The Pacesetters programme is a partnership between local communities who experience health inequalities, the NHS and the Department of Health. Working with the strategic health authorities and trusts it aims to deliver:

- Patient and public involvement in the design and delivery of services;
- Reduced health inequalities for patients and service users; and
- Working environments that are fair and free of discrimination

The Royal Free Hampstead NHS Trust has been participating in the Pacesetters Programme since November 2007, engaging with a wide range of local communities and taking action to improve their access to services and experience of care in our hospital.

This guide has been developed in partnership with transgender community members. Its aim is to provide information that will support staff in acute trust settings to better understand the issues that are often faced by transgendered people when accessing care and treatment. The guide should be used as a resource and also includes useful contact details for anyone who want to know more about the issues transgendered people may face, as well as for patients who may wish to access support within the community for themselves, their families and their friends.

“…it’s very much that we are the experts and we are being recognised as.”

Transgender Focus Group Member
This booklet provides the basic information required to understand the needs of Transgender and Gender Variant people in a hospital setting.

The ethos underpinning this booklet is the belief that human rights are for everyone. The core values of human rights and equality policy in the acute hospital trust setting, as throughout NHS provision and service delivery, are founded on firm patient centred and human rights principles, and include: fairness, respect, equality, dignity and autonomy. These core values will provide the essential framework to this guide, which seeks to inform the reader and promote best practice.

The intended audience is “frontline” staff, including clinicians, support, and administrative staff. It is also a useful introductory tool for directors and board members.

The TRANSGENDER GUIDE FOR NHS ACUTE HOSPITAL TRUSTS

PRIMARY AUTHOR: BEN THOM

Ben Thom is a non practising barrister and Trans advocate in his voluntary work for Press for Change and the Gender Trust. Graduating with distinction in 2000 from City University with a MSc in Disability Management and Rehabilitation in work. Subsequently Ben undertook both professional and postgraduate academic study to become a qualified lawyer in 2004. His interest in Trans health and social inequalities, specifically regarding the medical and legal treatment of transgender people provided the motivation for a post graduate degree specialising in medical law and for his current doctoral trans law research at Northumbria University. Ben has been actively involved with the recent DoH transgender initiative (SOGIAG), contributed to “Engendered Penalties” for the 2007 Equalities Review, and has been consulted by Health Commission Wales and several Specialist Commissioning Groups where he directly inputs and negotiates health policy reform for the treatment of gender dysphoria.

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Harri Weeks gained his Masters Degree in Gender from the University of Manchester in 2008. He is in his second year volunteering as Trans Students’ Representative on the National Union of Students LGBT Committee, and has contributed to research and to drafting policy and guidance regarding Trans people as both students and staff in the education system. Harri’s involvement with the Trans community includes both informational and arts-based projects, and his emphasis is on the diversity of the community, young Trans people, and the intersections between Trans identification and other identities.

FEATURED ARTIST: MARGARET PEPPER

Originally born as Maurice David Pepper on 16th January 1944, Margaret Pepper’s pre-transition life was one of going through the motions, whilst keeping up the pretence of respectable conformity. During that time she got married (1967), fathered 5 children and worked for 44 years at various jobs. The strange thing about this period is that no one knew what she was thinking. When she told family members, no one believed her. Margaret categorically states that all throughout this period she actually “hated my body”. Since coming out and transitioning and subsequently having transitional surgery, she feels happier and complete. All the pressure has gone, all the rage has gone. She has never had a days regret about her actions. Looking at old photos of herself, it seems that it was another person’s life. Life before transition was black and white, now it is in bright Technicolor.
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A person who is Transgender is someone who expresses themselves in a different gender to the gender they were assigned at birth. For transsexual people, this is usually a permanent gender change. Cross-dressers and transvestites are people who adopt the manner and dress of the opposite gender for part of their lives. Some, but not all, transvestites opt for gender confirmation (reassignment) treatment later in their life.

The noun “Transgender” as an umbrella term is appropriate for the majority of people who identify in some way as “Trans” although “Gender Variant” is fast becoming a popular alternative.

The short form “Trans” or “Trans person” is the descriptive term of choice adopted by trans people and a polite way to refer to a person who you know to be trans.
1.1 **AVOIDING LABELS:**

The term “transsexual” is a medical term and has a recognised medical diagnosis and care pathway for treatment. Specialist Gender Identity Clinics (GIC) under the care of psychiatry has historically led the treatment of trans people. This has led to stigmatisation and the mistaken assumption that trans people are mentally ill.

*(Being) Trans is neither a lifestyle choice nor a mental disorder but a condition widely recognised to be largely innate and somatic*  

It is important to understand that not all trans people are unhappy with their physical bodies even if they do present themselves in the opposite gender. What is vital in every case is for trans people to be given the freedom and respect to express their gender identity.

Fashions and dress codes for men and women change, and vary across the diverse cultures that form part of our society. Therefore it is not unusual that a patient may appear with an uncertain gender, but not identify as trans.

*Past medical records have been very revealing about what some clinicians think about trans people… That we are somehow sub-human. This particular letter from one hospital consultant to another had the following comments: “Her shoe size is 9, the elbow-fingertip is over 18”, the voice is very deep indeed gruff. I do not know what you feel about doing a hysterectomy on a patient like this but he/she/it has seen *** the great expert…” In reply the doctor said, “It was only when it undressed that I was able to confirm it was really a woman.”*  

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1. NHS Guidance for GPs, other clinicians and health professionals on the care of gender variant people. January 2008, Crown Copyright 286109 1p 1k
2. Trans man B, Royal Free Trans (Pacesetter) Group, 2009
1.2 **GENDER IDENTITY:**

Trans people are people whose gender varies from the gender they were assigned at birth. This means they have a gender identity that may differ from their secondary sex characteristics such as a beard or breasts. We all have what is called a “gender identity,” it is formed after we are born within the first 2 to 3 years of our early development. It is this gender identity that does not match the physical body of the trans person. For some trans people this mismatch is clear very early on in childhood and for others it becomes apparent later. Post mortem research indicates that trans people’s brains have developed the same way as the individuals’ confirmed gender identity and not the sex assigned at birth. Sex hormones during pregnancy are also believed to impact on brain development and may likely be a contributory factor that results in a gender identity inconsistent with biological sex.\(^3\)

1.3 **CAUSATION:**

Modern medicine now accepts that genitalia alone does not dictate the sex of a person. Rather, gonads, physical genitalia and the gender identity within the brain all play a part in determining what gender a person really is. This gender identity evolves independently of genital appearance and gender rearing. Despite this, the sex of a baby, and therefore the gender identity, is still assumed by genital appearance at birth. Only if there is a genital anomaly will there be any questions raised and other factors such as chromosomes tested.\(^4\)

The effects of hormones in the womb are known to play a part in some intersex conditions where babies are born with indeterminate genitalia. Some babies are born with a different combination of the X and Y chromosomes, and often this is not

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4. Parliamentary Forum on Gender Identity, Guidelines for health organisations commissioning treatment services for trans people.
discovered until puberty or sometimes later. Many intersex people also consider themselves “trans” due to not identifying with the gender surgically decided when they were young. Equally, many people with intersex conditions, like many trans people, only think of themselves as the men and women they are.

Whilst causation and diagnosis for trans people may be more complex than for intersex people, as there is no diagnostic test, clinicians and health professionals must accept the individuals’ belief in their own gender identity and respect the way their gender is presented. Some easy guidance for identifying gender will follow in 1.6 below.

**It should be noted that medical and scientific findings are often amended and clarified but the right of individuals to appropriate care and respect remains.**

### 1.4 GENDER DYSPHORIA:

Gender Dysphoria is a recognised medical condition, and not a mental illness. The dictionary definition of dysphoria means “hard to bear” and refers to the deep unhappiness felt by the trans person who cannot function in life as the gender they were assigned at birth. However it is not until gender dysphoria has been formally diagnosed that a trans person can get specialised help for the condition.

Having to behave and dress in a way that does not agree with one’s gender identity can cause real emotional difficulties and unhappiness. The stress this mismatch can cause is often made worse during adolescence and the onset of puberty, when the body develops further in the opposite direction to the person’s gender identity. In many countries such as the USA,
Netherlands and Australia, young people can receive hormone blockers to suspend puberty. This allows time without pubertal changes for the young person concerned to decide whether or not they wish to live as a man or a woman in their adult life. Whilst research at the Portman and Tavistock NHS Trust is being finalised prior to embarking on a closely monitored suspension of puberty programme for carefully selected young trans adolescents: Not having this option currently in the UK means all trans people have to wait until they are of legal maturity before gender confirmation treatment can begin. This results in less effective and more extreme treatment options, available only when secondary sex characteristics have fully developed.

Although some trans people identify as both or neither genders and therefore may not seek gender confirmation surgery or hormones, others, with the help of specialist doctors and surgeons, will go on to transition into the gender role that is right for them. Having established a sense of personal completeness they are then better equipped to make a valuable contribution to society. Trans people are from all walks of life; many are successful doctors, surgeons, lawyers, nurses and other professionals. Others, be they artisans or artists, fully contribute to society.6
The feeling that I must be a woman became so overwhelming I was thinking about it every day, all day. There was just no respite. I had no choice. The moment I started to transition, I immediately felt better. The best way I can describe it was that prior everything was like watching a black and white film, afterwards everything went into Technicolor. All the rage went, and I felt at peace with the world. No one who hasn’t experienced this personally can understand it. I have also noticed that all my emotions have been released. Before, I kept my emotions under extremely tight control, now I am much more emotional, and also much more highly motivated to achieve goals in life. If you asked me would I go through the whole process again, the answer is most definitely yes! Including all the surgery, as painful as it was."

1.5 THE TRANS POPULATION:

Historically it was thought that 1 in every 11,500 people was trans but this was an estimate of just transsexual people and did not reflect the wider transgender population, such as those who cross dress on a part time basis or those who did not undergo gender confirmation treatment or gender confirmation surgery.

Current prevalence, researched by GIRES\(^8\), may now be 21 per 100,000. 6,000 are believed to have undergone “transition”. The gender balance usually thought at around 3:1 in favour of trans women is believed to be levelling up as a greater understanding of trans people develops and there is wider social acceptance.
1.6 PRONOUNS AND CLUES:

Getting pronouns right often causes the greatest difficulty when meeting a trans person or any person who appears gender ambiguous or androgynous. This error made at the outset of a contact is likely to cause not only offence but also misunderstanding and suspicion even if unintended.

There are many clues to the gender identity of a person available, and all need to be evaluated together before a conclusion is drawn. It is suggested you assess the following before reaching a decision:

- More importantly and especially where there is doubt –
  - Listen: Ask the person their name and if appropriate how they identify – “is it Miss, Mr, Mrs…”
  - Accept: Accept the identity of the person as they present themselves to you and use the correct pronouns and title.

“There was the nurse explaining to her colleague as they left my room, ‘Oh, that’s a woman who wants to be a man’, clearly audible both by me and by other patients and visitors. (Female-to-male trans man)”  

In understanding the great difficulties in trans people’s lives, it is helpful to adopt the widely accepted disability model – that it is the barriers and obstacles presented in society that cause the problems and not being trans in itself.

The trans consultancy and campaigning organisation Press for Change carried out substantial research for the Equalities Review in 2007. It found that inequality and discrimination mostly impacted on the following sectors and spheres of life:

- Employment and the workplace
- Accessing healthcare
- Education
- Leisure and social public spaces.
2.1 ENGENDERED PENALTIES – THE REALITY OF DISCRIMINATION

- 73% of trans people surveyed experienced some form of public harassment including violence.
- 19% of GPs either appeared to not want to help or refused help in accessing gender reassignment services.
- 29% of trans people have been refused treatment by a doctor or nurse because they did not approve of gender reassignment.
- 35% of trans people have attempted suicide at least once in their lives.  

“Every trans person in the UK today has to undertake a risk analysis that weighs up home imprisonment on welfare benefits, suicide or the risk of physical harm, possibly even rape or murder as the price to be paid for living their lives.”

“I struggled for years when I was so very young before finally admitting to myself that enough was enough. I overdosed twice, and on both occasions ended up in hospital. I lost the girlfriend I loved, was denied education, work, a career and had to forgo family and even my childhood – Now, well, it’s been a very high price to pay, but I had no life at all if I could not be who I was.”

11 Twice the rate of attempted suicide compared to a similar vulnerable group of people who suffered childhood abuse and trauma
12 PFC Submission to Commons Public Bills Committee (CJ&I 391) November, 2007.
13 Trans man B, Royal Free Trans (Pacesetter) Group, 2009
2.2 BEST PRACTICE – THE ROYAL FREE SINGLE EQUALITY SCHEME

The Equality Act 2006 addresses the prevalent gender inequality that still remains in society despite over 30 years of anti-discrimination legislation. It does this by bringing in a statutory gender equality duty and places a duty on all public bodies to promote gender equality. ‘Gender equality’ does not only refer to equality between men and women, but also equality for trans people. Best practice, exemplified by the Department of Health Single Equality Scheme, is mirrored by the Royal Free below:

“The duty requires the trust to take action on the most significant gender equality issues within their functions. The promotion of equal opportunities between men and women requires the organisation to acknowledge that the two groups do not start from an equal position and that identical treatment is not always appropriate. Under the duty the trust also has an obligation to actively promote equality and eliminate discrimination and harassment towards transgender or transsexual staff and service users.”
At the time of writing this Trans Guide the law has developed and changed. The Equality 2010 Act received Royal Assent in April and is expected to come into force later in the year. Draft Codes of Practice for the public, and private sectors including Statutory Guidance can be found at the EHRC we site. This new Act has consolidated long standing disparate discrimination law into one single Act that as a point of principle gives equal weight and protection to all the 7 equality strands: age, disability, gender, gender identity, race, religion and belief and sexual orientation.

These strands are aligned with the notion of protected characteristics that are defined and protected under the Act and broadly cover both direct and indirect discrimination and protection from harassment. Protection for transgender people has been widened and strengthened. It now includes protection from being discriminated against when perceived as trans and is capable of protecting the friends and families of trans people discriminated against through association with a trans person.
An integrated public duty will exist similar in operation to that currently in place, whereby all public authorities and NHS trusts must, in the exercise of their functions, eliminate discrimination, harassment and victimisation. Additionally the duty must advance equality of opportunity and foster good relations between persons who share a protected characteristic (as aligned with the 7 equality strands as noted above.)

The wide protection for trans people under the Sex Discrimination Act 1975 (as amended) (SDA) will be enhanced and maintained in the new legislation when it comes into force and in the interim period provides the protection against discrimination and harassment in these key areas:

- Employment
- Vocational training
- Goods and services (including NHS health provision)

There is limited exception under section 35 of the Act to enable hospitals to provide single sex accommodation and ward accommodation. This ensures privacy, and that nobody is embarrassed by the mixing of genders in limited and confined spaces. However any such discrimination “must be proportionate to a legitimate aim.”

### 3.1 THE GENDER RECOGNITION ACT

The Gender Recognition Act 2004, (GRA) gives legal recognition to trans people who have or have had gender dysphoria, have had at least 2 years medical supervision in their confirmed gender, and intend to live in that gender for the rest of their lives. To get this legal recognition the trans person must apply to the Gender Recognition Panel (GRP) for a Gender
Recognition Certificate (GRC). If the application is approved, the trans person will receive a GRC and a new birth certificate. At that point they become their confirmed gender for all legal purposes, and must be treated as such.

The GRA works together with the Data Protection Act 1998, (DPA). The DPA requires data controllers such as the NHS to keep consistent and accurate electronic records about an individual as well as creating the obligation to protect this personal data.

It is against the law to ask a trans person to show you his or her GRC; if verification of identity is required they may show you their birth certificate or other identity documentation such as a passport.

The law makes it a criminal offence, with a financial penalty, for an organisation or the employee of an organisation to knowingly reveal the status of a trans person with a GRC and disclose this “protected information”.

S22: “It is an offence for a person who has acquired protected information in an official capacity to disclose the information to any other person.”

3.2 DATA CONFIDENTIALITY

Health records are classified under the DPA as “sensitive personal data.” They must be used and accessed “lawfully, fairly, only if necessary and with explicit consent.”

14 Data Protection Act, 1998, Schs 1,3.
Unless it is a significant threat to life and to protect the “vital interests” of the trans person “sensitive data” may not be divulged to another colleague without consent.\textsuperscript{15}

Gender Recognition law with its “protected information,”\textsuperscript{16} operates in a similar way to the “sensitive personal information” that defines all medical records under the DPA 1998. The extreme sensitivity of trans medical records suggests that “implied consent” cannot be assumed; rather that consent must be expressly given.

\begin{quote}
After tests following a head injury, the doctor wrote to my GP starting with: “This transsexual...” which was completely irrelevant to the injury (Survey respondent)\textsuperscript{17}
\end{quote}

Whilst confidentiality is not absolute and may be overridden by law, public health and the patient concerned, good practice should ensure that the Caldicott Guardian of every acute hospital trust is fully aware of his or her responsibilities, under the GRA 2004, towards transgender people both with and without GRC’s. The personal data of trans people known to the hospital trust has a greater expectation accorded to it that confidentiality will rarely be breached and that when this occurs the trans person has consented to the processing of each and every instance that data is shared.

5.— DISCLOSURE FOR MEDICAL PURPOSES

(1) It is not an offence under section 22 of the Act to disclose protected information if–

(a) the disclosure is made to a health professional;

\textsuperscript{15} Data Protection Act, 1998, Schs 1,3; Montgomery J, 2002, “Health Care Law 2nd ed”, p259,
\textsuperscript{16} The Gender Recognition Act 2004
(b) the disclosure is made for medical purposes; and

(c) the person making the disclosure reasonably believes that the subject has given consent to the disclosure or cannot give such consent.

(2) “Medical purposes” includes the purposes of preventative medicine, medical diagnosis and the provision of care and treatment.18

My GP referred me to a hospital podiatrist for the bunion on my foot. The consultant went through an assessment with me including previous medical history. I did not mention I was trans or the operations I had related to this – He then accused me of concealing my medical information relating to me being trans. He said that he would not operate on me as he could not be sure what else I was hiding.19

The Department of Health Confidentiality Code of Practice, 2003 suggests: - “Patients must be made aware that the information they give may be recorded, may be shared in order to provide them with care, and may be used to support clinical audit and other work to monitor the quality of care provided. Consider whether patients would be surprised to learn that their information was being used in a particular way – if so, then they are not being effectively informed.”

A trans person may refuse permission to disclose all or part of their medical data. Even if this is not in the medical best interest of the person – that wish must be respected.

18 The Gender Recognition (Disclosure of Information) (England, Wales and Northern Ireland) (No. 2) Order 2005, SI No 916
19 Trans man Y, Royal Free Trans (Pacesetter) Group, 2009
Caldicott principles should be adopted throughout every acute hospital trust and strictly applied in order to protect the information of transgender and other vulnerable people. This will in turn protect staff, the Trust and of course trans people themselves.

“...My GP needed me to have an urgent endocrinological test that included both oestrogen and testosterone levels. Even though both genders have these hormones in their bodies, but in a different ratio to each other, the hospital computer system refused to allow my GP to order these tests for me. He explained the problem to me and said “We really need these tests about you and if I cannot say why, the hospital will not do the analysis. Is it ok to put transgender on the blood form?”}

CALDICOTT PRINCIPLES

1 Justify the purpose/s for using a persons’ confidential information.

2 Only use it when absolutely necessary

3 Use the minimum that is required

4 Access should be on a need to know basis

5 All staff must understand their responsibilities

6 All must understand and comply with the law
3.3 **HUMAN RIGHTS**

Everyone has protected rights under the European Convention of Human Rights (ECHR). Some of the Articles that protect these rights have important relevance for Acute Hospital Trusts and for trans people. They are clarified and outlined below.

**Article 2: Everyone’s right to life shall be protected by law.**

Trans people have no less a right to life as everyone else. The refusal of life saving medical treatment cannot be justified in any circumstances because a person is transgender. Active or passive euthanasia is illegal and especially has no place in a hospital setting.

“I have polycythaemia a disorder of the red blood cells. If I do not get treatment for this I risk stroke, heart attack and an early death. My consultant said it was my own fault as I took medically prescribed testosterone, which exacerbates this condition. He questioned me as to why NHS resources should be spent controlling my blood levels. I felt my life was in danger as he was being so judgmental.”

**Article 3: No one shall be subjected to torture or to inhuman or degrading treatment or punishment.**

It is possible that health care or lack of it, or inappropriate medical treatment may breach Article 3. Patient dignity is implicit within Article 3 and expressly part of Article 8 ECHR. Degrading treatment means treatment that is grossly humiliating and undignified.

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21 Trans man X, Royal Free, Trans (Pacesetter) Group, 2009
22 *Pretty v UK* [2002] FLR 45. In *Pretty*, Article 3 was not engaged but it set the criteria in health and social care where this might occur,
I was in London with a lower abdominal cavity infection subsequent to pancreatitis caused by gallstones blocking my bile duct and to the removal of my gall bladder - I had a fentanyl pump for pain relief. A young nurse was told to give me a bed bath - she freaked out and said that it was against her religion to touch someone like me. I think the issue was me being trans rather than my being a lesbian, but I could not say for certain; she would have known me to be lesbian because my partner was there much of the time. She was ordered to wash me and I refused to have her wash me on the grounds that proper training of nursing staff is not my control and I would rather haul myself into the bathroom and clean myself than be touched by a bigot.  

23 Trans woman R, Royal Free Trans (Pacesetter) Group, 2009

Article 6: Everyone is entitled to a fair and public hearing

Any NHS staff may find themselves in situations where they are making serious decisions concerning a trans person. These may be life and death decisions or relatively minor – whatever the nature of the decision is must be just, fair and equitable, taking into consideration all the patient’s views and concerns. It must also be “proportionate to achieving a legitimate aim”. Where the decision itself, or the process, is questioned by the patient, all steps should be taken to reach local resolution on the ward or in the office. If the patient makes an official complaint it will follow the NHS complaints procedure and PALS may become involved. Not all contact with PALS is to process a complaint. The purpose of PALS as the name suggests (Patient Advice and Liaison Service) is also to “advise” and “liaise.” All PALS staff have an Article 6 duty and must ensure they give a fair and impartial hearing to any issue raised.
My consultant lost his temper and would not listen to me. I understood he was exceptionally busy teaching students and treating patients at the same time, but my mobility appeared affected by the drugs he prescribed. Feeling very distressed I went to PALS for help. To explain my problem I had to disclose I was trans. They were initially defensive and unhelpful and sent me away for 10 minutes whilst they discussed amongst themselves how they would react. On my return I was met with stony smiles. I stressed that I did not want to make a complaint but I needed help in communicating with my consultant. They said they could not act unless I went through the complaints procedure. I implored them to take an alternative action, as I was fearful about my consultant’s response. One of the PALS advisors appeared to relent and said she would make phone calls and try to help me. She said she would phone me and give me an update. I heard nothing and a few weeks later had to return to see my consultant. He was livid and said if I ever complained about him again he would not treat me.”

It is understandable that some staff will be unsure how they should treat trans people in every circumstance that may present in a busy hospital setting. It is perfectly acceptable to admit you are unsure or that you are having difficulty in coming to a decision because the person is trans. If this is the case ask a senior colleague or line manager to give you advice.

Article 8: Everyone has the right to respect for his private and family life, his home and his correspondence. Article 8 is broad in its reach for all patients, staff and service users. As implied above Article 8 also includes privacy and personal data. It also includes “gender identity” within the scope of its
protection. It is Article 8 in conjunction with common law that can ensure the personal and medical data of trans people without GRC’s is given the same respect and level of confidentiality.

It is both good practice and compliant with law to respect a trans person’s identity and amend and protect all records accordingly in line with the individual’s confirmed gender.

**NB: DO NOT ASK FOR A GRC, but request a copy of the statutory declaration or other ID before amending records for the first time.**

Common law, in conjunction with Article 8, makes it possible for UK trans people to not only change their name by statutory declaration or deed poll (as can anyone residing in this country), it also permits change of the gender signifier on any and all records, as well as identification documents such as passport and driving licenses.

**Article 10: Everyone has the right to freedom of expression… (similar in application to Article 8 above.)**

Many trans people in marriages or heterosexual relationships prior to transition choose to remain with that original partner. Equally, some trans people are gay and may well have civil partnerships. Marriages and Civil partnerships must be respected, especially in relation to a living will or the refusal of medical treatment.

**Article 12: The right to marry and to found a family.**

Trans people like all other people have the right to found a family. This means they may come into contact with fertility treatment either for themselves or for their partner where both
partners are the prospective parents. The vetting of trans people in these circumstances is no different than for any other prospective set of parents.

A trans person either due to cross gender hormones or surgery will become sterile and must be offered the opportunity to store gametes. If this is done as part of NHS provision by the acute hospital trust and funded by the patients’ PCT, it must be routinely offered prior to any surgery or treatment that will lead to the sterilisation of the individual.

**Article 14: Non-discrimination on any protected ground such as sex, race, colour, language, religion, gender, belief**

The DH short introduction to “Human Rights in Healthcare”\(^\text{26}\) states: “Every single person in the UK comes into contact with the NHS at some point in their lives, usually when they are at their most vulnerable. Therefore it is essential that human rights are taken into account when delivering services to ensure quality care.” Trans people are especially vulnerable in this respect and it is essential to understand that the trans individual may often have experienced discrimination and may be additionally stressed and defensive in a hospital environment.

> I was really worried when I went see my liver specialist after my combination therapy to get my test results and find out if I had finally cleared my hepatitis. He knew I was trans. The doctor could see my worried face as he warmly shook my hand. Look he beamed you have been very brave no other patient has lasted so long, it’s a harsh treatment for the body but you have the result you need – there is no reason why you will not live as long as anyone else. His reassurance and kind words, perhaps said to all his patients, cost him nothing, but were so appreciated by me as a trans person.”\(^\text{27}\)
4. EQUALITY IN ACTION – GENERAL NURSING CARE

Trans people suffer from the same illnesses and medical conditions as everybody else and in doing so will need the same broad range of hospital facilities. They do not necessarily need hospital facilities any more or any less than other people, save for instances where persistent inequality and disadvantage, caused by transphobia and ignorance, have meant that the trans person, especially if they are older, has acquired one or more medical conditions that have been left untreated. There is a higher incidence of disability within the trans community compared to the general population, and sometimes for this reason, trans people may present with complex chronic medical histories. However a logical patient-centred approach to diagnosis and care can simplify and unpick even the most complex problem.

28 “Due to a variety of factors, often including lack of access to routine medical services, transgendered patients may be at increased risk for common, chronic medical conditions.” 2007, “Principles of Transgender Medicine and Surgery,” eds Rand Etna et al, Haworth

29 ibid, p10
The first thing to do is separate the treatment and care of gender dysphoria out from the trans patient in front of you. It is rarely material to the diagnosis. The person is there to receive medical treatment, diagnosis and/or care, not psychiatric care or referral to a Gender Identity Clinic. Never confuse the need for treatment for physical symptoms by referring the patient to a GIC.

“Never confuse the need for treatment for physical symptoms by dismissingly referring the patient to GIC.”

It may be apparent that a man or woman requiring hospital treatment possibly has a trans background. You will see in this guidance examples of when care has gone wrong. Try to find a way either directly or indirectly to relate to the trans person so they can feel confident under your care. All health care and support staff have both an individual and a shared duty of care towards all of their patients. In giving this duty the highest priority and ensuring it is inclusive of trans people, negative experiences of treatment and care will be minimised, if not prevented altogether.

“I have had to attend hospital several times due to my Crohn’s Disease. This necessitates staff looking at my anal area. Once the doctor insisted on having a nurse with him when he looked at me, but allowed me to choose the gender (I chose male).”

4.1 SAME SEX ACCOMMODATION

Transgender people who have been diagnosed as transsexual have very specific protection against discrimination within the current SDA 1975. This protects a trans person who intends to undergo, is undergoing or has undergone gender reassignment. Good NHS practice dictates clinical responses be patient-
centred, respectful and flexible towards all transgender people including those who do not meet these criteria but who live *continuously or temporarily* in their confirmed gender role.

It is essential that all acute hospitals have a sensible and flexible same-sex accommodation policy, which includes the needs of trans people. Within same-sex wards there is still a need for individual privacy. There are practical arrangements which help to protect the dignity of the trans person, such as the use of curtains around the bed area, and ensuring everyone in a same-sex ward has their privacy respected.

The key points extracted from the Department of Health, same-sex accommodation policy which, should be integrated into NHS acute hospital policies throughout the country follow below:

- **Trans people should be accommodated according to their presentation:** the way they dress, and the name and pronouns that they currently use.

- **This may not always accord with the physical sex appearance of the chest or genitalia;**

- **It does not depend upon their having a gender recognition certificate (GRC) or legal name change;**

- **It applies to toilet and bathing facilities (except, for instance, that pre-operative trans people should not share open shower facilities);**

- **Views of family members may not accord with the trans person’s wishes, in which case, the trans person’s view takes priority.**
In embedding this policy, the focus should be “patient-centred”. This ensures a flexible approach to caring for trans people at any stage in their transition towards their target gender. Adopting a flexible approach in policy and practice will benefit all hospital patients without incurring extra financial cost.

**Different genital or breast sex appearance is NOT a bar to having trans men in male wards, since sufficient privacy can usually be ensured through the use of curtains or by accommodation in a single side room adjacent to a gender appropriate ward.**

Those who live in their confirmed gender should **always be offered** accommodation according to their gender presentation. However it may be the case due to the nature of the treatment or surgery, availability of beds, genital operative state of the patient, patient history and wishes (including the patients’ own anxieties and concerns), that a side room or a single adjacent ward accommodation should be provided instead.

This approach may only be varied under special circumstances where, for instance, the treatment is sex-specific and necessitates a trans person being placed in an otherwise opposite gender ward. Such departures should be proportionate to achieving a “legitimate aim”, for instance, a safe nursing environment. For example, when a trans man is having a hysterectomy in a hospital, and the only ward available is female gynaecology, and no side room is available within the unit. The situation must be discussed with the individual concerned with agreed arrangements in place prior to admission that respect the patients’ wishes, without adding the penalty of additional waiting time compared to other patients needing the same service. All
arrangements must ensure the privacy and dignity of the patient rather than being for the convenience of the staff. 32

“When I was admitted to hospital to have my hysterectomy the doctor said I would be put in a side room near the gynaecology ward. She asked me to shave my beard so I would not embarrass female patients.

On arrival I was given a side room but in the main women’s’ ward. Nurses would not care for me after my operation and left me haemorrhaging. When I tried to leave my room to get help I was corralled in my room alone and unaided.

I felt stripped of my dignity and humanity by such insensitive and unprofessional treatment.” 33

4.2 EARLY TRANSITION

Sometimes it will be the case that a trans person is admitted to hospital who has only just started to transition. This is likely to mean the person has different genitals to those usually expected. It is also likely to mean the person may appear quite gender ambiguous and may not have developed any or all of the secondary sexual characteristics of their gender. In these instances a fair and reasonable approach that takes into consideration all of the circumstances is essential.

On admission it is important to discuss with the trans person the most suitable accommodation for him or her and reach a decision you can both agree upon. The priority is to accommodate the patient safely, ensuring their privacy and dignity.
4.3 PERSONAL CARE

In some circumstances, due to practical difficulties, additional arrangements will have to be made that ensure the trans persons’ privacy and dignity remain intact. This may only present a problem when there is a mismatch between genitals and secondary sex characteristics. Hospital policies already have guidance in place to protect and promote the privacy, safety and dignity of all patients. In short it will not be a problem unless it is made into one.

If a trans person is so unwell they have difficulty or are unable to wash and clean themselves independently, then nursing staff must provide this care. Whilst it is unacceptable for any member of staff to refuse to wash a person because they are trans this has been known to happen. If this view is known or were to become known to the patient, or the relatives and visitors, it would be inappropriate for senior nursing staff to insist that this staff member wash the patient. The staff member should be taken aside and appropriate hospital disciplinary procedures activated. Then an alternative member of staff found immediately to take over this duty.

“The last time I was in hospital for a hernia, I was bed bound, neglected and could not clean myself. This time it was a road traffic accident. I was so worried that this time would be the same. I sat in my bed in the female ward with my sheets tightly wound around my body. Sister calmly came over to me and pulled the curtains around us. “Come on”, she said quietly – “nothing I have never seen before. Let’s get you cleaned up.”

34 Trans woman, Gender Trust, 2009
If a trans person is living fully in their chosen gender role and has been admitted to hospital in that gender then it follows that the individual must be able to use the appropriate washing and toilet facilities of that gender where such facilities are segregated. It would be unreasonable, and a breach of the provisions detailed, if a trans person living and presenting in role was stopped from using the single sex facilities of their confirmed gender.

With regards to trans people who are early in their transition, if the decision is taken to house the patient in a segregated ward then it follows that the toilet facilities of that ward may be used. Alternatively if side room accommodation on a mixed ward is used there should be the possibility of the patient using the toilet appropriate to his or her gender identity, but it may be safer and more discrete for a gender neutral facility to be used.
Is this real
or am I
dreaming?
On meeting a trans patient for the first time it is likely you will not be aware of their “trans” status. If a patient is attending for an eye test, for example, or has a broken arm, it is likely you will never know whether or not the person you just met and treated was designated at birth male or female or is a trans person.

Most trans people, especially if alone, will not “out” themselves until circumstances force the issue.

It should be appreciated that fear of a negative reaction to a persons’ trans status weighs heavily on the individual, especially when attending hospital. Deciding when and if to disclose, before clothes are removed, or afterwards by blurting out the truth to the doctor or nurse, can make for some amusing moments. Trans people are quite capable of seeing the lighter side to their predicament. However, undressing in the hospital environment is fraught with fears and anxieties. Trans people neither want to be embarrassed, nor embarrass anybody else. A pragmatic, sympathetic approach will go a long way in allaying the fears of all concerned.
I found things far more problematic at this hospital. Most of the staff I met assumed I had mental health issues because I was trans. This included the physician who admitted me, A&E staff, GUM clinic staff, and nursing staff. I attended A&E twice, the GUM clinic three times, was an inpatient for 11 days and attended an out-patient oral-dermatology clinic several times and the main underlying cause of my symptoms i.e.; Crohn’s Disease, was never suspected. I believe this was due to them deciding many of my symptoms were psychosomatic. During this time I had severe mouth ulcers, which made it hard for me to speak, so sometimes I had to communicate by writing. The physician also tried to put me on a female ward twice…” 35
Not knowing whether or not a person is trans in A & E may be potentially life threatening in some circumstances. Gender presentation is indicative of gender role and how a patient should be accommodated but not what their birth sex was. For this information you must rely on any friends or relatives that accompany an unconscious or critically ill person, clinical notes or colleagues, if the person was a previous hospital patient. If it is not relevant to the critical incident you are investigating there is no need to determine whether the patient is trans even if you become aware after examination that they may be.

Where admission/triage staff are unsure of a person’s gender, they should, where possible, ask discreetly where the person would be most comfortably accommodated. They should then comply with the patient’s preference immediately, or as soon as practicable.

If it is not possible to ask the patient their preference, the Chief Nursing Officer, provides excellent advice within Annex E of the Department of Health same-sex accommodation policy letter.36

If upon admission, it is impossible to ask the view of the person because he or she is unconscious or incapacitated then, in the first instance, inferences should be drawn from presentation and mode of dress. No investigation as to the genital sex of the person should be undertaken unless this is specifically necessary in order to carry out treatment.
6. ONGOING TRANS HEALTH CARE

Trans people who have transitioned and have had surgery may still be at risk of getting medical problems and conditions that are normally only associated with the opposite gender.

Trans people often, due to acute embarrassment, will rarely present for the standard preventative screening tests associated with their natal sex offered routinely by GP surgeries. This means that when a concern is raised in a hospital setting it must be taken extremely seriously.
Additionally when taking cross gender hormones on a regular basis trans people will then share the same health risks as others of that gender. A greater incidence of heart disease in men is a good example of the acquired health risks for trans men. The reduction in the usual hormones present in the body of trans people (in this case testosterone or oestrogen), will also mean that while some gender specific risks are reduced or eliminated, the gender specific benefits of that hormone will also be greatly reduced. The benefits of oestrogen in preventing osteoporosis is one just one example.

Trans guidance recommends that trans men should consider cancer risks and have a total hysterectomy after 5 years on cross gender hormones. Further research needs to be done on this group of trans people and the long term effects of cross gender hormones, but good practice dictates that prevention of such a silent dangerous cancer is better than cure.

GP’s do not just need copy of a diagnosis and the prescribed treatment by itself, they also need clear instructions on when and how to monitor. Best practice equates to providing patients with copies of correspondence sent to their GP so the patient can be informed and pro-active in their care.
“When I was undergoing physio I did not reveal my trans status as it was not relevant to my wrist injury. However when the physio booked me for a scan it obviously came up on the computer under my notes. This in itself wasn’t a problem except that the physio said she had to ask me if there was any chance I might be pregnant! Even the physio thought this was an unnecessary question.”
7. DIAGNOSTICS

Diagnostics and blood tests can be a cause for concern if assumptions are made that the blood chemistry profile of a trans man will match that of other men, and that a trans woman will match the exact profile of other women. It cannot be assumed that if the individual is taking cross gender hormones this will mean that test markers and diagnostic results resemble stereotypical male and female ranges.

Cross hormone treatment can cause side effects, which may be misdiagnosed if a patient’s trans status is ignored. For example: trans men, especially if smokers or former smokers, are susceptible to polycythaemia (over production of red blood cells). This may have symptoms such as tension headaches, blurred vision, fatigue and joint pain that some clinicians wrongly diagnose as psychosomatic when really, further investigation is required. Best practice means that regular blood monitoring is essential to ensure the trans person’s good health.
If the patient has not had any recent blood test investigations then the clinician should, as an initial precaution at first assessment, ensure the trans person undergoes a full range of essential blood tests, to rule out the effects of either over or under dosage of hormones. This is a common problem that can be asymptomatic or can present as a more general non-specific malaise.

The results of X-rays, MRI’s and other imaging devices can surprise technicians and consultants not expecting to see scanned images of, for example, a man with a uterus or woman with a penis. It is sensible to make the operator aware and to discuss this with the trans person. Straightforward limb X-rays should not create an issue although a well-trained technician may be able to discern the skeletal difference between male and female. Ultrasound, MRI or other imaging devices scanning the abdominal cavity may show up physical discrepancies and give potentially misleading results if the clinician is not aware of the persons’ birth sex.
As a trans man I was having unexplained vaginal bleeding and had to have an abdominal ultrasound, which included my uterus. The ultrasound specialist carrying out the test did not know how to scan me and would not use the internal probe. I had to calm her nerves before she could start the procedure. In the end the investigation was aborted due to her embarrassment and my cancer went undiagnosed for a further 8 months. I could have died. 39
just as with any other patient, clinicians may be made aware of a trans person’s living will (the new term for this is an advanced decision) or express intentions as to the steps they wish to be taken by doctors or nurses if they become unconscious, unable to communicate or lose mental capacity. whilst respecting the patients’ wishes in this matter, death must not be hastened as a result of the care and medical treatment either given or withdrawn. it is possible to nominate someone you trust to make healthcare decisions for you in the event that you are unable make decisions yourself; this is called a lasting power of attorney.
BMA and GMC guidance as well as hospital ethical policy is quite clear and all steps necessary must be taken to resuscitate any patient where it is felt that there is a reasonable chance of recovery. Equally all steps must be taken to provide and deliver the necessary medical and clinical treatment to prolong life if that is within the control of the hospital. Appropriate treatment will be given to all patients, regardless of gender identity, wherever indicated. In cases of prolonged suffering, terminal illness, or where the trans person has severely debilitating conditions such as MS or motor neurone disease, the issue of artificial nutrition and hydration may be discussed. However, in some circumstances, giving artificial hydration and/or nutrition, which is considered a medical treatment, will only prolong the period of suffering. Doctors should only offer this where they feel it is in the individual’s best interests, and after discussion with the patient and/or next of kin. Any decision-making in this area must be clear and transparent, and fully involve the patient. All aspects of fundamental nursing care, such as personal care and meeting hygiene needs, will be provided and indeed at the end of life are of very significant importance in maintaining dignity.

Nobody is entitled to judge a trans person’s quality of life. Cases of treatment withdrawal especially in the case of trans people who are considered legally a “vulnerable class of people” can only be taken by a Court of Law. All medical staff must follow best practice in this area by ensuring the quality of health care given in hospital matches the high standards expected to be given to all other hospital patients. Where a trans person, or their family/carers, suspect discrimination they would have recourse to the legal system to challenge this decision. Trans people have protection under the law as a ‘vulnerable class of people’.
9. BEREAVEMENT

Bereavement in the hospital setting is a difficult time for next of kin, relatives and clinical staff. A trans bereavement must be treated very sensitively by nursing and mortuary staff. It is good practice to assume that a trans person who has changed their name by statutory declaration or deed poll is in fact a member of their confirmed sex for all purposes. The right to privacy and non disclosure for trans people is maintained in death. Even if relatives or senior colleagues feel the persons’ trans status is public knowledge or well known in the hospital setting, it would be circumspect not to divulge to anyone else the trans persons’ original birth gender. This does not apply where there is a medical or legal need to know. Discretion should be used when deciding how to formally identify the body. Liaising with a partner or next of kin, even the family GP, is acceptable to ascertain the correct name and gender in cases where this does not match the birth certificate. If you discover the deceased has been living permanently in their confirmed gender but without a GRC, then it is permissible to register the death in that gender.\(^\text{42}\)
If the death is within 24 hours of hospital admission or is sudden or unexpected then a coroner may carry out a post mortem. Nursing staff will need to ensure that the dignity of the trans person is maintained in death. If you are of the view that the deceased person is a cross dresser or just temporarily in the opposite gender role and the identification documents to hand do not conclusively tell you which gender the person lived in permanently, it is acceptable to ask the police to find out by getting in touch with the DVLA or passports office.

It is often the case that trans people become estranged from their families and from marriage relationships. Many relatives, including parents, fail to accept the confirmed gender of their relative, son or daughter, and refuse even in death to use their chosen name and gender identity, even in cases where the trans person has lived for many years in that gender role. In these situations, the confirmed gender identity and name should be obtained through liaison with a partner or friend and used on the death certificate and other official hospital documents.

A trans woman, who is a part-time cross dresser, dies in a road traffic accident while dressed in female role. The police at the scene establish that none of the documentation on her reflects the gender in which she was presenting. At the hospital mortuary, it is decided that as the documents of the deceased state that they are male, they will be referred to with male pronouns. This is a sensible assumption to make as members of her family may not know that she was a cross dresser. When the wife of the deceased comes to view the body, all evidence of the gender in which the deceased was found is removed (for example a wig, make-up, female clothing). When asked about what happened to the clothes the deceased was wearing, the wife is told that the clothing was badly damaged in the incident.43
The, “Bereavement: A guide for transsexual, transgender people and their loved ones” provides the following guidance:-

“Depending on the stage of transition, some bodies of trans people when unclothed may resemble that of a person of their former gender, or it may be a mixed gendered body” – all of these are matters that have to be considered carefully when determining how to handle the body, and what information is passed onto third parties.

The use of appropriately gendered pronouns is comparatively easy in most cases. If a person was dressed in male clothing, has a beard, then even with breasts and a vagina they should be referred to as ‘he, his, him’. Similarly if a person has small breasts and wears female clothing, they should be referred to as ‘she’ regardless of the penis present. The documentation of the deceased is also a good indicator of how they identify.”

Ensure that the deceased is presented respectfully in the appropriate gender and treated with dignity when preparing the deceased patient for any ward viewing prior to removal from the ward to the mortuary. For instance, ensure a trans woman has her wig or hairpiece placed properly or a trans man is suitably covered to hide any body scarring or his operative status. After removal from the ward and any required preparation to facilitate removal, such as removing an intravenous drip, follow standard hospital practice and guidelines.44
The intention of this guide is to help you to improve your practice. There are excellent sources of further information suggested in the bibliography or on the internet. Some relevant suggested sites where you can obtain accurate up to date information are as follows:

www.pfc.org.uk

www.gires.org.uk

www.gendertrust.org.uk
APPENDIX 1 - GLOSSARY

**Gender:** Self-identification (and usually presentation) as either a man or a woman.

**GRS:** This acronym means Gender Reassignment Surgery, but as there is no such thing as a “sex change,” the correct term is *Gender Confirmation Surgery*.

**Sex:** as described in 1.3. Or phenotype is based on gonads, chromosomes and genital appearance.

**Sexual Orientation:** A person’s sexual orientation refers to their choice of sexual partners (who they are sexually attracted to) in doing so a person may be gay, straight, lesbian, bi sexual or pan sexual. Trans people can be any of these options.

**Transgender:** An umbrella term inclusive of a wide variety of trans identities. A transsexual is just one of these many identities.

**Transition:** A trans person who wishes to live permanently in the social role of the opposite gender makes changes necessary for them to function in this role – this is known as transition or transitioning.

**Transsexual:** A trans person who experiences an extreme inconsistency between their physical phenotype and gender identity and may seek to adapt their phenotype through hormones and/or surgery to make it congruent with their gender identity.
Transsexualism: can be considered to be a neuro-developmental condition of the brain. Several sex dimorphic nuclei have been found in the hypothalamic area of the brain (Allen & Gorski, 1990; Swaab et. al., 2001).

Transvestite: and Cross dressers are (Trans) People who tend to spend short periods of time in a different gender role to that assigned at birth. Some are happy to do this all their lives. Some live part time for many years until their need to undergo permanent gender reassignment becomes too strong – usually later in life – at that point they will then be usually regarded as a transsexual person.
APPENDIX 2 – BIBLIOGRAPHY


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THE DEPARTMENT OF HEALTH


APPENDIX 3 - SUPPORT AND FURTHER INFORMATION

The following national organisations will be able to offer help and support to trans people and those caring for trans people. They may also be able to provide details of local support organisations:

**a:gender**
Tel: 020 7035 4253  
Email: agender@homeoffice.gsi.gov.uk  
Website: www.csag.org.uk

Support for staff in government departments and agencies who have changed – or who need to change – permanently their perceived gender, or who identify as being intersex.

**FTM Network**
BM Network, 27 Old Gloucester Street, London WC1N 3XX  
Tel: 0161 432 1915  
(Wednesday 8–10.30pm)  
Website: www.ftm.org.uk

Advice and support for female-to-male transsexual and transgender people, and for their families and professionals. ‘Buddying’ scheme, newsletter (Boy’s Own) and an annual national meeting.

**Gender Identity Research and Education Society**
Melverley, The Warren, Ashtead, Surrey KT21 2SP  
Tel: 01372 801554  
Email: admin@gires.org.uk  
Website: www.gires.org.uk

Promotes and communicates research, and provides information and education to those who can improve the lives of people affected by gender identity and intersex conditions.

**Gender Trust**
PO Box 3192, Brighton, Sussex BN1 3WR  
Tel: 01273 234024 (office hours)  
Helpline: 0845 231 0505  
(12 noon–10pm Monday to Friday and 1pm–10pm Saturday and Sunday)  
Email: info@gendertrust.org.uk  
Website: www.gendertrust.org.uk

Advice and support for transsexual and transgender people, and for their
partners, families, carers, and allied professionals and employers. Has a membership society and produces a magazine (GT News).

**Mermaids**
BM Mermaids, 27 Old Gloucester Street, London WC1N 3XX
Tel: 07020 935066 (Monday to Saturday 3–7pm)
Email: mermaids@freeuk.com
Website: www.mermaids.freeuk.com

Support and information for children and teenagers who are trying to cope with gender identity issues, and for their families and carers. Please send an SAE for further information.

**Press For Change**
BM Network, 27 Old Gloucester Street, London WC1N 3XX
Tel (emergencies only): 0161 432 1915
Website: www.pfc.org.uk

Campaigns for civil rights for trans people. Provides legal help and advice, information and training for individuals. Newsletter and publications. Please send an SAE for further details.

**THE SIBYLS**
BM Sibyls, 27 Old Gloucester Street, London WC1N 3XX

Christian spirituality group for transgender people.

**Women of the Beaumont Society**
BM WOBS, 27 Old Gloucester Street, London WC1N 3XX
Tel: 01223 441246 or 01684 578281
Email: wobsmatters@aol.com
Website: www.gender.org.uk/wobsmatters

Operated by and for wives, partners, family and friends of those who cross-dress.
The Pacesetters programme is a partnership between local communities who experience health inequalities, the NHS and the Department of Health. Working with the strategic health authorities and trusts it aims to deliver:

- Patient and public involvement in the design and delivery of services;
- Reduced health inequalities for patients and service users; and
- Working environments that are fair and free of discrimination

The Royal Free Hampstead NHS Trust has been participating in the Pacesetters Programme since November 2007, engaging with a wide range of local communities and taking action to improve their access to services and experience of care in our hospital.

This guide has been developed in partnership with transgender community members. Its aim is to provide information that will support staff in acute trust settings to better understand the issues that are often faced by transgendersed people when accessing care and treatment. The guide should be used as a resource and also includes useful contact details for anyone who want to know more about the issues transgendersed people may face, as well as for patients who may wish to access support within the community for themselves, their families and their friends.

“…it’s very much that we are the experts and we are being recognised as.”

Transgender Focus Group Member

Transgender Guide for NHS Acute Hospital Trusts
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