A regional gender reassignment service

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A Regional Gender Identity Clinic was established in Yorkshire ten years ago. It is an entirely NHS-based service and is well used by the psychiatrists in the region. The Director of the clinic is a psychiatrist and there is a cohesive group consisting of a plastic surgeon, gynaecologist (who supervises medication) and a speech therapist. The clinic has won the recognition of the Leeds Community & Mental Health Services Teaching NHS Trust which supports its continuation. An audit of outcome of the first 12 male to female reassignment procedures was conducted by a independent assessor. The result gave the team clear indication that the work should continue. A plea is made for the establishment of more regional services.

The procedures for gender reassignment for transsexual people are now an established aspect of health care services in many parts of the world, although in other areas they are not undertaken, perhaps due to religious objections or because of other pressing needs on the available resources for health care.

Transsexualism is usually a cause of severe distress to the individual. It is the most extreme aspect of the range of gender dysphoric disorders and has recently received the following definition.

> "Transsexualism is a desire to live and to be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with, or inappropriateness of one's anatomic sex and a wish to have hormonal treatment and surgery to make one's body as congruent as possible with the preferred sex; the transsexual identity should have been persistently present for at least two years and must not be associated with any intersex, genetic or sex chromosome abnormality". (WHO, 1992).

The prevalence of transsexualism is not definitively established and estimates will depend on the prevailing regional and social attitudes; a recent report (Eklund *et al*, 1988) estimated that 1:18,000 adult males were male-to-female transsexual and that prevalence in females was about one third of that figure; it was considered that the observation of an increasing prevalence over a 20-year period may have been due to a "more benevolent social climate" i.e. to readier access to a gender identity clinic (GIC). The reassignment of a biological male to a female status by a Danish medical team (Hamburger *et al*, 1953) drew public and medical attention to the problem. Under the influence of the late Harry Benjamin the International Gender Dysphoria Association was founded and his book, *The Transsexual Phenomena*, (Benjamin, 1966) led to the establishment of gender identity clinics in many parts of the world. Hormonal and surgical gender reassignment of transsexual patients were increasingly undertaken and many follow-up studies, listed in a recent study (Kuiper & Cohen-Kettenis, 1988), combine to show that this intervention generally led to an improved quality of life for the patients. However, hastily undertaken intervention, often conducted at the urgent behest of the applicants, sometimes led to disastrous results including suicide and requests for surgical restitution to the biological gender. The International Gender Dysphoria Association therefore drew up guidelines for ethical clinical practice (Walker *et al*, 1985) the elements of which are as follows.

(a) The person recommending gender reassignment should be trained in the treatment of a broad range of psychological conditions and sexual disorders.
(b) Hormonal and surgical reassignment require full justification and should not be carried out on demand; the state of transsexualism should be established.
(c) Hormonal gender reassignment should precede surgical reassignment as the latter may depend on the former.
(d) The patient must be informed of all effects, including unwanted effects, of hormonal treatment and receive regular physical monitoring including liver enzymes and serum triglycerides.
(e) The clinician whose decision it remains to recommend or withhold recommendation of gender reassignment procedures, is subject to pressures and must be fully aware of these and of all consequences of decision.

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(f) Surgical gender reassignment must be preceded by at least a one year period during which the patient has demonstrated the ability to live full-time in the preferred gender role.
(g) Aftercare must be available to patients following gender reassignment.
(h) Patients must be informed of their legal and civil status following reassignment.

Most gender reassignment procedures take place in national centres; this has the major advantage of increased experience and skill of the staff in the centres. The major disadvantage is that frequently the patient must travel many miles for assessment and possible treatment; this, of course, means that the close supervision, recommended in the clauses listed above, are difficult to maintain. In order to provide patients and their medical attendants with a regional service we decided to conduct all assessments and treatments strictly within the limits of the NHS, i.e. no fee-paying patients were to be seen at the Leeds Gender Identity Clinic, and the code of practice, outlined above, was so far as possible to be followed. The clinic team consisted of three of the authors, who were to conduct the assessments for suitability of gender reassignment, the prescription and monitoring of sex steroid drugs and the voice and appropriate non-verbal skills training, respectively. We were able to interest two surgeons, Mr P. H. Smith and Mr T. Brennan; although the surgeons and their ward nursing staff had no initial experience of the procedures of gender reassignment surgery, they were prepared to gain the necessary information and acquire competence in the procedure.

A decision was taken that there should be an independent audit of the outcome of all male-to-female patients who proceeded through all stages of the reassignment at the Leeds GIC. The important principles for survey of outcome of gender reassignment have been listed by one of us. Snaith *et al* (1993).

(a) Assessment by a person skilled in such work but with no prior conception of the ethics of gender reassignment. The assessor must have played no part in the clinical decision.
(b) A follow-up rate approaching 100% and at least some reliable information on patients who could not be interviewed.
(c) The lapse of sufficient time following completion of the gender reassignment to allow the patient to adapt to the changed status.
(d) Assessment based upon realistic expectation of what may be achieved in terms of changed quality of life.

The study

The audit was conducted on the first 12 patients who proceeded through all stages of the gender reassignment, including the vaginoplasty, at the Leeds GIC. Decision on the form of the assessment procedure was undertaken by the second author alone. Since the assessor had no knowledge of the patients and decided not to read case-notes, which might influence his attitude, the assessment had necessarily to be based entirely on the patients' progress since reassignment.

All existing procedures have their faults; these have been surveyed (Abramowitz, 1986) and attention was drawn to the fallacy of basing judgement on a single rating, for instance the composition on economic, interpersonal, psychological, legal, sexual adjustment, additional surgery requested and family reactions (Hunt & Hampson, 1980). It was decided that the interview should be conducted in the patients' own homes, and that a non-judgemental, conversational style should be adopted. During the course of this interview the assessor enquired about the patients' attitudes to their experience of the management of their gender reassignment. Their views on how they had changed since their operation was enquired and rated in relation to the following main variables: social relationships, self-confidence and enjoyment of leisure activities. Consideration of employment status was rejected on the basis of high prevailing rate of unemployment and the fact that some patients, on account of their dysphoric state, had been hindered from acquiring skills leading to employment. Assessment of sexual activity was also considered but rejected on the grounds that many transsexual people have little interest in sexual activity or have experienced a life-long difficulty in establishing successful relationships with partners. Attitudes to body image were also excluded on the grounds that some patients were still awaiting further surgical procedures, mainly augmentation mammoplasty.

The outcome ratings on the three selected areas based upon enquiry into the following areas: social relationships – meeting and mixing with established friends and acquaintances; self-confidence – meeting people for the first time, appearing in public places such as shops; leisure activities – the degree to which these could be enjoyed and the taking up of new interests or activities. For each area allotment was made to one of four categories: worse (W), no change (N), some improvement (S), marked improvement (M).

Aspects of psychopathology were assessed by self-assessment scales; this alternative to the interview assessment was considered likely to throw a further perspective on the state of the patients and provide some indication as to

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Table 1. Interview ratings

Case no.	1	2	3	4	5	6	7	8	9	10	11
Social relationships	++	++	++	+	0	+	+	+	+	+	++
Self-confidence	+	++	++	++	0	++	++	++	+	+	++
Enjoyment of leisure activities	++	++	+	+	0	++	+	++	+	+	++

0= No change
+= Some improvement
++= Marked improvement

whether the assessor may have been inaccurate in his ratings. The two scales selected were the GHQ-28 (Goldberg & Hillier, 1979) which provides an overall assessment of the patient's emotional state with subscales for anxiety, depression, somatisation and social dysfunction. The second instrument was the Hospital Anxiety And Depression Scale (Zigmond & Snaith, 1983) which provides separate measure for the states of anxiety and depression.

Findings

One of the 12 patients did not respond to the assessor's letter requesting the interview; subsequent enquiry of the general practitioner revealed that nothing was known of the whereabouts of the patient. The audit therefore is based on interview with the remaining 11 patients.

The age range was 21 to 46 years (mean 33). The lapse of time since the vaginoplasty operation was 4 to 36 months (mean 19 months). The interview ratings are shown in Table 1. All GHQ+HAD ratings were within the range for good emotional health.

It may be noted that assessments in all but two patients were conducted at a period of over a year since the vaginoplasty operation; the other two were at intervals of four months and eight months respectively.

The results of the audit establish that most patients had undergone a marked improvement in their general well-being following the gender reassignment. One patient did not record any improvement in the variables assessed and one patient could not be traced. No patient rated herself as depressed or anxious on either of the subscales on the HAD Scale. The low level of GHQ ratings indicates an absence of major psychological disturbance in the patients and all GHQ subscales were within normal range.

All of the subjects spoke about the misery of their lives before reassignment. They talked about depression, the purposelessness of life, of coming home from work and going straight to bed. All of them expressed a much more positive view of the world, and of a profound relief that surgery had been available to them. Most of the patients said that, at the time, they considered the progress toward surgery had been too slow, but that now they realised that the requirement that they should have lived for two years as a woman was correct advice. It should be noted that, during the period of the survey less than a third of all patients referred to the GIC and less than half of those who received a diagnosis of transsexualism, were proposed for gender reassignment. Three patients who had been accepted into the reassignment programme dropped out of contact with the clinic. It was almost certain that one of these withdrew under family pressure, one was known to have joined a fundamentalist religious sect and it is believed that the other patient sought reassignment in the private sector but without request for referral from the Leeds GIC.

Comment

This audit supports the view that gender reassignment, if carefully undertaken on well selected patients, is a procedure which enhances the quality of life of the patients. However it must be undertaken with caution since collusion with the applicant's fantasy that he can 'change sex' and pass successfully in the opposite gender role may have disastrous results; moreover gender reassignment is a potentially dangerous undertaking; the prescription of feminising drugs carries a definite risk to life (Editorial, *The Lancet*, 1991) and this requires careful explanation and supervision. It is our recommendation that such prescription should not be commenced unless the avenue forward to surgical reassignment is clear; the state of patients who have been 'feminised' by medication but then denied surgery is probably worse than if they had not commenced on the course for gender reassignment. The practice at the Leeds GIC is that no intervention in terms of medication or speech therapy is commenced until the patient has complied with clinic attendance for at least a year and this ruling is explained to all applicants for gender reassignment. It has been our experience that a proportion of applicants for reassignment

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drop out of clinic attendance during this period, probably because of lack of motivation for the strenuous programme or insuperable personal difficulties.

Clinical facilities for the assessment of gender dysphoric people should undoubtedly continue. Although the majority of the patients are not mentally ill, the clinic should be directed by a psychiatrist or clinical psychologist with ample experience of the assessment of personal problems and personality disorders. The field is one that clearly calls for good liaison between professional workers (Pauly & Edgerton, 1986).

Objections are sometimes raised that gender reassignment is merely an expensive and dangerous undertaking in psychologically disturbed individuals. We do not agree and we present this audit in support of our view. Present emphasis on quality of life assessment is pointing to the need to assess health service intervention in terms of quality adjusted life years (QALY) (Spiegehalter *et al*, 1992) as well as immediate relief of disorder. It is certain that most transsexual patients would continue to lead unhappy lives, and present a burden to the social and health services in other ways if supervised gender reassignment were not available.

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