Letters to the editor

We welcome original letters of less than 300 words; we may edit them for clarity and length. Letters may be emailed to journal@doctorsofbc.ca, submitted online at bcmj.org/submit-letter, or sent through the post and must include your mailing address, telephone number, and email address. Please disclose any competing interests.

AccessBC: The case for no-cost contraception in British Columbia

"Doctor, can I have a Mirena IUD? I can't afford to get pregnant again," asked a postpartum patient who had multiple adverse conditions in pregnancy. "Of course, let's chat about it," I replied. "You don't understand, my OB said she might be able to get me one for free."

It quickly became apparent that the issue was not obtaining a prescription or finding a provider for insertion, it was cost. She told me that she was a single mother and could not afford the roughly $400 cost, that other contraceptives had proved intolerable, that her private insurance had denied her claim for a Mirena intrauterine device (IUD), and that her health care provider was trying to obtain a no-cost Mirena IUD when she became pregnant.

Unfortunately, scenarios like these are all too common. You name almost any permutation of unintended pregnancy and I have probably taken care of a patient with that outcome in my short career as a pharmacist and now an OB/GYN resident. Consequently, I have taken a leadership role in AccessBC, a grassroots campaign lobbying for universal no-cost contraception in BC.

I write in my own opinion today—an opinion informed by caring for people who found themselves in the working poor and in need of prescription contraception. Where their miniscule wage disqualifies them from income assistance and associated drug coverage, yet they are unable to afford the cost of contraception outright. My opinion is also informed by caring for teens. Currently, a teenager filling a prescription using their parents' private insurance has the Drug Identification Number uploaded to the insurer's platform. As you can imagine, this serves as a deterrent for many teens, as their parents could readily learn what medications they are taking. My opinion is also informed by taking care of people in abusive relationships, who may be in high-socioeconomic-status households but have no control of their finances. My opinion is informed by working on the front lines of the COVID-19 pandemic and seeing the impact on reproductive health care.

All these people, and more, would benefit from universal free prescription contraception, and the projected savings for this kind of program are well established. A 2010 study from Options for Sexual Health estimated that providing universal no-cost contraception coverage in BC would cost approximately $50 million but would save up to $95 million per year.[1] Another study in Colorado provided long-acting reversible contraceptives (LARCs) to young people (n = 43 713) at a cost of US$28 million.[2] The program demonstrated a reduction in teen pregnancy by 54% and teen abortion by 64% over 8 years, resulting in $70 million of estimated governmental savings.[2] In 2015, a Canadian cost model found roughly 180 000 pregnancies were unintended annually nationwide, representing a direct cost of over $320 million.[3] However, with increased uptake of LARCs, savings after 12 months was over $34 million.[3]

When I think back to this patient and countless others I have cared for who are unable to access contraceptives due to cost, I think of the human cost of delaying this program's implementation. I think of the cost to our health care system and the disproportionate impact that lack of access to contraception has on particular groups. I think of our calling as physicians to advocate for patients and our health care system, and to end the inequities we encounter in practice.

Universal access to contraception is a vital component of people being able to recognize their full reproductive rights; it is also fiscally responsible and equity based. Free prescription contraception was included in the three major political parties' platforms in the last election. Every month that we wait, more folks experience unintended pregnancies. I hope you will join me in upholding reproductive rights and send a letter via www.accessbc.org/the-campaign urging the government to put no-cost prescription contraception into action.

—Ruth Habte, MD
Vancouver

Dr Habte is an obstetrics and gynecology resident physician at the University of British Columbia and a former registered pharmacist. She currently *serves as campaign coordinator for AccessBC, the grassroots campaign to bring no-cost prescription contraception to BC.*

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Crisis in health care

It was nice to see articles in the June *BCMJ* reflecting the seriousness of the crisis in our health care system. I have worked as an internist under a Social Credit government, Liberal government, and NDP government. They had one thing in common: they made physicians fight very hard for any improvements across all aspects of health care.

Remember reduced-activity days? That was a revolution of doctors against an oppressive, bureaucratic system, and yes, some positive changes were achieved. There is, unfortunately, only one way to make politicians listen: you get the public on your side and then you start pushing politicians so hard that they begin to fear the next election. Unions never achieved any concessions from their employers by being nice!

Canadian medical students are supposed to finance their education, but when they become doctors, they are expected to be happy to be paid poorly for their services. This is most obvious in primary care.

—J.J. Simice, MD
Comox

Informed consent for gender-questioning youth seeking gender-affirmative care is a complex issue

In their guest editorial for Part 2 of the Gender-affirming care in BC series, the authors state that "not all parents are supportive of their transgender youth, and some are even openly malicious."[1] The disregard for the role of the family and the overemphasis on the adolescent's gender identity as something "only they can fully know" disregards all prominent theories of adolescent identity development and the growing understanding of the complex etiological pathways to gender dysphoria. Their position is concerning given that the field should be advancing cautiously, with the long-term best interests of the individual in mind. These authors would have us believe that those who do not immediately affirm these youth and support medical transition are causing harm.

The authors acknowledge that the care of gender-questioning youth is an area of controversy. However, they neglect to mention that the scientific evidence for gender affirmation is extremely weak. In fact, based on systematic reviews of the literature, Sweden, Finland, France, and the UK have concluded that the risks of these interventions outweigh potential benefits and are now tightly regulating medical treatments for youth under 18, in favor of psychological treatments. The Cass Review's interim report reviews some of these concerns.[2]

They also fail to mention the controversy regarding the sharp rise in youth presentations, particularly adolescent girls, requesting gender reassignment. Research on these cohorts[3] is disregarded, as it does not neatly fit into the gender affirmation model they propose. The increasing numbers of desisters and detransitioners suggests that gender identity is mutable and that youth, at a time of identity formation, may not fully "know who they are." The potential for permanent, iatrogenic harm is significant if we jump to the medicalized treatment youth think they need in the moment.

The concept of gender being immutable is clearly controversial. Yet this premise of immutability forms the basis of the informed consent argument described by barbara findlay.[4] If gender is mutable, however, as is evidenced by desisters and detransitioners, this argument falls apart. Further, the article avoids discussion of whether youth are capable of consenting to medical treatments that are still being studied—treatments that can cause permanent damage to sex organs and future sexual and reproductive capacity. Someone who has not gone through puberty and has not experienced an orgasm cannot understand what they would be giving up in terms of their sexual functioning. Levine and colleagues[5] provide a good review of the issues regarding informed consent for gender dysphoria.

We suggest that providers inform themselves of the current growing scientific consensus on gender-affirming medical treatments and work with youth and their families to provide the best possible care, keeping long-term health in mind. Informed consent should include a discussion of all available options for treatment, including watchful waiting and exploratory therapy. The affirmation model proposed excludes these treatments, nullifying all informed consent and leaving youth open to lifelong medicalization and harm.

—Joanne Sinai, MD, MEd, FRCPC
Victoria

—Leonora Regenstreif, MD, FCFPC, MScCH
Hamilton, ON

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A closer look at the evidence for gender-affirming care

Like Dr Joanne Sinai, I believe that transgender and gender-nonconforming (TGNC) youth deserve compassionate and evidence-based care. For this reason, I find it important to reply to her letter titled “The current gender-affirming care model in BC is unvalidated and outdated.”[1]

Since I drafted this reply, Dr Sinai coauthored a second Letter to the Editor with Dr Leonora Regenstreif, titled “Informed consent for gender-questioning youth seeking gender-affirmative care is a complex issue.”[2] Both letters promote the idea that TGNC youth are being treated in a way that is potentially harmful in the long term. I find this insinuation to be problematic. Drs Sinai and Regenstreif imply that care providers are failing to comprehensively assess a youth’s capacity to consent to medical interventions and provide appropriate information to obtain informed consent, despite findings that 89% to 93% of youth age 10–18 have been found capable of providing medical decision-making competency for gender-affirming care based on clinical assessment and validated tools, respectively.[3] They present a limited and biased selection of the evidence and disregard the existing literature that indicates potential harm to TGNC youth when affirming care is delayed or denied.[4] While appealing for evidence-based care, these letters promote interventions that are not based in evidence and that delay affirming care. In the Premise[5] published in this issue, I summarize the available evidence and respond in two parts, the first looking at the evidence for our current model of gender-affirming care, and the second discussing specific interventions and outcomes.

—Julie Leising, MD, FRCPC
Vancouver

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Guest editors reply to Drs Sinai, Regenstreif, and Leising

As the guest editors of the two-part Gender-affirming care in BC series, we thank you for your responses.[1-3] In reply, we emphasize that the current standards of care guiding health care providers in BC (*Standards of Care Version 7*)[4] and the approach taken by the team at BC Children’s Hospital require a comprehensive psychosocial assessment of an individual before providing gender-affirming hormones or surgery, especially where youth are involved. It is emphatically not “hormones or surgery on demand.”

We know that for youth, the best predictor of quality of life post-transition is parental support,[5] so where a youth consents, the process mandates significant efforts to educate parents and to encourage them to support their child.

The World Professional Association for Transgender Health is expected to publish version 8 of its *Standards of Care*[6] in 2022. As BC was the first jurisdiction in Canada to follow version 7, we are confident the Ministry of Health will follow suit with version 8, which will then become the standards of care guiding physicians in British Columbia.

Like abortion, the provision of medical care to trans and gender-diverse people is controversial in some quarters, but it is the obligation of health care providers to follow the accepted standards of care.

The current *Standards of Care* (version 7) do not mandate “treatment on demand.” On the contrary, they require a comprehensive psychosocial assessment, especially for youth.

We encourage health care providers to educate themselves with the best available research to provide compassionate and competent health care to transgender and gender-diverse people. Dr Leising[1] has written a detailed response[7] to the issues raised by Drs Sinai and Regenstreif.[2,3]

—Gail Knudson, MD

—barbara findlay, QC

—Daniel Metzger, MD

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