Correspondence

Transsexualism

SIR

The coverage of transsexualism in the June 1980 issue was very welcome. But I for one greatly regretted the omission casually admitted in your editorial, namely all discussion of hospital policy. Doctors, lawyers and the general public all came in for criticism, but not a word of the specialists in gender identity clinics.

I am not suggesting that the rightness of gender identity clinics is to be questioned. I am concerned merely with the suggestion in your editorial – a misleading one in my experience – that ‘there are now reasonably well established medical and psychological criteria’ in the field of gender identity. Perhaps there should be; perhaps there is no excuse for there not to be – any more. But if that be so, I can only say that a great many specialists in the field do not behave as if this were so.

The latest book by Professor Robert J Stoller may provide a clue to why this is so, for since his first book, Sex and Gender, in 1968, Dr Stoller’s criteria for distinguishing between genuine and counterfeit transsexualism have been increasingly subjective. Theoretical hesitations are bound in this inherently controversial field to render practical programmes insecure and their ethical practices opaque. We have seen some of that insecurity manifested in the remarkable vox fames at Johns Hopkins University Hospital last year.

In your editorial on general issues of surgical ethics you raised the question of whether the ‘fobbing off’, as it were, of some patients with placebos to provide control group tests for real surgical activity might be justified in terms of the ‘best interests of patients in general’. This is an issue of the greatest delicacy in the handling of transsexualism, for there are grounds for claiming that some transsexuals are just left for years on end with nothing more than hormone tablets to see how they make out by comparison with those who receive urogenital and other surgery.

Personally I think such a practice would be ethically questionable under any circumstances. But it seems to me to be especially questionable in this case where the specialists are not consistent even in their evaluation of gender identity. It is very convenient when there is no consistency in evaluation to opt for giving surgery to the least problematical individuals and to leave the more problematic to stew in their own juice as members of experimental control groups.

Oh, by the way, I had better declare an interest. As well as being a theologian, I am also a transsexual, and I haven’t done consciously well with the specialists in the space of five years!

Reference


ROBYN SMITH
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SIR

The Editorial in your June issue, in stating that there are ‘reasonably well-established medical and psychological criteria’ for the assessment of gender identity, would seem to suggest that all is also ‘reasonably well’ with the National Health Service provision following such assessment.

It is clear, however, that long delays in obtaining surgery (over and above the arbitrary period laid down by the Psychiatric Departments involved) are causing a great deal of distress and difficulty. Where there are waiting lists for surgery, then it is understandable that sexual re-assignment procedures are not normally regarded as high priority. Surely, however, additional delays could be avoided if patients could be placed on the waiting lists as soon as it has been agreed that surgery is indicated.

The lack of back-up services in terms of practical guidance at a social level is also lamentably absent in some cases. (A number of transsexuals would welcome social skills training and guidance on employment problems, for example, and this is not always available.)

Perhaps the most disturbing aspect of the problem is the understandable reluctance patients have in complaining about their treatment, since they feel this may prejudice their chances of being recommended for surgery – they think that to display anxiety, depression, or even justifiable annoyance, is to risk being labelled ‘unstable’, ‘neurotic’ or ‘difficult’.

Transsexualism, like abortion, is inevitably an area with many ethical overtones. It is therefore even more essential that doctors dealing with these are seen to do so frankly, so that the patient is reassured that he/she is an informed partner in his total management programme. Transsexuals have problems enough without feeling insecure and mis-trustful about the treatment they sometimes receive from the medical profession.

Surgery for the mind

SIR

Your editorial, ‘Surgery for the mind’ (September 1980) provided most welcome support for the introduction of a multidisciplinary review in cases where the patient does not or cannot consent. I respect your considered opinion that a multidisciplinary review would be unnecessary in the case of a fully
consenting adult, but I should be grateful if I may briefly examine the reasons why a review should be statutorily required in any case where psychosurgery is to be performed.

You suggested that it was not clear whether the proposals for multidisciplinary review in my article 'follow those of the White Paper and thus apply only to patients from whom valid consent to psychosurgery cannot clearly be obtained, or whether [I and MIND] seek to extend such multidisciplinary reviews to any potential candidate for psychosurgery'. My view is that the review should apply to all cases and, it was for that reason, that I did not qualify the general proposal in the article. More importantly, the proposal put forward in my article does comply with the White Paper proposal (para. 6.25) which states that, even if the patient does consent, irreversible treatments should not be provided without an independent review.

In the great majority of circumstances a review procedure should apply only to non-consenting patients; it is a tenet of sound policy that the law ordinarily should not intervene in a mutually agreed therapeutic transaction. However, psychosurgery should remain an exception to this because of its irreversible qualities and, as you have suggested, because 'it is still being carried out in ordinary neurosurgical units on an occasional basis often using relatively hazardous freehand techniques'. Where would the profession stand, for example, in a case where an aggressive detained patient or prisoner, who does not suffer from an established psychiatric illness, consents to an amygdalotomy ostensibly to prevent future dangerous behaviour? On the one hand, no-one would wish to interfere in a treatment arrangement agreed upon by a doctor and his consenting patient. However, where the medical procedure is not fully established by clinical research or by contemporary practice, where the 'patient' is not suffering from an identifiable medical illness and where there are informal pressures on a confined patient to provide consent, it may be prudent to regulate that particular therapeutic relationship. This is the course already taken by the American judiciary and is similarly suggested in the White Paper on the 1959 Act.

It is possible to conclude by suggesting that the gap between your own compromise proposal and the original proposal in my article is very limited indeed. Contemporary psychosurgery is often given to persons with a severe psychotic illness such as chronic depression. Although such patients may tacitly agree to the procedure, it is unlikely that they could provide an informed and meaningful legal consent. An independent review of the propriety of the treatment and the competency of the patient to consent is warranted in such cases, both for the sake of the medical profession and for the individual patient.

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Medical groups

Further information on Medical Groups

For fuller details, complete lecture lists are available from the secretaries of the medical groups listed below. Please enclose a stamped addressed A4 envelope.

ABERDEEN MEDICAL GROUP
Dr James Hendry and Dr David Hood, Medical Buildings, Foresterhill, Aberdeen AB9 22D

BIRMINGHAM MEDICAL GROUP
Dr Anthony Parsons, Department of Obstetrics, Birmingham Maternity Hospital, Edgbaston. Birmingham B15

BRISTOL MEDICAL GROUP
Dr Martin London, 11 Somerset Street, Kingsdown, Bristol BS2 8NB

CAMBRIDGE MEDICAL GROUP
Mr Patrick Doyle, Department of Urology, Addenbrooke’s Hospital, Hill’s Road, Cambridge

CARDIFF MEDICAL GROUP
Dr Jonathan Richards, Flat 2, 1 Howard Gardens, Routh, Cardiff

DUNDEE MEDICAL GROUP
Dr Douglas Shaw, Department of Pharmacology and Therapeutics, University of Dundee, Nine Wells Hospital, Dundee

EDINBURGH MEDICAL GROUP
Dr Brian Potter, EMG Project Office, 24 Buccleuch Place, Edinburgh EH8 9LN

GLASGOW MEDICAL GROUP
Dr Valerie Kyle, 8 Crown Road North, Glasgow G12 9DH

LEICESTER MEDICAL GROUP
Dr Liam Donaldson, Department of Community Health, Clinical Sciences Building, Leicester Royal Infirmary, PO Box 65, Leicester LE2 7LX

LIVERPOOL MEDICAL GROUP
Dr Colin Powell, Department of Medicine, Royal Liverpool Hospital Liverpool L7 8XP

LONDON MEDICAL GROUP
Director of Studies, 68 Tavistock House North, Tavistock Square, London WC1H 9LG

MANCHESTER MEDICAL GROUP
Dr Mary Lobajo, Teaching Unit 4, University Hospital of South Manchester, Nell Lane, West Didsbury, Manchester M20 8LR

NEWCASTLE MEDICAL GROUP
Dr Christopher Drinkwater, 14 Belle Grove Terrace, Newcastle-upon-Tyne NE2 4LL

OXFORD MEDICAL FORUM
Dr James Falconer Smith, 20 Park Close, Bladon, Oxon OX7 1RN

SHEFFIELD MEDICAL GROUP
Dr Martin Hayes-Allen, 183 Whitham Road, Broomhill, Sheffield S10 2SB

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Surgery for the mind

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