Written evidence submitted by Dr Sara Dahlen [GRA1355]

A response to the Women and Equalities Committee Call for Evidence on "Reform of the Gender Recognition Act"

I have a medical degree from Barts and the London and am currently studying for an MSc in Bioethics and Society at King's College London. I completed a diploma course in the Philosophy and Ethics of Healthcare from the Worshipful Society of Apothecaries in London and for my dissertation I researched the topic of sex and gender identity and their moral dimensions for medical practice. My ethical analysis of changing sex markers on medical records is published, which outlines my position & why at some length(Dahlen, 2020). My main focus of concern in this submission is a challenge in how to interpret the Gender Recognition Act 2004 (GRA 2004) and the Equality Act 2010 (EA 2010) in the clinical record for trans patients and healthcare systems. The question is whether the existing framework and any future amendments to the GRA 2004 *may* inadvertently negatively impact clinical care, patient safety and doctors' ability to confidently do their work. I write in personal capacity.

In my experience, there exists a general lack of clarity and understanding around the entirely separate nature of the concepts of sex and gender identity, which I've personally encountered when speaking to people about the dangers in conflating the two in clinical practice. I believe there is an inadequate acknowledgment and significant confusion of certain key biological facts when it comes to policy-making in this area and accompanying uncertainty for doctors (Griffin *et al.*, 2020). The most salient points are as follows:

1) Sex is anchored in and defined by reproductive biology. It is fundamentally binary: there are only two types of gametes (egg and sperm), and therefore only two sexes (female and male). In humans, there is no third gamete or third named type of sex with a distinct reproductive role.
2) Our reproductive, biological sex is immutable. We can modify certain physical features through hormones and surgical interventions, but these are essentially cosmetic alterations. Biologically speaking, no human being literally "changes sex."
3) Strong subjective, personal feelings related to one's sense of self, including gender identity, are important to some individuals and should be expressed freely and without fear of discrimination. However, gender identity is irrelevant to how we define sex from a reproductive standpoint.

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In 2018, I corresponded with both the Medical Protection Society (MPS) and Medical Defense Union (MDU) regarding whether they could foresee any potential legal implications for the medical profession of changing the GRA 2004 so the law becomes "self-declaration" instead of the current system which is requires medical reports and application to a panel. As I understand it, the GRA 2004 makes it potentially a criminal offence for professionals to disclose the "gender history" - biological sex - of trans people who have undergone the process stipulated in that law. The MPS and MDU responses to my query were not in clear agreement, suggesting to me a likely grey area for doctors, medico-legally. The problem is that disclosure of biological sex can routinely and non-maliciously happen in ordinary clinical practice, and indeed I would argue this is entirely correct and appropriate for them to do. For example, a doctor might ask their evening colleague to check a trans patient's blood test results. Common tests have reference ranges that are sex-specific. Given that knowledge of the patient's biological sex would therefore be needed to know how to interpret blood results, should doctors legally only be sharing with their colleagues the trans patient's gender identity, or reveal their sex, or both? What's better for healthcare and keeping the patient safe at 1AM when that busy colleague finds the time to check those blood tests? What does a perceived obligation on the doctor to attempt to hide a patient's biological sex, undoubtedly an incredibly important feature of anyone's medical history, mean for the patient-clinician relationship, alongside implications for liability? Could such advice make doctors more uncertain of treating trans patients, rather than more confident?

Furthermore, the GRA 2004 would seem to apply solely to patients who have a Gender Recognition Certificate (GRC), who represent only a fraction of the total number of trans patients doctors are likely to encounter. As I understand it, medics are also not allowed to ask about whether an individual holds a GRC. So, the legal situation seems very unclear. We *might* have, in essence, two distinct groups of trans patients seeking healthcare (GRC holders and non-GRC holders) who are technically covered by different laws, but doctors might not be able to distinguish one from the other. Yet, both patient groups *will* need their actual reproductive biology and medical history properly understood by the healthcare professionals providing their care, and I would argue accurately documented somewhere in their medical records. This is a vital matter concerning patient safety, and has wider implications for trans healthcare

in terms of audit, research and resource allocation. For further useful sources exploring this specific topic, see this analysis from Scotland (Wheater, 2020), this piece by the BBC (Gorvett, 2020), this Guardian article (Davis, 2019).

In the process of writing my ethical analysis of the General Medical Council (GMC) advice regarding trans health(General Medical Council, 2016), specifically how to acknowledge biological sex on medical records, I asked the GMC how they created their trans health material. The GMC responded that their pages constitute advice, rather than guidance, thus were informally developed. Their team did not have documentation of performing any impact assessments or legal checks. Additionally, I have discussed this matter with the Professional Records Standards Body (PRSB), whose advice on sex and gender identity and the medical record in their Core Information Standard (The Professional Record Standards Body, 2019) seems to be based on their understanding of the GRA 2004. Though, as mentioned before, I wonder if it might actually only cover a handful of trans patients.

Thus, I believe a key area for work in trans healthcare would be clarifying the subject of sex and gender identity in the medical record, and the interaction between GRA 2004 and the EA 2010 as applied to clinical contexts. EA 2010 protects both Sex and Gender Reassignment as separate characteristics, but I believe in policy, education and popular parlance these concepts are too often confused and conflated, usually to the detriment of sex. *Both* ought to be seen as having standing and be of *equal* importance. Patients must not be discriminated against on the basis of any protected characteristic in EA 2010, and this includes sex. However, sex discrimination is actually what happens in a real sense if gender identity (which I believe belongs under gender reassignment) is thought to supplant or replace sex (biologically determined) in policies governing clinical practice or healthcare or medical records. An analogy is that such a situation would be as though healthcare systems collectively decided that the protected characteristic of "Religion or Belief" should be recorded in the place of "Sexual Orientation", and I would sincerely hope this would never be the case.

I have argued that for medical records we would benefit more from a system wherein we document sex (a fixed, binary category of female or male related solely to the reproductive biology determined at conception and observed at birth, vital for medical understanding and guiding clinical care) *alongside* gender identity (my suggestion would be a free-text box, which can be left blank or changed at will and

open enough to describe identities such as gender-fluid, ambigender or neutrois, important for patient psychological wellbeing and guiding clinical communication). I believe such a solution would be more appropriate for the confidential medical records system than the advice we may have right now, but from my research it seems the whole situation would benefit from legal clarity.

References

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