Gender dysphoria services: a guide for General Practitioners and other healthcare staff

Introduction

This document was prepared by representatives of Gender Identity Clinics (GICs) across England, at the request of the Department of Health, to provide an outline of necessary gender services. The information in this guide is primarily aimed at General Practitioners (GPs) but will also be of relevance to other healthcare practitioners, NHS England, Clinical Commissioning Group Commissioners and all users of gender services.

Clinical representatives from GICs in London, Nottingham, Leeds and Sunderland met in April 2012 to agree the basics of a draft common protocol based on best current NHS practice. An early draft of this document was shared with all UK gender clinics and specialists for their input. Following that, trans people and organisations representing them were given an extensive opportunity to comment on the draft. This document is also informed by the seventh edition of the World Professional Association of Transgender Health (WPATH) Standards of Care and later drafts of the Royal College of Psychiatrists Standards of Care for Treatment of Gender Dysphoria.

This document is not able to cover in any detail issues relating to future commissioning arrangements for Gender services. From April 2013, commissioning for such services will be carried out nationally by NHS England. Further information will appear on their website in due course.

This document also does not cover in detail such related issues as self-medicating, the specifics of official name change, arranging gamete storage, etc. Some of this information can be found on the relevant pages of the NHS Choices website at:
http://www.nhs.uk/livewell/transhealth/pages/transhealthhome.aspx

KEY POINTS

1. **Refer early and swiftly to a reputable Gender service**
2. **Support the treatment recommended by the Gender service**
3. **Get pronouns right; if in doubt, (discreetly) *ask***
4. **Be particularly mindful of medical confidentiality**
5. **Avoid misattributing commonplace health problems to gender**

This document will be updated in future by in consultation with a range of users and providers of gender services.

General Principles

Gender Dysphoria is a term describing the discomfort or distress caused by the discrepancy between a person's gender identity (their psychological sense of themselves as men or women) and the sex they were assigned at birth (with the accompanying primary/secondary sexual characteristics and/or expected social gender role).

Sometimes, that distress is sufficiently intense that people undergo *transition* from one point on a notional gender continuum to another – most commonly from Male-to-Female (sometimes abbreviated to MtF or known as *trans women*) or Female-to-Male (sometimes abbreviated to FtM or known as *trans men*). This typically involves changes to social role and presentation, and may necessitate their taking hormones or having gender related surgery. Some people regard themselves as non-gender or elsewhere on a gender continuum (see Names and Pronouns below) and present accordingly. These gender presentations are less common but no less valid.

Transsexualism is an extreme form of Gender Dysphoria. It is the desire to transition and be accepted as a member of a sex other than that assigned at birth, and to make one's body as congruent as possible, typically through hormones (endocrine treatment) and surgery. Transsexualism is coded in the current International Classification of Diseases as ICD-10 F64.0.

It should be noted that sexual orientation (for example, bisexual, heterosexual) is distinct and independent from gender identity.

There may be additional psychological problems related to gender. However, it should be emphasised that Gender Dysphoria and Transsexualism are not considered, in and of themselves, mental illnesses in any essential sense. The associated pressures of unmanaged dysphoria and/or the social stigma that can accompany gender diagnosis and transition may, however, result in clinically significant levels of distress. Disentangling, identifying and managing these factors can be complex, requiring specialist experience of the field.

Names and Pronouns

Terminology can vary widely, and individual preferences should be respected: people with Gender Dysphoria might identify simply as men and women – or as gender variant, transgender, transsexual, transvestite, non-gender, pangender, polygender, genderqueer, androgyne, neutrois or any other of a myriad of terms. All of these presentational variants might legitimately need input from gender services and should be considered for referral.

An attempt to list and define all possible gender terms is potentially controversial and outside the scope of a single document. However, the Department of Health's publication *Trans: a practical guide for the NHS* makes the following point:

Of all the things that could offend a trans person or lead them to feel misunderstood, excluded and distrustful, mistakes involving forms of gender-related speech are perhaps the most upsetting. Potentially they are also easiest to pay attention to getting right.

GPs and other clinicians should address users of gender services as those users would wish to be addressed. If in doubt, an opportunity should be found to ask the individual (discreetly) which form of address they prefer. This is not contingent upon official name change (see Appendix A). For example, some non-gender individuals may request the prefix "Mx" rather than "Mr" or "Ms". In waiting rooms and other public settings where there is no opportunity to ask beforehand about preferred form of address, a reasonable compromise might be to use initial and surname, for example "R Brown".

Written medical correspondence should take into account the possibility that others in the household are unaware of the individual's gender circumstances.

Gender services

Gender services provide specialist assessment and treatment of Gender Dysphoria.

Responsibility for all Specialised Commissioning, including the commissioning of gender services, moved to NHS England in April 2013.

The most recent WPATH guidelines emphasise the pivotal role of the qualified Mental Health Practitioner (MHP): a mental health professional (e.g. a psychiatrist or psychologist) who specialises in transsexualism/gender dysphoria and has general clinical competence in diagnosis and treatment of mental or emotional disorders.

Gender services typically provide access to a multidisciplinary team including MHPs, which commences appropriate assessment and treatment for all gender dysphoric people aged 18 years and over (there is no upper age limit).

Available treatments will include specialist assessment and diagnosis, and may include consideration of psychological therapies, speech and language therapy, endocrinology, referral for hair removal, referral for surgical procedures and aftercare.

Gender services provide specialist assessment and treatment of Gender Dysphoria; this may or may not include related social and/or physical changes.

People in need of help with psychological functioning and to make the transition of social status will require additional input from specialist mental health professionals with knowledge, training and experience in the treatment of Gender Dysphoria. This extra input may be available within the GIC or elsewhere.

Who is it appropriate to refer to Adult Gender Services?

Within the NHS, healthcare providers may be *primary* (the GP) or *secondary* (services accepting referrals from the GP, such as the local mental health team). Some specialist services are *tertiary* (they accept referrals from secondary providers).

Gender services are usually tertiary and, as such, receive referrals from secondary (and, less commonly, primary) care. This varies according to local service arrangements, and referrers must familiarise themselves with these local arrangements.

Referrals to gender services should be on the basis of the patient's reported history of gender discomfort, including a full description of the nature and extent of any co-existing mental health diagnoses, if present.

The following may all co-exist with Gender Dysphoria, and are not considered contraindications to referral: disorders of mental or physical health, disorders of learning, development (including autistic spectrum) or personality, dependence on alcohol or other substances. It is the responsibility of the referrer to ensure that any such conditions are stabilised. Where there are significant elements of associated risk, these should be well managed by referrers and additional (including forensic) services involved as appropriate.

It is recommended that any *clinically significant* medical or mental health concerns are stabilised before physiological treatments are initiated. It is recognised, however, that some health concerns arise from the stress of dysphoria or transition and commonly diminish or disappear altogether with successful addressing and management of the Gender Dysphoria itself.

Individuals referred to a gender service are not required to have started living in their desired future gender role, and it is not necessary for them to have undertaken psychotherapy prior to referral. Equally, some people will already have taken steps in this direction before approaching their GP, including full transition.

Who is it appropriate to refer to Specialist Child and Adolescent Gender Services?

Currently, young people under 18 should be referred in the first instance to the local Child and Adolescent Mental Health Service (CAMHS), for initial assessment of the Gender Dysphoria and possible associated psychological difficulties, such as depression or an autistic spectrum condition. This may

lead to onward referral to a nationally funded specific Gender Identity Development Service for Children & Adolescents, currently based in London (the Tavistock & Portman NHS Foundation Trust) and Nottingham GIC. These services work closely with local professional networks.

Child & adolescent Gender Services

There is a range of opinion among professionals about the treatment of children and young people who show atypical gender behaviour. Clinicians working psychologically with children are necessarily aware of the broad spread of non-problematic behaviour shown by young people that may have, in the past, been deemed gender atypical or non-conforming. In this context, it is important to note that *gender non-conformity* is not the same as Gender Dysphoria.

Gender non-conformity refers to the extent to which someone's gender identity, role or expression differs from the expected cultural norms. *Gender Dysphoria* is as defined above (in General Principles). Only some gender non-conforming people experience Gender Dysphoria.

There is some variation in the specific practice of specialist clinics and practitioners, but national and international guidelines emphasise the particular importance of a multidisciplinary approach. Generally speaking, options for adolescents with well established Gender Dysphoria include access to a series of treatments stages – in order of increasing irreversibility.

These treatments include the option of arresting puberty using Gonadotrophin Releasing Hormone Analogue (GnRH analogue) to reduce the distress commonly associated with pubertal physical development and provide a space for the young person to continue to consider whether full transition is their pursued objective. There is a particular emphasis on ongoing supportive counseling and psychological input, and any stage of the process can last as long as is deemed necessary by the young person, with input as appropriate from family and treating clinical team.

As an individual approaches 18, the child & adolescent specialist Gender Service will liaise with the appropriate adult Gender Service to ensure a smooth transfer of care. This may include ongoing prescriptions of oestrogen or testosterone where these have already been commenced, or initiating such treatment without undue delay.

The role of Gender Services

Diagnosis

Anyone referred to a Gender Service will be assessed to confirm a diagnosis of or relating to Gender Dysphoria. A diagnosis is medical shorthand for a

particular combination of symptoms (what the individual reports) and signs (what the clinician observes).

In the UK, diagnoses are generally coded according to version 10 of the International Classification of Diseases (ICD-10).

The most common gender related diagnosis is *Transsexualism.*

The ICD-10 diagnosis of Transsexualism (F64.0) in adults requires three criteria to be met:

- The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment
- The transsexual identity has been present persistently for at least two years
- The disorder is not a symptom of another mental disorder or a chromosomal abnormality.

Some clinicians might also refer to the US equivalent of ICD-10, the fourth edition of the Diagnostic and Statistical Manual (DSM-IVR), which states that Gender Identity Disorder *"is a medical condition in which there is strong and persistent cross-gender identification and a persistent discomfort with the sex or a sense of inappropriateness in the gender role of sex".*

The next edition of the DSM (DSM-V) is expected to replace the term "Gender Identity Disorder" with "Gender Dysphoria".

As a general principle (since patient needs vary considerably and do not necessarily fit the narrow definitions in older classification systems), it is recommended that GPs and other practitioners refer patients to gender services on the basis of the definition of Gender Dysphoria set out above (in General Principles).

Treatment

Within gender services, individuals are offered tailored support and intervention in order to best meet their individual needs and circumstances.

The therapeutic goal of a gender service is to work in partnership with the individual to facilitate a clear and realistic understanding of their feelings and aspirations. During this process, the individual will typically be encouraged, by their clinician(s), to explore options that they may not have considered. Neither the individual nor the clinical team should pre-judge the direction of the treatment pathway to be followed. Full gender transition – with or without provision of hormones/surgery – is generally a *possible* outcome, but the individual might also be assisted in considering alternative ways of dealing with their Gender Dysphoria. It should be noted that not all patients seek

surgical intervention - indeed, only a minority of female to male patients seek phalloplasty.

Individuals discharged from gender services, with or without having had hormonal, surgical or other interventions, will usually have a stable gender identity and be accepting and confident about the decisions they have been supported to make with regard to their treatment pathway.

The role of the General Practitioner (GP)

A supportive GP can be crucial to the longer-term health of people with Gender Dysphoria, with some patients requiring more support at the primary care level than others might. It is not acceptable for a GP to block or withhold treatment from dysphoric individuals on the basis of their own religious, cultural or other doctrinal beliefs around gender

GPs as well as other clinicians, should recognise that surgery is not always wanted or needed and that hormone therapy may be sufficient for some people.

Referring patients

As outlined above, when referring patients to gender services, the GP must consider whether there are any co-existing conditions, mental or physical health issues, or risk and vulnerability factors which need to be taken into account. These do not necessarily preclude treatment, but the gender service does need to be made aware of them. The GP should explain that this is the case and that in order to assess the patient; they may need to access any existing mental health records the patient may have. GPs may also need to work with referring psychiatrists at mental health teams to ensure there is support available between referral and appointment if needed.

Depending on local service arrangements, a mental health assessment may be required. If so, the GP should refer swiftly to the local Community Mental Health Team (CMHT) for assessment. The GP must then include the CMHT assessment in their referral to the Lead Clinician of the receiving gender service.

The GP will be required to carry out basic examinations and/or investigations, as a precursor to physical treatments that may later be recommended. This will include checking the patients' weight and blood pressure, as well as their general health and well-being. Patients are entitled to refuse these examinations, although physical examination will become inevitable if gender related surgeries are considered.

Depending on local service arrangements, the GP may also be required to organise funding for steps in treatment, as recommended by the gender service. This should be done in a timely manner, to avoid patients

experiencing a distressing sexually incongruous appearance. GPs should also advise patients which treatments they can receive free on the NHS.

Providing and monitoring treatment

After assessment at the Gender service, the GP is responsible for the initiation and ongoing prescribing of endocrine therapy and organising blood and other diagnostic tests as recommended by the specialist gender clinician. In the longer term, primary care is responsible for the life-long maintenance of their patient's wellbeing. This involves conducting simple monitoring tests, examinations and medication reviews as recommended, initially by the discharging gender specialist, and thereafter according to extant best practice. It should be noted that the standardised mortality ratio for those receiving these treatments seems to be that of the general population.

The GP is also responsible for making appropriate changes to patient record systems to reflect the patient's desired future gender role and to ensure that such changes facilitate screening for physiologically appropriate risks. For Male-to-Female patients, this includes a theoretical risk of breast and prostate cancer, but not cervical cancer. For Female-to-Male patients, the GP should arrange for a suitably dignified gynaecological examination according to the patient's genital physiology. All such arrangements should take into consideration the need to ensure that patients' gender histories are not disclosed (directly or indirectly) to third parties, in part because such disclosure can represent a criminal offence. Diligently kept and universally consistent records should minimise the risk of disclosure, but also of inadvertently addressing or referring to the patient inappropriately. The best general rule is to discuss matters in advance with the individual patient and obtain their informed consent for each process.

GPs and other clinicians can refer patients to the NHS Choices website for further information

The role of the CMHT

As with GPs, it is unacceptable for CMHT clinicians to refuse to assess or to otherwise block the treatment pathway of a dysphoric patient on the basis of their own religious, cultural or other doctrinal beliefs around gender.

Referring patients

The role of the CMHT, in terms of providing the necessary assessment, is consideration of a diagnosis pertaining to Gender Dysphoria and identifying (or, at least, flagging up) any mental health diagnosis that might be causing apparent gender identity issues. People with co-existing conditions (including, but not restricted to: disorders of mental or physical health, learning, development, personality; alcohol or substance dependence) are *not*

excluded from referral to gender services. It is, however, important to ensure that these conditions are stabilised as far as is possible. Where there are significant elements of risk, these should be well managed, using additional (including forensic) services, as appropriate.

Individuals referred to a gender service are *not* required to have started living in their preferred gender role, and it is *not* necessary for them to have undertaken psychotherapy prior to referral.

Some patients may already have progressed significantly in terms of transition and integration of their gender identity. Their purpose in seeking referral may simply be to obtain access (via the gender service) to endocrine treatment or surgery.

Ongoing involvement

The CMHT's involvement will be required in the management of any significant ongoing or new co-morbid condition.

Gender service: initial assessment

Commonly, assessment takes place over at least two appointments, usually with two separate clinicians, effectively forming parts of a whole. Sometimes, individuals with complex circumstances or with a history of having de-transitioned (returned to a gender role in accordance with their birth sex) will require further assessment.
Sometimes, as in the case of individuals who were previously known to the gender service or to other gender services, a second appointment may not be necessary in identifying and addressing their specific needs.

Typically, there is an intervening gap between initial appointments, to allow for reflection and, if appropriate, initiation or consolidation of a social gender role change, interpretation of the results of blood and other investigations, etc. Ideally, there should be no more than four months between appointments.

Blood tests

If required, routine blood tests are carried out in advance of the first appointment, by the GP. The gender service should inform the GP if this is necessary.

Those blood tests typically consist of the following.

Male-to-Female (phenotypic males transitioning to female): serum lipids, LFTs, bone metabolism, LH, FSH, SHBG, oestradiol, testosterone, dihydrotestosterone, prolactin, prostate specific antigen.

Female-to-Male (phenotypic females transitioning to male): serum lipids, LFTs, bone metabolism, LH, FSH, SHBG, oestradiol, testosterone, dihydrotestosterone, FBC.

It is important for the gender service to review results of blood tests (preferably with the assistance of a Specialist Endocrinologist) before endorsing hormones.

Smoking

Smokers are advised to stop. This is to minimise the overall risk of thromboembolism and polycythaemia, which are increased by oestrogens and testosterone respectively. Smoking is strongly discouraged and assistance to stop is offered. As a general rule, hormones are not initiated, or hormone dosage increased, while the individual continues to smoke, though hormone replacements such as nicotine patches, gum or electronic cigarettes are acceptable.

Alcohol & substance use

Alcohol consumption must be within recommended weekly limits. This is to lower the risk of hepatotoxicity further. Substance use must be stabilised and, where possible, stopped.

Obesity

Obese individuals are advised that their weight increases thromboembolic and surgical risks, and may indeed prove a contraindication to surgery. They are encouraged at an early stage to lose weight.

Occupation

It is recommended that patients are engaged in meaningful day-to-day activities as they progress through their gender treatment. This might involve being in paid or voluntary employment, full or part-time study, caring responsibilities or being otherwise meaningfully occupied. This is typically a requirement for genital surgery rather than for starting hormones - although individuals should be living full time in their preferred gender role. A person could start on hormones without fulfilling occupational criteria. However, if their intention is to seek genital surgery in the longer term, they do need to address the issue of occupation in this broad sense.

Individuals will not be required to disclose their birth-assigned sex to employers who know them only in their post-transition gender role: a reference can be marked To Whom It May Concern and state only that Ms X has worked at Company Y since Date Z. Alternatively, contracts, pay slips or

statements confirming voluntary work or education may be acceptable, if in the female name (and gender signifier, if relevant) and showing a span of dates. Contacting employers without express permission from the patient is unacceptable.

Official name change

If an official name change has not been made, the individual should be advised on how to go about this. It is possible for people of UK nationality to make an official name change at any time. An information sheet from the Gender Recognition Panel sets out three ways of doing so (see Appendix A).

Sometimes it is not possible for people to make an official name change. Non-UK nationals, for example, may be unable to change their name in their country of origin and this should be taken into account by the gender clinician.

Clinicians may seek to confirm name change by asking to see relevant documentation.

Hormones

As a general rule, the prescription of exogenous hormones (oestrogens, androgens) is not endorsed until initial assessment is completed. This will take more than one appointment unless the individual is transferring from an appropriate child and adolescent or other gender service. In these cases, hormone treatment decisions may be managed in a shared care arrangement with the other gender service until the second appointment.

If the individual is already taking hormones (having been started by a private gender specialist or through self-medication), it is generally not stipulated that they stop altogether, although there *is* emerging evidence that self-medication can lead to a poorer outcome. The focus is rather on safe use of hormones, and blood investigations inform this. If someone is taking doses or combinations which represent a risk, they will be advised of this and appropriate guidance given.

Dependent on whether an individual has socially transitioned in the sense of living full time in their preferred gender role (or is felt by the specialist gender clinician to be likely to do so imminently), it may be reasonable to recommend that the GP prescribe exogenous hormones - oestrogen for trans women (Male-to-Female) and testosterone for trans men (Female-to-Male) - possibly in combination with a GnRH analogue. It is important to note that there is every indication that these are safe and effective treatments.

Before starting either, however, it is important to explore implications for fertility. This might include discussion of gamete storage. The GP is usually best placed to advise on local availability of gamete storage services.

Oestrogens: the patient must be made aware of likely effects and side effects, some of which may be irreversible, and warned of the signs of deep venous thrombosis. It is also useful to discuss the rationale for starting on a low dose and increasing in staged increments (this appears to lead to better outcomes in terms of breast growth).

Androgens: the patient must be made aware of likely effects and side effects, that some of these (voice change, clitoral enlargement) may be irreversible soon after starting treatment.

There may be a role for additional preparations, such as GnRH analogues. This should be discussed on an individual basis with the Gender clinician.

Other recommendations

If appropriate, the gender service clinician might make a referral to Speech and Language Therapy, either local to the individual or based at the gender service. Referral will usually depend on people having begun living full-time in their preferred gender role, as they cannot practise the new vocal techniques consistently if switching between roles.

Facial hair removal by laser or electrolysis is not always funded but, in accordance with local arrangements, the GP can be asked to apply for funding.

Gender service: ongoing assessments

People are required to attend the gender service regularly (ideally, at least three times yearly) for review with one or more specialist gender clinicians. This might reasonably include: discussion of hormones; referrals to other services (for example, speech therapy, surgery, etc.); support as necessary with social, occupational, family/relationship changes and other developments.

Some gender services are able to offer more frequent follow-up where required, including periods of more intensive input from other therapists, usually with a defined aim and timescale. Other possibilities include one-off workshops (often focused on a particular aspect of transition) and therapeutic group work. Attendance at group or other therapy sessions is not compulsory.

Gender service: surgical eligibility

In general

Sometimes, when an individual first comes to a gender service having already lived in their preferred gender role for the requisite length of time, suitability for genital surgery might reasonably be considered. It is important to establish understanding of surgical technique, and realistic expectations of outcome.

It must be noted that gender services, being tertiary, have no direct influence over funding for surgical procedures. As indicated above, from April 2013, NHS England is responsible for commissioning gender services.

There is no set requirement for people to undergo surgical procedures in a particular pattern or order or, indeed, at all. The following are, however, commonly requested.

Male-to-Female surgery

Male-to-Female throat surgery: generally speaking, patients might reasonably be referred to specialist Ear, Nose & Throat (ENT) surgeons after a year or so of living as a woman. With cricothyroid approximation (phonosurgery, vocal cord surgery), ENT surgeons require both psychological/psychiatric and Speech and Language therapist (SLT) referral, so it is important to ensure that those pursuing phonosurgery have actively engaged with and are supported by a SLT, before and after surgery.

Facial feminisation surgery: at the present time, this is not, generally speaking, funded within the NHS. It is not uncommon for Male-to-Female individuals, in particular, to have undergone (or plan to undergo) facial feminising procedures in the private sector.

Male-to-Female genital surgery

Social gender role transition is usually considered to have started from the point that the individual makes an official name change – assuming they have also established a changed social gender role.

It is standard practice for people to be considered eligible for genital surgery after a set period (usually, two years) of social gender role transition. This means living full time as a woman, including official name change and documentary evidence of some sort of occupation, for at least twelve months. Some flexibility should be allowed to accommodate particular personal situations such as disability and for those with unusual occupations.

Sometimes, if social gender role change appears to have been straightforward (and particularly in cases where the individual has been in an occupation as a woman from the outset, and can demonstrate this clearly), it is reasonable to plan a first surgical eligibility assessment at 18 months.

Male-to-Female genital surgery typically requires a hospital stay of about a week and a period of recuperation that can vary from a fortnight (for those with sedentary jobs) to two months (for those with complications, or very physically active jobs). Very occasionally revisional procedures are needed, typically as an overnight stay.

Female-to-Male surgery

Female-to-Male chest reconstruction surgery: typically, individuals are eligible for this after having lived for at least one year as a man and taken androgens for at least six months. Full-time occupation in the male role is desirable but not required where more general social functioning/stability as a man can be otherwise demonstrated. This typically involves an overnight stay and a week or two of recuperation and some restriction to vigorous physical activity.

Female-to-Male genital surgery

In essence, the same eligibility requirements pertain as with Male-to-Female genital surgery. A set period of social gender role transition, living full time as a man for two years, including proof of occupation (as defined above, in Male-to-Female genital surgery) for at least 12 months.

Female-to-male genital surgeries vary but can (in the case of phalloplasty) be multi-stage, with several separate surgical procedures over a period of one to two years.

Gender service: aftercare

In the case of patients who have undergone genital surgery, follow-up by the gender service is offered at four to six months post surgery. This will review the outcome and make recommendations for the ongoing prescribing and monitoring of their life-long treatment by the GP in a primary care setting.

Patients are discharged from gender services in the following circumstances:

- they have a stable gender identity in which they feel content;
- following endocrine and/or surgical interventions, their care can be transferred wholly to their GP;
- they request discharge;
- they fail to attend appointments;
- they are repeatedly unable to engage constructively with services.

Upon discharge, the gender service will provide detailed recommendations and guidance to enable primary care practitioners to take full responsibility thereafter. Some clinics have websites that GPs can refer to in order to ensure discharged patients continue to be prescribed hormone therapy in line with the most up-to-date recommendations.

Ongoing health

It is the responsibility of the GP to monitor and manage the ongoing healthcare of users of gender services in exactly the same way as they would look after any other patient.

Former users of gender services are just as likely as any other person to become physically or psychologically unwell, and it must not be assumed that relatively commonplace conditions (such as a urinary tract infection, brief depressive episode or even development of cancer) automatically necessitate re-referral to tertiary gender services. Equally, it should not be assumed that commonplace conditions are a result of the gender treatment.

When making referrals to other services, GPs should take care not to disclose the gender history unless it is relevant and appropriate to do so.

Individual GICs will generally provide individual recommendations on long term monitoring. The following is a general rule:

Male-to-Female (post genital surgery):

- Annual lipids, LFTs, prolactin, oestradiol, blood pressure;
- Annual PSA prostate cancer checks for those who started treatment later in life;
- Routine breast screening;
- GnRH analogues are not required, post-surgery, but oestrogen must be continued indefinitely to prevent osteoporosis.

Female-to-Male (post genital surgery):

- Annual lipids, LFTs, FBC, testosterone, blood pressure;
- If individuals have not undergone hysterectomy, pelvic ultrasound scanning is recommended every two years, to exclude uterine/ovarian pathology;
- If individuals have retained a cervix, routine cervical screening is recommended. GPs are responsible for ensuring that patients are invited to screening and screened in ways that preserve their dignity and privacy. The best way to accomplish this is through explicit discussion of the planned approach with the individual patient.

It is important to appreciate that some individuals feel sufficiently dysphoric about their genitalia in particular, that they choose to avoid pelvic/cervical screening altogether.

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Appendix A

In practice, many individuals embarking on social gender transition subsequently wish to change their birth certificate, using the Gender Recognition Act (2005). The following statement outlines the varieties of name change acceptable under the Gender Recognition Act.

Change of name for the purposes of the Gender Recognition Act (2005)

The Gender Recognition Act 2005 requires a person to have lived exclusively in his/her acquired gender for at least 2 years prior to his/her application for a Gender Recognition Certificate (GRC). A key element to the evidence of the persons acquired gender and living exclusively in that gender is that he/she has adopted an appropriate name. There is no legal requirement for the change of name to be documented. However, for practical purposes to change a name with official bodies, a document evidencing the change of name is required. The Gender Recognition Panel (GRP) would normally expect to see such a document.

The documentary evidence of a change of name can take several forms. The simplest and most common form is a *Change of Name Document*. This is a document confirming that the person making the document relinquishes his/her former name and in its place assumes a new name from the date of the document. The document has to be signed by the person changing his/her name, in the presence of a witness. The witness then signs to confirm that he/she has witnessed the person signing the document in his/her presence and add an address where they can be contacted in case there is a query over when or how the document was signed. There are no specific requirements as to who can and cannot be a witness. The document can be prepared by a solicitor or a blank form can be obtained from the internet or a stationers.

A slightly more formal approach would be for the change of name to be evidenced by a *Statutory Declaration*. This will usually be drafted by a solicitor (although again blank forms can be obtained from the internet or a stationer). In this case, the Declaration has to be sworn in front of a person authorised to administer Oaths, which will be a solicitor, Commissioner for Oaths, Notary Public, or a Legal Executives authorised to administer Oaths, all of whom are available through a solicitor's office. Alternatively, the Declaration can be made before a Magistrate (also called a Justice of the Peace) or some Magistrates Clerks at a Magistrates Court. Abroad, Consular officials are allowed to administer oaths. A small fee will be payable when swearing an Oath.

The GRP would normally expect to see one of these two types of documents. A more formal version of the Statutory Declaration is a *Deed Poll*. They are formally registered and are more costly to produce. A solicitor would advise when a Deed Poll was legally required instead of a Statutory Declaration.

Deed Polls are rarely used these days and the GRP certainly does not require one.

Some applicants changed their names so long ago that they have either lost their document evidencing the change of name, or did it informally without a document to evidence the change. In these exceptional circumstances, the GRP would require other forms of documentary proof of the change of name such as a statement from someone who has know the individual in their previous and current names. Where the GRP does not consider there is sufficient evidence of the change of name, directions can be given to highlight the additional evidence that needs to be produced. If an applicant is aware that he/she lacks the necessary evidence of the change of name he/she can seek general guidance from the GRP before lodging his/her application and supporting documentation.

The GRP needs to be satisfied that the person making the application for a GRC is the same person as appears on the birth certificate. It is, therefore, necessary to produce evidence of all changes of name if there has been more than one during the individual's lifetime.