselves as targets for study. First, I wanted to test the claim that men who had undergone sex-change surgery found resolution for their many general psychological problems. Second (and this was more ambitious), I wanted to see whether male infants with ambiguous genitalia who were being surgically transformed into females and raised as girls did, as the theory (again from Hopkins) claimed, settle easily into the sexual identity that was chosen for them. These claims had generated the opinion in psychiatric circles that one's "sex" and one's "gender" were distinct matters, sex being genetically and

hormonally determined from conception, while gender was culturally shaped by the actions of family and others during childhood.

The first issue was easier and required only that I encourage the ongoing research of a member of the faculty who was an accomplished student of human sexual behavior. The psychiatrist and psychoanalyst Jon Meyer was already developing a means of following up with adults who received sex-change operations at Hopkins in order to see how much the surgery had helped them. He found that most of the patients he tracked down some years after their surgery were contented with what they had done and that only a few regretted it. But in every other respect, they were little changed in their psychological condition. They had much the same problems with relationships, work, and emotions as before. The hope that they would emerge now from their emotional difficulties to flourish psychologically had not been fulfilled.

We saw the results as demonstrating that just as these men enjoyed cross-dressing as women before the operation so they enjoyed cross-living after it. But they were no better in their psychological integration or any easier to live with. With these facts in hand I concluded that Hopkins was fundamentally cooperating with a mental illness. We psychiatrists, I thought, would do better to concentrate on trying to fix their minds and not their genitalia.

Thanks to this research, Dr. Meyer was able to make some sense of the mental disorders that were driving this request for unusual and radical treatment. Most of the cases fell into one of two quite different groups. One group consisted of conflicted and guilt-ridden homosexual men who saw a sex-change as a way to resolve their conflicts over homosexuality by allowing them to behave sexually as females with men. The other group, mostly older men, consisted of heterosexual (and somebisexual) males who found intense sexual arousal in cross-dressing as females. As they had grown older, they had become eager to add more verisimilitude to their costumes and either sought or had suggested to them a surgical transformation that would include breast implants, penile amputation, and pelvic reconstruction to resemble a woman.

Further study of similar subjects in the psychiatric services of the Clark Institute in Toronto identified these men by the auto-arousal they experienced in imitating sexually seductive females. Many of them imagined that their displays might be sexually arousing to onlookers, especially to females. This idea, a form of "sex in the head" (D. H. Lawrence), was what provoked their first adventure in dressing up in women's undergarments and had eventually led them toward the surgical option. Because most of them found women to be the objects of their interest they identified themselves to the psychiatrists as lesbians. The name eventually coined in Toronto to describe this form of sexual misdirection was "autogynephilia." Once again I concluded that to provide a surgical alteration to the body of these unfortunate people was to collaborate with a mental disorder rather than to treat it.

This information and the improved understanding of what we had been doing led us to stop prescribing sex-change operations for adults at Hopkins-much, I'm glad to say, to the relief of several of our plastic surgeons who had previously been commandeered to carry out the procedures. And with this solution to the first issue I could turn to the second-namely, the practice of surgically assigning femaleness to male newborns who at birth had malformed, sexually ambiguous genitalia and severe phallic defects. This practice, more the province of the pediatric department than of my own, was nonetheless of concern to psychiatrists because the opinions generated around these cases helped to form the view that sexual identity was a matter of cultural conditioning rather than something fundamental to the human constitution.



Several conditions, fortunately rare, can lead to the misconstruction of the genito-urinary tract during embryonic life. When such a condition occurs in a male, the easiest form of plastic surgery by far, with a view to correcting the abnormality and gaining a cosmetically satisfactory appearance, is to remove all the male parts, including the testes, and to construct from the tissues available a labial and vaginal configuration. This action provides these malformed babies with female-looking genital anatomy regardless of their genetic sex. Given the claim that the sexual identity of the child would easily follow the genital appearance if backed up by familial and cultural support, the pediatric surgeons took to constructing female-like genitalia for both females with an XX chromosome constitution and males with an XY so as to make them all look like little girls, and they were to be raised as girls by their parents.

All this was done of course with consent of the parents who, distressed by these grievous malformations in their newborns, were persuaded by the pediatric endocrinologists and consulting psychologists to accept transformational surgery for their sons. They were told that their child's sexual identity (again his "gender") would simply conform to environmental conditioning. If the parents consistently responded to the child as a girl now that his genital structure resembled a girl's, he would accept that role without much travail.

This proposal presented the parents with a critical decision. The doctors increased the pressure behind the proposal by noting to the parents that a decision had to be made promptly because a child's sexual identity settles in by about age two or three. The process of inducing the child into the female role should start immediately, with name, birth certificate, baby paraphernalia, etc. With the surgeons ready and the physicians confident, the parents were faced with an offer difficult to refuse (although, interestingly, a few parents did refuse this advice and decided to let nature take its course).

I thought these professional opinions and the choices being pressed on the parents rested upon anecdotal evidence that was hard to verify and even harder to replicate. Despite the confidence of their advocates, they lacked substantial empirical support. I encouraged one of our resident psychiatrists, William G. Reiner (already interested in the subject because prior to his psychiatric training he had been a pediatric urologist and had witnessed the problem from the other side), to set about doing a systematic follow-up of these children-particularly the males transformed into females in infancy-so as to determine just how sexually integrated they became as adults.

The results here were even more startling than in Meyer's work. Reiner picked out for intensive study cloacal exstrophy, because it would best test the idea that cultural influence plays the foremost role in producing sexual identity. Cloacal exstrophy is an embryonic misdirection that produces a gross abnormality of pelvic anatomy such that the bladder and the genitalia are badly deformed at birth. The male penis fails to form and the bladder and urinary tract are not separated distinctly from the gastrointestinal tract. But crucial to Reiner's study is the fact that the embryonic development of these unfortunate males is not hormonally different from that of normal males. They develop within a male-typical prenatal hormonal milieu provided by their Y chromosome and by their normal testicular function. This exposes these growing embryos/fetuses to the male hormone testosterone-just like all males in their mother's womb.

Although animal research had long since shown that male sexual behavior was directly derived from this exposure to testosterone during embryonic life, this fact did not deter the pediatric practice of surgically treating male infants with this grievous anomaly by castration (amputating their testes and any vestigial male genital structures) and vaginal construction, so that they could be raised as girls. This practice had become almost universal by the mid-1970s. Such cases offered Reiner the best test of the two aspects of the doctrine underlying

such treatment: (1) that humans at birth are neutral as to their sexual identity, and (2) that for humans it is the postnatal, cultural, nonhormonal influences, especially those of early childhood, that most influence their ultimate sexual identity. Males with cloacal exstrophy were regularly altered surgically to resemble females, and their parents were instructed to raise them as girls. But would the fact that they had had the full testosterone exposure in utero defeat the attempt to raise them as girls? Answers might become evident with the careful follow-up that Reiner was launching.

Before describing his results, I should note that the doctors proposing this treatment for the males with cloacal exstrophy understood and acknowledged that they were introducing a number of new and severe physical problems for these males. These infants, of course, had no ovaries, and their testes were surgically amputated, which meant that they had to receive exogenous hormones for life. They would also be denied by the same surgery any opportunity for fertility later on. One could not ask the little patient about his willingness to pay this price. These were considered by the physicians advising the parents to be acceptable burdens to bear in order to avoid distress in childhood about malformed genital structures, and it was hoped that they could follow a conflict-free direction in their maturation as girls and women.

Reiner, however, discovered that such re-engineered males were almost never comfortable as females once they became aware of themselves and the world. From the start of their active play life, they behaved spontaneously like boys and were obviously different from their sisters and other girls, enjoying rough-and-tumble games but not dolls and "playing house." Later on, most of those individuals who learned that they were actually genetic males wished to reconstitute their lives as males (some even asked for surgical reconstruction and male hormone replacement)-and all this despite the earnest efforts by their parents to treat them as girls.

Reiner's results, reported in the January 22, 2004, issue of the *New England Journal of Medicine*, are worth recounting. He followed up sixteen genetic males with cloacal exstrophy seen at Hopkins, of whom fourteen underwent neonatal assignment to femaleness socially, legally, and surgically. The other two parents refused the advice of the pediatricians and raised their sons as boys. Eight of the fourteen subjects assigned to be females had since declared themselves to be male. Five were living as females, and one lived with unclear sexual identity. The two raised as males had remained male. All sixteen of these people had interests that were typical of males, such as hunting, ice hockey, karate, and bobsledding. Reiner concluded from this work that the sexual identity followed the genetic constitution. Male-type tendencies (vigorous play, sexual arousal by females, and physical aggressiveness) followed the testosterone-rich intrauterine fetal development of the people he studied, regardless of efforts to socialize them as females after birth.

Having looked at the Reiner and Meyer studies, we in the Johns Hopkins Psychiatry Department eventually concluded that human sexual identity is mostly built into our constitution by the genes we inherit and the embryogenesis we undergo. Male hormones sexualize the brain and the mind. Sexual dysphoria-a sense of disquiet in one's sexual role-naturally occurs amongst those rare males who are raised as females in an effort to correct an infantile genital structural problem. A seemingly similar disquiet can be socially induced in apparently constitutionally normal males, in association with (and presumably prompted by) serious behavioral aberrations, amongst which are conflicted homosexual orientations and the remarkable male deviation now called autogynephilia.

Quite clearly, then, we psychiatrists should work to discourage those adults who seek surgical sex reassignment. When Hopkins announced that it would stop doing these procedures in adults with sexual dysphoria, many other hospitals followed suit, but some medical centers still carry out this surgery. Thailand has several centers that do the surgery "no questions asked" for anyone with the money to pay for it and the means to travel to Thailand. I am disappointed but not surprised by this, given that some surgeons and medical centers can be persuaded to carry out almost any kind of surgery when pressed by patients with sexual deviations, especially if those patients find a psychiatrist to vouch for them. The most astonishing example is the surgeon in England who is prepared to amputate the legs of patients who claim to find sexual excitement in gazing at and exhibiting stumps of amputated legs. At any rate, we at Hopkins hold that official psychiatry has good evidence to argue against this kind of treatment and should begin to close down the practice everywhere.

For children with birth defects the most rational approach at this moment is to correct promptly any of the major urological defects they face, but to postpone any decision about sexual identity until much later, while raising the child according to its genetic sex. Medical caretakers and parents can strive to make the child aware that aspects of sexual identity will emerge as he or she grows. Settling on what to do about it should await maturation and the child's appreciation of his or her own identity.

Proper care, including good parenting, means helping the child through the medical and social difficulties presented by the genital anatomy but in the process protecting what tissues can be retained, in particular the gonads. This effort must continue to the point where the child can see the problem of a life role more clearly as a sexually differentiated individual emerges from within. Then as the young person gains a sense of responsibility for the result, he or she can be helped through any surgical constructions that are desired. Genuine informed consent derives only from the person who is going to live with the outcome and cannot rest upon the decisions of others who believe they "know best."

How are these ideas now being received? I think tolerably well. The "transgender" activists (now often allied with gay liberation movements) still argue that their members are entitled to whatever surgery they want, and they still claim that their sexual dysphoria represents a true conception of their sexual identity. They have made some protests against the diagnosis of autogynephilia as a mechanism to generate demands for sex-change operations, but they have offered little evidence to refute the diagnosis. Psychiatrists are taking better sexual histories from those requesting sex-change and are discovering more examples of this strange male exhibitionist proclivity.

Much of the enthusiasm for the quick-fix approach to birth defects expired when the anecdotal evidence about the much-publicized case of a male twin raised as a girl proved to be bogus. The psychologist in charge hid, by actually misreporting, the news that the boy, despite the efforts of his parents to treat him and raise him as a girl, had constantly challenged their treatment of him, ultimately found out about the deception, and restored himself as a male. Sadly, he carried an additional diagnosis of major depression and ultimately committed suicide.

I think the issue of sex-change for males is no longer one in which much can be said for the other side. But I have learned from the experience that the toughest challenge is trying to gain agreement to seek empirical evidence for opinions about sex and sexual behavior, even when the opinions seem on their face unreasonable. One might expect that those who claim that sexual identity has no biological or physical basis would bring forth more evidence to persuade others. But as I've learned, there is a deep prejudice in favor of the idea that nature is totally malleable.

Without any fixed position on what is given in human nature, any manipulation of it can be defended as legitimate. A practice that appears to give people what they want-and what some of them are prepared to clamor for-turns out to be difficult to combat with ordinary professional experience and wisdom. Even controlled trials or careful follow-up studies to ensure that the practice itself is not damaging are often resisted and the results rejected.

I have witnessed a great deal of damage from sex-reassignment. The children transformed from their male constitution into female roles suffered prolonged distress and misery as they sensed their natural attitudes. Their parents usually lived with guilt over their decisions-second-guessing themselves and somewhat ashamed of the fabrication, both surgical and social, they had imposed on their sons. As for the adults who came to us claiming to have discovered their "true" sexual identity and to have heard about sex-change operations, we psychiatrists have been distracted from studying the causes and natures of their mental misdirections by preparing them for surgery and for a life in the other sex. We have wasted scientific and technical resources and damaged our professional credibility by collaborating with madness rather than trying to study, cure, and ultimately prevent it.

Paul McHugh is University Distinguished Service Professor of Psychiatry at Johns Hopkins University.

# J Michael Bailey to be Disciplined in Secret

By Christine Burns

First Published 30<sup>th</sup> November 2004

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## Introduction

The book "The Man Who Would Be Queen" rocked the transsexual world in 2003 when it was published as an apparently serious scientific work by the American National Academy of Science. In hindsight some have come to see it as one of the defining moments of modern trans history, bringing campaigners together from around the world to discuss and then investigate what was really going on behind its' publication and energetic promotion. The denouement of the book's author occurred with not so much a bang as a whimper, amidst strenuous efforts to play down the spectacular scandal that had been uncovered. A very detailed chronological account of all the relevant details of the trans community's own investigation can be found on the web site of Professor Lynn Conway at:

<http://ai.eecs.umich.edu/people/conway/TS/LynnsReviewOfBaileysBook.html>

**From:** Christine Burns

**Sent:** 30 November 2004 19:41

**To:** 'Press for Change News Distribution'

**Subject:** : NWU To discipline J Michael Bailey in Secret

## North Western to Discipline J Michael Bailey in Secret

### News report by Christine Burns

#### CHICAGO Illinois - 29th November 2004

North Western University Professor J Michael Bailey is to be disciplined in an unspecified manner, according to letters sent this week to trans women who had complained about his behaviour.

The Professor, whose book "The Man Who Would Be Queen" caused an international furore when published in March 2003, faced multiple complaints from several transsexual women. Many of these contended that he had made them into his research subjects without their knowing or written consent, when they though he was simply writing surgery referral letters for them. One of the women also alleged that he had had sex with her whilst participating in what she later realised to be a possible research project.

The exact findings of the NWU complaints investigation are seemingly to remain a secret. With a degree of evasion which has stunned US trans observers, University Provost Lawrence B Dumas avoids giving any clue as to what the investigating committee actually concluded after more than a years' deliberation. A letter received this weekend by complainant Professor Lynn Conway is practically identical to those also being received by the women who claimed to have been his unwitting research subjects. It states,

*"Your July 29, 2003, complaint has been thoroughly investigated, following Northwestern University's established procedures for handling such matters.*

*I have now received the formal report of the committee charged to investigate the matter; and I have taken action that I believe is appropriate in this situation.*

*Consistent with the established procedures pertaining to such matters and general University practice, personnel actions concerning University employees are confidential. Northwestern remains committed to ensuring that research activities involving human subjects are conducted in accordance with the expectations of the University, the regulations and guidelines established by the federal government and with generally accepted research standards."*

Professor Conway was quick to condemn the statement:

*"...it's a kind-of Catholic Church type of "Cover-Up", a retreat into total secrecy about their findings, and from telling the public what they're going to do about those findings"*

She adds,

*"Here we have the elite science establishment simply saying to those were abused by rogue scientists, like the Catholic Church said to those who were abused by rogue priests, "trust us, we've investigated and we've taken care of it"...when in fact they never even looked at the most serious charges."*

Although the committee's findings haven't been revealed, it is nevertheless clear that Professor Bailey has not been exonerated. Had the investigating committee found him innocent of the charges made in the complaints, it is inconceivable that they would have passed up the opportunity to say so. Institutions only adopt this kind of tight lipped approach when they are extremely embarrassed and hope that the problem will go away. In this case observers say the only logical conclusion they can draw is that the committee *did* find Bailey to be at fault, but found the consequences of condemning his behaviour to be overwhelmingly embarrassing to confront.

Why might that be?

One good clue lies in the complaint which *wasn't* investigated. The allegation of sex with a research subject has not actually been considered by the university's investigating panel, since the first task was to establish whether the woman making the allegation was a research subject or not.

Conway says that by failing to spell out the conclusions of the investigating panel the university hopes to avoid the obligation to investigate this second serious issue, which could continue embarrassing them even further.

Moreover, for a university reliant on contentious US Government funding, the "was it research" question is considered by other observers to be highly embarrassing in its own right...

Since its publication in March 2003, gender identity experts, trans academics and scientists from many backgrounds have joined in condemning J Michael Bailey's book as bad science and dangerous drivel. In peer review terms Bailey's only fans come from the small clique of eugenically-inspired "bio ethics" researchers, who expected his book to further their stigmatising aims.

At first Bailey claimed it to be a serious science book about his research. When the condemnations started coming, however, he hastily changed tack and claimed that the book was a popular work about his exploits trawling gay bars as part of his interest in the field. Had the investigating committee found that the subjects featured in his gay bar antics WERE research subjects however (ignoring the ones he made up), funders would be even more inclined to think very hard about how he has been spending their money all this time. A case of "Research Jim, but not as we know it".

Meanwhile, there are still more complaints in the system, regarding further alleged acts of unprofessional conduct, so the professor is certainly not out of the woods yet.

For US-based researchers the refusal of the authorities to state their findings in this case will leave a big question mark over what constitutes "research" with human subjects, and what kinds of human research require informed written consent. This is a very serious question affecting far more than J Michael Bailey's sexploits, and some might have hoped a prestige university like North Western to take this opportunity to provide some answers.

For trans people around the world the "non-findings" are a huge disappointment too...

The latina trans women who just wanted a referral letter and got an unwanted place in a controversial book have been denied a reasonable outcome to their complaint. All they know is that a secret committee looked at their cases in secret and the university's provost reports that they came to a secret conclusion. They are denied the right to know that conclusion or to know whether the sanctions taken are reasonable or not. No reasonable person would describe that as a meaningful complaints process. It is a denial of due process. Nobody knows yet whether, as a result, they will take their complaints to law or not.

For the rest of us, the result is also very frustrating .. in an affair where, above all, people most likely just want to see closure.

Many may choose to read between the lines and deduce that the moral victory has already been won in any case. The University would not have hesitated to say if it believed that J Michael Bailey was innocent of the allegations made. The only reasonable conclusion, therefore, is that he is considered at least partly culpable. Some might be disappointed not to know the disciplinary outcome -- a loss of tenure, a fine, a written warning? Who knows? That's speculation.

What we DO know, however, is that other complaint allegations still have to be heard .. the issues are so serious that they still remain confidential .. and that this is a story which will continue to play out for months (if not years to come) .. so watch that space over there.

- Christine Burns

# Health Trust to Examine Comments by Psychiatrist

By Christine Burns

First Published 26<sup>th</sup> February 2005

**From:** Christine Burns

**Sent:** 26 February 2005 19:20

**To:** 'Press for Change News Distribution'

**Subject:** : Health Trust to Examine Comments by Psychiatrist

The Chair of West London Mental Health Trust, Professor Louis Smidt, has confirmed that investigations will be undertaken concerning remarks made in an internal memo last summer by the next head of the Charing Cross Gender Identity Clinic, Dr James Barrett. The assurance follows a letter sent by the chair of the Parliamentary Forum on Transsexualism, Dr Lynne Jones MP, questioning whether Dr Barrett's remarks were in line with the Trust's policies within the NHS.

The memo in question was first penned by Dr Barrett in August 2004 and was sent to the existing head of the Clinic, Professor Richard Green. Professor Green asked Dr Lynne Jones to circulate the memo to members of the Parliamentary Forum and, following the voicing of widespread concerns by Forum members, Dr Jones agreed to query some of the points made with the Chair of the Trust.

Three weeks ago the MP wrote to Professor Smidt, with a copy also to the trust's Chief Executive and the Medical Director.

Dr Barrett's August 2004 memo was apparently prompted by sight of a draft guidance document for NHS Purchasing Managers, setting out the way in which treatment for "gender dysphoria" should be commissioned. Some of the Charing Cross psychiatrist's remarks have been reported before. See "Echoes of a Bygone Age" (page 8).

Ironically Dr Barrett's retiring boss, Richard Green, has been closely involved in the lengthy collaborative authorship of those purchasing guidelines, along with many other leading practitioners who also attend the Forum. Many of the authors and reviewers in the project are also involved with the parallel work of a committee set up by the Royal Colleges of Medicine and Psychiatry to develop new Standards of Care for Gender Dysphoria treatment in the UK. That committee's chair, Dr Kevan Wylie (Porterbrook Clinic, Sheffield) is also a member of the Parliamentary Forum and, not surprisingly, the work of the two groups are fairly convergent... representing the consensus viewpoint of some of the principal movers and shakers in this area of medicine and among representatives of service users.

However, it is not the critique of individual statements or policy lines by Dr Barrett which has raised people's eyebrows. The concerns of those who've seen the angry memo are directed at what the next head of the country's biggest Gender Identity Clinic reveals about his overall attitudes and beliefs within a rapidly modernising health service.

The NHS Improvement Plan, published by the Government in June 2004, is the latest stage in a programme of fundamental steps to modernise the country's 60-year-old health service. See <http://www.publications.doh.gov.uk/nhsplan>

It follows consultations, vision statements and policy documents which have been progressively published over the last eight years since the Labour Government came to power in May 1997. By now, therefore, the philosophy should come as a surprise no no-one, from board executives and clinical consultants through to receptionists and porters.



Among the fundamental concepts running through the strategy great attention is given to remodelling services around the patient. "Patient Centred Care" is more than a buzzword. It is one of the most fundamental principles from which everything else follows. Patient choice isn't a luxury but an essential. Likewise, attention to quality... The patient's role in measuring that quality is a principle which all departments (without exception) are expected to uphold. The vision is one of partnership between providers and consumers in achieving what the health service is there to achieve.

These concepts also strongly reflect the ways in which trans people have traditionally criticised UK GIC's over many years. Some centres dealing with transsexual people have been anything but focussed on the needs of the individual. Choice has been practically non-existent without resort to private treatment. Quality has often been the last word which patients, their families and general practitioners would reach for to describe the process and the outcomes.

Dr Barrett's angry memo to Richard Green reveals a very reactionary attitude towards the winds of change though... and a thoroughly disparaging view of his patients:

Dr Barrett writes in his memo to Richard Green that he looks upon Patient-Centred Care as a "*jargonistic phrase*" and adds that he has "*never seen an adequate definition*" of the term. Referring to the comment in the Forum's guidelines that "*the terms a transsexual, transsexuals, male transsexuals and female transsexuals are now regarded as unacceptable*" he sniffs disparagingly, "*They are perfectly acceptable to me*". The NHS plan directs that "*patients and citizens will have a greater say in the NHS and the provision of services will be centred on patients needs*". Yet, in contrast, Dr Barrett makes the dismissive comment: "*I note that it doesn't say it should be centred on their wishes*".

The distinction between patient "needs" and "wishes" exercises Dr Barrett's mind a great deal. At one point he comments, "*My concern is that patients 'wishes' are being followed in preference to their 'needs'*", leaving the reader to conclude that the good doctor thinks he has a far better idea of the latter. Later he writes, "*I think that 'supervision' should be a rather active process, not that of simply agreeing with the patient's wishes*".

Overall, the impression is conveyed of someone who regards the preferences and views of patients with scepticism .. hardly a good basis on which to base any partnership approach to therapy.

On the idea that the Charing Cross GIC and his work should be subjected to patient audits, Barrett angrily comments, "I take extreme exception to [that idea]". He adds, "I think a more independent measure of outcome than patient satisfaction audits should be applied".

It remains to be seen how the West London Mental Health Trust will respond to Lynne Jones once it has had a chance to examine comments like these and weigh up the other expressions of concern voiced about the Clinic. A report commissioned by the Primary Care Trust serving the Brighton and Hove area of Southern England was extremely critical of Charing Cross and the Trust's sole dependency on that one Clinic when published last November (see <http://www.pfc.org.uk/pfclists/news-arc/2004q4/msg00069.htm>). Other PCTs are also said to be re-examining their referral and purchasing strategies in this area.

Across the board, services for trans people also fall short in terms of many of the initial measures by which service improvement is being judged in the NHS. For instance, the NHS plan promises that:

*"From the end of 2005, patients will have the right to choose from at least four to five different healthcare providers. The NHS will pay for this treatment. In 2008, patients will have the right to choose from any provider, as long as they meet clear NHS*

*standards and are able to do so within the national maximum price that the NHS will pay for the treatment that patients need."*

Yet this seems an unlikely prospect for trans people so long as many Primary Care Trusts carry on relying upon Charing Cross as their sole provider for services in this field. To achieve choice, regions will have to start building alternative services to service local need and provide real choice in methods and approaches. They will also need to fund the kind of patient-friendly private services which UK trans people so obviously seem to prefer, judging by the ways in which so many have obviously voted with their wallets in the past. In a small field, patients may need to be able to go elsewhere within the European Community to access specialist talents in short supply. The standards of care currently being drafted under the Royal Colleges of Medicine and Psychiatry will also need to ensure that the ability to mix and match services is preserved too, in the face of some practitioners who would rather write the rules to favour "one stop shop" centres, which Charing Cross would presumably like to remain.

Similarly, according to the Government's plan:

*"In 1997 patients waited up to 18 months for treatment - after seeing a GP, after seeing a consultant, and after diagnostic tests. Those times have fallen and now the maximum wait for an operation is nine months and the maximum wait for an outpatient appointment is 17 weeks. When this programme has been delivered in four years time, the 1997 maximum wait of 18 months for only part of the patient journey will have been reduced to 18 weeks for the whole journey. The previous long waits for GP referral, outpatient consultations and tests are included in that pledge."*

Clearly those statistics don't apply to the real experiences of trans people yet... and there is no excuse whatsoever why someone seeking help with the distress of Gender Dysphoria should find themselves subjected to a second or third class standard of care compared to any other need.

Undue reliance on a single centre by many health areas has created unacceptable waits for people to obtain a consultation in the first place. It has also fostered a service which has become arrogant as the result of holding an officially encouraged monopoly position. Now, in a post-gender recognition climate, Britain's trans people need to be asking increasingly tough questions within their local NHS ... just as those down in Brighton and Hove have already done.

In many parts of the world trans people's calls for service improvement are that much more of an uphill battle because the things we so often complain about are things which medical establishments have a vested interest to maintain. They even write so-called "Standards of Care" in ways that cement the status quo and "control" or "manage" the client.

In Britain we are luckier. The things we call for as the result of bitter experience are uncannily aligned with the principles which the Government espouses as a goal for all NHS care in the 21st Century. To use a colourful but evocative expression, trans people aren't pissing into a force nine gale with these ideas. Anyone who thinks we don't deserve more say in treatment; in real choice; in shorter waits; and in better quality; needs to justify why those things don't apply to our care when the Government sets them as measurable goals across the board for every other sphere of treatment.

The emphasis shifts from us needing to justify why these principles should apply, to the providers needing to explain why they don't yet do so.

For consultants brought up in the halcyon days of unbridled power this must all be rather upsetting. Dr James Barrett will not be the first or the last practitioner to find their attitudes questioned against the Government policy and performance yardstick. Trans people must now be increasingly prepared to use such national standards as tools... because everything that has come before has served to emphasise that we belong on an equal footing with everyone else.

The Government's health service strategy transforms the things we seek from a risible-sounding plea into mainstream rights. But nobody will simply grant those advances unless people using services are show they are prepared to couch their expectations and questions in those terms.

All in all it will therefore be extremely interesting to see how the West London Mental Health Trust responds.

- Christine Burns

# French Activists “Zap” Psychoanalyst’s Presentation

By Christine Burns

First Published 26<sup>th</sup> February 2005

**From:** Christine Burns  
**Sent:** 26 February 2005 21:40  
**To:** 'Press for Change News Distribution'  
**Subject:** : French Activists "Zap" Pschoanalyst's Presentation [GAT]

## Introduction

A couple of weeks ago Stephen Whittle posted a news item about a public meeting of the association of jungian analysts in London, where the guest speaker will be one Collette Chiland. (See <http://www.pfc.org.uk/pfclists/news-arc/2005q1/msg00050.htm> for a reminder of the details.) The event is this coming Tuesday, 1st March, starting 8.15pm at the Institute of Psychoanalysis, 112a Shirland Road, London W9 2EQ

The item drew quite a lot of comment from other campaigners in France and the United States, as Ms Chiland is certainly no friend of trans people and is being increasingly cited by US religious extremists as a handy justification for the policies they would like to promote against trans people over there ... in the land where one exposed human nipple is all it takes to create a frenzy of moral angst.

Seen in a UK context, we can generally look on people like Collette in much the same way as the purveyors of snake oil and other patent remedies. Psychoanalysis doesn't have the kind of hold in the UK that it exerts elsewhere.

In Britain we are in the fortunate position that the idea of trying to psychoanalyse people out of being who they are doesn't have the following which it commands in other parts of the world. And that's just as well, since although they may occasionally try to impress the public with long words and psychobabble, the one thing which the likes of Collette Chiland can never do is point to any volumes of successes in treating trans people's simple difference as a psychotic illness.

Having been droning on with their ideas for at least fifty years you'd think they would have something to show for their efforts by now! Instead they try to throw doubt on the process of gender reassignment, in the hope this will distract folks from their woeful lack of convincing long term outcomes.

When Chiland turns up in London to talk about us in stigmatising terms of psychosis and perversion, she may admittedly find a polite audience, but she comes to say her piece in a country where the party has moved on... to a world where we talk not about *whether* trans people should be have gender reassignment, but about the quality and choices of treatment on offer. You could say she has missed the party.

In France it is rather different. The French medical establishment holds trans people in the vice-like grip of a state sanctioned monopoly. Although French trans people have theoretically had the right to change their mandatory state ID card since a European Court of Human Rights judgement back in 1991 (B vs France), the catch has been that the mechanism which the French created to comply with the judgement is restricted to those who have been treated in the state system .. widely criticised for bothcd surgeries and a repressive approach to psychiatric control.

As a French trans you have the choice... go elsewhere for quality and live with an unchanged ID, or get the precious card and a substandard apology for new genitals.

One can therefore sympathise greatly with French campaigners when they adopt a rather more aggressive style of campaigning than we've traditionally advocated. Tomorrow (27th Feb) is PFC's thirteenth birthday. In all that time we've only ever led British Trans people onto the streets twice, and both times in the most law abiding and civilised of ways.

See <http://www.pfc.org.uk/pfclists/news-arc/1997/msg00063.htm> and <http://www.pfc.org.uk/pfclists/news-arc/2002q2/msg00017.htm> and <http://www.pfc.org.uk/pfclists/news-arc/2002q2/msg00037.htm>

...for reminders of those occasions.

A release describing the way in which French Trans campaigners approached a speech by Chiland is attached below... as you can gather it was quite a direct way of making a point .. and Chiland's audience reacted, not by talking with the campaigners but by further illustrating their closed mind approach and running away.

Press for Change still doesn't advocate direct action as a means of working... not to suggest that there is no place for it in the range of approaches which people can take in political struggle... but to just to emphasise that it isn't *our* way.

Similar differences apply in other fields: Stonewall campaigns for LGB advances in much the same way as we do... by engaging with ideas and seeking legislative and social change through winning the argument. Nevertheless there is also a place sometimes for the rather more attention-grabbing approach taken by an organisation like Outrage! It's horses for courses. And in this case who knows what constructive dialogue might have occurred if all those psychs hadn't run off at the first sign of their victi... oops, sorry, patients.

Karine Espineira of the French trans campaign coalition GAT says that Chiland describes herself as "*a feminist, essentialist and traditionalist*". She tells us "*Transsexualism is in [Chiland's] own words a 'crazy idea', an 'insane idea', a 'heresy' and the transsexual is a 'pathetic patient'.*" According to Karine, transsexualism is, for Chiland, "*an affection resulting from an overshrill narcissism*" but also "*a suffering and everything should be done to avoid it*". Espiniera adds,

*"When the GAT requires accounts of her, and in particular with the questions of Tom Reucher (see below) about a follow-up which she claims to have carried out, she won't do anything but avoid its responsibilities and its incompetence".*

If you are in London on Tuesday night and you have the time then I very much hope that people will get along to hear and challenge Collette's views in our time honoured fashion. The difference here is that the meeting is a public one .. so they can't run away from us that way .. and a good showing of eminently sane and intellectually sharp trans people is perhaps the best remedy of all to undermine all the easy lies which someone like Chiland would like to peddle.

Meanwhile our sympathies as always to our sisters and brothers living just a few miles away on the other side of the channel. In France, the distortions peddled by Collette Chiland find a ready audience and have a real and negative effect on people's lives. The least we can try to do is to ensure that Ms Chiland finds out that other people don't fall for the lie so easily.

- Christine Burns

*For further reading see the writings of Tom Reucher, a trans man and psychologist, on "When Shrinks are Frightened by Transsexuals" -*  
<http://syndromedebenjamin.free.fr/textes/englishtexts/englishtexts.htm>

## **News Release by Act Up PARIS and Groupe Activiste Trans**

**12<sup>th</sup> February 2005**

<http://www.actupparis.org/article1883.html>

Today (Feb 12th), about twelve activists of Act-Up Paris and of the Groupe Activiste Trans' (GAT) interrupted a conference organized in Sainte Anne and reserved for psychiatrists, registrars in psychiatry, psychologists, students in psychology and other care providers in mental health. They were intending to protest against psychiatrization and hatred exerted towards transgender people by the organizers of this conference.

We wanted to present our expertise against the one they impose on us but the organizers preferred to call upon participants to leave the room when we arrived. Replying to our protests about the fact we were not invited, Thierry Gallarda, one of the co-organizers, asked us in an exasperated tone : "Are you Psychoanalysts or Psychiatrists ?"

This colloquy set out to exclude the most legitimate experts of trans' issues : trans people themselves.

Psychiatrists speak in place of trans people, psychiatry stigmatises trans folk ... as the advance advertising for this "clinical seminar" demonstrated. It was announced that "gender identity disorders are linked to the field of psychosis" and also "the temactic of taking action and perversion". If you ask the shrinks, trans don't exist outside of their presumed mental health systemic disorder.

This seminar was co-organized by Colette Chiland, a spécialiste in promoting hatred toward trans people. In her books (*Changer de sexe, son "que sais-je" about transsexualism*), she shows her worst generalisations about gays and trans' ... "an attack on the foundations of our civilisation" according to her. "One can't use the opposition transsexual man/transsexual woman because one doesn't know who wants to say what". She writes about one of her patients: "he focussed attention by presenting himself as a foil". And is this the model the university offers to its students?

For Colette Chiland "the idea of sex change is a mad idea". This seminar is the application of this appalling prejudice. To shrinks, we can exist only as mad, perverted, depressed. We keep on showing what we are : angry with views full of hatred.

We require :

- ❖ for Collette Chiland, to be silent;
- ❖ for the trans issue to be removed from the psychiatric field;
- ❖ for trans people to be able to take part in seminars approaching this topic, and to work with groups for improvement of access to care and their management.

*Translated into english by Marlène Riwek Mèges and Karine Solène Espineira of the Groupe Activist Trans' (Paris, France) with further idiomatic editing by Christine Burns*

## ***Postscript to Collette Chiland Story***

**From:** Christine Burns  
**Sent:** 27 February 2005 10:08  
**To:** 'Press for Change News Distribution'  
**Subject:** : UK: Colette Chiland Meeting Cancelled

Dear Readers

Since my news item yesterday about the talk in London by Prof Colette Chiland I have received two mutually corroborating messages from readers to say that the meeting planned for Tuesday 1st March will not be taking place after all.

People contacting the organisers to book places by email have received the brief and perfunctory reply that "due to unforeseen circumstances" the event has been cancelled.

If we receive any news about the meeting being rescheduled then we will let you know.

- Christine Burns

# Belgique – Loi Discriminatoire – Trans Action

Belgian Activists

First Published 18<sup>th</sup> May 2005

## Introduction

To reinforce the point that trans people are increasingly campaigning for less discriminatory provision throughout Europe, this item highlights moves underway in Belgium at the same time as those in France. Belgium is not the only European State where the first instincts of legislators are to make certain medical procedures obligatory in return for legal protection of fundamental rights to privacy, family life and protection from discrimination. It is an ethical challenge for doctors not to allow themselves to be co-opted into processes that use the carrot and stick to normalise rather than accept differences.

### ----- Original Message -----

**From:** marlene <marimeg@wanadoo.fr>

**Sent:** Wed, 18 May 2005 23:12:02 +0200

**Subject:** : Belgique - loi discriminatoire - trans-action

## Belgium – Petition Against a Discriminatory Bill

The trans' (transsexuals, transgenders) signatory associations groups and organizations of this letter have just been informed by Belgian Collective Trans-Action that a bill to legislate on the transsexualism issue is being debated in the Justice Committee of the House.

This bill would propose some improvements particularly by allowing civil status change by administrative proceedings.

On the other hand, the signatory associations protest against the insertions in a legislative text of inadmissible and discriminatory paragraphs.

The bill actually intends to set a legal definition of transsexual people by assuming medical competences. The legislators means to substitute oneself to physicians by determining who is transsexual and who is entitled to treatments and by defining terms of access to these cares (Chapter II of the bill).

It is finally a screening of access to treatments and such provisions are unacceptable.

Furthermore, the bill intends :

- ❖ to set irreducible times in the path without reason;
- ❖ to forbid civil status change to people who cannot undergo surgery, particularly for health grounds;
- ❖ to forbid to undergo surgery to minors, what is an additional interference in medical practice and patient's interest;
- ❖ to impose infertility as a condition of access to civil status change, what is an eugenicist view ethically intolerable.

Moreover, the drafting of some provisions could allow a very discriminatory reading. For an example the paragraph 3 provides that : "*Hormonal and surgical sexual reassignment can be performed only within multidisciplinary teams at least made up of a psychiatrist, an endocrinologist and a plastic surgeon.*"



This concept of multidisciplinary team remains vague and drawn up differently in Dutch version of the text (cooperation of physicians). A restrictive reading of this paragraph could establish a de facto monopoly of teams of self proclaimed experts.

Finally, other legitimate issues are not broached in the bill.

So what about people who have done path abroad or are given some treatments in an other country ?

The question is also tabled for people who follow an other track than the one officially recommended.

Signatory associations request insistently to Belgian authorities to take into account Belgian associations comments and amendments, particularly Transaction collective ones

Signatory associations request that trans' (transsexuals and transgenders) shouldn't suffer, in the guise of a law, some additional discriminations in the recognition of their identity and in the fundamental right to access to treatments.

The petition against this discriminatory bill can be signed at :  
<http://www.petitiononline.com/betslaw/petition.html> (in french)

The petition can also be sent to :

Madame Van Kerckhove  
Karel De Preterlei 182 bus 7  
2140 Antwerpen (Anvers)  
Belgique - Belgie

Do not forget to indicate the name and address of the signatory association, group or organization.

# A Petition About Healthcare in the NHS

By Christine Burns

First Published 11<sup>th</sup> June 2005

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## Introduction

The NHS petition wasn't a Press for Change initiative. In fact PFC as an organisation believes in using petitions very sparingly as a tool – especially in a field where the community is itself very small, often isolated and not always able to access the Internet. That said, we also believe that if someone else has taken the initiative to kick off a petition then, so long as we approve the sentiments, we'll use the campaign's communication resources to help promote the initiative. This particular example went on to produce far more evidence of serious problems than we expected. It illustrates the seriousness of the problem all too well – with more than 10% of the UK's trans population expressing serious dissatisfaction.

The petition can still be found at <http://www.petitiononline.com/nhsgidsp/petition.html>. At the time of writing (May 2006) the signature count has grown to 575.

**From:** Christine Burns  
**Sent:** 11 June 2005 19:27  
**To:** 'Press for Change News Distribution'  
**Subject:** UK: A Petition About Healthcare in the NHS

## Some Background

The general state of medical provision for trans people will not need to be described to most readers. Next to the overall struggle for broader acceptance in society, I'd guess that the controlling and demeaning way in which trans people have traditionally been treated by some medical practitioners is the *second* most discussed topic when trans people come together anywhere on the planet.

Western medicine offers us a system which is at present still founded in a long tradition of pathologising and proscribing difference. This is especially the case within psychiatry.

Trans people are not the only minority to have suffered this way in the West. Long after psychiatrists officially gave up stigmatising gay and lesbian people with a mental illness label, there are still many self-aggrandising "experts" who would like to put the clock back. And, in our case, there are many who would quite like to keep the clock just where it is.

See "Echoes of a Bygone Age" (Page 8).

Many developments are taking place at the current time. On the heels of the Gender Recognition Act there is actually quite a lot of activity to try and reform UK health provision for trans people in various ways... from challenging the monopolistic power of the largest GIC to drafting new UK-specific guidelines for care which everyone can embrace.

## New Guidelines on Commissioning

Earlier this year the Parliamentary Forum on Transsexualism agreed and published its own long awaited guidance for health organisations commissioning treatment services for trans people. See <http://www.lynnejones.org.uk/transsex.htm> for more details.

These commissioning guidelines are not intended to be a recipe or manual for modern standards of care as such - that will follow later this autumn we hope (see below). However, with the input and support of many of the leading figures in UK trans health care, you CAN look upon the Parliamentary Forum's guidance to the people who make and pay for referrals as an indication of the way in which the wind is blowing. Notice in particular the strong emphasis on concepts such as rights, partnership, autonomy and choice.

Work is now underway to promote awareness and adoption of these guidelines. One product of that will be more questioning of the way in which care is structured and provided, and which services can be sourced locally to provide choice and convenience, whilst still achieving joined-up care. *You* can help by ensuring that your own local health hierarchy is aware of this document and uses it to ask overdue questions about spending hundreds of miles away in a service which so many detest.

### **Local Pressure for Change**

On various other fronts there are initiatives to actively encourage local health care trusts to break away from an unthinking reliance on Charing Cross and to design their own approaches to meet local needs. One particularly notable example is in Sussex, where one Primary Care Trust set the ball rolling by commissioning a study... and (in spite of some high level embarrassment about the powerful conclusions) the process is now broadening into a region-wide debate about alternatives.

See "Report Criticises Charing Cross" (Page:5) followed by the report itself at

<http://www.pfc.org.uk/medical/spectrum.pdf>

Other local care trusts are going through similar processes. The challenge for these is to ensure that they evolve into a healthy system of diverse services, and not simply local-funded clones of the same repressive and archaic thinking. Another challenge is to ensure that guidance on the actual approach to care in the UK (so-called "standards of care" or SoC) develops in a way which doesn't inhibit the evolution of different approaches and the achievement of realistic CHOICE for service users.

### **Standards of Care**

Work on standards of care designed specifically for the UK's modern vision of health provision began around two years ago with the formation of a joint committee of the Royal College of Psychiatrists (RCPsych) and the Royal Society of Medicine (RSM).

The committee is chaired by Dr Kevan Wylie of the Porterbrook Clinic in Sheffield. (<http://www.porterbrookclinic.org.uk/>) and still has a long way to go before getting to something which everyone can endorse. Nevertheless, at present, this is the cutting edge when it comes to the question of whether practitioners simply document what they do at the moment, or can be challenged to think out of the box about how it *can* be done better.

This is an area of deep conservatism in some quarters. Others on the committee hold more modern and liberal views about their role and the way they work. But we need to help *those* friends to help us.

Experienced trans campaigners can lobby and in some cases win individual points; however they need a strong mandate to lend power and authenticity to what they say. That is why it is particularly valuable if a significant number of trans people ARE now finding the courage to stand up and denounce the traditional way of controlling rather than caring.

## Christopher's Petition

Christopher's petition was actually a surprise from the blue. Communications somehow failed on this occasion... which is a shame, because we could have done more than to help shape the statement of the petition to maximise its impact and to help us encourage people to support it sooner. Press for Change has the largest mailing list and news forwarding capability of any trans organisation in the UK, and PFC's entire organisational philosophy is about nurturing the campaigning initiatives of people who want to stand up and do their bit, large or small.

Some may debate the value of petitions. On their own, petitions are seldom large or powerful enough to create change. Nevertheless they *can* be a good indicator of the strength of feeling about an issue - and that's certainly where this one holds the greatest potential value.

## Defending the Behemoth

Charing Cross claims to have recently carried out its own audit of service user satisfaction (partly in response to concerns voiced about James Barrett's unfortunately expressed views). In spite of MP's questions being raised with the Chairman of the West London Mental Health Trust about Dr Barrett's views, the Trust has recently appointed Dr Barrett as the new clinical lead, replacing Professor Richard Green (who is moving now to a part time involvement). In a recent letter to Dr Lynne Jones MP, chair of the Parliamentary Forum, Trust Chair Professor Smidt apologises (in effect) for the fact that Dr Barrett's email came into our hands, rather than for the content and says that,

*"...Dr Barrett supports patient centred care and patient satisfaction questionnaires have been undertaken by the service"*

The latter was in fact no surprise. At a recent meeting of Kevan Wylie's SoC committee, Dr Barrett was keen to volunteer news about the Charing Cross patient satisfaction "audit". According to Dr Barrett, all users of the Claybrook Clinic (aka "Charing Cross GIC") had completed a questionnaire and 75% of the responses had given "satisfied" (or higher) ratings to the service. Dr Barrett advised the committee that,

*"Most discontent was around time taken for funding and then a second discontent over time taken for obtaining funding for surgery. Speech and Language Therapy were rated very highly and one of the suggestions to improve the service was to have refreshments and snacks in the waiting area which the Clinic has followed up."*

Some might find it strange, therefore, that at the present time (and long before this first ever promotion by the country's largest lobbying group) a petition critical of NHS services (but Charing Cross in particular) should have drawn 100+ signatures.

Some of the disparity could be accounted for by the methods used in the Charing Cross audit.

Sources say that the questionnaire was distributed by the staff of the clinic itself, who also then received back the completed forms and analysed them. Respondents to the questionnaire could in many cases be identified by their answers, so it was hardly an independent process designed to elicit opinion from critics.

In politics, of course, people just remember the headlines. "75% satisfied with our service" sounds good to outside observers and peers. Do 100 signatures saying something different in a petition alter that?

## ***The Importance of Speaking Out***

History teaches that bad things happen when people are afraid to speak up. This certainly seems to have been the case with the treatment of transsexual people, where methods and medical attitudes have changed very little in 40-50 years.

Once those methods could have been defended as necessary in a world that was generally very hostile towards us. The world has changed, but some practitioners behave as though it hasn't; instead they cling on to ways of thinking about and controlling transsexual people as though it were still 1955 rather than 2005. And that's the way it will continue unless people begin to change it by voicing their feelings.

One hundred signatures sounds impressive. Unfortunately, even in a community of just 4-5,000 people it isn't enough. Charing Cross boasts a case load of 600 service users at any one time. 1 in 6 complaining is therefore no more significant than the results of James Barrett's own internal poll – less so, in fact.

Charing Cross is developing a take it or leave it attitude these days too. Richard Green certainly stunned me this week when he said that he wasn't bothered if people went elsewhere because the clinic is happy enough with the 600 clients it has got.

So, the opportunity is in your hands. If you agree with the broader statement of Christopher Pearse's petition then, by signing it, you signify the extent to which trans people in the UK are dissatisfied in general with the quality and choice of services made available to them through the NHS.

One hundred points to a problem. Five hundred (10% of the community) suggests some sort of crisis. How many signatures make this a scandal? You decide.

The petition will be found at <http://www.petitiononline.com/nhsgidsp/petition.html>

- Christine Burns

# No Welcome in the Hillside

By Christine Burns

First Published 1<sup>st</sup> October 2005

**From:** Christine Burns  
**Sent:** 01 October 2005 20:12  
**To:** 'Press for Change News Distribution'  
**Subject:** UK: No Welcome in the Hillside

The following account is based on the first hand accounts of a person living in Wales whom I will call Rhia.

Rhia, registered male at birth, considers herself transsexual. Nobody (as far as I can see) disagrees with that. This much will become apparent as you read on. Rhia's main problem isn't with being most probably transsexual. Her problem concerns where she lives.

In Wales, access to funding for medical help dealing with the needs of transsexual people is controlled by a body called "Health Commission Wales" (HCW). And if Rhia's account of her "care" by HCW is even only half true, my personal recommendation to other trans people living in the Principality would be to get out of the place as quickly as possible and join the 21st Century.

For what Rhia describes in her emails and bulletin board postings is Abuse, pure and simple. Care simply cannot be used to describe any part of the handling she has received to date. It cannot be described as "treatment" either.

I'm confident that you'll share my conclusions as you read on.

Rhia first wrote to me about six weeks ago in August -- clearly quite distressed -- attaching an account she had already posted on a bulletin board, looking for help.

Describing her twelve months of go-nowhere treatment as "Sick and Twisted", Rhia began her tale by explaining the point that her lengthy saga had reached,

*"I have just received the most sick, twisted, and in all ways uncaring and wrong decision on whether or not Health Commission Wales will allow funding for my referral to Charing Cross"*

As you read the rest of this account, it is worth keeping in mind that Health Commission Wales acknowledge their controlling responsibility for access to treatment for what they call "Gender Identity Disorder Services" (GIDS). In January 2005, they published a policy document for this under the web site of the devolved Government in Wales, the "Welsh Assembly". The policy, presented by the Acting Deputy Medical Director and the Assistant Commissioner for Mental Health Services, can be found at <http://tinyurl.com/ba26t>

The introduction to the HCW policy for GIDS looks equitable enough,

*"[This] paper aims to ensure that those most in need and able to benefit are given equitable access to the service across Wales."*

The goal is supposedly clear too:

*"This paper presents Health Commission Wales (HCW) policy on Gender Identity Disorder (GID) services for adults, including sex reassignment surgery (SRS). It addresses the criteria for selection for genital and breast surgery, and the provision of other clinical interventions to assist feminisation or masculinisation."*

As you'll see shortly, however, the reality for Rhia has been very different to these fine-sounding words. However, I'll let Rhia introduce the story in her own words:

*"Last August, [Health Commission Wales] referred me at the request of my local psych to a specialist psych in Birmingham for an assessment."*

*"The psych in question was very bizarre and I was in two minds as to whether to report him for his behaviour or bear with it to hopefully get treatment faster."*

*"He started psychoanalysis without HCW offering funding for treatment, which promptly stopped thereafter."*

At present the question of how people should first be assessed when presenting with gender issues is not approached with any consistency across the country. The Commissioning Guidelines recently put forward by the Parliamentary Forum on Transsexualism (chaired by Dr Lynne Jones MP) have this to say on the topic:

*"Gender Dysphoria is likely to present initially as a self-diagnosis. The individual may speak to his or her GP about the discomfort experienced historically and currently with the gender role in which he or she is living. However, the individual's initial request for help may be via any other member of the caring professions with whom that individual feels able to share his or her concerns. Whatever initial route is taken, the GP should endorse the treatment pathway and ensure funding from the NHS. The GP may refer the individual to a specialist clinician. This will usually be a psychiatrist, clinical psychologist or any other specialist working in the field of transsexualism. This referral may well be 'out of area', but should be within reasonable travelling distance. A first appointment at the service to which an individual is referred should occur in accordance with NHS waiting list times."*

**Source :** "Guidelines For Health Organisations Commissioning Treatment Services For Individuals Experiencing Gender Dysphoria And Transsexualism" - Parliamentary Forum on Transsexualism, April 2005. Para 8.2

<http://www.pfc.org.uk/medical/index.htm#healthauthority> or via <http://www.lynnejones.org.uk/transsex.htm#forum>

Unfortunately the Parliamentary Forum's commissioning guidelines have no official force as yet, though they were drafted and agreed with the active involvement of some of the leading clinicians practicing in Britain at the time. The separate Royal College of Psychiatrists Committee headed by Dr Kevan Wylie, charged with formulating the British equivalent to "Standards of Care" says practically nothing about referral in its current pre-consultative draft.

The HCW Policy on "GIDS" says this, however:

*(8.1.1) Welsh GPs will refer the patient initially to a local NHS consultant psychiatrist.*

*(8.1.2) The local consultant psychiatrist will assess the patient, and if appropriate, will refer the patient for a second opinion from a Welsh NHS consultant psychiatrist, preferably with an interest in gender disorders.*

*(8.1.3) Following the receipt of a second supportive opinion, the patient will be referred by the original consultant to an HCW approved GID service for Welsh residents, following prior funding approval from HCW's NPSA Panel.*



From Rhia's account, therefore, she had certainly passed through step 1 of the above process. She had been seen by a local (general) NHS consultant psychiatrist. As a result of that consultation Rhia had then apparently also been referred to a second consultant psychiatrist -- although why it should be necessary for her to travel as far as Birmingham for that is something of a mystery.

The second consultant seems to have decided to treat her to a round of Psychoanalysis, which seems odd given that no part of HCW's policy recommends this in the case of Gender Identity. There is no indication of whether the person concerned had "an interest in gender disorders" .. though, quite frankly, taxpayers funding the National Health Service should be entitled to be seen by someone whose qualifications and experience exceed mere "interest".

At least, however, we must assume that the Birmingham psychiatrist thought Rhia had a gender problem, otherwise why offer to treat it? This being so, the logical next stage in Rhia's treatment path should have been (8.1.3) above - involving a decision to fund referral to "an HCW approved GID service for Welsh residents".

Rhia continues her tale:

*"It then took my local psych 4 months to request funding for a referral to Charing Cross, which he did in May of this year, but he didn't give a full report of all the clinical information. HCW turned me down."*

*"At the same time that I found out that my referral request was turned down (GID services carry - apparently - the lowest priority of all), I found that my psychiatrist had changed, but I had to find out all this for myself as nobody had seen fit to tell me any of it."*

*"At the beginning of June, my new psychiatrist appealed on my behalf, telling them (such is the truth) that in no uncertain terms I was at risk of serious self harm and/or suicide, and that this was as a result of a depression at the root of which is my gender dysphoria. She stated in no uncertain terms that I am unable to integrate in society in any real way and that I would not get any better at all until I recieved a sexual re-assignment (the full works)."*

*"That was the beginning of June. HCW claimed repeatedly that the decision wouldn't take long, and in the meantime kept moving the goalposts. They've put me through a hellish mental torture since then while I have been desperately trying to find out any information I can from them."*

Being messed around by an NHS system that's dogged with changes of faces and responsibilities is not unique to trans people of course; nor is it unique to Wales. That's just the nature of the NHS, within which Mental Health Services are often the worst offenders of all, since their "customers" are usually in the least likely condition to complain.

It is a mark of the lack of qualification of Rhia's carers that they should think a suicide risk to be a good way of emphasising the urgency of need for referral to a gender specialist. The irony is that it is quite the reverse. Having a "suicide risk" label attached is the most reliable way to NOT be treated by a Gender Identity Clinic. People presenting with such a risk are normally expected to receive treatment to fully mitigate that risk first before any treatment for their gender issues can begin. Rhia's local NHS team was therefore setting her up for the classic "Catch 22" of gender treatment:

**To obtain referral funding to a GIC we need to say you're suicidal**

**But if you're suicidal the GIC won't treat your gender identity issues**



Note that already, by this time, Rhia had been passed around the system from before August 2004 till June 2005. She had been seen by three psychiatrists, one who bungled her case and one who tried to treat her with snake oil (psychotherapy). Yet she had still not yet been seen at all by anyone actually qualified or experienced in treating people with gender identity issues.

In August 2005 Rhia suffered the blow which prompted her to tell the world about her experiences. On August 17th she wrote,

*"Today, I recieved a call from them regarding a decision on my case. Apparently, I meet all the criteria for funding, but unfortunately because of the low priority policy, I've been having to fight to get it – and I still don't have it. They would apparently consider me to be an exceptional case, depending on this..."*

*They are asking my local psych to obtain a second opinion – not on my GID – three different consultant psychiatrists have already diagnosed that I have a serious case.*

*No. They want a fourth psychiatrist to give a second opinion on how likely I am to kill myself or cause myself serious harm."*

And she adds,

*"Surely they've tortured me enough already?"*

*"Do they want me to die out of the way to avoid paying out?..."*

You can understand Rhia's dismay after having already come so far, taking more than a year just to have her diagnosis confirmed, and then to be told she wasn't yet sick enough to be treated. Maybe this is what HCW actually mean in their policy when they state:

*(8.1.6) Referrals for initial assessment for NHS treatment should be prioritised according to clinical need and in consonance with HCW's prioritisation policy."*

Except of course that, by now, this was far from an initial assessment.

Some of the thinking at work in HCW can be seen in the published results of a consultation among health agencies in Wales. See <http://tinyurl.com/7txyl>.

Following publication of the Commission's policy document in January 2005, a decision was made the following month to seek the views of Local Health Boards and the Welsh Trusts about the priority to be accorded to commissioning for transsexual people; whether the policy's criteria were clear, workable and equitable; and whether the bodies would support the policy's application.

Overall the committee received 13 responses. None considered commissioning to be a high priority. Two thought such services shouldn't be a high OR a low priority. Three were clear: they thought it was a LOW priority; and eight had no opinion at all. Notably the consultation defined a "Stakeholder" in terms of local health boards and NHS Trusts. No mention of Service Users at all. So that's a big welsh thumbs down for people like Rhia.

One responding authority is even quoted as saying,

*"We (NHS Trust) would not support an application for this service to be established and maintained within Wales"*

Among the implementation options considered in the consultation review were:

*"Option 1: no gender identity disorder provision for Welsh patients"*

Which the authors considered to have

*"No financial implications to HCW"*

Presumably the committee, in their ignorance, were not aware of the Court of Appeal decision in the case of A.D. & G vs NW Lancs Health Authority (July 1999), in which the Court upheld an earlier High Court opinion that a refusal to fund was "unlawful and irrational". (See <http://www.pfc.org.uk/legal/index.htm#medicfund>)

In practice, the committee concluded that their recommended course would not be "Option 1", but:

*"Option 2: implement the policy only in exceptional circumstances, considering each case on an individual basis"*

Nevertheless, it was still perhaps remarkable that the reviewers could conclude with confidence that,

*"There are no known issues relating to the Human Rights Act and/or Welsh Language Act, however the Office of the Counsel General have been asked to consider any legal implications of such implementation."*

As well they might!

In fact my own response to Rhia at this point was to give her the details of a string of legal practices recommended by contacts at "Liberty", the UK Human Rights group.

Understandably, many people in a position like this may feel that they don't have the stamina at that point to contemplate a long and stressful legal battle. If at all possible it IS best to try and avoid such things, as the process can take years and (during that time) the person who feels they've been neglected or abused is unlikely to get any closer to getting treated.

I also recommended that she should consider engaging the help of her MP or Welsh Assembly Member. Sometimes elected representatives can be very effective at knocking heads together at a local level, or going over those heads to encourage the application of general NHS policy on access to healthcare, as it is intended to apply to every British citizen. Again, however, like many people who just desperately want help from the NHS, Rhia wasn't convinced this would help in her case. Given the extent to which people in authority had already failed to help her, I can fully understand her reluctance.

Rhia's story doesn't end there, however.

A few days after the refusal to fund her referral to Charing Cross, she had another appointment with the local psychiatrist's team. Her normal psychiatrist was away ill, but she saw one of his colleagues instead. In her words,

*"I informed him that HCW was looking for a second opinion on my state of mind, and that they had stated that his opinion should be sufficient even though he was on the same team. He claimed that he was unable to give such a report because he was on the same team. I repeated that HCW had said that this was ok, and still he refused."*

Just to remind you, in case you've lost the plot at this time -- Rhia was told she needed a second opinion on whether she would harm herself or become a suicide risk if not referred to Charing Cross. She was therefore not going to get anywhere unless someone would offer to give that assessment.

She says,

*"He then proceeded to try to pathologise my depression, and asked me why I thought I was depressed"*

With the clinical agenda now defined by glorified accountants, perhaps this was a starting point for giving Rhia the pathology which the funders wanted to hear. However, as Rhia says,

*"This is old ground. These were the sort of questions I was first asked three or four years ago - the fact I have depression is not really in question. It's been diagnosed fairly thoroughly."*

Indeed, could anyone fail to be depressed having been so thoroughly neglected already by the system? Let's remember what Rhia wanted. She wanted to see someone with specialist background in dealing with the issues which no-one denies she had. Yet, for years, she had simply been passed like a parcel from one person to the next -- each one asking the same old questions and getting her no nearer to an actual treatment. Now she was being asked to collude in being diagnosed with a mental illness that would ultimately disqualify her from the treatment she sought. I think a little NHS-induced depression could be understood in such circumstances.

She continues,

*"I then suggested that my visit, which I had put so much hope in, had been a complete waste of both my time and his. He disagreed because apparently "At least now we know how you are feeling".*

In exasperation she writes,

*"Surely that was fairly obvious?"*

The system hadn't finished with her yet though...

*"A few days ago, I called my psychiatrists secretary for more information on what correspondance there had been between themselves and HCW."*

*"My psychiatrist informed me that she had seen HCW's request for a second opinion, and had written back to them informing them that they would have to provide funding for a referral to get one".*

HCW had written back to Rhia's psychiatrist explaining what they wanted (and what she had tried to simply explain to the psychiatrist's colleague). Accordingly, the psychiatrist sent Health Commission Wales a report stating that Rhia was depressed and was getting worse.

Rhia now has to wait for a response to that. However in the meantime she has understandably decided after all these years that she will simply self medicate with HRT.

As she says,

*"It's something that I've told EVERYONE would happen if there was no progress, and now it has."*

She told the Commission themselves when they explained that an appeals panel would not be able to even sit and consider her case until the middle of 2006. Her account of the conversation goes like this:

*Rhia: "So you're saying that the appeals panel might not sit even until the beginning/middle of next year?"*

*HCW: "Yes"*

*Rhia: "OK, so I've spoken to my GP, and he is more than happy to prescribe HRT on the recommendation of a private psychiatrist."*

*HCW: "If you go along that route you need to consider it carefully as it will mean that you won't be able to get help on the NHS in future."*

*Rhia: (slightly annoyed) "Why?"*

*HCW: "Well it's queue jumping, that's why we have this policy on not allowing funding for those who have previously gone private. It's just not fair on those people who have been waiting patiently."*

*Rhia: "How is it queue jumping? It's me happily waiting in line, and while doing so taking action to make my life a little more bearable until such time as treatment is available. I'm not asking you to pay for it, and in fact it would be saving you money"*

*HCW: "It's still queue jumping"*

*Rhia: (sighs) "OK, so if I self medicate by buying hormones on the internet, and deciding on my own regimen, that will still allow me help on the NHS because it's not private treatment?"*

*HCW: "That's correct".*

The last part is, of course, breathtaking.

Health Commission Wales -- the body with a statutory duty for the care of all citizens living in its jurisdiction -- appears to be advocating a course of action generally regarded to be very unwise indeed, if Rhia's account and recollections are true. Not only do you not know the quality or contents of what you are buying from Internet Pharmacies but to take hormones and anti-androgens without proper screening and regular checks is positively dangerous for some.

On the bright side, Rhia reports feeling a lot better and experiencing improved emotions as a result of finally obtaining a key to what she simply wants to do. Her former symptoms, as you might expect, are those of being neglected and abused by the system, rather than the symptoms (or contraindications) of any gender identity related "disease".

Starve a man and they'll get ill. Treat the problem -- feed the hunger -- and they'll get better. It's a simple equation. Yet, in Rhia's case, Psychiatrists and Commissioners appear to have become the problem, denying the cure. That is why, at the outset, I characterised this story as one of abuse and neglect. In any other context that is what such actions would be called.

Rhia's case is far from unique. Many readers of PFC-News can relate past experiences of a similar kind. You may even be going through them. I'd certainly like to thank Rhia for her kind permission to write about her experiences almost word for word. However, other than resorting to lawyers, I'm very sad that we cannot at this time offer a lot of hope.

Worse, in Rhia's case, she is likely to suffer the cruellest of further abuses should she finally win the dubious pleasure of treatment by Charing Cross. For they are likely to tell her for starters that they won't even begin to treat her unless she stops taking hormones and goes back to square one for their evaluation.

The saddest thing of all is that the current draft of the Royal College of Psychiatrists' guidelines (or "Standards of Care") don't even begin to address the kind of problems I'm describing here. That's because the "experts" gathered together to work on such a vitally important document have so far been unable to think outside of their own little sphere of expertise.

Endocrinologists write "standards" for administering hormones. Surgeons write "standards" for when it's safe for *them* to cut people up. Speech Therapists put in a good word for enabling people to be able to speak right.

But *none* of them have even considered in committee the vital overriding requirement for ensuring that care takes place in a joined up fashion from the first point of contact with the system till the last -- including referral and funding. They've been working for more than two years and it has not even seemingly occurred to them.

There are many reasons why the RCPsych committee have already been told by the trans stakeholders that their efforts to date are unsatisfactory. Much of that concerns the attempts by some Doctors to write in provisions to preserve and tighten their grip on a monopoly of the worst kind -- a monopoly which seeks to prohibit choice by preventing alternative forms of provision.

The political attitudes are visible in the bizarre conversation which Rhia reports -- "Go private and our bit of the NHS won't treat you" (an illegal threat, by the way). The same attitudes are also there in the well-reported circumstances that are bringing trans people's most trusted independent therapist before a GMC hearing next year. The consequences could see him struck off.

As Rhia has discovered, the ultimate safety net for trans people who can afford it is to abandon the seriously politicised madhouse of the NHS and construct their own care pathway privately.

However BEWARE! Unless you can finish what you started that way, the NHS has a very brutal way of dealing with your impertinence. The Government favours choice and autonomy. HCW bureaucrats evidently think it should be punished by the withdrawal of the right to NHS treatment paid for in taxes.

This is why the process of dealing with the Committee set up by the Royal College of Psychiatrists and the Royal Society of Medicine is such a vital activity for the future of trans people in Britain.

With the authority of not one but two Royal Colleges, the document eventually published by Kevan Wylie's committee can either be a positive instrument for change for a generation to come, or it may be the mechanism for controlling trans people's lives even more closely. They can describe real standards for caring for us throughout the health service (even in the face of financial restraints). Alternatively, by omission, they can mandate petty officials and disciplinarian psychiatrists to go on limiting choice. They can allow monstrous administrations like HCW to happily keep people going nowhere for years on end, as they really *do* become mentally traumatised as a result of institutional abuse.

Which will it be? Well, that's hard to call at the moment. However if anyone thought that the fight was over with the passage of the Gender Recognition Act, it isn't. The new fight now is about people who may never even get to qualify for gender recognition if they can't get referred to a GIC for the all-important diagnosis.

-Christine Burns

# Pipedream or Prelude?

By Christine Burns

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**From:** Christine Burns  
**Sent:** 31 July 2005 16:29  
**To:** 'Press for Change News Distribution'  
**Subject:** UK: Pipedream or Prelude

**Pipedream** (noun) - a hope or scheme that will never be realised

**Prelude** (noun) - an action or event acting as an introduction to something more important

*(Pocket Oxford Dictionary)*

**LAST WEEK** I published here an article introducing the idea of a "Manifesto for Care".

See <http://www.pfc.org.uk/medical/cb-eval1.pdf>

"A Basis for Evaluating Care Approaches and Services for Trans People in the UK" contains a lot more material besides the seven "big ideas" that I talked about last week. In particular, there is a very useful piece on Patient Centred Care, kindly researched and contributed by Dr Stephen Whittle. You'll also find a detailed set of "tests" which could be levelled at any proposals for both care guidelines and services.

The tests are directly tied to the same modern health service principles which I referred-to last week:

**Accessibility -- Timeliness -- Empowerment -- Choice -- Dignity**

**Respect -- Equality -- Partnership --Autonomy -- Independence**

and, last but not least, **The Right To Complain**

It's worth noting that, in my "day job" helping to run a sizeable private sector care organisation for vulnerable adults, most of these headings are not optional or frivolous. Failing to meet many of those goals would simply break the law (The Care Standards Act, 2000). At the very least, ignoring them for any length of time would see an end to our funding and get us closed down by the Commission for Social Care Inspection.

... That's if you ignore such principles in caring for Children, Elderly People, or adults with Learning Disabilities or long term Mental Health problems.

Sadly, I'm afraid, most of those same principles are very sorely lacking in contemporary healthcare for trans people in the UK at this time. You only have to look at the words of all those people who've contributed to the Petition which one desperate service user decided to organise through personal frustration:

[http://www.petitiononline.com/mod\\_perl/signed.cgi?nhsgidsp&1](http://www.petitiononline.com/mod_perl/signed.cgi?nhsgidsp&1)

## **Reasons for Caution**

When I wrote my paper, I was drawing on thoughts that had occurred to us when reading the first early drafts from the RCPsych / RSM committee tasked with producing new guidelines for the UK. Since then, there are signs that some of our concerns have been taken on board. That's what consultation is all about. Nevertheless, at last sight, I'm sad to say that many other concerns, though voiced in the same way as in the "Manifesto", were still unaddressed. The optimist in me hopes that the next draft, destined for wider consultation and debate, will address some of those other holes. Nevertheless, I have perhaps explained enough about some of the personalities running loose in certain UK GIC's, for readers to appreciate that I'm not going to pin my reputation on that hope.

It is healthy to be sceptical. And I can well understand many readers looking at last week's article and the larger document in the same way. I can imagine many people saying, "Yes, that's all very nice and starry eyed Christine, but could it really happen? Could we really expect one day to see the same kind of care standards that other health service users are promised as a right?"

## **Nothing Actually New**

When summarising lots of people's ideas into our set of seven "big ideas" or "principles" there was one immensely useful reference that I had temporarily forgotten about. I ought to be embarrassed too, because the ICTLEP principles have an important place in the PFC web site's medical index at <http://www.pfc.org.uk/medical/>

See <http://www.pfc.org.uk/medical/ictlep.htm>

The Health Law Standards of Care for Transsexualism were first adopted at the 2nd International Conference on Transgender Law and Employment Policy, August 1993, in Houston, Texas. In other words, they've been around almost as long as Press for Change. I was quite surprised when I went back to study them, however, and realised how much similarity there was in the thinking.

Certain key principles overlap very strongly with the priorities many of us identified when looking at the conservative thinking which practitioners were still proposing to regurgitate in their 2005 guidelines:

**ICTLEP Principle 1** : Transsexualism is an ancient and persistent part of human experience and is not in itself a medical illness or mental disorder. Transsexualism is a desire to change the expression of one's gender identity.

(We even recognise that principle as so important that it comes as number one)

**ICTLEP Standard 1** : Physicians participating in transsexual health care shall provide hormonal sex reassignment therapy to patients requesting a change in their sexual appearance subject only to (1) the physician's reasonable belief that the therapy will not aggravate a patient's health conditions, (2) the patient's compliance with periodic blood chemistry checks to ensure a continued healthy condition, and (3) patient's signature of an informed consent and waiver of liability form. If the patient is married, the physician may not require divorce but may also require the spouse to sign a waiver of liability form.

(This overlaps considerably with concepts in my own paper, especially in terms of the principle that people should be able to make and take responsibility for informed decisions, so long as there is no evidence of an inability to do so. Put bluntly, a practitioner would have to have sufficient evidence to forcibly institutionalise their patient before having the right to override or disregard their wishes).

In case you think that is a little ambitious even for modern health care in the UK, then it really is worth studying the Mental Capacity Act, which received Royal Assent on 7th April 2005.

See : <http://www.dca.gov.uk/menincap/intro.htm>

And <http://www.dca.gov.uk/menincap/legis.htm>

And, of course, <http://www.opsi.gov.uk/acts/acts2005/20050009.htm>

The Act itself says at the very start, in a statement of Principles that:

- (1) The following principles apply for the purposes of this Act.
- (2) A person must be assumed to have capacity unless it is established that he lacks capacity.
- (3) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- (4) A person is not to be treated as unable to make a decision merely because he makes  
an unwise decision.
- (5) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
- (6) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

It is therefore rather sad to think that some practitioners in our own field may wish to carry on promoting the kind of approach to care which flies in the face of such strong legislative thinking.

### ***Alternative Models***

The kind of manifesto principles which we are talking about today therefore not only owe their heritage to ideas which have been in gestation for many years, but they are also thoroughly aligned with not only health service *thinking* but contemporary legislative aims too.

For all that, of course, it is a pretty tall order to suddenly start thinking about constructing UK services for trans people in radically different ways from the centralised, monolithic, authoritarian, monopolistic temples of power that so many people detest and avoid.

Two particular questions are likely to arise.

Firstly, is there any evidence that other ways of working *are* actually capable of meeting the trans community's manifesto objectives *and* of being safe for both parties to follow – practitioners as well as service users?

We've pointed out that the repositioning of informed decision-making responsibility is actually beneficial to professional care workers (in a way that would please the Medical Defence Union, I'm sure). Nevertheless, in the age of evidence-based medicine, it is entirely reasonable to look for any existing evidence of success with alternatives, before charging headlong into embracing them.



Secondly, one of the most important areas we highlight besides the decision-making responsibility of service users is connected with principles of accessibility and flexibility. The "old school" is very keen on the idea of "Multidisciplinary Teams" (MDTs).

Superficially MDTs sound like a grand and very sensible idea. It is all about the no-brainer that service users are better-served when different kinds of specialists talk to one another.

So, GPs should interact with psychs, electrologists and speech therapists should be able to contribute towards a consensual view of how best to help the individual. Unfortunately, if you belong to some conservative GIC psychiatry teams, MDT is also code for "all under one roof". A complete monopoly. And a device carefully constructed so as to make it impossible for independent practitioners to be able to function within the "standards of care". It's a case of beware of Greeks bearing gifts. (Or beware of Charing Cross psychiatrists bearing grand ideas).

One well known independent practitioner would be especially affected by this idea.

Actually, you *can* reap some of the benefits of MDT working without the downsides. It's called networking, guys, and if you want lessons in that then ask your nearest friendly trans activist. However, I want to come back to that in a moment. First, I want to tackle the question of whether there are other models to study.

### **The Canadian Way**

Over the coming weeks and months I am hoping that the kindling of this important debate will bring forward lots of good examples of people doing things differently around the world. Anecdotal evidence already suggests that these may produce better results too. So nobody should be afraid to study and learn from them... Unless they are unhealthily obsessed with control, of course.

For now I want to draw attention to some of the developments that are happening across the Atlantic in the Canadian province of British Columbia. And especially in that most English-like of North American cities, Vancouver.

For my example I would like to draw attention to initiatives that have been trialled very successfully by Vancouver Coastal Health (VCH) <http://www.vch.ca/>

According to the programme introduction at <http://www.vch.ca/transhealth/> :

*"The Transgender Health Program was launched by Vancouver Coastal Health in June 2003 to bring together transgender people and loved ones, health care providers, health planners, and researchers to work on improving transgender health services in [British Columbia]"*

More insight into the history can be found in the published review of the first year's operations, which you'll find on their site at :

<http://www.vch.ca/transhealth/resources/library/thpdocs/0407yearend.pdf>

The authors explain,

*"The Transgender Health Program (THP) was launched by Vancouver Coastal Health in June 2003 to coordinate the shift from a hospital-based system of care to a community-based system of care. The THP seeks to provide information, referrals, advocacy, and support to transgender community members in BC; coordinate training for people who provide service to transgender community members in BC; and initiate and participate in research and evaluation relating to transgender health."*

They continue,

*"Prior to May 2002, services for transgender people in BC were provided by the Gender Dysphoria Program at Vancouver Hospital (also known as the "Gender Clinic"). The Gender Dysphoria Program, established in the early 1980s by Dr. Diane Watson, focused on the assessment and treatment of people who met psychiatric criteria for "Gender Identity Disorder". As part of the Centre for Sexual Medicine, the Gender Dysphoria Program offered endocrinological, urological/gynaecological, psychiatric, psychological, and social services, and was the sole gatekeeper for public health coverage for transition-related surgeries.*

Then the crunch reason for setting up the new service,

*"In May 2002, as a result of budget constraints, Vancouver Hospital made cuts throughout the Department of Psychiatry, including several staff positions at the Gender Clinic. The remaining staff felt the Clinic could not continue to provide service and announced the closure of the program. The closure of the Gender Clinic left people unsure where to get care, and unable to apply for public health funding for surgery."*

I'll leave you to study the rest of the background if you are interested, but there is perhaps some irony in considering that the window of opportunity for creating something new and better actually came from the demise of the local monopolistic equivalent to our own Charing Cross.

Demand for the service is undeniable. Quote (page 13) :

*"The Transgender Health Program currently receives more requests for general transgender health education than can be filled. There has been discussion about trainingvolunteers from the Education Working Group (or other interested community members) to teach the program's "transgender health basics" workshop; curriculum has already been developed for the workshop itself..."*

And the service is not afraid to engage community expertise:

*"The health of transgender people and loved ones is significantly enhanced by peer support. In the last year, three new transgender peer support groups have started in rural areas (Kamloops, Nelson, and Prince George); the Transgender Health Program should seek to actively support these and other community-based peer support programs by sharing resources and training materials."*

However, it is the closing words which really resonate:

*"The decentralized, community-based, peer-driven framework for the Transgender Health Program articulated in the community survey and in the Kopala report is a significant change from the centralized, hospital-based, professionally-driven service that operated prior to 2002. Given the magnitude of the changes proposed, there is tremendous satisfaction in reviewing activities conducted and seeing the breadth and depth of work done to shift the approach and structure of the transgender health system."*

One reason perhaps for success is that the planners were prepared to listen to the trans community's own clear desire for choices and look for evidence of how other people organised things. For more about this see the literature review which the service undertook in February 2003:

<http://www.vch.ca/transhealth/resources/library/thpdocs/0302litreview.pdf>

In the introduction, the author comments:

*"... while the HBIGDA guidelines are arguably the most familiar to service providers and service users, and used by some practitioners (e.g., Gender Dysphoria Program of Central Ohio, 2000; Green Mountain Gender Clinic, 2001), very few of the service providers surveyed in this review followed the HBIGDA guidelines. This suggests that while the HBIGDA guidelines may provide some theoretical guidance, there is little professional consensus about actual best practices."*

For more background, see also: <http://www.transgender.org/transcend/health/>

The Vancouver project is not the only innovative work taking place in Canada. Many will probably be more likely to associate Canadian healthcare for trans people with the infamous Centre for Addiction and Mental Health (CAMH) in Toronto – the home of J Michael Bailey's mentor, Ray Blanchard. It is less well known, however, that the reluctance of many trans people to go near that institution led to an alternative service being provided by the Sherbourne Health Centre (<http://www.sherbourne.on.ca/>). Their objective is to provide a healthier and safer alternative to desperate people obtaining hormones on the black market. See: <http://www.sherbourne.on.ca/programs.html> and their information leaflet at : <http://www.sherbourne.on.ca/Trans%20Male%20to%20Female.pdf>

The Toronto and Vancouver examples are not necessarily complete yet, in terms of offering a mechanism for getting people through the gateway to surgery. The irony is that, in Vancouver, the old hospital system was so thoroughly entrenched as a monopoly gatekeeper that its demise left an unresolved dilemma:

*"Prior to its closure, the Clinic provided endocrinological, urological/gynecological, psychiatric, psychological, and social services to trans and intersex people throughout BC, and was the sole gatekeeper for public health coverage for transition-related surgeries."*

(<http://www.transgender.org/transcend/health/>)

There should be a public health service commissioning moral for everyone there.

### **Not the Only Place to Study**

The Canadian projects therefore provide a marvellous source for study. In particular, the literature review of alternative services provides a lot to read and digest. However, I'm sure Canada is not the only place to look, and hopefully (with the global reach that PFC-News has these days) it won't be long before people are pointing us at other living examples of different approaches to examine.

Meanwhile, we are confronted with the gloomy fact that when UK practitioners were first invited to contribute towards the brand new RCPsych / RSM "standards of care" project, the most some of them could manage was to simply write down what they already did and claim it was "best practice". Hopefully, by the time we see their final draft, someone will have taught them to carry out something called "research". Otherwise, quite frankly, my personal opinion is that the only term for their collective actions would be "gross professional negligence".

## ***Too Specialised to Localise***

To wrap up this commentary, I would like to come back to what I said was the second thing that needed to be explored, especially if the care team approach was to be devolved to local provision so far as possible.

The belief of some vocal members of the RCPsych / RSM committee is that you have to centralise in order to provide sufficient knowledge and expertise in what is purported to be such a specialist area. The result of this philosophy is that we end up with GPs feeling that they have no real part in coordinating their own patients' care, PCTs seeing no reason to provide for any kind of services in people's own locality, and huge numbers of trans people making regular train or car trips the length of the country to be seen for 30 minutes in a West London clinic which has sometimes abruptly cancelled their appointment when they get there.

Imagine the outcry if this were the situation for any other kind of healthcare. And, in case you think that the rarity of trans people provides some sort of exceptional excuse for the approach, try imagining this for a comparably rare care need, such as looking after people with Muscular Dystrophy (1 in 5000 births).

Another consequence of this "send them off to London" mindset is that it also gets applied to trans people's other healthcare needs too. Some health authorities will send trans women experiencing ANY kind of urological problem straight off to Charing Cross, as though they perhaps fear their own specialists will struggle with finding or knowing what to do with our poorly urethras and vaginas.

All of which is a bit of an easy cop out.

This is something that true "standards of care" and "continuing professional development" are perfectly capable of addressing.

Unfortunately, I'm not aware that anyone has even sat down to explore and document *which* parts of trans health care are in reality specialised to any great degree, and the amount of tuition which competent local practitioners might have to undergo to be able to function within a networked, flexible care team. Until someone has actually done that, it would seem reasonable to class the case for single site MDTs as an unproven argument.

## ***Summing Up***

This has been a very long and detailed follow-up to last week's introduction of a Manifesto for Care. The object was to rhetorically ask whether radical new approaches to care were really just pipedreams or the prelude to a new era for the next generation of trans people in the United Kingdom.

Along the way, I've sought to show that there *are* alternative models and experiences to study. Evidence is important when contemplating change. The worry is that many of the alleged professionals contributing towards new written guidelines in this country show dangerous signs of insularity when it comes to a preparedness to learn and innovate. The first test of the intellectual validity of what comes out of the RCPsych / RSM committee will be to ask whether professionals taking part got off their backsides and looked for opportunities to innovate and improve, or whether they just wrote down what they already do. The latter just won't do for two pre-eminent bodies in Psychiatry and Medicine.

I've provided a great deal to follow-up and read. I have a feeling that people out there watching us will probably rise to the challenge and provide much more. That's OK though. Because this isn't an exercise in rhetoric. The objective of encouraging the whole UK trans community to engage in this debate, to learn the issues and to ask hard but valid questions, is to improve care for this generation of people in transition, and those thousands who will most likely follow in our lifetimes.

I hope that everyone who calls themselves a gender practitioner takes note and is prepared to approach the challenge as seriously as we do.

- Christine Burns

# Walter Bockting – Errors and Consequences of the Bailey Affair

By Christine Burns

First Published 21<sup>st</sup> August 2005

**From:** Christine Burns

**Sent:** 21 August 2005 12:15

**To:** 'Press for Change News Distribution'

**Subject:** US: Book Review - Walter Bockting on the Errors and Consequences of the Bailey Affair [Journal of Sex Research]

## Foreword

It seems an age now since J Michael Bailey's infamous book, "The Man Who Would Be Queen" burst into the lives of transsexual people the world over to insult us all. In fact it is just two and a half years since the book was published in March 2003, and already almost a year since the *first* chapter of the story closed, with the author unceremoniously removed from his position as Chair of the Psychology Department at North Western University in Chicago, following investigations into complaints about research misconduct.

The anger aroused by Bailey's allegedly "scientific" trashing of our reputations was great enough at the time to spill over into other areas. The Lambda Literary Foundation, for instance, was forced into a humiliating reversal of its initial decision to shortlist the book as a contender in their annual LGBT awards. Angry trans activists and authors called on the organisation to "Give us Back Our T". Eventually, in March 2004, the nomination was withdrawn. In June 2005 the Executive Director of LLF, Jim Marks, resigned from the post he had held since 1995.

Although slow to react at first, some academic and clinical commentators stood up to be counted during the first crucial months of the controversy.

In July 2003 Kinsey Institute President, John Bancroft, spoke out at a meeting of the International Academy of Sex Research to proclaim that the book, "...is NOT Science". Dr Bruce Frier, a classical scholar and law professor in Bailey's own University wrote in an Amazon.com review, "This book is pretty awful by anyone's standards: voyeuristic in the extreme, with little in the way of actual research or bibliography".

Unfortunately, it was notable that the vast majority were silent, or at least very slow to react in support of the people who literally support their careers. For the most part the campaign to challenge Bailey's slander fell mostly on the shoulders of his victims.

Stanford University Professor Joan Roughgarden (a prominent and published academic trans woman herself) rounded on the profession in March 2004, describing the affair as "Psychology Perverted". She said,

*"I wonder if many psychologists fully grasp the image some of their colleagues are projecting – psychology as a discipline without standards, nourishing a clique of dumbly insensitive bigots."*

*"These psychologists don't seek to help people, but to dominate them by controlling the definition of normalcy."*

*"Their bogus categories and made-up diseases are intended to subordinate, not to describe."*



By 2004 critics were finding voice. In March 2004, four UK psychologists felt sufficiently goaded by the criticisms now being levelled at the professional community to write,

*"We are particularly concerned that Bailey's work will be seen as representative of scientific psychological research, both by the trans community and by other sections of the public."*

*"...the danger that Bailey's expressed anti-trans opinions might be confused with scientific evidence is particularly high in this case."*

Yet these words only appeared a full year after the book had been published ... after 12 full months of increasingly blunt criticism of the profession. Psychologists were, it seems, slow in waking up to the consequences of leaving their clients to roast.

The HBIGDA was particularly slow to react at first. Yet finally, and belatedly, they roused themselves.

At the HBIGDA symposium in Ghent, Belgium, in September 2003, outgoing President Dr Eli Coleman showed a slide of the infamous book's front cover as he said, "*We Need to Challenge Bad Science*". He commented on the need to "*promote sound and ethical research*" and of the need to work with the trans community to "*end antipathy and distrust of researchers*".

This was a telling comment. It showed that leaders in HBIGDA could see the writing on the wall. They could see the possibility of a tipping point when the trans community might decide that the benefits of accepting a degree of medical pathologisation were outweighed by the disadvantages.

A few weeks later, HBIGDA's officers and Board of Directors wrote in an open letter to Lynn Conway, Joan Roughgarden and other trans academics,

*"The HBIGDA Board of Directors believes that a relationship of trust and mutual respect between the scientific and the transgender communities is essential to further its mission to promote the health and well-being of transgender and transsexual individuals and their families. It is felt by many of our members that this poorly referenced book does not reflect the social and scientific literature that exists on transsexual people and could damage that essential trust"*

The latest review of the Bailey book in the August edition of the Journal of Sex Research should be seen in that context, therefore (see below for the full text).

Walter Bockting is a board member of HBIGDA, an Editor of the International Journal of Transgenderism (<http://www.symposium.com/ijt/>) and has been in the trans care business for more than long enough to understand the political history of trans treatment. He goes right to the heart of the debate we've been highlighting in recent weeks when he comments in this review:

*"...the inclusion of gender identity disorder in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994) has not resulted in broad health insurance coverage for transgender care, more and more transgender individuals perceive this diagnosis and the need to consult with a mental health provider as unnecessarily pathologizing"*

It's a welcome admission of the principal defence for keeping trans people in the psychiatrists' book of mental disorders all these years. And what a blow to the DSM's credibility. We're not in there for a good clinical reason, but through the history of expediency.

The question is, are reviews like this, and their expressions of support and common interest, too little or too late to repair the damage done since October 2003 when J Michael Bailey set out to define the views of the psychology profession in the public's eyes?

Have trans people gone so far down the road of having to defend themselves that the days of reliance on psychological patronage and control are well and truly over?

Should the marriage partners be hastily booking a romantic getaway to patch up their differences and learn to cuddle one another, or is it time to bring in the lawyers and start packing separate boxes to move out?

This week Kevan Wylie circulated our "Manifesto for Care" to the various representatives taking part in the RCPsych committee drafting new UK standards of care.

See <http://www.pfc.org.uk/medical/cb-eval1.pdf>

Many thanks to Kevan for recommending that his professional peers should study our invitation to rethink things from the ground up.

One can only hope that the practitioners on the committee wake up and smell the coffee, if they have not already done so. For we are truly at a turning point following the events of the last couple of years.

Bockting summarises it with commendable succinctness:

*"...being transsexual means sometimes not knowing who to trust"*

Absolutely! Except that I would delete the word "sometimes".

Trust is most certainly at an all time low between trans people and people who would like to be involved in their care. It has sunk SO low that much of the debate on the trans side is how to diminish or eliminate the control dependency that arises from the system of psychiatrists' letters for surgery. The talk is increasingly about divorce, because there is so little faith in the possibility of reconciliation.

And yet our "Manifesto for Care" is focussed quite squarely on how it might be possible for trans people and care professionals to work together in *trust* and mutual respect towards shared goals for individuals and the trans population as a whole.

Will things change? Will the RCPsych committee members be prepared to put *everything* about current practice on the table for close appraisal? Will they create a manual that seeks to limit innovation and diversity, or can they do the *very* brave thing, put their illuminated scrolls in a museum, and start designing a care system framework for *today*, based on principles and aspirations which everyone can subscribe to?

Walter Bockting demonstrates that you CAN arrive late at the party and be welcomed. Just make sure you bring a damned good bottle of wine.

- Christine Burns



## **Biological Reductionism meets Gender Diversity in Human Sexuality**

**The Journal of Sex Research**  
**Volume 42, Number 3,**  
**August 2005: pp. 267-270**

*The Man Who Would Be Queen: The Science of Gender-Bending and Transsexualism*, by J. Michael Bailey. Washington, DC: The Joseph Henry Press, 2003, 233 pages. Cloth, \$24.95.

Reviewed by Walter O. Bockting, Ph.D., University of Minnesota Medical School, Program in Human Sexuality, Department of Family Medicine and Community Health, 1300 South Second Street, Suite 180, Minneapolis, MN, 55454; e-mail: bockt001@umn.edu.

Web version transcribed by Prof Lynn Conway and published at: <http://tinyurl.com/cfh5p>

The Man Who Would Be Queen is the most controversial book on transsexuality since Janice Raymond's *The Transsexual Empire* (1979) and is the latest challenge to what already was a fragile relationship between the scientific and the transgender communities. What is all the fuss about? What does the book say, why is it so controversial, and what does this controversy tell us about sex research with stigmatized populations like the transgender community?

### **What the Book Says**

Bailey argues that there are essentially two types of male-to-female transsexuals who can be distinguished on the basis of their sexual orientation. The first type is homosexual transsexuals, extremely gender-transposed (feminine) men whose sexual object choice is toward men instead of women. According to Bailey, their primary motivation to change sex is to attract more men sexually: "*Those who love men become women to attract them*" (p. xii).

The second type is autogynephilic transsexuals, meaning paraphilic men whose sexual object choice is toward the image of themselves as women. For this group, the primary motivation for changing sex is to become the object of their desire: "*Those who love women become the women they love*" (p. xii). According to Bailey, the sexual attraction to men that this latter group may report is secondary to their idea of what it is like to be a woman (i.e., interested in men). The sexual attraction to women that autogynephilic transsexuals may report is deemed less than genuine; they envy, rather than love, other women. As Bailey explains, "*Autogynephilic transsexuals might declare attraction to women or men, to both, or to neither. But their primary attraction is to the women that they would become*" (p. 147).

By fitting all male-to-female transsexuals into this typology, Bailey attempts to fortify theory and research that postulates a biological link between gender identity and sexual orientation, between gender transposition (demasculinization and feminization) and homosexuality. As Bailey states, "*Succinctly put, homosexual male-to-female transsexuals are extremely feminine men*" (p. 146).

This is not a new typology. It was coined by Ray Blanchard in the 1980s and has been widely published in the scientific literature (e.g., Blanchard, 1987, 1989). However, Bailey's book is accessible to a lay audience through its non-academic style that, especially to the uninformed reader, makes a very convincing case that the gender diversity found within the transgender community can be reduced to these two types. The book contains eleven chapters divided

into three parts. Part one is about childhood femininity among boys, part two about femininity and masculinity among gay men, laying the foundation for part three: the typology of homosexual versus autogynephilic transsexuals.

Unfortunately, the book fails to offer a balanced and well-cited review of the scientific literature that would have shown that the diversity found within this community cannot as easily be reduced to the two types. Bailey dismisses clinical experience and ignores research that provides evidence of much greater diversity in gender identity, gender expression, and transgender sexuality. For example, to explain accounts that do not conform to the typology, he states: "*Autogynephiles who claimed to be homosexual transsexuals could account for the apparent cases of homosexual transsexuals who practiced erotic crossdressing*" (p. 173).

### **Why the Book is Controversial**

Bailey criticizes scholars who support a social constructionist perspective on transsexuality for giving ideology precedence over science. What he omits is that gender transposition theories have been challenged in the scientific literature on psychological, sociocultural, and biological grounds (Coleman, Gooren, & Ross, 1989). Bailey further limits his focus to male-to-female transsexuals. However, research on female-to-males attracted to men shows that they do not fit as easily into the reductionistic typology (Bockting & Coleman, 1991; Coleman & Bockting, 1987; Coleman, Bockting, & Gooren, 1993).

Another point of controversy is Bailey's portrayal of scholars and clinicians who provide transgender-specific health care and who provide access to sex reassignment services according to the Harry Benjamin Association's Standards of Care (Meyer et al., 2001). According to Bailey, these professionals are ignorant of the homosexual versus autogynephilic typology of transsexuals. Bailey offers several explanations for this. He argues that the two types of transsexuals rarely mix, that gender clinics only see heterosexual (i.e., autogynephilic) transsexuals because homosexual transsexuals tend to obtain their hormones on the black market, that clinicians take their clients' self reports at face value when they shouldn't, and that "*sex researchers are not as scholarly as they should be and so don't read the current scientific journals*" (p. 176).

These claims do not mirror the experience of the majority of scholars and clinicians in this field (see [www.hbgda.org](http://www.hbgda.org) and [www.symposion.com/ijt](http://www.symposion.com/ijt)). They do see male-to-female transsexuals attracted to men who mix with male-to-female transsexuals who are in satisfying intimate relationships with women. Members of both groups pursue sex reassignment to alleviate a gender identity conflict, not to attract more men or to satisfy their paraphilic sexual desire. Clinicians also see a number of male-to-female transsexuals who are genuinely bisexual and attracted to both men and women. Clients' self-reports are verified when necessary (e.g., by including in therapy significant others, family, and friends). Although every field has its more or less informed workers, many scholars and transgender-specific health providers (as well as their transgender clients) stay abreast of the scientific literature in the areas of transgender identity and sexuality.

Bailey's perceptions might have been skewed by his lack of contact with the health professionals in this field (he is not a member of the Benjamin Association) and his reliance on very limited field work with a very small sample of transgender informants in Chicago gay bars.

Perhaps it is his lack of extensive clinical experience with transsexuals that prompted his criticism of clinicians and prevented him from recognizing that sex and gender are more diverse than is generally assumed.

The reality is that many individuals are encountered in clinical practice who do not fit the typology of homosexual versus autogynephilic transsexuals. These individuals continue to challenge our limited understanding of gender and sexual identity development. Autogynephilia does exist, but in light of this limited understanding, the term is better used as a descriptive phenomenon present in the lives of certain transgender individuals rather than elevated to one of only two essentialist etiological types. It is difficult to understand a clinical population based on limited field research and a read of the literature; it takes extensive clinical experience under supervision to understand and treat clients presenting with such issues as autogynephilia. Moreover, research in nonclinical settings has revealed a greater diversity in gender identity and expression across cultures and throughout time (e.g., Herdt, 1994).

Although some members of the transgender community endorse the typology outlined in the book (e.g., Lawrence, 2004), Bailey's book has elicited a storm of criticism and personal attacks by his informants and by transgender community activists (e.g., Conway, 2003-2004). Allegations include violations of ethical research conduct such as lack of informed consent and dual relationships. The informants and their peers have stated that the book inadequately represents the reality of their experience. In the book, Bailey explicitly states how much he respects his informants, yet information from transsexuals that contradicts his theory is dismissed as self-justification, identity politics, and lies: ". . . *they are often silent about their true motivation and instead tell stories about themselves that are misleading and, in important respects, false*" (p. 146).

Self-report bias certainly does exist, but the subjectivity of gender and sexuality is just as valid and undeniable as its biological manifestation. The book proclaims to be "free of ideology," yet a biological, essentialist perspective is simply another point of view. Due to his narrow biological orientation and dismissal of the social constructionist and clinical perspectives, Bailey may have under-appreciated the psychosocial and cultural context (one of intense stigma) in which his transsexual informants actualize their gender identity and sexuality.

### **What the Controversy Tells Us About Sex Research with Stigmatized Populations**

The impact of this controversy is not limited to Bailey and his book. Instead, it is yet another blow to the delicate relationship between clinicians, scholars, and the transgender community. The establishment of mutual respect and trust among these groups has always been complicated. After Hirschfeld (1910) medicalized transvestism and transsexualism, clinicians attempted through psychodynamic and behavior therapy to change transsexuals' gender identity to make it match their sex assigned at birth (for a review see Gelder & Marks, 1969, or Kuiper, 1991).

With Christine Jorgenson's widely publicized sex change and Harry Benjamin's book *The Transsexual Phenomenon* (1966), the tide turned away from conversion therapy, but clinicians took on the role of gatekeepers controlling access to sex reassignment. In 1979, the sex reassignment program at Johns Hopkins University closed on the basis of a study that evaluated the outcome of sex reassignment (Meyer & Reter, 1979), a study that since has been criticized for being methodologically flawed and politically motivated (Money, 1991). In that same year, Janice Raymond published *The Transsexual Empire* (1979), in which she attacked transsexuals' claim to womanhood and went so far as to equate sex reassignment with rape (see Stone, 1991). This history has made many transgender persons wary of scholars and clinicians.

Finally, because the inclusion of gender identity disorder in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994) has not resulted in broad health insurance coverage for transgender care, more and more transgender individuals perceive this diagnosis and the need to consult with a mental health provider as unnecessarily pathologizing. The controversy surrounding this book adds to the challenge of delivering transgender health services and threatens the partnerships and participation of the transgender community required to conduct research to promote transgender people's well-being.

Research as well as clinical work with the transgender community has to take into account the stigma that transgender and transsexual individuals experience because of their gender nonconformity. Such stigma contributes to a dynamic that Freire (1970) called the pedagogy of the oppressed, in which transsexuals struggle to question existing norms and validate their unique experiences of gender. In this context, being transsexual means sometimes not knowing who to trust. Bailey appears to have underestimated the power of this dynamic and the vulnerability of his research participants. At the same time, the transgender community needs to be reminded that the vast majority of sex researchers and clinicians are on their side, that they experience stigma associated with the transgender focus of their work, and that they cannot do this work without the cooperation and support of the transgender community.

Science can be part of bringing about desired social change for stigmatized populations such as the transgender community. For example, research on the efficacy of sex reassignment contributed to the decision of several health insurance companies in Minnesota to cover transgender-specific medical care. The Benjamin Association has issued a number of legal briefs to support the civil rights of transgender individuals. Advocacy is an important task of professionals working in this field. It is unfortunate that Bailey and his supporters seem to confuse such advocacy with a less-than-critical stance toward patient self-reports and toward attacks launched by members of the transgender community against this book.

### ***What the Book Could Have Been***

An up-to-date, evidence-based discussion of the broader scientific literature on transgenderism and transsexuality, written in a manner accessible to the general public, would have been a valuable contribution. The book could have educated readers about the increasingly visible diversity in gender and sexual orientation among the transgender population and discussed the implications of this diversity for our understanding of sexual identity. It could have shown how the approach of clinicians has changed from trying to identify the "true" transsexual toward client-centered, transgender-affirmative health care. Bailey could have called for more research to explore the next frontier in the study of gender. He could have illuminated how science can play a role in promoting transgender rights and sexual health. Alternatively, Bailey could have stuck to research on sexual orientation with which he is more familiar rather than have ventured into the study of gender, an area he appears to know less about.

### ***Conclusion***

This book's primary strength is simultaneously its major weakness: It is a powerful and eloquently described synthesis of available data that supports a reductionistic, biological theory of gender identity and sexual orientation, but without adequately recognizing the role of psychosocial and cultural factors (such as social stigma and cultural constructions of gender) in the development of gender identity. Hence, the book will appeal to those who share Bailey's essentialist point of view while alienating those who favor a biopsychosocial perspective.

We need a book that is as well written as this one, but that is more comprehensive and leaves room for what is yet to be discovered about the diversity in gender and human sexuality. In the interim, we can let the evolving stories of transgender individuals speak for themselves.

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# Big Issue Feature on Medical Treatment in the UK

By Someone Else

First Published 18<sup>th</sup> October 2005

**From:** Christine Burns  
**Sent:** 18 October 2005 18:35  
**To:** 'Press for Change News Distribution'  
**Subject:** UK: Big Issue Feature on Medical Treatment in the UK

## *Introduction*

The following feature about the UK's provision for trans people's care appears this week in the London and South East edition of "The Big Issue" (also distributed in many other regions too).

For readers outside the UK, The Big Issue is a major weekly "street paper" with a very strong circulation in the key fields such as health and social care. For more details see <http://www.bigissue.com/aboutmag.html>

Unfortunately I don't yet have the headline title for this feature; however the text (and permission to reproduce it here) comes direct from the authors Zena Alkayat and Judy Kerr.

It would be very nice if everyone with an experience of the system were to write to the editor of the Big Issue and tell them your personal experiences and opinions of the system and whether the feature has got it right or not. Any comments you have can be emailed to [letters@bigissue.com](mailto:letters@bigissue.com)

Persia West's Spectrum report on treatment options is still available on the PFC web site. See <http://www.pfc.org.uk/medical/spectrum.htm> for her findings.

The Big Issue are certainly to be thanked (in my view) for bringing prominence to the issues concerned. It will be interesting to see whether the story transfers and is taken up by other media as a result.

We will also report progress with the Sussex PCTs' initiative to develop an alternative kind of treatment service when any more details are ready for release.

- Christine

## *Story by Zena Alkayat and Judy Kerr The Big Issue, w/c 17<sup>th</sup> Oct 2005*

Transsexual people are being forced to seek care in private hospitals or go abroad for costly surgery due to the raft of obstacles they face in the NHS - from "dogmatic" psychiatrists to disorganised administration – campaigners have claimed.

Activist Persia West has written a scathing account of the inadequate service transsexuals receive when going through the process of a sex change, in a report that focuses particular on the Gender Identity Clinic (GIC) at Charing Cross hospital, responsible for the vast majority of gender reassignment surgery in the UK.

The study, funded by Brighton And Hove NHS Primary Care Trust, and Spectrum, the lesbian, gay, bisexual and transgender forum, raises serious questions about the treatment at the GIC, which has around 500 patients a year.

Transpeople interviewed by West accused psychiatrists encountered during formal assessment of being "*unreasonable, erratic and irrational*". Some psychiatrists were said to be "*dogmatic and fixed in their views as if one size fits all... and [transpeople] simply have to take what they are given.*"

Interviewees, who included a conductor, academic, priest, engineer, lawyer, pilot and care assistant, also complained they were "pathologised as mentally-ill" within a system that denied them "choice and respect".

Patients complained that further treatments they considered absolutely essential, such as laser treatment or electrolysis, were labelled merely 'cosmetic' by commissioners, a position they found "grimly amusing". One trans woman claimed: "*If they really understood us, they wouldn't treat us like this.*"

A female Brighton GP who has been working with trans patients for over 10 years, and contributed to the report, wrote:

*"Not one of my patients with contact with the GIC team there had a single positive thing to say about either the process or consultations. The difference in treatment [on the NHS and abroad] on all levels is stark. Invariably women who went abroad talk of a positive experience where they were treated with respect, kindness, and great professionalism. Contrastingly, those who continued to operation with Charing Cross reported patronising attitudes, insensitivity and no sense of caring."*

Echoing many of the trans interviewees, the doctor added:

*"The NHS seems to be designed to test nerve, resolve and mental strength at every opportunity rather than understanding. There should be easier access to aspects such as hair removal, speech therapy, and there must be psychological support built in, rather than judgement."*

Another local doctor canvassed on his transsexual patients wrote:

*"On the whole there seem to be many areas of discontent. . . Another problem is the strictness of criteria imposed by Charing Cross. This is particularly true on the working in role front, as most transsexuals may well have problems getting jobs in their new chosen gender before surgery, partly due to being self conscious about their bodies. . . there seems to be a constant wall for transsexuals to come up against."*

The report further criticised the lengthy and often delayed process that leaves patients uncertain as to whether they will receive treatment or not. In addition, interviewees claim Charing Cross is plagued with a wide range of administrative problems - including paperwork often getting lost and appointments often being cancelled at short notice without reason.

Furthermore, despite the catalogue of alleged problems, the report reveals some patients were unaware of a system for complaint - and felt too scared to complain in case of a negative reaction from psychiatrist consultants.

The author, West, who had her own gender reassignment surgery in Belgium, claimed:

*"Anyone who can afford it will choose private, or go abroad to Europe or Thailand where they will receive quality care with more understanding."*

One of the recurring criticisms levelled by campaigners at the NHS is the over emphasis on the medical side of sex change at the expense of the "extreme emotional challenges" patients undergo.



A trans woman who has first-hand experience of the trauma involved, Sophie, spent 20 years on heroin, was imprisoned on a drugs offence and constantly "ran away from the truth", before deciding to seek surgery.

*"I couldn't afford private care so despite the negative stories I heard, I had to go through Charing Cross," she told The Big Issue. "It was the lack of support that was the most challenging. The NHS has no framework set-up, like a counselling service, to support people like me. My family had stopped talking to me and it was so hard to stay off the drugs. I practically starved myself to pay for private counselling that I desperately needed."*

A person wishing to make a gender transition is required to live as that sex for a minimum of two years. In Sophie's case this was particularly stressful because she did not yet look or feel feminine but was reluctant to ask the GIC for help, fearing they would delay her surgery because they thought she wasn't coping with life as a woman.

*"The problem is the reality that no amount of make-up can cover up a hairy face. You can imagine how people stare, they can be very hostile on the street," she recalled.*

Claire McNab, the vice-president of Press For Change, a campaign group for transsexual people, told The Big Issue:

*"The feeling that we must jump through hoops to persuade the psychiatrists we need treatment is ridiculous. There should be a better understanding and a way for people to communicate their problems without fear of treatment being refused."*

The leading psychiatrist that transpeople turn to for private surgery, Dr Russell Reid, backed the move for more support. He said: *"Depressive, reclusive behaviour is common in transpeople who have trouble receiving treatment in the NHS."* Reid has found that five per cent of Britain's estimated 5,000 transpeople suffer from social isolation or chronic depression and nearly two per cent commit suicide.

However, a spokeswoman for Charing Cross GIC defended its service.

*"We endeavour to provide the best support, care and advice to those wishing to undertake a sex change. We understand that the process clients have to go through before they receive surgery can be frustrating, but it is necessary to ensure this radical treatment is not taken lightly as the process is irreversible."*

*"A key priority at the moment is the expansion of the clinic and we will be moving to bigger premises in the coming months. This will reduce the time people have to wait to be seen - a problem which has occurred due to an increase in the number of referrals."*

*"We have also set up a clinical improvement group to look at issues such as waiting times, attitudes of psychiatrists and the quality of information given. In November, we will be meeting a group of clients to discuss these areas and their experiences. We have a complaints procedure and would encourage anyone who is unhappy with the care they have received to contact us to discuss their concerns further."*

Campaigners are now hoping that a unique new approach being developed in Brighton, that aims to meet the full range of physical, mental and emotional needs of patients undergoing a sex change, can act as a model for others to follow. The West Sussex Health And Social Care NHS Trust is working with specialists and transpeople on a new service which takes account of the personal trauma they endure.

Sue Morris, the executive director, leading the initiative, said:

*"We hope to offer a more tailored style of support by working with GPs, social services and the council." The future aim is to remove the need to go to London for treatment by ensuring local specialists can offer a complete 'one-stop-shop style' service."*

*"Changing the fundamentals of your identity is going to be stressful. We need support, not to be tortured on the way," concludes West.*