Testimony of a GP Who Will Not Affirm
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This article was written by an anonymous doctor who is concerned about gender-affirming care and the expectation that GPs in the UK will prescribe hormones for young adults who have been seen by Gender Identity Clinics.

The author would like to thank Nick Wallis, who first published the article on his blog.

Introduction

I am a GP working for the NHS in the UK. I am writing this piece anonymously because I am worried I might be targeted, either by activists, or by people within my profession who don't share my views and have the capacity to harm my career.

I want to explain why I don't prescribe hormones for people who identify as trans. I also want to explain my serious concerns about the way people who present with gender dysphoria are being treated. I also want to empower other GPs to think about what they are prescribing and why.

Currently, GPs are leaving themselves open to litigation by prescribing off-licence medication in a specialist area which lacks robust medical evidence and is known to cause irreversible harms.

There appears to be a basic misunderstanding of the Equality Act 2010, which leads GPs to fear being accused of discrimination if they do not give these patients what they want. The Equality Act does not state this. Instead, it mandates that transexuals must not face discrimination and should not be treated differently due to their protected characteristic—gender reassignment."

Internal activists and external lobby groups have a stronghold within organisations such as the Royal College of GPs (RCGP). This activism has enabled the indoctrination of the NHS by an ideology, and as a result it has discarded its ethical framework under the guise of caring, or being kind. However, 'being kind' necessitates striving to practice evidence-based medicine, striving to do no harm, and striving to practice the art of medicine, which requires exploration, not affirmation.

GMC guidance states: "You are responsible for the prescriptions you sign". Doctors are therefore responsible for any short and long-term harms caused by what they prescribe.

The Chalmers Gender Identity Clinic shared care protocol ends with:

"This shared care agreement does not compel a primary care prescriber to prescribe if they feel that it is out with the scope of their competencies (as per GMC [General Medical Council] guidance on safe prescribing) or resources, as ultimate responsibility lies with the prescribing, not the recommending, clinician."

I have looked at six other shared care agreements from Gender Identity Clinics (GICs) and a statement to this effect is absent.

Most children who trans-identify do not trans-identify by adulthood. Yet affirmative care (agreeing a child or young adult is what they say they are, and helping them attain their short-term goals) is the dominant model.

This causes problems for GPs from the moment a trans-identifying individual walks through the door. Gender-affirming care means using chosen pronouns and allowing, accepting or encouraging social transition.

The Cass review states: *"In an NHS setting it is important to view [social transition] as an active intervention because it may have significant effects on the child or young person in terms of their psychological functioning and long term outcomes"*. [p.158]

Your affirmation may be part of their journey towards medical transition, when a holistic, watchful wait approach would be better for the patient.

My pronoun use in this piece reflects biological sex.

Testosterone

A female patient in her twenties on testosterone presented at my surgery with urinary incontinence and vaginal atrophy. Vaginal atrophy occurs when the tissue in the wall of the vagina becomes thin and fragile, which can lead to pain and bleeding. The incontinence was caused by the effects of testosterone on the bladder and urethra – it was unable to function properly. The patient was in distress. Together these symptoms are known as urogenital atrophy.

The treatment was topical oestrogen, the hormone which was being suppressed. Suggesting this treatment added to the patient's distress as it increased her gender dysphoria, but after some discussion, she decided to try it as her symptoms would persist without oestrogen.

The patient had not been told that hormone therapy could result in incontinence and vaginal atrophy. This made me question whether patients are giving informed consent. The patient had been lost to follow-up by her Gender Identity Clinic (GIC), so I referred her back.

Another female patient came to me suffering from painful chafing. She had clitoral hypertrophy due to the testosterone she was taking. The clitoris was firm and it hurt. Clitoral hypertrophy is not likely to regress if testosterone is reduced or stopped. All I could offer were common sense measures.

The British Menopause Society calls vaginal atrophy *"a chronic and progressive condition due to oestrogen deficiency" and notes "the effect of lack of oestrogen on urogenital tissue quality is an intermediate effect, often taking three to five years to become apparen*t".

We are yet to see the enormity of the harms being caused. The longer a woman is on testosterone the more progressive her symptoms may become. As a GP this causes me great concern. This long term adverse effect presents itself years after transition, when there will be an accumulation of other long-term irreversible harms, such as clitoral hypertrophy.

This surely goes against the ethical principle of nonmaleficence: do no harm. We need data collected on adverse effects so as to provide better evidence.

If patients are not affirmed, but have holistic care at Gender Identity Clinics, they may not be medically transitioned, thereby being free from the long-term adverse effects of medications. Instead they become dependent on the NHS from a young age; a dependency that is likely to be life-long. Putting aside the financial burden this will be to the NHS, my main concern is the increasing symptom burden for patients over time.

We are going to see a lot more patients with adverse effects of testosterone over the next 5-10 years. The Cass Review found there has been an exponential rise in referral rates to Gender Identity Development Services since 2009, rapidly increasing from 2015, with the majority of patients being female.

Oestrogen

A male patient in his twenties taking oestrogen and decapeptyl (also used to block puberty) had chronic widespread pain. As it was poorly controlled with medication he had been referred to the chronic pain clinic by a colleague. The pain was thought to be multifactorial. He was under psychiatry for depression and anxiety, as well as known autism and was a vulnerable patient. Having no guidelines or protocols to follow in general practice I turned to Google and found that patients who had medically transitioned were at higher risk of chronic pain. However, no mention of chronic pain had been noted in his most recent Gender Identity Clinic letter despite the BNF (medicines guidance) noting that a common or very common side effect of decapeptyl in men and women is joint disorders.

All that was mentioned in his letter was a request for blood monitoring and mention of his prescription. This made me wonder if Gender Identity Clinics routinely screen patients for adverse harms at their annual reviews. It concerns me that patients are not being given the standard of care they should be.

Of the shared care protocols I compared, not all mentioned vaginal atrophy, not one mentioned joint pain as an adverse effect, and not one mentioned urogenital atrophy.

Mental health, surgery and suicide ideation

I have seen trans patients referred to the community psychiatric service by GPs or by the out-of-hours service, in crisis, with suicidal thoughts, anxiety and depression, having not been under psychiatric care prior to transition. Patients are often in more distress post-medical transition: I have witnessed this on numerous occasions. There is a palpable vulnerability. I am aware from other GPs that patients are disclosing sexual abuse post-transition. Patients are being diagnosed with autism post-transition. Have these patients had a sufficiently thorough psychological assessment prior to transitioning? It also raises more questions about informed consent.

A patient of mine who presented out-of-hours in crisis due to suicidal thoughts opened my eyes about the care Gender Identity Clinics were providing to their patients post-transition. At the time the patient came to see me, he was the only young adult in the practice who had medically transitioned. He had also had feminising surgery. I remember asking him if he could access psychological support through his Gender Identity Clinic and the reply from the patient was that he had not been seen in years. I was horrified.

Increased suicide risk is often used as leverage in the process of affirmation. The introduction to this article summarises it well:

"On the surface, 'Would you rather a dead daughter or a living son?' sounds like a plea for compassion and understanding. Functionally, however, this appeal shuts down all public debate, stifles any pushback from parents, and places vulnerable youth on a conveyor belt towards risky hormone treatments and radical surgical interventions."

I wonder if GPs prescribe hormones because they believe this myth about suicide. A paper published in the British Medical Journal found:

"Clinical gender dysphoria does not appear to be predictive of all-cause nor suicide mortality when psychiatric treatment history is accounted for… It is of utmost importance to identify and appropriately treat mental disorders in adolescents who are experiencing gender dysphoria, in order to prevent suicide."

Detransitioners

Let's also not forget those who detransition. There is, as yet, no robust medical evidence on how to help them. I could not find any detransition protocols online.

I have reviewed seven shared care protocols for testosterone, including the Tavistock and Portman, the Nottingham Centre for Transgender Health, and the Greater Manchester Medicines Management Group. Not one advises how a GP should manage a patient who detransitions. The Cass review addressed the issue of detransitioners, stating:

"There is a need for better services and pathways for this group, many of whom are living with the irreversible effects of transition and no clear way to access services. Most will have been discharged from [gender identity clinics] with no planned follow up." [p.227]

Transgender Trend has a web page dedicated to articles on detransition and advice for detransitioners. A paper by two detransitioners notes: *"It is very difficult to find information on this coming from health professionals, as there is a lack of research overall about medical detransition".*

It is shocking that patients are left to support themselves through their own lived experience, and surely unethical of Gender Identity Clinics to aid transition but not have a protocol to support and manage those that have regret.

The state of primary care in the UK

Official guidance from organisations supporting GPs to practise safe medicine has clearly been written by consulting gender activists. Some of it encourages or leads more GPs to prescribe in a specialist area, despite being generalists.

The GMC still signposts clinicians to the World Professional Association for Transgender Health. WPATH is an organisation which lacks an ethical framework. This article in the British Medical Journal describes how WPATH *"meddled with its own guideline development".*

Leaked WPATH files revealed how activist members knew that so-called treatments were causing life-long harms such as sterility and inability to orgasm, and that patients did not have informed consent or an understanding of the potential long-term harms.

MDDUS (Medical and Dental Indemnity Protection UK) states that the GMC believes *"transgender patients are at an increased risk of self-harm or suicide, and GPs should discuss access to mental health support services where appropriate."*

The disgraced Mermaids charity wrote in evidence to the UK parliament that 45% of trans-identified young people have tried to take their own lives. However Suicide Facts and Myths on the Transgender Trend website details how the statistics for suicide attempts claimed by Mermaids were exaggerated.

More recently an independent review suicides and gender dysphoria at the Tavistock and Portman NHS Foundation Trust did not support the claim that there has been a large rise in suicide in young gender dysphoria patients at the Tavistock.

In the MDDUS ethical hub, GPs are being told about the suicide risk of patients in the section on prescribing. This could put pressure on GPs to prescribe. We are being scaremongered.

The British Medical Association (BMA) states the broad principles of WPATH for supportive care within its guidance. It also asks for "inclusive care". Within the BMA webpage "Demonstrating a trans inclusive approach" there is a box outlining A Quick Guide To Pronouns. This states:

"We all have pronouns. The most common ones are 'she', 'her' and 'hers' or 'he', 'him,' 'his'. Some people prefer gender-neutral pronouns, like 'they', 'them,' and 'theirs'. Some people will use different pronouns at different times. Changing pronouns can be an important part of transition."

It goes on to state that misgendering can make people feel disrespected. This is the language of activism. Using these pronouns is part of affirmation.

The Royal College of GPs (RCGP) states in bold type under "Your role as a GP" that:

"There is a high incidence of suicide and substance abuse in the Trans population who are left untreated. There is also a high incidence of suicide in those who do undergo gender reassignment surgery."

However, it is reassuring that the most up to date RCGP position statement requests that "the position of GPs who do not feel they have the expertise or resource to share care with either NHS specialist services or the private sector is respected".

It also references GMC guidance that "care for any condition should only be carried out if… the GP feels clinically competent."

How can GPs be competent to provide good clinical care as per GMC guidance if the treatment we prescribe is not based on the best available evidence? Current guidelines for GPs are not consistent, confirming this area lacks robust medical evidence.

I believe GPs are being silenced into prescribing because of a fear of complaints from patients and by the advice of professional organisation for whom GPs depend on assurances that they can practice safe medicine.

To safeguard high standards of patient care:

1. Patients should remain under Gender Identity Clinics for long term monitoring.

2. All guidelines, protocols and standards should be based on the best available evidence, e.g. the Cass Review rather than WPATH.

3. The medical profession should no longer allow themselves to be influenced by activists and lobby groups, but by the best available evidence.

The choice I have made

The evidence that supports my decision not to be involved in prescribing and long-term monitoring trans patients has come from reading the BMA, GMC, MDDUS advice, trawling the internet and from medical colleagues sharing relevant information with me. I am now confident in my incompetency to prescribe.

I appreciate that many GPs will not feel as confident as I do in saying no, so please use this article to empower you. Use the statements by the BMA and RCGP to do no harm, to not prescribe and not have the responsibility for long-term monitoring. Specialists should be responsible for long-term monitoring.

Jamie Reed is a whistleblower who was case manager at the Washington University Pediatric Transgender Center at St. Louis Children's Hospital. Earlier this month she gave evidence to the US Assembly Committee on Health, Aging, and Long-Term Care at a public hearing on the "Help Not Harm Act", a bill designed to protect children from long term, irreversible harm.

Reed says for many years she was an "absolute true believer" in the affirmative care model, then what she saw changed her mind. She told the hearing about the various medical disasters she witnessed:

"We removed the breasts of a young woman who called us back begging to have them put on. She not only had detransitioned and was re-identifying as a woman. She was also pregnant, she also grew up in foster care, and she literally told us that part of this identity for her was a social contagion."

Reed highlighted a case from the study that formed the basis of the Dutch protocol in which a child had been put on puberty blockers as a pathway towards transition. Unfortunately, when it came to surgery, the boy's penis was not large enough to make a neovagina, "to the point where that child was put through a vaginoplasty that used their colon instead, and they died of a massive infection."

In an article for the Free Press, Reed wrote *"The doctors I worked alongside at the Transgender Center said frequently about the treatment of our patients: 'We are building the plane while we are flying it.' No one should be a passenger on that kind of aircraft."*

Writing about her evidence to the Assembly Committee, the campaigner Graham Linehan wrote that Reed's testimony *"stands as a warning to the institutions that continue to endorse a reckless medical experiment rather than face the facts. These institutions can resist accountability for now, but the public is no longer in the dark. Tomorrow always comes, and when it does, there will be nowhere left to hide.*"

I don't want any part in this. You may feel the same.

Going forward

The Gender Identity Clinics need to take lifelong responsibility for all patients. This is a specialist service, so patients deserve the best standard of care. This must include collecting evidence of adverse outcomes immediately, including retrospectively. GICs must follow up every patient that they have discharged into primary care. There is a wealth of data currently lost within general practice.

All the guidelines for GPs that I have read appear to have been influenced by activists. We need to stop the affirmative approach with immediate effect and start practising holistic medicine, so as to first do no harm.

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Reading list:

Hello, my name is – SEEN in Health (on pronoun use)

What's wrong with WPATH version 8? – Sex Matters

The Gender Identity Takeover of the Royal College of GPs – Rebecca Says No

Brief Guidance for Pediatricians and Primary Care Providers – Genspect

'Bridging hormones': Increasing number of UK GPs leery of prescribing treatment - 4th Wave Now

Activist doctors are urging GPs to prescribe cross-sex hormones - The Economist