

# A Basis for Evaluating Care Approaches and Services for Trans People in the UK

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## *Introduction*

This document defines a set of generalised criteria by which care services for transsexual people, and their underlying governance protocols, can be evaluated against contemporary healthcare principles and in terms of acceptability to the client group.

As explained below, the history of the way in which services for transsexual people came into being and have been governed has tended to muddy the waters in terms of understanding whether ways of working are reasonable or not.

Three key factors have changed in recent years:

- ❖ Society has evolved a far more understanding and accepting attitude towards transsexual people, culminating in several changes to the law in recent years
- ❖ Healthcare philosophy has transformed in the last decade particularly, with significant emphasis on evidence-based medicine, patient-centred care, and a sea change in the relationship between doctor and patient. The latter is now characteristically described in terms of the equal partnership of provider and informed service user
- ❖ Transsexual people have also become more self-aware and demanding of treatment standards which match contemporary norms in other areas

Proposals for the overhaul of care services in this area are only just being considered, yet it has long been clear that providers and service users both need some overall points of reference to refer to when debating change. That is what this document's lists of seven fundamental principles and seven tests seeks to provide.

Most of the ideas are not uniquely trans-related. In fact they are drawn from contemporary references such as the Government's "Valuing People" white paper, the "Changing the Balance of Power" vision for the NHS, and principles which run throughout legislation such as the Care Standards Act 2000 and the Mental Health Bill of 2004.

The terms used are familiar in other care contexts – accessibility, appropriateness, choice, timeliness, autonomy, independence, privacy, dignity, empowerment and respect for individuality.

Often the history of treatment services for transsexual people has been deficient in some (if not most) of these areas. In particular, there is a danger of doing things in a particular way because "that's how they are done". It is easy to forget the historical reasons for past ways of working and the ways in which the world has changed. A point of reference is therefore needed for sense checking both governance proposals and existing services, so that evaluation can be anchored in modern thinking.

In arranging these concepts into principles and tests relating to transsexual people's care, the author has therefore sought to define an up-to-date and inherently sound means of "sense checking" ideas.

## Historical Context

Healthcare and related services catering for the needs of transsexual people have evolved very little during the fifty years since Harry Benjamin first described the phenomenon which he labelled “transsexuality”.

Although there is ample historical and anthropological evidence that gender variant people have existed throughout recorded history and are to be found in every culture around the world, Western medical treatments were defined at a point in time where transsexual people were perceived by society to be sick and perverted.

Whilst many practitioners rapidly came to realise that gender variance was an innate characteristic, there was a shared presumption by physicians and clients alike that medical assistance in transition (as opposed to deterrence) was something that wider society would scorn. This wariness of public opinion and potential disapproval for caring strategies led to the received wisdom that patients should keep their heads down, and that people should be grateful for what they got. The consequence of this belief was the idea that transsexual people should accept the unusually defensive and restrictive terms and conditions which surgeons and psychiatrists stipulated as a condition for sticking their necks out for the patient.

The result of this history is not only an enduring “sickness” model for the phenomenon of being gender atypical but also the retention of an anachronistic power relationship between people seeking medical assistance to transition between gender roles and those holding the keys.

Nobody has ever *actually* needed permission in order to undertake a process of gender transition. Although gender crossing behaviour has in the past been criminalised in some sections of Western Society it has certainly not been *illegal* in Britain for decades. Insofar as transition can be accomplished without hormonal or surgical interventions, *anyone* can change their name, the hairstyle and clothes they wear and a range of official documents without needing “diagnosis” or permission.

Unlike almost any other self-initiated major life change, transsexual people do however reach a point where the assistance of medical technology is desired to optimise the outcome. Administration of sex hormones is desired to bring about bodily changes to match expectations that accompany the gender role. Surgery is often sought in order to take the process further and mould the primary and secondary sexual characteristics to the desired appearance and function.

The only major life event that equates with this patient-led desire for medical support and collaboration is the process of carrying a foetus from conception to birth. Being pregnant is not an illness and permission is not required to start. Some doctors and commentators behave as though they believe otherwise on both counts. That does not make them right, however. Becoming pregnant is not a reason to set aside the principle of patient autonomy. The same is true of seeking medical assistance to express one’s gender identity.

Both examples of engagement with care services have historically suffered from the same problem – that physicians are generally uncomfortable with inversion of the power tradition in which they have been raised and trained. It is an arrangement that traditionally places the doctor in the position of power and the patient in the role of compliance.

## The “Patient Centred Care” Context

*(Thanks are due to Dr Stephen Whittle OBE for the contribution of this section)*

One overarching theme throughout the NHS plans for improvement is patient centred care (PCC). The reasons for promoting PCC are based upon research results which indicate that

*“patient-centred care results in increased adherence to management protocols, reduced morbidity and improved quality of life for patients.”<sup>1</sup>*

The core principle of PCC is that it is

*“about sharing the management of an illness between patient and doctor (which requires joint participation in) shared goal setting, written management plans and regular follow-up.”<sup>2</sup>*

In order for the approach to be successful there is a need for

*“Supportive community-based services and programs, combined with healthcare system commitment”<sup>3</sup>*

According to Moira Stewart

*“Patients want patient centred care (PCC) which*

- 1. explores the patients' main reason for the visit, concerns, and need for information;*
- 2. seeks an integrated understanding of the patients' world that is, their whole person, emotional needs, and life issues;*
- 3. finds common ground on what the problem is and mutually agrees on management;*
- 4. enhances prevention and health promotion; and*
- 5. enhances the continuing relationship between the patient and the doctor<sup>4</sup>*

However, putting PCC into practice requires translating this broad framework into systematic approaches to health care policy, strategy and consequent provision.

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<sup>1</sup> Adrian E Bauman, H John Fardy and Peter G Harris (2003) *The Medical Journal of Australia*, [http://www.mja.com.au/public/issues/179\\_05\\_010903/bau10856\\_fm.html](http://www.mja.com.au/public/issues/179_05_010903/bau10856_fm.html) acc: 24/06/05

<sup>2</sup> Adrian E Bauman, H John Fardy and Peter G Harris (2003) *The Medical Journal of Australia*, [http://www.mja.com.au/public/issues/179\\_05\\_010903/bau10856\\_fm.html](http://www.mja.com.au/public/issues/179_05_010903/bau10856_fm.html) acc: 24/06/05

<sup>3</sup> Adrian E Bauman, H John Fardy and Peter G Harris (2003) *The Medical Journal of Australia*, [http://www.mja.com.au/public/issues/179\\_05\\_010903/bau10856\\_fm.html](http://www.mja.com.au/public/issues/179_05_010903/bau10856_fm.html) acc: 24/06/05

<sup>4</sup> Moira Stewart (2001) Towards a global definition of patient centred care, *BMJ* 322:444-445 ( 24 February )

*"Patient-centred care has various definitions, but three elements are important: communication with patients; partnerships; and a focus beyond specific conditions, on health promotion and healthy lifestyles."*<sup>5</sup>

However PCC is not without problems, as Bauman et al say

*"Patient autonomy can be a two-edged sword. Occasionally, a fully informed and empowered patient may decide to take risks or not to adhere to management guidelines. This concept of "fully informed choice" may sometimes frustrate the clinician. Nonetheless, patient-centred partnerships are still warranted and will result in a net population health benefit."*<sup>6</sup>

and PCC can be burdensome in that it is necessary to be realistic about the resources available and their allocation<sup>7</sup>

Despite the potential problem areas, the NHS Improvement plan is committed to developing a PCC-led NHS. However, it does set out areas which offer safeguards and to which there must be a commitment to meeting standards. The "National Standards, Local Action" document sets out seven domains of care which touch all aspects of patients' needs:

- ❖ *safety*
- ❖ *clinical and cost effectiveness*
- ❖ *governance*
- ❖ *patient focus*
- ❖ *accessible and responsive care*
- ❖ *care environment and amenities*
- ❖ *public health.*"<sup>8</sup>

Accordingly:

*"In order to be patient-led, the NHS will develop new service models which build on current experience and innovation to:*

- ❖ *give patients more choice and control wherever possible*

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<sup>5</sup> Little P, Everitt H, Williamson I, et al. Preferences of patients for patient centred approach to consultation in primary care: observational study. *BMJ* 2001; 284: 468-472.

<sup>6</sup> Adrian E Bauman, H John Fardy and Peter G Harris (2003) *The Medical Journal of Australia*, [http://www.mja.com.au/public/issues/179\\_05\\_010903/bau10856\\_fm.html](http://www.mja.com.au/public/issues/179_05_010903/bau10856_fm.html) acc: 24/06/05

<sup>7</sup> Moira Stewart, Judith Belle Brown, W.Wayne Weston, Ian R.McWhinney, Carol L. McWilliam, Thomas R. Freeman ( 2003) " Patient-centered Medicine: Transforming the Clinical Method", Radcliffe Medical Press Ltd

<sup>8</sup> DH/NHS, (2005) *Creating a Patient-led NHS - Delivering the NHS Improvement Plan*, Department of Health, p 10

- ❖ *offer integrated networks for emergency, urgent and specialist care to ensure that everyone throughout the country has access to safe, high quality care*
- ❖ *make sure that all services and all parts of the NHS contribute to health promotion, protection and improvement.*

*A(s such a) patient-led service will require new ways of delivering services that are responsive to patients:*

- ❖ *fast, convenient services, often delivered very locally and shaped around people's needs and preferences*
- ❖ *high quality, integrated emergency, urgent and specialist services for patients wherever they are in the country.*<sup>9</sup>

Thus when considering the development of PCC services for patients who present with gender dysphoria (of whatever type and intensity) we can conclude that the principles of PCC led services will ensure that:

**Services should be:**

❖ **Accessible i.e.**

- *Locally available wherever possible*
- *Provided at primary care level*

❖ **Appropriate**

- *High quality*
- *Preferably integrated*
- *Contributing to overall health promotion, protection and improvement for the patient*

❖ **Recognising the diversity of patients, their needs and their choices i.e.**

- *Patient focused*
- *Responsive to individual patient needs*
- *Promoting the overall health of the patient rather than specific treatments*

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<sup>9</sup> DH/NHS, (2005) Creating a Patient-led NHS - Delivering the NHS Improvement Plan, Department of Health, p 13

## Seven Fundamental Concepts – A Manifesto for Care

An understanding of the history leads to an appreciation of the fundamental ways in which transsexual people seek to promote a change of underlying emphasis in the underpinning of care services. This is a statement of expectation from a service user perspective.

### 1. Not Sick But Different

Researchers have tried for many years to determine a “cause” for people expressing cross-gender identification and wishing to live their lives accordingly. Such searches have led to some interesting insights into how it is *possible* that people can feel and identify in this way. This is no different to understanding how people can be short or tall, light or dark skinned – or just “different” in any other way. In examining all of these parameters, it is understood (in medicine if not universally in society) that no characteristics in nature are strictly binary; all are infinitely variable. So it is with gender and sex:

To be differently gendered is not itself a flaw. The flaw lies in the assumption that sex and its relation to gender should be a unique exception to nature’s otherwise universal principle of diversity.

Transsexual People therefore seek the reflection of this understanding in the way that approaches towards care are conceived and described. It can be summarised thus:

**Gender Variance is not an illness but a natural form of variation in humankind which is only conceived as a problem when it is incorrectly assumed that sex and gender are strictly binary.**

### 2. Different Ways To Be Different

From this it also follows that it is wrong to approach transsexual people as though they are homogeneous as a group. People may experience and conceptualise their gender variance in different ways. Some may look upon their difference as something they wish to be rid of or “saved” from. Others may look for help in accommodating their feelings without making major changes to their lives. A proportion of people may look for help in discovering how they really *do* feel, and to explore options with the benefit of impartial advice. A further group may have worked out such questions for themselves already, with or without assistance, and simply know what they want to do and merely seek medical help to realise their goals.

It may be tempting for researchers to try to simplify people into categories for the purposes of study and statistical analysis; however it is important to differentiate this from the goal of good care, which should be to treat each person as a unique individual, with different needs and an essential stake in meeting them. Putting individuals into one box (“transsexual”) or a set of boxes (“Type 1”, “Type 2”, etc...) is no more scientific than labelling all patients as “Tall” or “Short”. Dictating a care pathway on the basis of such reductive taxonomies is an abuse of the patient’s rights to be viewed and treated as an individual with responsibility for their own destiny.

**Transsexual People do not wish to be labelled or categorised but to be respected and treated as individuals whose care pathway will always need to be individually tailored. It follows that the individual must be at least equal in the process of determining that pathway. Service users need to be empowered to achieve autonomy and to be offered real choices so as to achieve independence and maintain responsibility for those choices.**

### 3. Help To “Be”, Rather Than to “Not Be”

Some people may express the desire to be “cured” of their cross-gendered feelings. In these circumstances, practitioners must be honest in their evaluation of the likelihood of achieving this goal, and of their capabilities to offer that.

The majority of service users are not seeking to be changed from who they are but are looking for the means to be at peace with their feelings, in whatever form that accommodation may take within themselves and within society. As explained above, the means of achieving that goal may be as unique as the individual. The goal should be to help individuals, if they so desire, to explore any options they have not already considered and rejected. This is a normal part of empowerment. The emphasis must be upon respect for the individual’s right to determine which path to take. The care provider’s role is not to seek to normalise the individual or pathologise their process of discovery by labelling the service user’s difference as an illness.

**Unless there is clear evidence of a mental impairment serious enough to affect the individual’s ability to make informed decisions and assume full responsibility for outcome(s) there can be no place for any approach which seeks to impose a specific regime of compliance or an unwanted course of treatment on a service user seeking help with gender issues.**

### 4. Autonomy and Independence Requires Choice

None of the foregoing fundamentals can be realistically offered or achieved unless the individual has access to meaningful choices.

Choice in this context operates on two levels:

- ❖ Service users require access to informed and impartial advice from which they can achieve the knowledge necessary to make meaningful choices. This form of choice leads to the *empowerment* of the individual to make further informed choices and *to take responsibility* for them.
- ❖ Service users also require access to a diverse range of services capable of providing (and permitting them to follow) those options.

It is recognised that some providers may have particular specialist approaches which they favour. Some may wish to pursue approaches which remain grounded in a traditional approach to treatment and a dirigiste approach to service user compliance. Some service users may favour this too and it is not the goal for standards of care to replace one sort of rigidity by another.

For those service users who wish to learn about and pursue other approaches, however, it must be possible for a range of services to exist, and for individuals to have the option to choose from a range of options in accordance with contemporary NHS policy.

**Standards of Care, local (PCT) commissioning policies and the operation of individual services must not (directly or indirectly) deny service users the ability to access a range of accessible choices for how and where to receive professional help. Standards of Care must also be flexible enough to permit different service approaches to flourish subject only to normal regulatory standards for quality.**

## **5. Where Care Begins and Ends, Succeeds and Fails**

The traditional model of “treating” people with gender issues has assumed that the process, once embarked upon, has only one goal and one way in which to get there..

Whereas the individual should be thinking in terms of facilitating a major and enduring life change and seeking help with that, practitioner’s appear instead to have been focussed upon specific stages where they perceive risk and want to mitigate that for themselves. This is why many successive revisions of the Harry Benjamin “Standards of Care” have been principally been accused of caring for the practitioner to the detriment of the client.

Thinking only in terms of genital surgery and upon getting to that point is unhealthy for all concerned. Such thinking ignores the whole person, and the essence of what they were seeking help to achieve. Surgery-led goals lead to the assumption that the means is the end – that the seat of desire for transsexual people is to be rid of (or obtain) certain body parts, rather than to lead an enduringly happy life as a complete person. The logical failing in that line of reasoning is that one or both parties may also see no purpose in continuing a therapeutic relationship after surgery has been achieved.

**The proper goal for care services designed to help transsexual people should be to assist the individual to successfully navigate all the stages of change and adjustment necessary to achieve a comfortable and sustainably happy life for themselves. Procedures such as hormone administration and surgeries should be viewed by service user and provider alike as (optional) steps in the overall journey and not the goals. It follows that they should also occur at the appropriate time in a mutually agreed approach and not be unnecessarily delayed or withheld.**

**Above all, progression should never be offered as a reward or denied as a punishment for service users making autonomous choices. There is no specific end point in such a process (nor one specific starting point). Approaches that listen and respond to needs and aspirations will need (as always) to negotiate a mutual understanding about when the relationship should end, and how the disengagement should occur.**

## **6. Determining Responsibility – Achieving Partnership**

An unfortunate by-product of the past conservative and highly controlled approach to every stage of “traditional” treatment in this field is the removal of responsibility from the individual and its complete transfer onto the shoulders of the care provider.

The rationale for this approach has always been the disproportionate concern on the part of practitioners (surgeons especially) that people may come to regret and then seek to blame them for having provided the services they had sought.

The concern is disproportionate because similar concerns are not in evidence when almost identical treatments are offered in other circumstances. A woman may seek private cosmetic surgery to drastically reduce or remove breast tissue through surgeons who advertise these services but a transsexual man seeking essentially the same process as part of gender transition is required to provide one or more diagnoses of a condition that is still classified as a mental illness. It is only this insistence (and similar limits on provision of hormones) which require such men to submit to therapy in order to obtain the services they require. Similar provisions dictate the autonomous options for trans women.

There is nothing wrong in trying to persuade people that professional help might be able to help them in their quest. Relying upon indirect compulsion of this kind can never be an honest way to begin or form a partnership which requires mutual trust and respect however.

The paradox is that, by building a process of care provision which insists on such overriding control, practitioners are actually set up to bear the responsibility in the rare event that a client *does* feel regrets. It can be argued that, by taking away the obligation for the client to take responsibility for the process, the client has also been encouraged to place undue trust in the provider. Thus, if anything does go wrong it is clear whom they should blame.

This vicious circle is counter-productive in terms of all the aims of empowerment, autonomy, choice and responsibility which have been articulated before.

**Service users must be encouraged to take responsibility for decisions they have made with informed consent. Ways of working which disempower the user, or which remove responsibility from them in any way are not to be encouraged in care standards or practice.**

## **7. Second Opinions**

It follows from the above that the only person who should logically be seeking a second opinion for any stage in a process of this sort should be the person with the responsibility for the decision to be taken. Moreover, in that case, a second opinion must have specific goals.

When traditional practitioners have sought second opinions then it has always been unclear what kind of opinion they are being required to provide. Are they for instance seeking to confirm the diagnosis of a “condition” which mandates a particular “curative therapy”, or are they being asked whether the individual is sufficiently sane to give the normal form of informed consent?

In the former case there is a paradox. Gender practitioners generally insist that they need considerable time and familiarity to arrive at their “diagnosis”. The norm demanded of service users is at least 7-8 hours of face to face time spread over at least 12-24 months. It is hard to see how an equivalent second opinion can therefore be delivered on a complete stranger in a single hour.

If the question is one of competence to make an informed decision and to take responsibility for it then this also contradicts contemporary practice in other areas. It is increasingly accepted that merely thinking a person’s decision is ill-advised is not sufficient reason to prevent them from doing it.

**Second opinions should be for the benefit of the service user as opposed to the provider. They should have clearly stated objectives so that everyone is clear about the purpose. The purpose should not be to protect practitioners to any greater extent than normally provided through consent forms. If the provider genuinely feels in an individual case that the service user is incapable of giving informed consent then they should state this.**

## Seven Practical Tests

These seven tests are an alternative but complementary way of assessing both care standards and actual services, seen from the perspective of contemporary quality and outcome expectations across the modern health service.

### 1. Accessibility

**Do standards of care have due regard to enabling people to take advantage of services close to where they live?**

**Do services have rules that prevent users from being able to gain physical or financial access to the expertise they offer?**

**Do funders have procurement principles which make all or parts of a service inaccessible unless the user pays themselves?**

**Do standards of care and funders operate in a way that enables service users to access the best available expertise, whether part of the NHS or not?**

Accessibility is the most important of all the healthcare principles for transsexual people. Above all services must ensure (and governance standards must require) that appropriately qualified service providers are both physically and financially accessible to the individual concerned.

Trans people should not have to travel exceptional distances to access the specialist services they need. So far as possible (having regard to the exercise of choice and the availability of appropriate expertise) services making up a complete programme should be available locally and other practitioners involved in the overall programme must be prepared to work in ways that enable access to local provision.

### 2. Timeliness

**Do service users need to wait excessive time for an initial consultation, or between consultations?**

**Do waiting lists for specific services prolong the overall treatment to a degree that harms or distresses the service user?**

**Do standards of care base their recommendations for the timing or duration of treatment stages on the service user's own circumstances?**

Services must provide access to consultation and treatment within timescales that are considered at the time to be reasonable for other publicly funded healthcare.

Timeliness applies in particular to initial consultation, the frequency and spacing of follow-up consultations and to the timing of other treatments deemed necessary to advance the overall care programme. Services and care standards must not artificially delay the start or prolong the overall duration of the complete treatment through rules or ways of working that prevent timely provision of a particular stage.

### 3. Empowerment, and Choice

**Do services operate in ways that lead to empowerment of service users and encourage them to make informed choices for which they take full independent responsibility?**

**Do standards of care support independence and the exercise of informed choice on the part of such empowered individuals?**

**Do both services and standards of care contain rules that effectively limit choice?**

The idea of empowering people to make informed choices about their own healthcare is a strong principle within modern healthcare thinking. It is embodied throughout current health and social care legislation. It is strongly emphasised for people who have not been traditionally thought able to be offered choices of their own, such as children, and adults with learning difficulties or mental health problems.

Throughout contemporary legislation it is emphasised that people should be supported to make their own choices, even when carers consider the decision to be unwise. A high standard is set for overriding the individual's independence on grounds of mental incapacity.

Yet, traditionally, treatment for transsexual people has been based on principles of psychiatric control and decision-making.

The right for trans people to receive information which empowers their decision making and choice is therefore an essential principle to uphold in evaluating proposals to overhaul past practice. Above all, derogations from the principle have no place in standards of care. Any individual derogations from the principle of independence and choice must be justified on the same basis that would be required for any other kind of service user.

In considering choice, particular regard should be paid to rules or requirements which effectively limit or discourage flexibility. A service which only admits clients via a single entry point must, by definition, deny choice to users who may have already undergone other treatments elsewhere or who only wish to access a particular expertise there.

#### 4. Respect and Dignity

**Do services operate at all times in ways that maintain respect for service users and encourage others to do the same?**

**Do standards of care embody respect for the identity of the individual, including forms of address?**

**Do services or care standards operate in any way that compromises the dignity of the individual?**

Services offered for the care of people experiencing cross gender feelings and identification need to recognise that personal identity is a sensitive issue in such circumstances. Respect begins in acknowledgment of the way that people describe and experience their identity. The aim should not be to assign the individual a category or label that equates them with others, but to accord respect to the way in which the individual conceptualises themselves and wishes to be accepted.

The most obvious signs of respect lie in the use of chosen name(s), preferred pronouns and other aspects of address.

Services must equally be aware of the ways in which dignity (and therefore self esteem) is either enhanced or diminished.

Depriving an individual of their autonomy and independence or requiring them to meet conditions which expose them to derision from others can be ways of disregarding dignity. Listening and entering into equal partnerships of trust with individuals are ways of maintaining and promoting dignity.

#### 5. Equality and Partnership

**Do standards approach the relationship between the service users and providers from a perspective of equal partnership and trust?**

**Do services operate in a way that maximises partnership potential between all the parties involved in an individual's care, without compromising choice?**

The transition of an individual from one gender role to another is a big undertaking for anyone and may involve many different contributors towards success. Some of those parties may be non-specialised and can therefore be contracted locally. In order for a service user to be able to select the most appropriate specialist practitioners for

their needs, it may also be necessary for some services to be contracted at a distance. It is considered beneficial for all parties to work together in advising the client and to reinforce each other's contributions. Therefore it is essential for all parties involved in the process to be able to work in partnership, regardless of geographical boundaries.

Partnership must also be reflected in the relationships encouraged and achieved between the service user and everyone involved in care. See above (Respect and Dignity).

## 6. Autonomy and Independence

**Do standards for care place due emphasis on the independence and autonomy of the individual?**

**Do services also implement those standards in a way that meaningfully enables the exercise of autonomous decision making and independent action on the part of the service user?**

Autonomy refers to an individual's freedom of action and the ability to self-govern what they do. Independence refers to the ability to operate free from external control or influence

In terms of the past history of treatment with transsexual people, these are very important concepts without which many of the forgoing objectives are arguably unachievable.

Care services which are true to the spirit of maximising autonomous decision making will reflect this in the way they approach all dealings with service users. It involves a major shift in the care approach from "this is what you must do" to "what are your objectives and how would you like us to contribute towards achieving them?"

It is acknowledged that the service user may in some cases reply "I want you to *tell* me what I should do". However, as in all healthy counselling contracts, the professional is well advised not to fall into that trap too willingly. Down that road lies potential blame for the carer's part in the outcome. An emphasis on encouraging the user to take control is therefore not about the practitioner losing control, but about putting the relationship on a much more healthy footing, where partnership and trust may flourish, and where the service user has true responsibility.

## 7. The Right to Complain

**Do standards for care services deal with the issues of dissatisfaction and complaint?**

**Do services based on the standards have a clear and accessible complaints process?**

Having encouraged the principle that service users need to be able to take ultimate responsibility for the major decisions involving their life, it still remains necessary to ensure that practitioners remain accountable for the quality and technical proficiency of the services they've been asked to provide. It is by clarifying the boundaries of where everyone's responsibilities begin and end that people then know where they stand.