De-sexing the Medical Record? An Examination of Sex Versus Gender Identity in the General Medical Council’s Trans Healthcare Ethical Advice

Sara Dahlen

To cite this article: Sara Dahlen (2020): De-sexing the Medical Record? An Examination of Sex Versus Gender Identity in the General Medical Council’s Trans Healthcare Ethical Advice, The New Bioethics, DOI: 10.1080/20502877.2020.1720429

To link to this article: https://doi.org/10.1080/20502877.2020.1720429

Published online: 03 Feb 2020.

Submit your article to this journal

Article views: 1104

View related articles

View Crossmark data
De-sexing the Medical Record? An Examination of Sex Versus Gender Identity in the General Medical Council’s Trans Healthcare Ethical Advice

SARA DAHLEN
King’s College London, Strand, London WC2R 2LS, UK

What do the terms sex and gender identity, or gender history, mean in a medical context? When does it matter to a healthcare professional whether a patient has male or female reproductive biology? How should a doctor approach a patient who does not wish for their biological sex to be openly acknowledged? The General Medical Council (GMC) advises doctors that transgender patients may have the marker for their sex amended to instead reflect their gender identity. This paper will attempt to critically examine two key points in the GMC trans healthcare ethical advice using Beauchamp and Childress’ Four Principles approach, exploring how doctors might consider an incongruence between sex and gender identity in clinical practice.

KEYWORDS Sex, gender identity, transgender, four principles (Principlism), general medical council (GMC), medical communication

Introduction

The General Medical Council (GMC) provides ethical advice for doctors on how to manage patients who are trans or transgender (i.e. patients who do not identify as their biological sex). Under ‘Confidentiality and equality,’ the GMC (2016) writes:

Respect a patient’s request to change the sex indicated on their medical records; you don’t have to wait for a Gender Recognition Certificate or an updated birth certificate.
Don’t disclose a patient’s gender history unless it is directly relevant to the condition or its likely treatment. It’s unlawful to disclose a patient’s gender history without their consent.

The GMC appears to suggest that some patients be allowed to change the marker for biological sex in their medical records, implying that their sex observed at birth should be ignored (or at least hidden) in a confidential medical history.

Christine Burns (2018, p. 7) wrote: ‘The roots of trans people’s journey into public consciousness were sown long ago. They reach deep and they have been growing for decades.’ Has bioethics as an academic field taken enough of an interest in trans health? While it may seem a too-specific subject, issues of sex and gender identity are vital to examine sensitively but critically, to consider professional obligations and better serve the needs of patients. Perhaps this topic is too politically controversial. However, it seems unreasonable that medical ethics can be concerned with all manner of highly-charged questions, including abortion and euthanasia, but not a potential paradigm shift in how doctors should approach reproductive biology when it may conflict with the expression of an internal sense of self. Reconceptualising the medical meaning of ‘sex’ has broader implications, particularly for clarity of language, which warrant careful consideration and reflection.

I will start with definitions of sex and gender identity. I will then examine these two stipulations within the GMC’s ethical advice on trans health (2016) using Beauchamp and Childress’s (2001) four principles framework of respect for autonomy, nonmaleficence, beneficence and justice. Finally, I will reflect on these principles, noting Gillon’s (1994) scope, and suggest a way to proceed. I will not evaluate any legal claim made by the GMC advice. This is beyond the scope of this paper and legal experts have voiced uncertainty regarding the interpretation of existing laws in the UK (Norman et al. 2018).

Sex

The *Oxford Concise Medical Dictionary* (2007) does not define the terms sex, female or male despite using the words when explaining other medical concepts, such as:

reproductive system: the combination of organs and tissues associated with the process of reproduction. In males it includes the testes, vas deferentia, prostate gland, seminal vesicles, urethra and penis. In females it includes the ovaries, Fallopian tubes, uterus, vagina and vulva. (Oxford Paperback Reference 2007, p. 618)

I hypothesise that the words sex, female and male were assumed to be uncomplicated: common knowledge for the intended user of said medical dictionary. Therefore, I will use the traditional understanding of biological sex as male or female, based on genetics, anatomy and physiology of an individual’s reproductive system. The language of sex in medicine reflects the process of human (mammalian) sexual reproduction. Humans have two types of gametes, two categories of
reproductive systems, and two types of sex chromosomes. For the vast majority of individuals, sex is easily determined and not in dispute.

My analysis does not include differences or disorders of sexual development (DSD). These biological phenomena are largely irrelevant to transgender issues. Empirical data, such as from routine karyotyping of trans youth (Butler et al. 2018), do not support the notion that DSD are more common in trans patients (WPATH 2012). The majority of trans patients are correctly and unequivocally reproductively categorised as male or female at birth: chromosomal, gonadal, and phenotypic sex are not in any doubt or misalignment in a physical sense. Rather, the trans patient sincerely identifies that their true sense of inner self is other than their sex. The questions concerning trans patients are unrelated to the minority of patients born with more complicated combinations of genetics and reproductive features, where management may involve multidisciplinary clinical input (Kumar and Clark 2007, WPATH 2012). DSD are a separate issue meriting specific attention, not conflation in discussions on a wholly different topic.

The question is whether an individual who is reproductively clearly male or female can, at the point of self-declaration, reject the biology they possess and then for all purposes be treated by doctors as though they are materially and medically the same as individuals of the opposite sex, or as though that patient has no sex at all.

Biological sex is fixed, set by empirically observable genetic and developmental factors. Humans cannot change biological sex. Iatrogenic physical changes may be achieved through inducement of secondary sex characteristics via administration of cross-sex hormones, surgical alteration of genitalia, or excision of reproductive organs. However, the notion that these interventions actually change an individual’s underlying sex is untrue. If it were true, this position would imply that the reproductive system a person was born with no longer holds relevance to the meaning of the word sex, uncoupling the concept from its role in describing the mechanism of human sexual reproduction. In order to change the definition of sex, the proponents of the revision need to justify how alteration of the concept is more scientifically accurate and helpful to medicine. If the word male now signifies both those biologically male as well as some biological females who identify as male, what specific information is communicated by the term? If reconceptualising terms, it seems likely that medics would either need to rename the two reproductive systems, or find alternative ways of alluding to a person’s sex. Perhaps by referring to anatomy, so male becomes prostate-haver. The latter option is unsatisfactory: it reduces the description of a whole person to whether they possess an organ (cardiologists might bristle at calling patients aorta-havers), and this substitute for the word male would not include patients who have undergone radical prostatectomy.

If certain medical interventions were argued to actually change biological sex, this implies all patients should be categorised somewhere on a scale between being more or less female or male, affected by hormonal changes, alterations of secondary sex features, or removal of reproductive organs. It is inaccurate, and somewhat cruel, to state that boys experiencing transient gynaecomastia should now be classed biologically as being more female, or that women post double-mastectomy for breast cancer are now more male. What then of the double-mastectomy undergone by a
female who identifies as a man (a trans man), or oestrogen-induced gynaecomastia of a male who identifies as a woman (a trans woman)? It is untenable to argue that in the former examples biological sex remains unchanged, yet in the case of trans patients sex becomes altered. One might argue that intent or psychological identity is a key differentiating factor to how we accommodate someone’s social categorisation. However, from a medical standpoint, it is illogical to say that two separate individuals of the same reproductive category, who experience alterations to equivalent biological parameters, should now be classified differently. Until such time that medical science allows a reproductively normal female to completely biologically transition to fulfil the reproductive role of a male, and vice-versa, including genetic make-up and production of gametes, my position is that sex remains a constant.

Gender identity and trans

It is beyond the scope of this paper to fully explore the ontology of gender identity, trans, and gender dysphoria. That conversation would likely invoke the mind–body problem, and I am mindful that I do not share the experience of being a trans patient. Nagel writes:

I want to know what it is like for a bat to be a bat. Yet if I try to imagine this, I am restricted to the resources of my own mind, and those resources are inadequate to the task. I cannot perform it either by imagining additions to my present experience, or by imagining segments gradually subtracted from it, or by imagining some combination of additions, subtractions, and modifications. (1974, p. 439)

Therefore, apart from simply giving current working definitions, I will not attempt to elucidate any underlying philosophical questions. The ideas involved in trans as a phenomenon will be taken at face value: these are the definitions and beliefs which may be deeply and firmly held by trans patients. The UK’s leading Lesbian, Gay, Bisexual and Transgender (LGBT) campaign group Stonewall (2017) defines terms like this:

Gender Identity: A person’s innate sense of their own gender, whether male, female or something else … which may or may not correspond to the sex assigned at birth.

Trans: An umbrella term to describe people whose gender is not the same as, or does not sit comfortably with, the sex they were assigned at birth. Trans people may describe themselves using one or more of a wide variety of terms, including (but not limited to) transgender, transsexual, gender-queer (GQ), gender-fluid, non-binary … trans man, trans woman, trans masculine, trans feminine and neutrois.

Trans patients are a heterogenous group. The astute reader may notice that the word gender itself hasn’t been defined in this paper; a deliberate omission due to the fact that gender may have different meanings. In popular use, gender might be a synonym for sex. The World Health Organisation (2011) uses gender to describe a culturally established framework of behaviours expected of men and women. The meaning of gender, in and of itself, is therefore not clear.
Gender dysphoria (GD) is where a person experiences discomfort or distress because of a mismatch between their biological sex and gender identity (NHS 2016). This is treated by a highly individual process known as transitioning, often overseen by specialist services, and may range from changing one’s name or clothing, or hormones and surgery (NHS 2016). I use gender identity to denote a trans person’s internal sense of who they truly are, as related to their bodily sex or how they feel their behaviours, personality traits, and preferences fit with the societal role expectations of members of their sex. In other words, it is a subjectively determined identity unrelated in any physical sense to the properties of reproductive biology.

There is no empirical evidence that can be used to diagnose GD. No genetic marker, biochemical test, brain imaging, or objective measurement exists in medical practice for gender identity, which is itself of an unknown aetiology (NHS 2016, Bizic et al. 2018, Gerritse et al. 2018, Bewley et al. 2019). The central claim rests on a consistent declarative statement of the trans patient’s subjective experience of self-hood. Therefore, we cannot prove or disprove a gender identity. Gender identity is a deeply held, spiritually significant, personal belief that can neither be confirmed nor rebutted by external evidence and biological data.

Why is the GMC ethical advice worthy of bioethical exploration, using a four principles approach?

Transgender patients are a marginalised group, with unique health needs. Every trans person is worthy of dignity, respect and excellent medical care. I do not argue that someone’s identity should not be respected, or that confidentiality should be broken, or that doctors should disobey any law, or that records should not accurately document a patient’s individual sense of self. My position is that because sex and gender identity are two separate concepts, the potential for tension between them within healthcare exists, therefore we should examine the issue carefully from a medical ethics angle.

The GMC advice changes the medical meaning of biological sex in the clinical record, as they stipulate that patients must be allowed to change the marker for sex upon request. The GMC also appears to minimise the importance of sex, when they state that doctors must avoid communicating about gender history unless directly relevant and with explicit permission, which in practice reads as a prohibition on mentioning the natal sex of trans patients. Medical records are kept in order to accurately document clinically salient information about a patient, important to continuity of care. The doctor is responsible for producing a factual, faithful representation of a patient’s medical history, which can be understood by other professionals who may later need to provide care for said patient. Furthermore, amendments to records are generally given some explanatory detail, for instance if the wrong test result was previously documented in error. In light of standard clinical practice, the GMC advice regarding altering sex in medical documentation might raise some questions.
The bioethical literature I have read predominantly focuses on other questions in trans healthcare, such as trans youth, fertility, surgical regret and treatment decisions (Bizic et al. 2018, Gerritse et al. 2018). There appears to be a paucity of current papers examining tension between gender identity and sex for clinical practice. I will quote the stories of trans patients to help illustrate why I believe the subject is important.

For the purposes of analysing ethical advice from the GMC, I wanted to compare their principles with general ones. Beauchamp writes: ‘Principles should therefore be understood less as norms that are applied, in the model of “applied ethics” and more as guidelines that are interpreted and made specific for policy and clinical decision making’ (2001, p. 481). The four principles are well-suited to the task, better so than virtue ethics, as the GMC in this case emphasises professional duties for action rather than character traits. The advice and its impact, rather than the agent, are the primary focus here. Principles also allows for the consideration of different ethical perspectives, giving various ideas from deontology or consequentialism weight, without the need to argue for the superiority of one theory over the other in every context.

**Respect for autonomy**

**Sue’s story**

I always have anxiety about using medical services. There is always the fear new doctors will not accept me as real or will try to turn me into something I am not. They always seem to use the wrong pronouns, with some openly refusing to use ‘they’ to refer to me, stating they feel it is a term for an object and not a person. (Henry 2017, p. 180)

Autonomy, or self-rule, refers to a person having agency and liberty to make independent decisions. Beauchamp and Childress write: ‘We analyse autonomous action in terms of normal choosers who act (1) intentionally (2) with understanding and (3) without controlling influences that determine their action’ (Beauchamp and Childress 2001, p. 59). Gillon (2003) considers respect for autonomy in the four principles as ‘first among equals,’ due to its influence on the other domains.

Sue’s description demonstrates issues of autonomy: a trans patient’s sense of reality and selfhood being challenged by health professionals, inducing worry that doctors will treat them with disrespect. In medical practice and record keeping, we do not deny a patient the opportunity to update their demographic information, or to add in relevant details, or to amend erroneous facts. The same must hold true of gender identity: it would be wrong to deny a trans patient a clinical record that accurately depicts who they are. A patient’s gender identity communicates important information to the clinician about how the patient sees themselves, guiding doctor-patient interaction. My concern is whether gender identity must be recorded within the category sex, as the GMC recommends. Should patients have absolute autonomy over all aspects of their medical records, or are there limits?
Accurate language when patients and doctors communicate with each other is vital: autonomous actions require adequate understanding. The phrase ‘sex assigned at birth,’ used in Stonewall’s (2017) definitions, illustrates a potential source of confusion. A clinician does not ‘assign’ an infant’s sex at random, rather sex is an observed, fixed biological property that neutrally documented. In order to ensure trans patients are knowledgeable enough to make an autonomous choice, the clinician might therefore need to confirm that their trans patient adequately understands the meaning of the term sex, the consequences of changing the marker for sex on a medical record, and the realistic limits of medical intervention. To respect a trans patient’s autonomy, ought there be some form of informed consent including a competence check, rather than leaving the matter to administrators, as appears to be current practice?

One may argue that a trans patient’s belief they are not of their sex is demonstrably false, given empirical evidence. If so, might doctors have a moral obligation to persuade the patient otherwise? Not if the issue is specifically about the unverifiable property of gender identity, rather than sex. If a trans patient is competent, able to reason normally, has been given enough information, and are simply acting in accordance with their conviction that their inner identity is other than their sex, then the doctor has little justification in attempting to dispel that patient’s beliefs. The comparison is to religion: a trans patient who feels they have a different gender identity to their sex is similar to a Jehovah’s witness (JW) who believes that a blood transfusion will doom him for eternity, so refuses life-saving treatment. Doctors would not compel a JW to consent to a blood transfusion. In an analysis of rational autonomy in such a case, concluding a JW has not necessarily made an irrational choice, Savulescu writes:

... religion is a construct that gives meaning to people’s lives, rather than an empirical statement about the nature of the world ... Since non-descriptive statements do not describe properties of the world, they cannot be assessed for their truth or falsehood by empirical examination of the world or the people in it. (2006, p. 679)

Gender identity gives meaning to trans people’s lives, and cannot be assessed for truth or falsehood. As long as the trans patient is aware of empirical truth (i.e. their biological constitution), yet truly believes in their gender identity, then gender identity is similar to a religious assertion and ought to be respected. The challenge lies in untangling and navigating language during the clinical encounter, as the terminology of sex and gender identity designates the same words to denote very different concepts.

Non-Maleficence

**Angela’s story**

I called the GP’s surgery to make an appointment. The receptionist asked me to repeat my name twice. I said Angela - twice. The receptionist sort of sniggered and turned to the other receptionist and said, quietly, but loud enough for me to hear: ‘he says he’s Angela - what do I do?’ I did get my appointment, but my stomach was churning.
I felt terrible. That feeling comes back every time I need to make an appointment. (GMC 2016)

Nonmaleficence requires ‘intentionally refraining from actions that cause harm’ according to Beauchamp and Childress (2001, p. 115). They describe harm as obstructing or hurting the interests of another party. Nonmaleficence includes ‘not only obligations of not inflicting harms, but also ... obligations of not imposing risks of harm’ (Beauchamp and Childress 2001, p. 117).

A clinician may cause a trans patient significant distress by reminding them of their biological sex or by disrespecting their identity, as witnessed in Angela’s story. Worse still would be to display overtly negative attitudes or provide less-than-favourable treatment. The obligation of nonmaleficence may have been considered like this by the writers of the GMC advice: a trans patient should not have their sex explicitly stated repeatedly instead of their gender identity, as it might cause them upset and therefore harm.

However, if medicine is not actually able to fundamentally change sex, and a patient’s self-declaration of sex does alone not change their biological constitution, then one could argue that the changing of a sex-marker in the medical records (even if symbolic) may actually be a form of deception, a promise modern medicine cannot adequately fulfil. This, too, is a form of potential harm. Negative consequences and risks might be incurred for the trans patient from changing sex-marker or not acknowledging natal sex. This may range from being unable to formulate accurate differential diagnoses to recognising pregnancy. An example is cancer screening for a trans man. Upon changing his sex-marker from female to male, he must now remember to book in regular cervical smears. If he forgets, it might place him at higher risk of cervical cancer being unidentified (PHE 2018).

The doctrine of double-effect is worth considering, to frame whether the intended good of the GMC advice outweighs foreseeable negative consequences. Before arguing that we should dismiss the doctrine of double effect on the grounds of lack of intuitive plausibility or distinctions, Glover writes

This doctrine can be summarised crudely as saying it is always wrong intentionally to do a bad act for the sake of good consequences to ensue, but that it may be permissible to do a good act in the knowledge that bad consequences will ensue. (1977, p. 87)

The doctrine of double effect first makes us examine the initial act: saying that a patient’s sex is now a self-determined category in the medical record. One might argue that this act is morally good or neutral, as it grants a trans patient the ability to redefine their sex-marker according to their gender identity, gaining greater autonomy over what information is communicated about them. From that perspective, if the benefits outweighed potential harms for the trans patient, the act might be justified. Even so, the anecdotal evidence of trans patients’ negative experiences with healthcare following a change of sex-marker would not solidly support such a claim.

My view is that implying to a patient that a biological sex change is possible (or that sex is a not a term with accepted scientific definitions, but now a subjective
identity) goes against the principle of veracity, a moral obligation to tell the truth. This impacts patient autonomy. Even if clinicians intend only the laudable aim of reducing distress and confirming a trans patient’s identity in the records, doctors should not promote untruths. If a tuberculosis patient ‘identified as cured’ when they objectively were not, the clinician would have a moral responsibility not to document a falsehood, even though it might cause discomfort to the patient.

Beneficence

Annabelle’s story

Annabelle … tried to find out what updating her gender marker to female on her records would mean for her medical care after her practice manager asked if she would like it to be changed. “I was like I don’t know actually because what are the implications for managing my health provision moving forwards?,” she said, adding that, for example, in the case of an accident it would be important for doctors to know she would not be expected to be pregnant. The upshot was a phone call that lasted around two hours. “I was trying to ask them what the medical implications were of them changing my gender marker on my notes and they were trying to do the politically correct thing of saying well it is what you want, it is not about what we want.” In the end Annabelle had her gender marker updated. A week later she received a letter inviting her for cervical screening – despite not having such anatomy. (Davis 2019)

Beauchamp and Childress (2001, p. 166) explain that the principle of beneficence ‘refers to the moral obligation to act for the benefit of others,’ not merely to refrain from doing harm but contribute to the welfare of persons. Beneficence involves assessing principles of utility: ‘The requirement to benefit may be overriding if we can produce a major benefit by causing a minor harm, or a major benefit for many people while causing a minor harm to only a few’ (Beauchamp and Childress 2001, p. 168).

In the sense of specific beneficence to a particular group of persons, we might consider trans patients a diverse collection of individuals with health needs, united by a shared experience of having a gender identity that does not match their sex. The ability to change sex-marker may well benefit some trans patients. Yet Annabelle’s story is notable for her sense of confusion, the extra time and effort she had to put in to seek answers, only to still receive an invitation for a procedure that was completely inappropriate for her.

Beneficence should consider why sex is routinely recorded. The purpose to give the clinician relevant information, required in their role of promoting patient well-being. Many other biological data are not documented as baseline demographic information, yet sex is, likely because it is important to almost any medical history. Biological differences between females and males impact many aspects of medical interpretation, exactly how they will apply to a specific patient’s clinical needs may not be predictable in advance. This includes interpretation of symptoms, for example lower abdominal pain will have a very different range of possible explanations depending upon sex, or laboratory results, such as the reference ranges for certain common blood tests. In the event of an apparent mismatch between sex and
gender identity, many clinicians might seek clarification. Such actions are justifiable on the grounds of gaining a better understanding of a patient’s biology in order to medically treat them, and to verify that particular information is indeed correct. However, this may cause extra stress on the trans patient, who may be put in a position of explaining their situation repeatedly, perhaps to more individuals than originally intended.

Specific beneficence also entails thinking about potential health needs for trans patients as a group, including research. If trans patients are obscured within medical records, and communication around trans-specific issues is restricted, how are doctors to identify trans patients’ particular health needs? The case for separating sex and gender identity for clinical research purposes (Clayton and Tannenbaum 2016) is persuasive, as appropriate data collection is key to producing better scientific understanding. Similarly, from a pathology perspective, it would seem sensible to be able to establish and use correct reference ranges for a trans patient’s blood tests (Gupta et al. 2016). If gender identity is subsumed into the larger category of the opposite sex, it may become more difficult for clinicians to monitor long-term outcomes, or gain an adequate signal for any unforeseen effects of treatment. Many of the drugs used in GD are off-licence, and transgender patients are thought to be at risk of self-medicating (GMC 2016). A practical question is how clinicians will be able to determine the number of trans patients, for example to justify funding for specialist trans services, if such individuals are not being recorded separately in medical documentation.

We now consider general beneficence, the promotion of well-being for all persons. It is unquestionably morally good to allow transgender patients the liberty to live according to their true selves, free of restriction or repressive forces. As John Stuart Mill wrote: ‘Mankind are greater gainers by suffering each other to live as seems good to themselves, than by compelling each to live as seems good to the rest’ (Mill 2006, p. 633). The concern regarding general beneficence here, however, is the lack of distinction between sex and gender identity in the GMC trans health advice. Whereas everyone has the liberty to live according to their personal gender identity, sex is not a mutable characteristic. By suggesting otherwise, even for the purposes of changing one letter in a medical record, the action might lead to a poorer understanding by trans patients and the general public as to the meaning and importance of sex as a medical category.

Paternalism is interesting to reflect on in this context, defined by Beauchamp and Childress (2001, p. 178) as: ‘the intentional overriding of one person’s known preferences or actions by another person, where the person who overrides justifies the action by the goal of benefiting or avoiding harm to the person whose preferences or actions are overridden.’ It could be seen as highly paternalistic to deny a trans patient the right to change their sex on demand in the medical record. However, does this notion that sex could be changed not also risk doctors placing themselves as the ‘loving parent with ... ignorant and fearful children’ (Beauchamp and Childress 2001, p. 178)? If doctors believe that sex and gender identity are distinct, that both are relevant in healthcare, but policy conflates the two concepts, could the GMC advice be viewed similarly to the practice of non-disclosure, not wanting to harm a patient with words or a reality they may find distressing? Another aspect
of paternalism to consider: if there are multiple members of society who do not hold the view that humans can change sex, are doctors potentially overriding their beliefs by implying humans can, or assuming that the general public would be too ignorant to understand the knowledge of the medical profession in this matter?

Attempting to obscure a patient’s sex is often unpractical. Siegler considered confidentiality to be a ‘decrepit concept’ (2006, p. 599), due to the increasing complexity of healthcare and number of persons who have justifiable access to a medical record. Gillon’s (2001) suggestion of a social contract when it comes to confidentiality, of explaining the nature of information sharing and justification for potential disclosures could be helpful also in the context of sex. Accidental disclosure of a trans person’s sex might happen in scenarios such as a nurse being asked to perform a urinary catheterisation or a laboratory phoning up to ask why a prostate-specific antigen test has been requested for bloods labelled female. In such examples, the good effect and intention to help the patient by changing their sex-marker may have been in vain, perhaps even causing otherwise unnecessary discussion of the patient’s gender identity.

Justice

Jack’s story

“It essentially makes a really life-saving kind of care dependant on your ability to be resilient, and to be prepared to go through something that I think a lot of patients don’t ever have to go through in terms of being vulnerable and being willing to have basic dignity and selfhood challenged,” he said. “And a lot of people can’t do that, a lot of people just can’t do it. They don’t go to the doctors any more, they stop going on care, they self-medicate, or they self-harm, or they experience suicidal ideation and that is often where we as advocates actually have to step in and unfortunately not enough people know that advocacy is an option”. (Davis 2019)

The notion of justice is rooted in the requirement to treat equals equally and unequals unequally, in Beauchamp and Childress’s formulation, distributive justice refers to ‘fair, equitable and appropriate distribution determined by justified norms that structure the terms of social cooperation’ (2001, p. 226). The principle of justice incorporates multiple approaches: utilitarian theories promoting the greatest public good, libertarian theories focusing on rights to personal liberty and fair process, communitarian theories deriving from practices of justice in a community, and egalitarian theories promoting equal access (Beauchamp and Childress 2001, p. 230).

From Jack’s story we are reminded of the vulnerabilities trans patients confront, and the burden when accessing healthcare. Trans patients face inequality. Obeying the principle of justice means that specific accommodations ought to be made. Undoubtedly, trans patients should be given the ability to flourish like other members of society. Central to this is healthcare.

The GMC advice that trans patients ought to change their sex in the medical records might be considered appropriate justice on egalitarian grounds: an accommodation devised to correct for life’s lottery of being trans, promoting equal
opportunity for such patients. Perhaps, on an individual level, this is felt to be a just solution by some, or even many, trans patients. However, trans patients face problems even after altering their record, which in some sense means they may still be treated less favourably. The case of the trans man needing to remember to book in for cervical screening after changing sex-marker means he accepts extra burdens than other members of the female sex. There is also the question of gender identities that cannot be adequately described using a male/female system, and how to document those in clinical records. One should also consider ‘passing’ (Stonewall 2017), whereby the biological sex of some trans patients is harder to immediately detect yet other patients are more noticeably trans. It appears morally dubious to have a system where some trans patients might be treated more favourably than others just because of nuances in gender identity or physical appearance.

Considering this from a community angle, one might argue that this is a policy devised for and by trans people, which they consider to be morally good. Without a coherent account of exactly how the advice was devised, including what stakeholders were consulted, this is hypothetical. We may also be missing the views of the community tasked with putting guidelines into practice: healthcare professionals, who should be given an opportunity to reflect on whether all implications have been duly considered.

A libertarian might ask about fair procedures, whether it is just to extend privileges to one specific group. There does not seem to be an absolute right for all patients to dictate what is written down or communicated in other areas of clinical practice, when it comes to observable facts. Counteracting the discrimination of trans people influences our deliberation on justice, yet mental health diagnoses may also still carry considerable societal shaming and psychiatric patients have historically been treated poorly. By such logic, perhaps a patient with a history of schizophrenia can also request all references to this diagnosis or treatment be deleted from their medical records. Elliot (2006) draws parallels between patients who desire amputation of a healthy limb and GD. Should patients with two arms be documented as having one, in order to alleviate their distress? The justification for why trans patients specifically should alter clinical facts in a medical record is unclear. If the rule is adjusted so that all patients may freely amend any facts they find unpleasant, clinicians might find themselves in a difficult situation of not knowing what parts of their documentation they can trust.

Doctors do make accommodations for certain patients to write information down separately or withhold facts from the medical record. An example may include omission of sexual orientation in a general clerking. Whilst non-inclusion of a fact is different to writing down a technically incorrect statement, a trans patient might point out such a discrepancy as evidence that sex should be treated in the same way. The comparison between disregarding sexual orientation versus a person’s sex in the medical record is therefore worth rebutting. Sexual orientation is rarely relevant when it comes to the medical understanding of a patient’s health needs. A patient’s biological sex, and what medications or surgery they have undergone, is often highly materially significant.
Using a utilitarian analysis from a healthcare systems perspective, the GMC advice raises concerns. The first is patient safety: if sex-markers ought not always reflect biology, and doctors must not ask about mismatches, it could lead to removal of one layer of safeguarding. Professionals might find it more difficult to detect genuine labelling, request, or prescription errors, if they are trained to assume that any misalignment between what is expected biologically and what is written down is nothing to worry about. The second is resource allocation: inappropriate testing or procedures. The third is information handling: an increase of uncertainty or inefficiency in communication. For example, if a patient’s imaging from another hospital needs to be accessed, are doctors permitted to ask about prior names and sex? Might doctors end up spending extra time and energy on piecing together the clinical history for a trans patient that they could have gained more efficiently? How does this affect what resources are available to other patients?

From a feminist approach, philosophers such as Reilly-Cooper (2016) and Stock (2019) argue the potential negative impact of including biological males who identify as women in a previously female-only space. When considering justice in healthcare, we should also concern ourselves with the safety, privacy, dignity, beliefs and comfort of other patients. If same-sex spaces are organised only around self-declared identity, how will we responsibly balance the respect for autonomy and material needs of all patients within that space, as well as protect vulnerable patients? The promotion of any policy that leads to effectively mixed-sex spaces must be carefully considered. Is it appropriate to put a physically completely male-appearing person in an open hospital bay, or locked psychiatric facility, with female patients who may get distressed by that prospect? A female patient requesting a healthcare provider of her own sex for a gynaecological procedure might become very upset if she is greeted by a clinician she perceives to be male, even if the practitioner identifies as a woman (Hellen 2017).

Reflection on scope and conclusion

The four principles are *prima facie*, morally binding unless they come into conflict with another principle; they are not a hierarchy, Gillon (1994) writes that reflection on the scope of each is needed. The principles have been examined in turn, but ought to be balanced: attempting to reach some conclusion as to overall moral aspects of the GMC advice. I could not see any tensions between the principles in this case. In analyses of respect for autonomy, nonmaleficence, beneficence, and justice, all four principles appear to highlight potentially troublesome issues. I find the GMC position perplexing, potentially disruptive to patients and practicing doctors who aim to deliver excellent, compassionate, quality care.

It seems one solution might be to come up with a compromise position, whereby gender identity and sex could both be accurately documented and medically acknowledged, alongside other relevant facts such as surgery or hormones. The underlying issue seems to be one of stigma, a problem needing specific effort to tackle.
Endorsing a system that denies a trans patients’ biological sex seems the wrong way to solve misunderstandings, as it may lead to more confusion, poorer healthcare outcomes, and frustration on behalf of both doctors and patients. A way forward should be sought where we encourage more open dialogue about what is desired by trans patients, what is medically sound, and what is realistically achievable from healthcare systems. Slowly, we might move towards a place where doctors might quickly glance at a patient’s records, see sex and gender identity incongruence, and think it largely as interesting as whether a patient is diabetic. Trans patients ought to be treated with medical comprehension of their specific needs and the dignity they deserve. I am not convinced the GMC advice, although likely well-intentioned, adequately achieves this goal.

Disclosure statement
No potential conflict of interest was reported by the author.

References

Notes on contributor
Sara Dahlen is currently an MSc Student at King’s College London. This work was originally produced as a dissertation for the Diploma in the Philosophy of Medicine convened by the Worshipful Society of Apothecaries, London.