GPs' brief guide to caring for trans service users

1. Legislation: In accordance with legislation and the NHS ethos, trans people - those proposing to undergo, undergoing or having undergone gender reassignment – are entitled to treatment that includes hormone therapy, surgery and psychological support; they have the right to prompt access to treatment, and to non-discriminatory delivery of services. Providers must have due regard for the equal treatment of trans people, their right to dignity and privacy, and their personal autonomy. This applies whether the treatment is for gender dysphoria, or for some unrelated health need.

Some trans patients may have Gender Recognition Certificates according them their post-transition gender status 'for all purposes'. The Certificate is granted on the basis that the recipient has lived for at least two years, and will continue living permanently, in the 'new' gender role; surgery is not a pre-requisite.

Regardless of legal gender status, names and pronouns should be consistent with the gender presentation, and accord with the wishes of the service user. Presentation may fluctuate so patient notes may need to record more than one name for unofficial use, until more final decisions are made about permanent name change. Deed Poll or Statutory Declaration of name change may be done, but this is not a legal requirement and treatment should not be made contingent upon it.

2. Referrals: The GP should make referrals as necessary to: a provider of gender care in the NHS (locally where possible) or in the private sector; to a provider of psychological support if required; and/or, where there are unrelated mental health concerns, to a local clinical psychologist or psychiatrist. The provider(s) may be in a specialist centre, or a local network. The GP has shared care, providing ongoing hormone therapy and monitoring under the guidance of the gender clinician and/ or an endocrinologist. A GP with 'special interest' may be the lead clinician.

3. Patient choice: treatment should be patient led; trans people may choose any combination of gender role adjustment and/or hormone therapy, and/or surgery (see points 4d and 4e below). Identities may be anywhere on a spectrum between 'man' and 'woman'; a few individuals will wish to neutralise their sex appearance, and some may not change their gender role continuously but will still require medical support.

Typical treatment components:

4a. Assessment and psychological support

Assessment with a view to making a diagnosis may be undertaken, provisionally by the GP, and confirmed by the gender specialist. This may be a GP with special interest.
(see page 36, www.gires.org.uk/assets/DOH-Assets/pdf/doh-guidelines-for-clinicians.pdf.

Diagnosis: there are no physical signs of gender dysphoria that can be measured with certainty. Diagnosis depends upon the service user declaring ongoing symptoms of persistent gender dysphoria that may lead to a wish to adjust the gender role, and it usually includes discomfort with primary and secondary sex characteristics.

It is important to identify any co-existing psychopathology that may require treatment in parallel with the gender treatments. As above, a referral to a local psychiatrist or clinical psychologist may be necessary where psychopathology is identified, or suspected. Local psychological support may be appropriate for many patients and can be undertaken, in tandem with the gender specialist provider.

Outcomes are better when families are supportive of the trans person. Some psychological support may be beneficial, especially for partners and significant others. This may be in the form of counselling.

4b. Hormone therapy: Typically, trans women have oestrogen therapy, sometimes accompanied by anti-androgens; trans men have testosterone therapy.

Eligibility: before starting hormones, an assessment leading to a working diagnosis should be undertaken, in association with a minimum of either three months psychotherapy (at least fortnightly), and/or a change of gender role for three months.

Pre-treatment blood tests, and ongoing monitoring are necessary, as determined by the supervising gender clinician. (UK guidelines at: www.rcpsych.ac.uk/pdf/Standards%20of%20Care%20Draft%20v8%203b%20final.pdf)

Where service users are already self-medicating, a prompt referral to a gender specialist is advised, and the service user must be brought into a prescribed and monitored regime as soon as possible.

Hormone therapy is likely to continue throughout life with ongoing monitoring of potential long-term side-effects, and of service user's personal comfort.

4c. Hair removal

Hair removal on the face is invariably needed by trans women, usually by light based treatments or electrolysis; this may continue for months or even years; body hair removal will also be desirable in many. Genital surgery is usually preceded by hair removal from graft donor sites. Surgeons will advise depending on their surgical technique and the service user's choices.

4d. Surgeries (non-genital):

Trans men may require surgical chest reconstruction before or at the start of transition to enable them to live as men. Until then, they use breast binders. Surgeons should be specialists in the field (not those who are only accustomed to performing mastectomy in women). Until vaginal closure is undertaken, cervical smears should be offered for those at risk.

Non-genital surgeries for trans women may be undertaken at any time: facial feminising surgery; thyroid chondroplasty and voice modification. Breast augmentation is not recommended until oestrogen has had its optimum effect (18 months – 2 years).

4e. Genital surgeries

Genital surgery is not always desired. Continuous gender role change for at least one year precedes genital surgery. A few weeks before surgery, hormones are usually discontinued, meanwhile testosterone blockers may be taken by trans women.

Surgeries for trans men include: hysterectomy and salpingo-oöphorectomy, closure of the vagina; metoidioplasty or phalloplasty and scrotoplasty. Relatively few trans men undergo phalloplasty. Scrotal and penile erectile prostheses may be done later.

Trans women may have penectomy, orchidectomy, vaginoplasty, clitoroplasty and labioplasty.

5. Post genital surgery

Local nursing care may be needed to assist recovery. Trans women will need to continue dilating the vagina in line with their surgeon's instructions. Testosterone and oestrogen therapy continues.

Post-surgical depression can occur, especially in trans women, so further psychological support may be needed. Monitoring for prostate disease in trans women is advisable where hormone treatment started late in life. Dexa bone scans may be advisable if a patient has been agonadal for a while and there is a risk of under-replacement of hormones.

For a full review: "Guidance for GPs, other clinicians and health professionals on the care of gender variant people" available at http://www.gires.org.uk/assets/DOH-Assets/pdf/doh-guidelines-for-clinicians.pdf