HOUSE OF COMMONS

Women and Equalities Committee

Oral evidence: Reform of the Gender Recognition Act, HC 129

Wednesday 12 May 2021

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Watch the meeting

Members present: Caroline Nokes (Chair); Theo Clarke; Elliot Colburn; Kim Johnson; Kate Osborne; Bell Ribeiro-Addy; Nicola Richards.

Questions 166 - 185

Witnesses

I: Dr Harriet Hutchinson, Community Organiser, Action for Trans Health Durham; Dr John Chisholm CBE, Chair of the Medical Ethics Committee, British Medical Association.

II: Dr Michael Brady, National Adviser for LGBT Health, NHS England; John Stewart, National Director of Specialised Commissioning, NHS England; Leigh Chislett, Clinical Manager, 56 Dean Street.

Written evidence from witnesses:

- Action for Trans health
- British Medical Association

Examination of Witnesses

Witnesses: Dr Harriet Hutchinson and Dr John Chisholm.

Q166 **Chair:** Good afternoon and welcome to this afternoon's session of the Woman and Equalities Select Committee and our inquiry into the reform of the Gender Recognition Act. This afternoon we have two panels of witnesses. The first panel includes Dr Harriet Hutchinson, community organiser for Action for Trans Health Durham, and Dr John Chisholm, chair of the medical ethics committee of the BMA. Thank you very much for joining us this afternoon. Can I start by asking Dr Hutchinson if you can briefly explain to us the process for getting a diagnosis of gender dysphoria in order to obtain a gender recognition certificate?

Dr Hutchinson: The problem with trying to do a brief description is that the process is not at all brief. The first thing that one has to do is to approach one's GP and ask for a referral to a gender identity clinic. In some cases, this is straightforward and a doctor will simply make a referral. In some cases, a doctor will ask you a series of questions in order to determine whether they think they should refer you on to that service. This is an existing problem for us at the moment, where a large number of people are not supported in receiving that referral when requested.

When you have had that referral, the gender clinic closest to Durham is the Northern Region Gender Dysphoria Service, for example. They will receive that referral and will send a form to your GP. You would fill out that form jointly with them, and then they would send it back. The next step is that the gender identity clinic will send you a letter to apologise for the length of the waiting list. You will then wait for an extended period. Currently, people who are at the top of the list have been waiting three years and three months before they have even had their first appointment. Unfortunately, you cannot be diagnosed at this first appointment. You will see a member of the clinic who is not a consultant, who will take a history and then ask you to come back in several months. This is potentially also quite a long wait.

Your second appointment is the first time that you will see a gender identity consultant. The people at the top of the list have been waiting for that for four-plus years. At that appointment, the consultant will go through a history and discuss your identity, your gender, your feelings about it, your sexuality, your relationships and a whole host of other aspects of your life. They will then decide whether you can be diagnosed at that point or whether you will need further follow-up appointments, at which they would be able to make a diagnosis. It is a long, drawn-out process that is dependent on the goodwill of your GP and the length of those waiting lists, but if somebody then meets the diagnostic criteria they should theoretically receive a diagnosis.

Q167 **Chair:** You just said that people require the goodwill of their GP, but right at the beginning you said that a number of people would not get the referral from the GP. Can you quantify that?

Dr Hutchinson: I can, yes. In the national LGBT survey, 80% of trans people who managed to access gender identity services said that they had difficulty doing so; 25% of those GPs did not know where to refer somebody with gender identity issues to discuss; 12% of their GPs would not support them in accessing those services.

Q168 **Chair:** It is not that they do not know?

Dr Hutchinson: It is both. We know that 7% of trans people have changed their GP due to discrimination. It is not currently possible for us to make self-referrals to gender identity services even though these are included within the current service specification, because the gender identity services require support from your GP in order to accept that referral.

Q169 **Chair:** In your written evidence, you referred to the requirement for trans people to prove their gender identity through medical reports as being intrusive and degrading. Can you expand a bit on that, please?

Dr Hutchinson: The current process of attempting to prove your gender to a clinician is a disturbing process, because there is no way of proving your gender to somebody. In the previous Women and Equalities Committee inquiry, one of the questions directed to NHS England was whether there was a clinical way for somebody to determine what living in role for two years looks like, and the answer was no. We have followed up with that, and there is still no clinical basis for this.

Our service users have been in appointments where they have been criticised for not wearing lipstick, or received lectures from cisgender women clinicians telling them that the trousers they were wearing were not feminine enough to be regarded as a female presentation. The idea of having to prove your gender is very reductive. It forces trans people to conform to stereotypes in order to receive a diagnosis, and then, of course, receive criticism for perpetuating gender stereotypes. These things are enforced by the institutions that we come into contact with.

Q170 **Chair:** Dr Chisholm, can you explain to us what the clinical requirements are for a diagnosis of gender dysphoria, and why many people seeking a certificate might not meet them?

Dr Chisholm: Let me make a point in advance of that. It is unfortunate that we have a situation where gender recognition certificates are requiring a medical diagnosis. The British Medical Association would certainly like to move to a position where a gender recognition certificate is primarily a legal process, not a medical one. We need to separate the two issues of having recognition for your gender and accessing treatment.

As far as the diagnosis is concerned, the medical requirements are a medical diagnosis of gender dysphoria provided by a registered medical practitioner or a registered psychologist practising in the field of gender dysphoria, and also a report from a medical professional detailing any medical treatment that you have received. That can be provided by any registered medical practitioner, not necessarily one practising in the field of gender dysphoria.

The NHS states that the signs of gender dysphoria in teenagers and adults may include: certainty that your gender identity conflicts with your biological sex; being comfortable only when in the gender role of your preferred gender identity; a strong desire to hide or be rid of physical signs of your biological sex; and a strong dislike of the genitals of your biological sex. I very much agree with what Harriet has said, first, about the difficulties of what certainty is, in this field, that your gender identity conflicts with your biological sex. What evidence is a doctor going to require, when it is essentially about your own self-perception? I also agree with Harriet that it is very onerous and dehumanising to have to be asked all these intrusive questions in order to prove, in essence, that you are who you say you are.

Q171 **Chair:** The certainty point is very valid. It must be almost impossible to demonstrate that with certainty.

Dr Chisholm: I entirely agree with you. Why should you have to convince a doctor that you are who you say you are? We have come a long way from regarding gender dysphoria as a medical problem, a psychological problem or a mental health problem, and yet we are forced back into those paradigms by the way the law operates.

Q172 **Chair:** In your written evidence, you referred to a diagnosis of gender dysphoria as not being in the interests of either the patient or the GP. Can you explain why you do not think it is in the interests of GPs?

Dr Chisholm: If somebody is seeing medical help, we need to make that easier for them. We are still in a situation where transgender and non-binary people are marginalised, and there is sometimes prejudice against them. That is a human rights issue but it is also a healthcare issue. If somebody is seeking medical help, in a way the system is stacked against them, not least by the very long waits for access to specialist services that Harriet has already described.

As far as general practice is concerned, the involvement of GPs in a medicalised process of gaining a gender recognition certificate is not in the interest of either individual patients or GPs. That is not what GPs should be there to do; GPs should be there to refer people to specialist services who are seeking medical help for how they perceive themselves.

Q173 **Chair:** You have both highlighted the wait for somebody to get an appointment at a gender identity clinic. Could you explain, once somebody has that referral, how the clinic can assist the individual in getting that diagnosis?

Dr Hutchinson: Once they have had the referral, again, they will receive an apology letter for the long wait, and then precisely nothing happens. One of the major issues with the waits that are built into the system is that, in some ways, these are couched as support, somehow. There is a similar idea embedded in the process for achieving a gender recognition certificate, where you must have lived in role for two years before you are eligible, with the idea that this is to teach transgender people the consequences and significance of their decisions, which, frankly, is deeply patronising.

Similarly, the waits built into the gender identity clinic systems—whether they are between the first appointment and the second appointment, or simply being on the waiting list—being considered as thinking time is deeply problematic. The support during these periods is non-existent. We often find that non-profit organisations are picking up the pieces from this. Our colleagues at Be in Newcastle are picking up the pieces where NHS services and the gender identity clinics have failed. People who are requiring increased mental health support during the times that they are on waiting lists, or the months and months between their first and second appointments, are ending up in crisis situations and being referred to unfunded third sector organisations to provide care that should be provided by the NHS.

Q174 **Chair:** So the time is not just about capacity. It is deliberately built in to effectively send people away to think about their decision without any support.

Dr Hutchinson: That is correct. Built into the surgical specification, there is a requirement for 12 continuous months of living in a gender role that is congruent with their gender identity. It says, “This requirement is not about qualifying for surgery, but rather preparing and supporting the individual to cope with the profound personal and social consequences of surgery.” Much of the time, the results of these surgeries will not be visible to other people. Similarly, a period of waiting without any kind of training, assistance or literal support does not teach somebody how to change dressings, or, in the case of genital reconstruction surgery, about things like dilating and douching.

The idea that this is about support for the consequences of surgery is nonsense. These waits have been built in historically as an idea that we must be taught that this is a life-changing decision, that you must be certain, and that you have to go away and think about this, in a way that is not extended to other life decisions on a similar scale with similar consequences. This is mostly about making the medical establishment and cisgender people comfortable. It is not about helping transgender people.

Dr Chisholm: I am really saddened to hear what Harriet is saying, because it seems to me to be entirely contrary to the ethos of the National Health Service, which is to provide people with access to timely care when they need it. The very idea that waiting lists are somehow good because they allow you to reflect on the seriousness of the choices you are making and give you thinking time seems abhorrent to me. Under NHS guidelines, an initial appointment for hormone therapy and surgery should be within 18 weeks. As you have already heard, the waits are in fact measured in years. Waiting lists for treatment throughout the NHS have escalated enormously over the last 15 months for reasons that are self-evident, but unfortunately, in relation to patients with a diagnosis of gender dysphoria or seeking such a diagnosis, these waits have been endemic from before the Covid-19 pandemic began.

Dr Hutchinson: The pandemic has of course had a huge impact on us, but the waiting times are increasing even without taking that into account. If we use the figures from 2019, before the pandemic hit, our local gender dysphoria service was increasing its waiting list at a rate of approximately five months year on year.

The waiting times on surgery are similarly very difficult. The contracting arrangements in particular have caused difficulties, with some contracts lapsing and clinicians retiring. The reliability of the gender identity services in making timely referrals is problematic as well. We know people who have had a recommendation for surgery who have then waited for a year before that recommendation has actually been provided to the surgeon responsible. After somebody has spent five years on a waiting list and 12 months living in role, and qualified for surgery because they have needed to take hormones for a particular length of time, they then have another period of waiting based on the administrative burden that the gender identity clinics have. Somebody could be waiting seven, eight or more years before they have the surgical interventions that they need.

Dr Chisholm: I just wanted to make three very brief points on this issue. First, as Harriet has said, there is a very real increase in demand for services, which has developed in recent years. Secondly, there are issues with the clinical workforce in terms of recruitment and retention, and those problems amplify the service provision challenges. Thirdly, there is a bit of a postcode lottery here, because service provision and waiting times vary according to where you live.

Q175 **Kim Johnson:** Good afternoon. I have three questions on the opening of the three new gender clinics. What is your view of the Government's proposal to open three new gender identity clinics?

Dr Hutchinson: I am afraid my response is an incredibly cynical one. When the announcement was made for three new gender identity clinics around the time of the results of the consultation on GRA reform, these were neither new nor gender identity clinics. These were pilot programmes. These are two-year pilot programmes that will take 500 patients each. That is 1,500 patients out of an existing waiting list of 13,500 people across the UK. Locally for our service users, it will have zero impact whatsoever.

There is still fundamentally a problem with diagnosis as bottleneck. The major problem we see is not necessarily even the scale of funding required, but the gatekeeping of the need for diagnosis of some kind in order to access healthcare interventions comparable to sexual health services, for example. The services that are coming into place are not able to perform all the functions of the gender identity clinics, for example the requirement for a particular period of time for the service to have existed before it can make surgical referrals. Those patients will need to return to the existing gender identity clinics in order to make progress there. Additionally, after two years we have no idea what will happen to those services. In terms of their benefit locally, it makes no difference to us. We will still be waiting.

Q176 **Kim Johnson:** Thank you for that information. It does seem strange, only 1,500 out of 30,000. You also say that they should be completely replaced. Can you say why and what you would like to see them replaced with?

Dr Hutchinson: Sorry, I should clarify that it was 13,500, not 30,000. We would like to see the replacement of a gatekeeper-based system. We have been systematically discriminated against in gender identity services. We have been poked, prodded and probed, sometimes literally, by psychiatrists who are trying to determine whether we are the gender that we claim to be on the basis of whether we are wearing the right thing on that particular day, even though these things are supposedly not things that are made judgment about. We still see those.

Our service users report questions on their sexuality. The reports that are generated that would then go to the gender recognition panel include detailed sexual histories and intimate details of people's current sex lives. The medicalisation of this process is deeply troubling; I completely agree with Dr Chisholm that there is a problem with the medicalisation element here. Fundamentally, trans people know who they are. Fundamentally, people should have the right to make the changes to their bodies that they want to. Fundamentally, it is wrong that the psychiatric profession gets to decide whether we are who we say we are.

The gender identity clinics, as a concept, should be removed and access to healthcare for things like hormone treatment can be made through primary care. Where other referrals need to be made to other specialist areas, they can be made as well, but the idea of a gender clinic that one has to attend where these structures have a history of gatekeeping, excluding us, discriminating against us and deciding whether we are who we say we are is wrong, and they need to be scrapped entirely.

Kim Johnson: Dr Chisholm, do you have anything to add on the benefits of opening the three new clinics?

Dr Chisholm: I agree with Dr Hutchinson that these will not make a great contribution numerically, with 1,500 or 1,600 new patients being seen when over 13,000 people are waiting. I share Harriet's concern about these only being two-year pilots and about the service being potentially withdrawn at the end of that time.

There is also a wider problem with specialist capacity. You cannot just magic up specialists out of nowhere. There is a need for trained clinicians who have both the resources and the experience to provide the necessary standard of care. It takes time to get fully trained clinicians in that way.

NHS England has neglected to commission local services for ongoing care for patients once they have been discharged from the gender identity clinic. We need a properly commissioned, comprehensive and quality-controlled service for patients who need these services. That could either be through specialist prescribing, which could be facilitated through the electronic prescription service, through properly funded shared care arrangements with GPs who have consented to provide this service, or through locally commissioned alternative providers within primary care.

I agree with Harriet that there is a deficit here between the specialist services and general practice, which needs to be filled by services that are commissioned and by clinicians who are interested in providing the service and have been adequately trained.

Q177 **Kim Johnson:** It sounds like both of you agree that the clinics are not going to meet the needs. The Government have argued that the GRA reform is not the top priority for transgender people, and that the most important concern is trans healthcare. What is your view of this assessment by the Government?

Dr Hutchinson: It is an interesting distraction. On the one hand, legal recognition of gender is very important to a lot of trans people. On the other hand, a lot of trans people would like to see gender markers removed from most official documents. Obviously we are constrained by international conventions on many things such as passports. For most purposes, a concept of legal sex is a difficult one.

For the majority of the trans people we come into contact with, the Gender Recognition Act is not the primary concern at this moment in time. Their concerns are things like access to housing, access to jobs, access to healthcare, access to mental health services and access to basic needs being met, without discrimination and in a timely fashion. To say that it is not our top priority is potentially true, because the scale of the remainder of the issues is so high that they need tackling now. However, to abandon GRA reform, which we feel they have done, is unhelpful, unproductive and an abandonment of responsibility.

Dr Chisholm: I agree with Harriet. We need both. We need an improved mechanism for achieving a gender recognition certificate, but we also need much better and substantially more capacious services for trans people. It is an issue of trans healthcare but also an issue of trans rights. We need to separate the two issues. In relation to recognition, we need to remove the requirement for medical diagnosis. The World Professional Association for Transgender Health statement on gender recognition states that, "Medical and other barriers to gender recognition for transgender individuals may harm physical and mental health. WPATH opposes all medical requirements that act as barriers to those wishing to change legal sex or gender markers on documents."

The other point I would make is that it is not a binary decision. We need to have better recognition of people who are non-binary, rather than just having people forced into stating that they are men or are women.

Dr Hutchinson: I want to thank Dr Chisholm for his pun and particularly for raising the importance of non-binary recognition. For a lot of non-binary people, recognition within legal frameworks is hugely important, and this has obviously been abandoned in the current reform. Access to services and, indeed, a feeling of self are not permitted in these current frameworks. There is a desperate need for Gender Recognition Act reform to include non-binary identities.

Q178 **Nicola Richards:** Dr Hutchinson, could you expand a little more on what the key concerns are for trans people accessing healthcare more broadly, for example in primary healthcare and mental health services?

Dr Hutchinson: Access to primary healthcare is awful. Our service users report barriers at a whole number of levels, whether that is access to GP services, access to the clinics where the GPs work or access to mental health services. We know that support per surgery or GP group is very, very patchy. For example, locally, we have some very supportive clinics, and another that will not change any of the details on your medical records unless you have had "the full sex change operation."

We know that people are put off accessing healthcare as a result. We know that 21% of trans people said their specific needs were ignored or not taken into account when they tried to access healthcare services; 18% of those said they were subject to inappropriate curiosity; 18% said they avoided treatment as a result of fearing discrimination and intolerance. It is not simply that people face discrimination when at the services. They are put off seeing practitioners where they have healthcare needs, across different healthcare needs, as a result of the system as it exists.

We know that particular types of healthcare have problems. Users of mental health services report their doctors outwardly and actively challenging their gender identity in ways that are entirely unrelated to their mental health issues. We know that GPs do not understand that mental health needs can exist independently of gender health needs. We see GPs referring people to gender identity clinics for mental health care that is not available through those services.

Other forms of support are widely unavailable. Several of our local hospitals refuse to see trans women for gynaecological examination. The clinicians are not comfortable to perform those examinations despite the parallel healthcare needs in those situations. Where there is provision, it can suddenly disappear through staff absence because there are not robust processes to support trans people, even when their healthcare is not trans related.

Dr Chisholm: First of all, I am distressed to hear the examples of prejudice and transphobia that are sadly still sometimes out there. There is also a training deficit here. We need more dedicated training for healthcare professionals on trans health issues, perhaps particularly so for general practice. I was a general practitioner for many years, and general practice is the area of medicine where practitioners are most likely to encounter trans patients. The Royal College of General Practitioners recognises that GPs are not experienced in treating and managing patients with gender dysphoria and trans health issues. Gender dysphoria and gender identity issues are not part of the GP training curriculum or GP specialty training. The BMA has certainly been calling on the Medical Schools Council and the royal colleges to ensure that trans awareness is part of undergraduate and postgraduate training.

There are two separate issues there. One is a clinical issue but the other is a cultural issue, where general practice is welcoming of every patient who comes through the door of the practice, treats them with dignity and respect, and tries to meet the healthcare needs that they have. I recognise that, while the great majority of healthcare professionals try to be respectful and treat patients with dignity, sadly there are stories where that is failing to be the case.

Q179 **Nicola Richards:** Dr Chisholm, in your written evidence you argue that access to support has been made even more challenging by the pandemic and by consistent, long-term underfunding of public health. Can you elaborate on this?

Dr Chisholm: The pandemic has obviously produced huge problems for the NHS and an enormous backlog in respect of people with non-Covid-related conditions. There has been a huge increase in waiting lists for surgical treatment and outpatient referrals right across the board. There is also obviously the issue of remote consulting. There has been a big switch in general practice in particular to many consultations occurring virtually: over the telephone, over video and by email. This will have had an impact on particular groups accessing services. Anybody with a complex problem may find it more difficult to explain and to get the treatment they need with remote consultations.

Throughout the NHS, staff are obviously under huge pressure and are experiencing burnout. There are worrying signs that many healthcare professionals are considering leaving their professions, and that is going to have a knock-on effect on the NHS. Last month, the BMA did a tracker survey. We have done well over a dozen of them during the pandemic, looking at changing views. The April survey found that 32% of respondents said they were more likely to take early retirement, and half reported being more likely to reduce their hours. As a result of the pandemic, which obviously was something initially quite outside the control of the NHS and Public Health England, we are storing up a lot of problems for the future, which need to be addressed with increased capacity and resources, but also with avoiding unrealistic expectations about how quickly the service can get back to normal. It is going to take a very long time.

Q180 **Nicola Richards:** What more should the Government be doing to improve trans healthcare more broadly?

Dr Hutchinson: One of the major ways that trans healthcare could be improved is improved training across the sector, with clearer guidance for medical professionals and for trans people, as the information seems to vary day in and day out. We need to ensure that the standards people can expect from their doctors are upheld. For example, we know that the specifications for various gender interventions are viewed by the gender identity clinics as more like guidelines. In cases where Members of Parliament have made complaints about the levels of service, the gender identity clinics have responded that they are not bound by these.

The issue of funding is a difficult one, because simply pouring money into gender identity clinics would not solve the problem. Fundamentally, the way that trans identity is conceptualised institutionally limits trans people's access to healthcare. The Government should be pushing for complete reform of the processes involved, with a change to the understanding of trans identity and how that relates to things like the Gender Recognition Act, improving access to mental health services and making sure that provision is sufficient to deal with the needs of trans people as well. It is about NHS funding more generally, upholding standards and pushing for changes of institutional response to gender issues away from psychological diagnosis through to support more aligned with sexual health services.

Q181 **Nicola Richards:** Dr Chisholm, you mentioned that there is a push to train GPs in the health needs of trans people now. Can you expand on what training healthcare professionals already receive on this topic?

Dr Chisholm: It varies. There is not any standard training. As I was saying earlier, this is not at present part of the specialty training curriculum for general practice. In truth, the training is somewhat ad hoc. Most of the postgraduate medical education for GPs and other doctors is done on a voluntary basis, in the sense that they have to show evidence of training for their appraisal and their revalidation, but they have a relatively free choice of what training in what areas they receive. There are relatively few areas of mandatory training that have to be undertaken, and this is not an area where there is currently mandatory training.

What that means is that across medicine, not just in general practice, some doctors will have received substantially more training than others in this area, and some will be considerably more interested in receiving training in this area. Sadly, some may be unaware of their need for training. Perhaps that is understandable in one sense, in that some general practitioners and hospital doctors will see quite a number of patients for trans healthcare issues, whereas for others it will be very rare for them to encounter a trans patient.

There is one other issue that I should raise, which is the importance of screening. Some trans patients may still require access to screening programmes that are predominantly provided to patients of another gender. Doctors must be vigilant and sensitive to ensure that trans patients continue to have access to the screening programmes that they will continue to need on a lifelong basis.

Dr Hutchinson: The issue of GP training is partly a real and present issue. For example, we are aware that at Newcastle University the medical training involves zero information about trans patients. The student medical society took it upon itself to organise a lecture at a lunchtime to bring in a clinician from the local gender identity clinic because they just were not receiving the training that they need. There is absolutely a skills issue.

On the other hand, some absolute basics are being neglected. GPs are saying that they do not understand how to interpret blood tests, whereas they would be very familiar with how to look at testosterone or oestrogen levels for cisgender people. They do this all the time in clinic, but as soon as it becomes a trans issue they suddenly lack the confidence to do the same, even though the basics are very, very similar. This is one of the things that push trans people towards informal routes, informal medication and unlicensed pharmacies. For a very long time, trans people have been reading the literature themselves, self-medicating and monitoring their own levels, simply because this is not available in GP practices.

GPs are abandoning their responsibilities to their patients in managing bloods or simply arranging bloods for people who have accessed services through gender identity clinics, accessed care through private providers or through self-medication. These are people who should be able to have bloods taken, and they are not getting that service because GPs are not comfortable doing it. There is a training issue, but there is also a cultural issue that needs to be addressed as well.

Q182 **Nicola Richards:** Dr Chisholm, are you aware of any work done by the national LGBT health adviser to help improve awareness in this area and, if so, what?

Dr Chisholm: I personally am not aware. I should say that I am no longer in clinical practice, so perhaps that is a reason why I am not aware. I am certainly aware that the Royal College of General Practitioners is seeking to develop and improve its electronic learning materials in the field of LGBT health, because it has realised that there is a deficit there. I agree with Harriet that there are cultural issues as well as clinical and capacity issues. One of the issues is that some GPs, who are generalist rather than specialist practitioners, feel that they do not have the competence or confidence to prescribe, for example, while patients are waiting to access specialist services. They come to GPs on issues such as prescribing hormone therapy and, while some GPs will be content to prescribe in those circumstances, others will be more reluctant to do so. Yes, we need to improve the training, but also to recognise that there is a need to commission services that are in between the most specialised services and the generalist services of GPs.

Q183 **Bell Ribeiro-Addy:** Dr Hutchinson, Stonewall's 2018 *LGBT in Britain—Trans Report* found that two in five trans people who responded to their survey said that healthcare staff lacked an understanding of specific trans health needs when accessing general healthcare services. In your own written evidence to our Committee, you state that misgendering and transphobia are rampant in medical spaces. Could you expand on the type of treatment trans people are experiencing when they access healthcare services, and anything you might not have touched on before?

Dr Hutchinson: At one of our recent meetings, a number of our service users discussed some of these issues. A lot of people described problems changing their records, with untrained staff not knowing how to do it or demanding strange things like GRCs in order to change their medical records. We have one person who said their GP started laughing at them as soon as they noticed a badge they were wearing that said "queer". We have had people being referred to with the wrong names, titles and pronouns over and over again throughout primary care, including in letters from gender identity clinics to people's GPs and back again. The wrong names and pronouns were used throughout.

We are aware of clinicians asking entirely unrelated questions about people's histories and their genital status. One of our service users was accompanying another person to a mental health appointment—for somebody else—and that service user was asked what their plans were for genital surgery. These basic discourtesies and intrusions are perfectly usual. We know of GPs who have said that they would play devil's advocate before permitting referrals to gender identity clinics. We are aware of practitioners at all levels who simply refuse to refer to people in the way that they have asked to be described.

It is endemic. I do not know of a single one of our service users who has not reported this. It makes people reluctant to seek treatment. I gave the statistic earlier about 18% of people avoiding seeking treatment as a result of these experiences. It is not just in trans medicine; it is in general medicine as well.

Dr Chisholm: All those examples are abhorrent, deplorable and inexcusable. They should not be happening. My hope and belief is that such intrusive and inappropriate questioning is a minority practice. I would be very appalled to learn that the majority of general practitioners were behaving in that way. I do not believe they will be, but any examples of the sort of problems that are being encountered as Harriet has described are unforgivable. I can well understand how distressing that must be and why people are sometimes forced to change their doctor in order to find somebody who is more sympathetic and respectful.

Dr Hutchinson: Doctors are often in a position of power. They have a very strong knowledge of the very specific things that they work with. They have undergone a great deal of training about the issues that they know a great deal about, but when it comes to transgender identity, which is something that is very close and known by trans people themselves, it is almost challenging for a GP to be in that situation. Some of this discrimination often comes through ignorance, but some of it also comes through the power dynamic between doctor and patient. This is another reason why we need to fundamentally reconceptualise trans medicine.

Q184 **Bell Ribeiro-Addy:** Thank you for raising that point. I have had young constituents approach me about that issue in terms of just accessing general healthcare from their general practitioner, simply because they are trans. That is quite a worry. Thinking of what can happen next, the Stonewall report also found that three in five trans people who have undergone medical intervention for their transition reported that they were unsatisfied with the length of time it took to get an appointment. The LGBT action plan highlighted that many LGBT people face inappropriate questioning and curiosity. You have touched on this already. What sort of impact do these delays and inappropriate questions have on treatment overall?

Dr Hutchinson: The trans community is left picking up the pieces. The impact of long waits on mental health care extracts a huge toll. The need for support is hugely increased. People find themselves faced with a five-year wait before seeing somebody and feel that there is no future for them. They may have gone through an awful lot to get to the point of asking their GP for a referral, and then find this huge let-down and very deflating feeling of, "What's next? Nothing is going to change for years. How are we possibly going to cope with this?"

Trans people are at significant risk of worse mental health. The incidence of addiction in trans communities can be up to 20%, depending on which studies you look at. In a community like this, adding that additional waiting time means that people end up needing treatment for addiction that they would not have otherwise needed and treatment for mental health crises that they would not have otherwise needed.

Regarding the way that trans people respond, we know they take less care of themselves, particularly in connection with self-esteem issues, which are endemic within the trans community. The lack of access to these things has a very literal cost to the NHS and is very damaging to the people involved.

Q185 **Bell Ribeiro-Addy:** Again in your written evidence, you argued that many trans people face data protection violations. Could you elaborate on what exactly happens in these cases?

Dr Hutchinson: There was a high-profile case—I want to say it was 2019—where a clinic sent two emails that were copied to all service users; those were two emails that went to about 900 people apiece. That was a very large user base of gender services that was exposed to a large number of people. In that way, being outed is a risk.

We see confidentiality breaches made by the gender identity clinics themselves. In the most recent patient experience report, five respondents out of a sample of about 109 had reported that the clinic was breaching their confidentiality in the way it had forwarded documents.

We risk being outed in all sorts of venues where the information is not necessary. It is another reason why things like the gender recognition process worry us. Our group, after a reasonable discussion on the issue, pointed out that, when you apply for a gender recognition certificate, you will end up on what is effectively a register of transgender people. This is a great worry to us, because this register is a target for data breaches and for blackmail.

In terms of information security, we usually regard a data breach as a "when", not an "if", occurrence. These deeply personal issues being exposed to the general public and potentially hostile actors is very worrying to the trans community. We are not very well protected at the moment. The Gender Recognition Act allows for liability with disclosure of information received in an official capacity, but, outside of that, we are very vulnerable. Once information has been made public, it does not go back into Pandora's box.

Chair: Can I take this opportunity to thank Dr Hutchinson and Dr Chisholm for your evidence this afternoon? That is the end of your set of questions, but please feel free, if you would like, to stay on and listen to the second panel. Thank you.