Transpire Southend

The Impact of Shared Care Agreements on Medical Discrimination Contributing to Health Inequalities for Transgender and Gender Diverse Patients

Initial Exploration

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Introduction

Transgender and gender-diverse (TGD) patients in the east of England face growing uncertainty under shared care agreements (SCAs). Between June 2025 and August 2025, Transpire Southend has collated information relating to the experiences of being under an SCA through informal workshops, interviews, and questionnaires.

Throughout, TGD individuals and their carers voiced pervasive anxiety about engaging with general practitioners due to the perceived fragility of SCAs and the potential for them to be rescinded at any time and without recourse. These first-hand accounts suggest that SCAs – intended to bridge specialist gender clinics and primary care – may instead amplify barriers to essential treatment.

Emerging literature on Gender-Related Medical Misattribution and Invasive Questioning (GRMMIQ), often known colloquially as “Trans Broken Arm Syndrome”, highlights how bias-driven assumptions by healthcare providers can derail routine care for TGD patients. Yet little is known about how the fragility of SCAs interacts with such discriminatory practices to produce health inequalities. This gap underscores the need for an initial exploratory study that systematically maps patient experiences and identifies critical points of failure in current protocols.

This article undertakes a simple thematic analysis of anonymised quotes collected during these three months. This data is presented in an anonymised aggregate format with the hope that the themes identified here will prompt further detailed research into this area.

We have identified five key themes for further research: access barriers, the precarious nature of SCAs, stigmatising clinical practices, secondary harms and intersectional risks, and calls for structural reform.

Findings

1. Access Barriers

- Participants frequently experienced GPs declining to prescribe HRT or provide monitoring blood tests because they “are not experts”, even when the individual was under the care of an NHS GIC, effectively cutting off all gender healthcare access.
- There was a general sense that GPs claim a lack of expertise even when this is not necessarily the case: for instance, some people having SCAs at the same practices that refused others, or practices that provided HRT for cisgender patients only.
- Geographical inequities leave no alternative practices when local GPs refuse SCA, with no pathway to register remotely or out-of-area.
- Prolonged GIC waitlists (of up to five years) force reliance on costly private assessments that may still not secure shared care.
- Long waiting lists and a refusal of treatment by primary care providers lead some participants to use DIY transgender hormone therapy when private options are not financially accessible. DIY refers to the phenomenon where TGD people obtain and self-administer medication as part of their gender transition, without the guidance of a licensed medical professional. The legality and risks of this vary.
- Many who were using DIY options found that healthcare providers refused to administer additional screening or monitoring to mitigate the risk factors of DIY options, as part of a recommended harm reduction strategy. In incidences where complications were experienced related to DIY approaches, participants found that there was a refusal from healthcare providers to provide care for harmful side effects, even including pain management. Participants felt that they were expected to “deal with the consequences” by themselves.
- Participants who were under an SCA often spoke of feeling “lucky”, often only achieving these SCA through the intervention of individual healthcare professionals who had the expertise to advocate for them.

2. Precariousness of Shared Care Agreements

- Participants reported experiencing fear and anxiety every time they put in a repeat prescription request, often feeling that they were expected to “prove” their trans identity repeatedly.
- Participants reported high levels of anxiety due to the risk that SCA could be unilaterally rescinded at any time, creating ongoing risk of abrupt treatment cessation.
- The fragility of these agreements deters patients from seeking additional medical support, even in areas unrelated to trans healthcare, for fear of losing HRT access.

- If an SCA is stopped, patients experience complete abandonment with no fallback option, sometimes losing access to care for years, even after having been on HRT and stabilised for decades prior.
- Fear of jeopardising SCAs leads individuals to avoid other NHS services, especially mental health and neurodiversity assessments.
- The absence of a seamless handover between private diagnosis, GPs, and GIC exacerbates health risks across the patient's life.
- The fragility of SCAs resulted in participants being unwilling, or unable, to leave their GP surgery, even after moving out of the area. Some reported having a GP surgery several hours away as a result.

3. Stigmatising Practices and Misdiagnosis

- Gender-related healthcare often involved invasive multi-appointment assessments and social worker interviews, which participants likened to conversion therapy and found traumatising.
- Misdiagnoses from primary care providers not understanding the term gender dysphoria (e.g., confusing it with other clinical terms, such as body dysmorphia, dissociative identity disorder, or disorders of sexual development) caused wrong referrals and further delays.
- Denials of healthcare rooted in GPs personal beliefs – including religious objections – undermined impartial care, with no recourse available.
- There was a prevalent belief that healthcare providers might “punish” patients by withholding or rescinding SCAs.

4. Secondary Harms and Intersectional Risks

- Mental health treatment is often avoided out of fear that it will threaten the SCA and continuity of HRT, leaving comorbid needs unaddressed.
- Some withdraw from autism or other diagnostic pathways out of fear it will impact SCA and gender care continuity.
- Untreated intersex variations or hormone deficiencies carry real medical dangers when following up becomes impossible. Some participants reported being left without any HRT, even when they no longer naturally produced hormones, leading to significant medical risks.

5. Demand for Structural Reforms and Advocacy

- Participants spoke of the need for independent advocacy services to navigate SCA refusals and register with supportive practices.
- Participants suggested the need for robust GP accreditation and training programs that screen out bias-driven practitioners.
- Participants suggested the need for out-of-area or remote GP registration to ensure geographic choice for SCAs.
- Participants spoke of the need for stronger SCA protocols that guarantee uninterrupted treatment and clear appeal routes.

Interpretation of Core Themes

- Participants’ accounts underscore a cycle of exclusion and anxiety.
- Access barriers arise when GPs decline routine prescriptions or monitoring, forcing reliance on costly private care or DIY hormone use – in some cases leading to abandonment of treatment altogether.
- The precariousness of SCAs manifests as chronic fear that agreements can be rescinded without recourse, deterring patients from seeking any NHS service, even unrelated to gender healthcare.
- Stigmatising practices, from invasive questioning to outright misdiagnoses, compound distrust and delay essential interventions.
- Secondary harms include untreated comorbidities, withdrawal from mental health and neurodiversity pathways, and life-threatening gaps of care for intersex individuals.
- Calls for structural reform highlight the need for clear protocols, oversight, and independent advocacy to safeguard TGD patients’ right to equitable care.

Additional Literature: Gender-related Medical Misattribution and Invasive Questioning (GRMMIQ)

GRMMIQ is an academic term defined by researchers in the Virginia Commonwealth University's (VCU's) Department of Psychology as:

> *"a form of medical discrimination faced by transgender and gender diverse (TGD) patients wherein a provider incorrectly assumes that a medical condition results from a patient's gender identity or medical transition. This phenomenon may take one of two forms: (1) the incorrect and explicit misattribution of gender identity or medical transition as being the cause of an acute complaint, or (2) invasive and unnecessary questions regarding a patient's gender identity or gender transition status.[1]"*

It is a term often colloquially referred to as "Trans Broken Arm Syndrome", which was coined by Naith Payton in a 2015 article for Pink News[2] who described the issues of TGD patient's concerns being automatically dismissed as a result of their transition without any further investigations into the underlying cause, even including broken arms.

Payton states that "*Trans Broken Arm Syndrome stems from a failure by health professionals to recognise that trans patients can have the same general health needs as any of the rest of us."*[3]

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[1] Wall, C. S. J., Patev, A. J., & Benotsch, E. G. (2023). Trans broken arm syndrome: A mixed-methods exploration of gender-related medical misattribution and invasive questioning. *Social science & medicine (1982)*, *320*, 115748. https://doi.org/10.1016/j.socscimed.2023.115748

[2] Payton, N. (2015, July 9). *Feature: The dangers of trans broken arm syndrome*. PinkNews. https://www.thepinknews.com/2015/07/09/feature-the-dangers-of-trans-broken-arm-syndrome/

[3] Coughlan, S. (2021, September 28). *Trans healthcare & broken arm syndrome: Why trans people fear going to the doctor*. Refinery29 UK. https://www.refinery29.com/en-gb/2021/09/10577670/trans-healthcare-broken-arm-syndrome

It is well documented that TGD patients experience worsened health outcomes,[4] [5] and that they often have a harder time accessing appropriate healthcare due to such medical discrimination.[6] [7]

We believe that Trans Broken Arm Syndrome also contributes to the false belief that any healthcare involving TGD patients is highly complex, niche, and beyond the general competencies of a GP, with research demonstrating that TGD patients are often denied access to treatment because of the belief from care providers that "'*this is too complicated for us. We need to pass this on to somebody else. You find a lot of trans people are passed from pillar to post.'*"[8]

When SCAs hinge on the GP believing they have the expertise to take on the care, this medical discrimination is likely leading to higher rates of SCA refusal, even when a GP would have the relevant competences to provide treatment.

We also believe that this medical discrimination contributes to the fear and anxiety that any healthcare sought by TGD patients will be seen through the lens of transgender healthcare, and will thus impact upon access to gender healthcare, even when the issues are unrelated.

We believe that the fragile nature of SCAs exacerbates these issues further, and results in health inequalities for TGD patients and worsened health outcomes. This is aggravated by the lack of recourse available when a GP refuses care, even when the refusal stems from anti-trans bias.

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[4] Vanderbilt University Medical Center. (n.d.). *Key transgender health concerns*. Program for LGBTQ Health. https://www.vumc.org/lgbtq/key-transgender-health-concerns

[5] Winter, S., Diamond, M., Green, J., Karasic, D., Reed, T., Whittle, S., & Wylie, K. (2016). *Transgender people: Health at the margins of society*. *The Lancet, 388*(10042), 390–400. https://doi.org/10.1016/S0140-6736(16)00683-8

[6] Hansford, A. (2025, May 21). *What is 'trans broken arm syndrome' and how can we help stop it?* PinkNews. https://www.thepinknews.com/2025/05/21/trans-broken-arm-syndrome-explainer/

[7] London Assembly Health Committee. (2022, February 25). *Trans health matters: Improving access to healthcare for trans and gender-diverse Londoners*. Greater London Authority. https://www.london.gov.uk/sites/default/files/health_committee_-_report_-_trans_health_matters.pdf

[8] House of Commons Women and Equalities Committee. (2016, January 14). *Transgender equality: First report of session 2015–16* (HC 390). UK Parliament. https://publications.parliament.uk/pa/cm201516/cmselect/cmwomeq/390/390.pdf

Policy and Practice Implications

Current Shared Care Agreement (SCA) protocols lack oversight, transparency, and appeal mechanisms. The precariousness of these agreements make TGD patients susceptible to prejudice from healthcare providers, and contributes to health inequalities and worsened outcomes for TGD patients. Without structural reform, the NHS risks increased DIY hormone use, longer waiting lists, and increased burden on all healthcare services.

1. Strengthen Shared Care Agreements

- Produce a simple guide for GPs and patients that explains, step by step, how shared care works, who's responsible for what, and how continuity of care can be achieved if their local GP lacks the relevant expertise.
- Encourage GPs to accept SCAs through providing additional training and incentives, and ensure that they take responsibility for ensuring the patient has continuity of care if they refuse or rescind an SCA.
- Encourage the acceptance of SCAs from private care providers who also work within the NHS, such as Gendercare, when waiting lists go beyond the 18-week NHS waiting time.

2. Mandatory Trans-Health Training for GPs

- Introduce a concise training module on TGD patient care and GRMMIQ awareness.
- Include trans+ representatives on primary care and equality boards to co-design training modules and SCA protocols.

3. Establish a Clear Appeal Process

- Implement an online appeal form at all practices when SCAs are refused or rescinded, with a 10-day response commitment and escalation to the ICB where appropriate.
- Establish a single point of contact to support appeals, register complaints, and navigate GP options for SCAs for TGD patients.
- Produce accessible leaflets/webpages detailing SCA rights, advocacy contacts, and registration routes.

4. Ensure Continuity of Care

- Pilot a “virtual practice” allowing patients to renew prescriptions online or register outside their postcode.
- Ensure that a general health provider can not suddenly stop a SCA unless the patient has an alternative way to continue receiving their prescriptions.

Strengths and Limitations

The strengths of this exploration includes leveraging rich, anonymised workshop data to surface emergent issues, and prioritising lived experience in theme development. However, limitations must be acknowledged:

- Some data was incidental to community workshops based on other themes, so SCA concerns were not systematically elicited.
- Summarised comments and self-selection bias may limit the depth and representativeness of insights.
- Findings are region-specific and may not generalise across the UK or internationally.
- The author is not a formally trained researcher; this analysis reflects an advocacy-driven perspective rather than academic methodology, which may introduce interpretive bias and limit the depth of empirical validation. More research is needed.

Future Research Directions

Building on this exploratory analysis, future work should:

- Conduct mixed-method studies to analyse these initial findings in more depth and with more academic rigour to provide further empirical evidence on the impact of SCAs on medical discrimination for TGD patients.
- Conduct mixed-method studies to quantify the prevalence of SCA rescission, refusal, and correlated impacts on health and wellbeing outcomes.
- Compare regions with differing SCA protocols to identify best practices and pitfalls.
- Evaluate the effectiveness of targeted reforms – such as appeal portals and remote GP models – through pilot programs and user feedback.
- Undertake longitudinal tracking of health outcomes for TGD patients under SCA frameworks.

Through a combination of empirical evaluation and co-produced policy design, research can guide sustainable reforms that protect TGD patients from discrimination and ensure equitable, uninterrupted care.