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 *volte face* 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 conspicuously well with the specialists in the space of five years!

Reference

- ¹Stoller, R J (1975) *The transsexual experiment* New York, International Psychoanalytical Library Vol 101.

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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 mistrustful about the treatment they sometimes receive from the medical profession.

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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