December 6, 2020.

Dear Justice Committee members;

RE: Bill C-6

I am a rural family physician in Alberta. I care for patients throughout the full spectrum of life, seeing every sort of condition, including mental health and sexuality concerns. As a medical professional, I strive to listen to my patients, make an accurate diagnosis, and offer the best evidence-based advice for health and thriving. At times, patients have their mind set on a certain course of care and are not aware of different treatment approaches available to them, or ones that might be less risky. Therefore one of the main tasks of a physician once a diagnosis is made, is discussing various options for treatment.

I applaud Parliament for endeavouring to protect vulnerable patients, especially where forced and harmful treatments are concerned. However I have significant concerns about Bill C-6. The definition of "conversion therapy" is overly broad and is itself at risk of causing harm to patients. Furthermore, Bill C-6 does not rely on any solid evidence and gives no consideration to emerging legal issues seen in other jurisdictions.

Classically, conversion therapy referred to forced treatments such as aversion therapy, including electroshock therapy, or forced hormonal treatments given to a person against their will in order to change their sexual orientation. In medicine, forcing treatment on anyone is contrary to the Canadian Medical Association (CMA) Code of Ethics, and standards and discipline regarding forced treatment would be covered by each provincial college of physicians and surgeons. In this sense, Bill C-6 is unnecessary to ban harmful or forced treatments, since they are already not permitted. Indeed, when communities in Alberta (such as Spruce Grove and Calgary) who brought in local conversion therapy bans were asked to provide evidence of conversion therapy happening, they were unable to provide any.

Unfortunately, the definition of conversion therapy in C-6 is dramatically expanded to include “a practice, treatment or service designed to change a person’s sexual orientation to heterosexual or gender identity to cisgender, or to repress or reduce non-heterosexual attraction or sexual behaviour.” This definition raises a multitude of questions as others have mentioned in their briefs - how is a practice defined? What constitutes a treatment or service? What if the person wants to have said practice/treatment/service or turn back to cisgender? Why the prohibition of conversion in only one direction? Does simply asking questions and talking about biological sex fall into this definition? Many try to align their conflicting feelings with their factual biology - is helping those persons when requested a form of conversion? These are only a few of the questions that come up.

In the clinical context, with Bill C-6 in place, anything short of affirmative therapy and starting patients on a transitioning pathway would be illegal. This actually limits patient autonomy and choice. Research shows that most children and young adults with gender dysphoria will actually desist in their transgender identification by adolescence or adulthood (Mayer and McHugh, 2016).

In early December in the UK, the courts ruled that clinics should not put adolescents with gender dysphoria on puberty blockers, due to the lack of evidence and difficulties with consent, and in part because "once on that pathway it is extremely rare for a child to get off it (Bell v Tavistock)." It is a self-reinforcing pathway. Indeed, the complainant herself, Keira Bell, said: "I should have been challenged on the proposals or the claims that I was making for myself." Furthermore, after the court decision, "Keira Bell said that she hoped the judgment marked the end of gender clinics “playing God with our bodies [by] experimenting on the young and vulnerable with untested, harmful drugs”. (Clarke 2020)"

Essentially, Keira was advocating for talk therapy and time to understand her biology despite her conflicting feelings. Instead, she was affirmed in her gender dysphoria and started down the path of hormonal and surgical transition which she now regrets. With Canada's proposed Bill C-6, this scenario will risk being played out repeatedly, since counselling and talk therapy to help patients feel comfortable in their biological bodies would be curtailed and even illegal.

The harms of rushing into affirmative therapy and transition are becoming more apparent. The World Professional Association of Transgender Health (WPATH) admits as much in their standards of care: “To date, no controlled clinical trials of any feminizing/masculinizing hormone regimen have been conducted to evaluate safety or efficacy in producing physical transition (WPATH v7).” Multiple websites of concerned citizens, parents, and people who have detransitioned are appearing. Some examples include: www.transgendertrend.com, www.4thwavenow.com, www.sexchangeregret.com, and www.piqueresproject.com. In addition, the best long-term study of transitioned persons shows that any benefit to mental health was very short lived, but over 30 years, those who had transitioned had completed suicide rates 19 times higher than the control group (Dhejne et al, 2011). Other harms from transitioning shown in that study included 2-2.5 times higher death rate from cancers, and almost 3 times higher hospital admission rates for psychiatric issues in those who transitioned. A ban on conversion therapy as defined in C-6 will only increase these types of harms.

This situation can be prevented by amending the definition of conversion therapy.

I suggest amending the definition of conversion therapy to include reference to forced or coerced treatment, or “a practice, treatment or service against the will of the patient.” In addition, as the case of Keira Bell shows, harms from gender transition can occur even with affirmative therapy, especially in young patients when they cannot fully understand treatment implications. In such cases, affirmative therapy is virtually coerced as individuals are not given any other option. Keira is now detransitioning by her own volition. Surely this should not be illegal, in any jurisdiction.

As such, the reference to heterosexual or cisgender in Bill C-6 should be removed. To put it a different way, coerced and harmful therapy for gender identity should be illegal regardless of which direction an individual is transitioning - whether that be from heterosexual to trans, or from their trans identity back towards cisgender.

In summary, people with gender dysphoria or who are questioning their gender identity are vulnerable. They need support, which can include talk therapy and delaying initiation of potentially harmful and irreversible treatments (Bell v Tavistock). Revising the definition of conversion therapy in Bill C-6 to specify “forced or coerced” treatments or those “against the will of the patient” will help to ensure patients maintain autonomy and choice of treatments and services, while being protected from harmful conversion therapy. Finally, removing reference to specific gender identities as mentioned above will ensure that all patients along the gender spectrum, no matter the direction of their shifting identity, are protected.

Thank you for your attention to these matters, and for your consideration of both the short and long term effects of transition.

Sincerely,

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