

Guest editorial

New standards of care for people with gender dysphoria

Kevan Wylie MD DSM FRCP FRCPsych

Consultant in Sexual Medicine, Sheffield and Chair, Intercollegiate Working Committee, Standards of Care for Patients with Gender Dysphoria (UK)

Transsexual people form a very small part of any primary care clinician's case load. As such it is usually regarded as a clinical scenario where secondary care or specialist care should be involved.

In recent years there has been a move away from one national centralised specialist service for gender dysphoria in the UK to the gradual introduction and development of regional services. Some of these have grown and established centres such as those in Leicester, Leeds, Nottingham and Sheffield, while others have developed as new services such as those provided in Plymouth, Northampton, Newcastle/Sunderland, Glasgow, Edinburgh and Belfast. Provision of services at a regional level gives greater convenience for patients and also allows for an increase in the overall number of patients being referred and seeking help for gender dysphoria. There is an increased awareness on the part of patients about the need for valid supported care for their gender transition. This increase in demand for services and Department of Health national policy for choice of provider has facilitated growth in regional services.

Some of these services have been developed in traditional mental health settings, whereas others have developed in alternative service provider areas where hormones may be traditionally provided for other reasons such as family planning and contraception services, genitourinary medicine and even primary care. In addition, the development of sexual medicine as a specialty and the background of this specialty crossing a number of disciplines has meant that delivery of care is now much wider than has traditionally been the case to date.

The development of shared-care guidance in promoting and integrating primary and secondary care services has been health practice in the UK for some years. A recent review by Hickman *et al* described six groups of schemes.¹ These were community clinics, basic exchange of letters or record sheets between departments, liaison meetings, shared-care record

cards, computer-assisted shared care and electronic mail. Of these, shared-care record cards or computer-assisted shared care would probably be most valuable in an area such as gender medicine where important information such as blood parameters and hormone prescriptions and dispensing of medications is necessary for good clinical care between specialists.

Provision of guidelines and advice to the general practitioner (GP) by telephone or letter is acceptable practice in both reducing waiting times for conditions such as erectile dysfunction,² and allowing safe and effect *in vitro* fertilisation (IVF) treatments to be available for GPs to use, usually alongside NHS guidelines where regional or national policies have been issued. The provision of an example of a shared-care guideline within the intercollegiate standards of care provides a degree of reassurance and guidance for those wishing to become more of a specialist in this clinical field.

There remains an ongoing argument against the provision of gender medicine services within mental health settings, but this is historic and is based on the argument of the stigma associated with mental illness and that gender dysphoria is not itself an inherent mental illness. Of course, modern physicians and psychiatrists are much less concerned about the classification, but rather look towards providing supportive and appropriate clinical services. As such, many psychiatrists, psychologists and psychotherapists are now much more supportive than has been the traditional experience of trans people in the past. There is some argument against a dual role of doctors, regardless of the specialty, and this is particularly the case within psychological medicine and in cases where there is a need for patients to have physical examinations. Whilst this is readily accepted as normal practice for most general medicine and sexual medicine conditions, in gender medicine it remains a concern. Of course, this is not a reason that patients should be denied access to

appropriate physical medicine checks as part of their overall care.³ With multidisciplinary or interdisciplinary services and networks, and the involvement of GPs either as the primary prescriber or as part of the overall support for the patients' hormonal care, these arguments should be less problematic and allow for full physical check-ups as part of the overall management of patients with gender dysphoria. This allows for the generalist, whether in primary or secondary care, or the specialist with appropriate support within or alongside a gender specialist clinic, to provide the necessary physical health care. In our own clinic, a number of clinicians across different specialisms provide care, and physicians, nurses and sexual medicine specialists can all share the roles for the necessary assessment and monitoring of patients for hormone prescriptions and for shared-care initiated in the clinic. These are then shared with primary care, and on occasions have been initiated in primary care with appropriate support and confirmation from the gender team.

The provision of hormones through supervised prescription with appropriate monitoring is, in principle, no more complicated than prescription for other indications. Although there are no licensed indications of prescriptions for trans people (with the exception of Sustanon – testosterone for trans men), the fact that hormones are used on an off licence basis is not a reason in itself to deny patients access to such treatments. This is especially the case for a treatment that is accepted worldwide as an appropriate one to allow gender transition. Some argument has been made that access to an endocrinologist should be standard practice, although this is not based on any evidence that this specialty group of physicians is any more experienced in the management of transgender medicines but rather that the treatments being prescribed are hormones rather than some other medication. However, sex steroid hormones offered in family planning contraception services and in menopause services are not routinely prescribed within hospital endocrinology services. The experience base is from knowledge of the use of sex steroid hormones on other target and non-target organs.

With the inevitable difficulties of introducing shared-care guidelines for the prescription of hormone agents on an off licence basis, and the controversy of the concept of GPs with a special interest (GPwSIs) in specialist areas that were formerly the remit of secondary care, it is no surprise that there will remain difficulties in engaging GPs in primary care with the ongoing prescription of hormones for patients with gender dysphoria who have not had confirmation of reassignment surgery.

A UK specific standards of care document has recently been developed, and some core concepts

are described within the main document alongside a number of additional appendices. Three of the appendices look specifically at hormonal treatments for male to female transsexual people and female to male transsexual people as well as suggesting a shared-care guideline for trans people.

One of the largest ever intercollegiate consultations was attended by representatives from the Royal College of Psychiatrists (acting as the host college), Royal College of Physicians, Royal College of Surgeons, Royal College of Obstetricians and Gynaecologists, Faculty of Family Planning and Reproductive Health Care at the Royal College of Obstetricians and Gynaecologists, Royal College of General Practitioners, Royal College of Nursing, Royal College of Paediatricians, Royal College of Speech and Language Therapists, Association of Hypnotherapists and Psychotherapists, National Association of Councillors and United Kingdom Council for Psychotherapy. Service user involvement was substantial, which is important in modern planning of healthcare services and in the development of good practice guidelines. Independent service users participated alongside user representatives from the Gender Trust, Press for Change, FTM (Female to Male) Network and the Gender Identity Research and Education Society (GIRES). In addition, consultation was carried out with the Harry Benjamin International Gender Dysphoria Association/World Professional Association for Transgender Health (HBIGDA/WPATH) standards of care committee and the independent (private healthcare) sector. Furthermore, other professionals were consulted for specific advice where expertise was not available within the core committee. A wide consultation followed the drafting of the guidelines, which attracted a substantial number of responses. These were then considered further by the committee and, where considered appropriate, assimilated within the guidance.

In a practice area where there are limited outcome data, for a number of reasons, the review of the published evidence is also limited, but where possible has been used to justify recommendations. In many instances, expert opinion has been relied upon to inform guidance, and where possible the input from service users has been incorporated to ensure a balanced presentation. Protocol-based decision helps to support clinical practice. In specialist areas this is crucial, as uncommon conditions are, by definition, rarely seen by GPs, and so guidance is necessary even for practitioners specialising within the clinical field.

While offering guidance and support to clinicians of various specialisms, there is also a degree of controversy associated with the guidelines. For example, they conclude that the addition of a gonadotrophin-releasing hormone (GnRH) agonist is beneficial in

the overall management of care. Such agents completely suppress endogenous testicular (i.e. reduce testosterone) or ovarian hormones (i.e. reduce oestrogen). While many of the effects are beneficial, with reduced sexual function and erections in transwomen and menstrual cycle bleeding in transmen, the effects are so marked that for some patients, the results are too severe! This can lead to requests for partial reversal, particularly for trans women who may demand a level of sexual function while going through a real-life experience and transition. Often the sexual partner is male, and sexual expression, particularly erectile function, remains important. This has led to clinical scenarios where a GnRH agonist has been prescribed but the patient has also been given prescriptions for a phosphodiesterase 5 (PDE5) inhibitor such as sildenafil, in order to maintain the ongoing relationship during the transition.

These kinds of issues raise a number of ethical conundrums for many practitioners in primary care. It is not the remit of this article to condone or argue for one resolution scenario or another, but it is important to remember that general legislation is now in place within the UK that prevents discrimination against individuals for a number of conditions, including race, creed, marital status, age and physical or mental disability. It follows that issues around sexual orientation and gender should have equal attention. Where, for reasons inherent to the individual, the clinician objects to providing clinical care for such patients, it is of course imperative that the patient is referred to another clinician so

that provision of medical care continues in a non-discriminatory and non-judgemental way.

The standards of care document makes strong comments and suggestions that there should be multidisciplinary and/or interdisciplinary working, and for specialist services these are likely to be provided on a regional if not national level. Patients will continue to seek advice from clinicians with regard to this condition over a period of time, and so consultation and familiarisation with the final standards of care document will be essential to ensure a seamless, fair and non-judgemental and progressive approach to helping patients make their transition as quickly, safely and easily as possible.

ADDRESS FOR CORRESPONDENCE

Kevan Wylie, Porterbrook Clinic, 75 Osborne Road, Sheffield, South Yorkshire S11 9BF, UK. Tel: +44 (0)114 271 8674; email: k.r.wylie@sheffield.ac.uk

REFERENCES

- 1 Hickman E, Drummond N and Grimshaw J. A taxonomy of shared care for chronic disease. *Journal of Public Health* 2004;164:47-54.
- 2 Wylie KR and Davies-South D. Returning a referral for erectile dysfunction to the referrer by two different routes. *BJU International* 2001;87:846-8.
- 3 Vardi Y, Wylie KR, Moser C *et al.* Is physical examination required before prescribing hormones to patients with gender dysphoria? *Journal of Sexual Medicine* 2008;5:21-6.

