Letters to the editor

We welcome original letters of less than 500 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.

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

[Revised version; earlier version was published in the September 2022 issue]

Care of gender-dysphoric youth is an issue of current debate. It demands closer attention to the science and also to the gaps in scientific evidence and informed-consent processes.

In their guest editorial for Part 2 of the Gender-affirming care in BC series, Dr Knudson, Dr Metzger, and Ms findlay state that "not all parents are supportive of their transgender youth, and some are even openly malicious."[1] If parents who support their child's gender dysphoria but question medicalization are deemed "unsupportive," distressed youth can become alienated from their families. We must acknowledge established theories of adolescent identity development and the complex etiological pathways to gender dysphoria. It is imprudent to suggest that not supporting medicalization is causing harm when it is entirely possible that the reverse may be true. The best long-term interests of the youth need to be kept in mind, including supporting healthy connections to family.

The failure to mention the weak evidence for medical gender affirmation is of significant concern. Based on systematic reviews of the literature, Sweden, Finland, France, and the UK have concluded that the risks outweigh potential benefits and now tightly regulate medical interventions for youth under 18, in favor of psychological treatments. The interim report of the UK's Cass Review outlines some of these concerns.[2]

Related articles also fail to address the sharp rise in youth presentations, particularly in adolescent girls.[3] We wonder if research on these cohorts is disregarded as it is a challenge to the gender-affirmation and informed-consent models that are based on the premise that gender is innate and immutable. The increasing numbers of desisters and detransitioners[4] suggests that gender identity is, in fact, mutable. This is especially important given that research has shown that most youth presenting with gender dysphoria who are not socially or medically transitioned realign with their bodies by the end of adolescence, growing up to be gay, lesbian, or bisexual. For example, the largest study to date of boys found an 88% rate of desistance.[5]

Given evidence of the mutability of gender identity, Ms findlay's informed-consent model is weakened, because we do not know for whom gender identity is immutable (and gender dysphoria persistent).[6] Further, the article avoids discussion of whether youth are capable of consenting to medical treatments that show potential negative impacts on long-term mental and physical health. These treatments are known to cause permanent damage to sex organs and future sexual and reproductive capacity. Someone who has not experienced an orgasm cannot understand what they would be giving up in terms of their sexual functioning. Levine and colleagues[7] provide a good review of the issues regarding informed consent for gender dysphoria.

Clinical practice and informed consent must acknowledge less invasive, nonmedical options such as watchful waiting, treating underlying psychiatric conditions, and exploratory therapy. The affirmation model excludes these treatments, leaving youth open to lifelong morbidity. The potential for harm is significant if we medicalize youth to soothe distress in the moment rather than treat the underlying cause(s). We need more research to help us understand which youths would benefit from a medicalized approach.

—Joanne Sinai, MD, MEd, FRCPC
Victoria

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

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Editor's note: An incorrect version of this letter was published in the September 2022 issue. The following related letters and premise were submitted in response to this version of this letter, and are published in the September issue:

- *"A closer look at the evidence for gender-affirming care"*
- *"Guest editors reply to Drs Sinai, Regenstreif, and Leising"*
- *"Gender-affirming care for youth—separating evidence from controversy"*

Re: Courageous leadership

It was a delight to read Dr Dosanjh's President's Comment regarding courageous leadership in the July/August issue of the *BCMJ* [2022;64:248]. The thoughtful and articulate call to our best selves—both as citizens and

as doctors—has rarely been more urgently needed. In a local, provincial, national, and global environment of unnecessary strife and easy access to weapons—both technological and verbal—it does indeed take leadership courage to rise above the temptations of the fray to imagine what we need to make positive contributions to complex problems—many of which threaten the survival of ourselves and our planet. Dr Dosanjh's call, as our president, to bring to this crisis our best selves, rather than self-serving finger-pointing, is worth heeding. If we style ourselves as healers of patients and societies, then she points us in that difficult, seemingly impossible direction. And isn't that what we seek to address daily with each patient and each community we serve—from the local to the global? If not us, then who? If not now, when? Thank you, President Dosanjh.

—Bob Woollard, MD
Vancouver

Re: Valuing time and care

While getting a haircut recently (for a price higher than the $31 average family practice fee) I was thinking about Dr David Chapman's editorial, "Valuing time and care" [*BCMJ* 2022;64:197].

My 40 years as a GP began in 1967. In those days, I would bill MSA $6 for an office visit. Gold was $30 an ounce, and a full hour of work on my car at a dealership was $5. Office overheads were easily manageable, and my secretary could handle the office (and billing) with a typewriter and a telephone. MSA would increase insurance premiums as necessary to cover costs.

Now, health care policy has made MSP payments to family physicians unrealistic, and overheads have become huge. To function properly, a family practice needs a secretary, nurse, and office manager. Their salaries come out of the undervalued payments to family physicians from MSP. Rents have skyrocketed, along with the many other overhead costs.

Recently, my plumber charged $266 for a 15-minute job that needed no new parts. Asked why, the answer was "overheads." My car

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News

We welcome news items of less than 500 words; we may edit them for clarity and length. News items should be emailed to journal@doctorsofbc.ca and must include your mailing address, telephone number, and email address. All writers should disclose any competing interests.

Left to right: Drs David Richardson, Caitlin Dunne, David Chapman, and Terri Aldred

BCMJ Editorial Board transitions

After 14 years of service at the helm of the *BCMJ* Editorial Board, Dr David Richardson retired from the position in May 2022. Dr Richardson joined the Board in 2006 and became editor in 2008, and the journal has thrived under his leadership. He will be missed by staff, Board members, and readers of his editorials alike.

We are pleased to announce that Dr Caitlin Dunne has been confirmed as the new editor of the journal. Dr Dunne joined the Editorial Board as a member in 2019 and has contributed her enthusiasm and valuable expertise both to her work on the Board and as an author in the journal over the years. She practises in Burnaby as a subspecialist in infertility, egg freezing, and women's reproductive health and is also co-director at the Pacific Centre for Reproductive Medicine and a clinical associate professor at UBC.

Many thanks to Editorial Board member Dr David Chapman, who stepped into the role of interim acting editor while selection of the new editor took place. His calm and thoughtful approach was the steady hand at the tiller that the *BCMJ* needed during this time of transition.

We also warmly welcome Dr Terri Aldred, who is joining the Editorial Board as its newest member. Dr Aldred is Carrier from the Tl'azt'en territory located north of Fort St. James. She is a member of the Lysiloo (Frog) Clan, who are traditionally known as the voice of the people. She follows her mother's and great-grandmother's line, Cecilia Pierre (Prince). Dr Aldred grew up in both the inner city of Prince George and on the Tachet reserve (in Lake Babine territory) and these experiences helped motivate her to go to medical school so she could give back to her community. She has a doctor of medicine degree from the University of Alberta and completed the Indigenous family medicine residency program through the University of British Columbia. At present, Dr Aldred is the medical director for primary care for BC's First Nations Health Authority, the site director for the UBC Indigenous family medicine program, a clinical instructor with UBC and UNBC, a family physician for the Carrier Sekani Family Services primary care team, which serves 12 communities in north-central BC, and the Indigenous lead for the Rural Coordination Centre of BC. For the past 3 years, Dr Aldred sat as an elected board member for the BC College of Family Physicians. Through her various roles she sits on a number of committees and leads several initiatives on cultural safety and humility. She is also an avid speaker about Indigenous health, cultural safety and humility, and anti-Indigenous racism, and has co-authored articles on diverse topics related to Indigenous health.

The history of the Family Practice Oncology Network and its digital future

In 2003, the BC Cancer Agency launched the Family Practice Oncology Network (FPON) to provide oncology education, resources, and connections to strengthen family physicians' ability to care for people living with cancer in their communities. In 2016, FPON expanded to become the BC Cancer Provincial Primary Care Program, with a multipronged mandate:

- Bring the lens of primary care into the strategic work of BC Cancer.
- Facilitate support for primary care providers through education.
- Codevelop primary cancer care guidelines.
- Advocate for clear lines of communication between primary care and oncologists to provide adequate resources to care for this complex population.

Our initial goal was to address the education and training needs for the implementation of general practitioners in oncology (GPOs) so every community with a catchment of 15 000 or more would have access to cancer treatment as close to home as possible through collaborative care with oncology specialists at a regional or provincial centre. The goal has expanded to provide twice-yearly GPO Education Sessions supporting new GPOs, nurse practitioners in oncology (NPOs), and residents in palliative care. Our annual GPO Case Study Day sees case-based, collaborative, interactive presentations by GPOs and oncology specialists on management topics relevant to GPOs and NPOs in regional cancer centres and community oncology sites throughout BC and Yukon. To promote interprofessional networking, GPO Case Study Day is offered as part of the BC Cancer Summit in November.

Educational activities (many in partnership with UBC CPD) for family physicians and members of the broader primary care team have expanded over the years to include:

- Monthly primary care webcasts (8:00 a.m. on the third Thursday of each month except July, August, and December) with presentations on a variety of cancer topics.
- An annual primary care CME day (next CME event 1 April 2023).
- Twice-yearly production of the *Journal of Family Practice Oncology* (spring and fall).

The journal brings follow-up articles to many of our webinars and CME events as well as updates relevant to community primary care and their patients with cancer. We have also partnered with the Guidelines and Protocols Advisory Committee to develop a number of primary care cancer guidelines, most recently on lung cancer.

Since 2013, the journal has been distributed to 6500 family practitioners, nurse practitioners, and other primary care providers across BC and Yukon in hard copy. Beginning with the fall 2022 edition, the journal has moved to a digital-only format and can be found at www.fpon.ca, along with electronic copies of previous editions.

We have recently developed a database to improve our ability to communicate with community providers about the latest FPON news, educational updates, practice gems, and other BC Cancer primary care communications, including information on the electronic publishing of the journal. To subscribe, scan the QR code and sign up for our communications database.

Questions? Please contact us at fpon@bccancer.bc.ca.

—Catherine Clelland, MD
Medical Director, Primary Care, BC Cancer

The importance of disability insurance review and the GIB period

The standard insurance-industry recommendation is to carry 60% of your net income in tax-free disability insurance, and the Guaranteed Insurability Benefit (GIB) rider is a valuable tool for maintaining the right disability coverage as your practice and income grow over time. Reviewing your disability insurance and exercising your GIB during the annual open enrolment period (1–30 November) will help ensure that your disability coverage continues to protect your needs. The GIB allows you to increase your disability insurance during the open enrolment period by up to $2500 without proof of health. Your personal tax return and corporate financial statements may be needed to determine that your income justifies the increase.

As your income grows, your lifestyle may grow with it. You may start a family, purchase a home, or begin planning for your children's education. As a physician, you also need to fund your own retirement during your earning years. The disability insurance you needed 3 or 5 years ago may not cover the expenses you have today. If you were unable to work tomorrow due to illness or injury, your family's monthly expenses would continue. Is your current disability benefit enough to maintain your family's lifestyle, or would you face difficult decisions such as canceling your children's activities, pausing mortgage payments or education-fund contributions, or depleting your savings to cover ongoing costs?

To increase your disability insurance outside of the annual GIB period or above the maximum annual limit, or if you did not select the GIB rider when you originally applied for coverage, you'll need to provide proof of health. The insurer will review your existing health and lifestyle to determine your eligibility and may decline your application or issue coverage with exclusions for health conditions or activities.

Scheduling a disability insurance and GIB review with a licensed Doctors of BC insurance advisor will help you protect the lifestyle you and your family enjoy today, as well as your plans for the future. Email insurance@doctorsofbc.ca or call 604 638-7914 for a complimentary meeting.

—Laura McLean, Client Services Administrator
Members' Products and Services

LETTERS

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dealership attaches an hour-rated fee to each service item, with a charge of well over $100/hour.

Family practice is an expensive business, but paying for those costs is hamstrung by the inability to pass them on to the customer. They have to come out of the payments from MSP, which have become limited in such a way that they are akin to a salary, without the perks of payments for sickness, holidays, or a pension.

It is no wonder that new physicians are shunning this branch of medicine.

—Anthony Walter, MD
Coldstream