Travesty at the Tavistock?
Yes, but what does that say about the rest of us?

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The Tavistock Clinic's many years of providing gender reassignment to young people was initially vaunted as pioneering and profitable. But somehow that mission overstepped into a mire of contended personal damage and litigation. Apart from institutional culpability, what may this tell us about *us*, our society?

On 12th February the *Sunday Times Magazine* emblazoned its main feature: *The Travesty of the Tavistock*. This was gritty and important journalism, telling us how a previously steadfast and wise institution degenerated into something quite alien: seemingly hijacked by a zealous team whose mission was to expedite gender change in young people, the team lost its larger human and clinical sense. This report was a cogent account of the damage then done by the subsequent professional group-think – to both vulnerable young people and ensnared staff. Historically this story of welfare-service corruption and abuse is redolent of the earlier Rochdale child abuse and Mid Staffs scandals.

Documenting for public consumption what happened is a first step in moral and social responsibility, but alone does not help us understand how and why it happened. How and why did this previously august and careful institution go rogue?

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Like any shockingly bad news, the causes are here not simple or singular. As a frontline NHS doctor for fifty years, I witnessed many reciprocating and antecedent changes in our healthcare and broader culture. The following reflections may help us understand a little more this tragic – also ominous – debacle.

So here – briefly summarised and itemised – are some germs of explanation:

1. Medical language, diagnosis and treatments work most effectively and reliably with conditions that have a clear (ie unarguable) basis in anatomy or

pathophysiology. This is an important limitation, easily disregarded.

2. The further any distress-condition departs from this basis the less well these medical tools work. That is why all 'mental health' is so often resistant and unreliable in its response to medical regimes and approaches.

3. Nevertheless, largely because of the often spectacular success of physical medicine, we persist in unrealistic expectations: that this approach – the medical model – can produce similar reliable effectiveness in our *humanly* generated distress – for example, our disorders of behaviour, appetite, mood and impulse (BAMI) – our mental health.

4. This unrealism is further fuelled by the technology-dependent consumerism of our contemporary lives. Our culture has become, increasingly, one of speedy wish-gratification, pain-avoidance and packaged solutions. Our accompanying growth economies depend on stimulating dissatisfaction with what we have and what we are. Humanly complex problems of fantasy and desire for what we are not, or cannot have, become fodder for marketed 'solutions' and medical 'treatments'. Human predicaments become all-too-readily medicalised and medicated.

5. Other guises of our consumer culture have been our neoliberalism; our embrace of marketisation of all things, and then trickle-down economics. Our increasingly marketised NHS has become an important development and tool of these. This marketised NHS is now clearly vulnerable to the corruptions and follies of markets: to ensure survival, many services must often promptly and cannily spot and exploit societal trends, desires and anxieties and then design and package saleable remedies. This is now all but inevitable in commodified and marketised

healthcare.

6. The US healthcare system exemplars the unwisdom and profligacy – whether by whimsy or financial opportunism – of such commercialisation. Our pre-marketised NHS used to demonstrate well the greater medical, financial and human sense of not doing so. It is a serious error and misfortune that the NHS continues to emulate so many features of the US system.

7. Problems of sexual or gender confusion or identification are mostly those of imagination: what is 'not there'. Only rarely are they based on anatomical or pathophysiological anomalies. Such chimeric human problems are rarely satisfactorily clarified or solved by medically-modelled approaches and procedures.

8. Investing the Tavistock with the funding, faith and faux-authority to do this eventually reveals an Emperor-without-clothes. But it also reveals our wish to make such investments – to elevate and venerate designated 'experts' who will relieve us of our burdensome, frightening and often unfathomable human complexity and insatiable restlessness.

9. Such are the risks to our healthcare integrity and provision. All of this is amplified by a system that so directly rewards increasing intervention-activity and throughput. The Tavistock – in its financially contracted, so zealous, programme to increase numbers of young people to consider and undertake gender-change – was both perpetrator and victim to our marketised and commodified NHS.

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Yes, this certainly was a travesty at the Tavistock – an egregious fall from grace within, and of, our healthcare.

But we should also turn our gaze around: what does this tell us about ourselves and the agency we are prepared to accept and tolerate – or not – for our own complexity and discordance?

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