Form 49

[Rule 13.19]

COURT FILE NUMBER	2401-17719
COURT	COURT OF KING'S BENCH OF ALBERTA
JUDICIAL CENTRE	CALGARY
APPLICANT(S)	EGALE CANADA, SKIPPING STONE SCHOLARSHIP FOUNDATION, APPLICANT DOE 1 by their litigation representative PARENT DOE 1, APPLICANT DOE 2 by their litigation representative PARENT DOE 2, APPLICANT DOE 3 by their litigation representative PARENT DOE 3, APPLICANT DOE 4 by their litigation representative PARENT DOE 4, and APPLICANT DOE 5 by their litigation representative PARENT DOE 5
RESPONDENT(S)	HIS MAJESTY THE KING IN RIGHT OF ALBERTA and HIS MAJESTY'S ATTORNEY GENERAL IN AND FOR THE PROVINCE OF ALBERTA
DOCUMENT	**AFFIDAVIT**

Clerk's Stamp

ADDRESS FOR SERVICE AND CONTACT INFORMATION OF PARTY FILING THIS DOCUMENT	David Madsen K.C./Karen Salmon, K.C./Brett Carlson Borden Ladner Gervais LLP 1900, 520 – 3rd Avenue SW Calgary, AB T2P 0R3 Telephone: (403) 232-9500 Facsimile: (403) 266-1395 Email: dmadsen@blg.com/ksalmon@blg.com/bcarlson@blg.com File No. 443347/000014

AFFIDAVIT OF DR. IAN MITCHELL
Sworn on February 7, 2025

I, IAN MITCHELL, of the City of Calgary, in the Province of Alberta, **MAKE OATH AND SAY**:

1. I have personal knowledge of the facts set out below, except when I say that they are based on information and belief, in which case I believe the facts to be true.

Professional Background

2. I am a pediatric respirologist and have practiced in Alberta since 1982. My practice involves caring for children with chronic lung diseases, many with complex home care needs. My undergraduate medical training was in Edinburgh Scotland, with post-graduate training in Pediatrics and Pediatric Lung Disease in Edinburgh and at the University of Toronto. I also hold a master's degree in Bioethics.

3. I am a Professor Emeritus in the Department of Pediatrics at the University of Calgary Cumming School of Medicine, where I also served as the Director of the Office of Medical Bioethics from 1999-2006.

4. I have dedicated a significant portion of my career to research and ethics in the pediatric profession. I chaired the Conjoint Health Research Ethics Board (University of Calgary and Calgary Health Region) and remain a member and vice chair of that board. In this role, I have worked extensively for 32 years with research and ethics boards across Alberta to review research protocols and help investigators achieve the highest standard of ethical practice.

5. In addition, I have served as the president of the Canadian Bioethics Society (2002-2004), and as a member of the Interagency Panel on Research Ethics (2002-2005), the Canadian Medical Association Committee on Ethics (2005–2015), and the Committee on Ethics, Canadian Pediatric Society (2011-2018).

6. I have also published extensively on the subject of ethics in pediatrics, including a textbook entitled "*Ethics in Pediatrics: Achieving Excellence when Helping Children*".

Background: Genesis of my Concerns re gender affirming care

7. I graduated in medicine in the UK, and to this day I still read the news column of the International Edition of the British Medical Journal almost every week. This is not just about British medical news, it enables me to have an international perspective on what is happening in medicine around the world, and in many ways helps me to understand what is happening in Alberta and Canada in pediatrics. I was seeing an increasing number of

news items on the complex issue of gender dysphoria, and saw that the English government had disbanded one clinic (Tavistock Clinic) as evidence emerged about the clinic's vast medicalization of minors under its "unquestioningly affirmative approach" to gender care.

8. I also learned that NHS England had commissioned a distinguished pediatrician (Dr Hilary Cass) to review the entire issue of gender dysphoria, and the prevailing model of care deployed to treat it. The Cass Review took 4 years to complete and contained, in turn, many carefully and conventionally structured reviews of the literature on the topic. There were multiple conclusions, but the overarching conclusion was clear: the evidence bases for gender affirming care were poor, and perhaps nonexistent. There were some publications in relation to the ongoing Cass Review that I have followed since its inception in 2020, and the more I learned about gender affirming care, the more my concerns grew.

9. My first concern was that in my view, children were likely being harmed by a novel yet widespread medical intervention for which there were very few long-term outcome studies. While my expertise qualifies me to do so, the purpose of my affidavit is not to opine on the scientific literature.

10. The second quite different concern, and the one on which I primarily focus herein, was that certain pockets of the medical community in Alberta – pockets of great familiarity to me - persist, not only in their position that medicalized gender affirmation is justified, but in fact that great harm will be occasioned on children and youth unless such care is offered without restriction.

11. The "pockets" of Alberta's medical community that I refer to above operate the on-site delivery of health care (i.e., physicians, psychiatrists, psychologists, family doctors, etc), and exist as component of the broader healthcare apparatus (e.g., medical associations, subspecialty organizations and societies, research and ethics boards, colleges, etc). In my case, I have sat for over 30 years on various research and ethics boards in Alberta and Canada (which includes my current vice-chair position with the Conjoint Health Research Ethics Board in Calgary),and have longstanding involvement with the Canadian Medical Association and the Canadian Pediatric Society.

12. What I have personally observed in both the research and medical association domains, regrettably, is twofold: (1) an aversion and hostility towards producing a research base required to support gender affirming care; and (2) politicization of medical associations and an abdication of their core values. I and many of my colleagues in this corner of the profession, have sensed a growing hostility to any questioning of what seems to have solidified into what can only be described as an orthodoxy. My observations of both foregoing issues most recently arose in the context of the Cass Review, and the reaction that followed its publication.

13. It is very important to understand, and this cannot be over-emphasized - from a pediatrics perspective in particular, and more generally from a broader health and ethics perspective, the Cass Review is massively important. Most areas of medical research develop incrementally over time, often with smaller scale local studies that coalesce into consensus (or disagreement) over time. It is a rare and exceptional occurrence when a study of such significant magnitude (the research program commissioned by Dr. Cass included 7 systematic reviews), so directly challenges virtually all aspects of an entire model of care. In the research board context, systematic reviews are considered to be the highest level of appraisal of evidence about the quality of research in a particular field.

14. I note that in or around May 2024, the Bioethics Group in our faculty had explored the possibility of inviting Dr. Cass to speak in Calgary. The invitation was never extended as we concluded sadly, that she would have been exposed to a very taxing environment.

Politicization of gender affirming care and opposition to research in Alberta

15. Against the backdrop of the Cass Review, I had reviewed various position statements issued by, among others, the Alberta Medical Association, Canadian Pediatric Society, and Canadian Medical Association in relation to gender affirming care. These statements have been adopted by many who ostensibly support the total affirmation model for the treatment of gender identity issues and are used to propagate further support for that model.

16. For example – in a letter written to the Government of Alberta, in response to the announcement that the legislation, that is now the subject of this proceeding, would be

enacted, Dr. Sam Wong, wrote in his official capacity as the head of the Pediatrics section within the Alberta Medical Association (and ostensibly my representative) denouncing the proposed legislation. A particularly troublesome statement refers to the assertion that the Government of Alberta's then proposed health care legislation "will lead to significant negative health outcomes, including risk of suicide and self-harm" There are indeed increased suicidal ideations in these young people but there is, to my knowledge, absolutely no certainty in the research that suicidal ideation differs amongst those with gender dysphoria who are prescribed puberty blockers versus those who are not so prescribed. A copy of the joint statement, dated February 2, 2024, is attached hereto and marked as Exhibit "**A**". Contrast the joint statement with the American Society of Plastic Surgeons statement regarding gender surgery for adolescents, a copy of which is attached hereto and marked as Exhibit "**B**".

17. Importantly, while Dr. Wong was writing in a representative capacity, I was not aware of any consultation before the letter was written, and through discussion with colleagues I have since established that there was no consultation with the membership.

18. The unsupported challenges to the good science and research continued. Shortly after the letter above, I noted an article in *Canadian Affairs* entitled "Expert review unlikely to shift Canada's transgender treatment model". The "expert review" noted in the article refers to the Cass Review, and it was Dr. Sam Wong, Head of Pediatrics, supporting that position. In another statement. Dr. Wong is quoted by the authors as follows:

> "To say that we don't have data on puberty blockers … it's a sleight of hand in some ways. We do have data, it's just we've been using it [to treat early puberty], and some people have moved it over to gender clinic care".

A copy of the *Canadian Affairs* article, dated June 14, 2024 is attached hereto and marked as Exhibit "**C**"

19. That is simply not good science, or good pediatric practice. In my view, it was time to speak up more publicly. On June 20, 2024, I and two other pediatric colleagues wrote a letter in response to Dr. Wong's statements referred to in *Canadian Affairs.* We thanked

Dr. Wong for his work as head of the pediatric section of the Alberta Medical Association, but disagreed vehemently with the notion that because puberty blockers are used in the treatment of precocious puberty, it follows that their use is justified in the context of gender dysphoria. In doing so, we noted that:

> "pediatric history has shown us that successful use of a drug in one situation does not mean it will be safe and effective in another. It may be, of course, but shouldn't we ensure it is effective and safe? The context is also vastly different, between early puberty and gender dysphoria. Use in this new context needs to be studied".

20. The letter concluded with an appeal to Alberta pediatricians to be leaders in moving the management of gender dysphoria into mainstream pediatric evidence-based practice. A copy of the letter, dated June 20, 2024, is attached hereto and marked as Exhibit "**D**".

21. On July 22, 2024, my colleagues and I requested a meeting with Dr. Wong and a member of the executive of the pediatric section of the Alberta Medical Association. Both expressed surprised that anyone would question the so-called "gender affirming" care. Dr. Wong repeated his previous public statements that most of pediatrics is not evidence based, to which I responded that, to the degree there are evidentiary gaps in pediatrics, I saw this as a challenge to overcome - to ensure that we bring the best of evidence based care to the children for whom we have responsibility – not a reason to justify methods of treatment that also lack evidence. This is especially the case when the treatment has potentially life-altering consequences. While we did not agree on much, the meeting was amicable.

22. The foregoing is not intended to single out Dr. Wong in particular, but to highlight the problem that pediatric health care professionals are faced with. They are being provided with information and recommendations that are not supported by the body of good quality research and it is hard to blame these health care professionals as they have little time to read the research themselves. To the best of my knowledge, this is the only area in pediatrics where opposition to attempts to acquire evidence are becoming institutionalized. Myself and others have begun to express our concerns, including in letters to the Canadian

Pediatric Society and Canadian Medical Association, copies of which are attached hereto and marked as Exhibits "**E**" and "**F**", respectively.

Examples of a Healthy Research Environment

23. In my direct experience, I have seen different approaches to similarly novel problems. Novel problems might be hitherto untreatable conditions in which there are glimpses of hope or previously unrecognized conditions that are harming children. In my experience, the first approach by almost everyone is to join enthusiastically in efforts to improve care using the tools and knowledge available. Where I have seen dramatic differences is in the next steps. For some, the next step is simply to continue what has been started, as some improvement have been seen, and to double down on the idea that this is only way to get improvement. For others, including me, the next step is to examine the evidence closely and determine which parts of the new regimen are really helpful, which parts make little difference, and which parts might be harmful.

24. I have been inspired by what I have seen in the approach to Cystic fibrosis. In this illness, hitherto fatal in infancy or early childhood, pioneers attempted treatment. I know from the historical record that some of these pioneers disagreed one from the other, often very strongly. However, I also know that these pioneers realized that they should collaborate on a program of research to establish the best possible treatments and hence the best possible outcome. In cystic fibrosis that approach continues today, and whereas death was once in infancy, mean age of survival is now in the late 50-year range. Physicians and researchers still continue to get the best evidence to find the best treatment to improve on even this remarkable improvement in survival.

25. In a much more modest way, I followed the same pathway in establishing where the antibody palivizumab might effectively prevent the severe illness RSV in high-risk infants. It had been established by well-done randomized control trials that palivizumab was extremely effective in pre-term infants and infants with congenital heart disease. The next question was whether it might be effective in high-risk infants, but suffering from much less common illnesses. Because the numbers in these illnesses were small, large scale

clinical trials would not be possible. I was able to establish across Canada a collaboration where we shared data and published reports showing which infants would benefit, and which infants would not benefit.

26. With respect to gender affirming care, other jurisdictions, including the U.K., under the recommendation of Dr. Cass, are or will be conducting more rigorous research in this area and until the results of that research is known, health care professionals should not, in my view, be prescribing puberty blockers, hormone therapy, or gender "affirming" surgery.

Ethical Framework in my Practice

27. In my pediatric practice, I try to conform to appropriate ethical guidelines. Much of the pediatric literature focuses on issues such as capacity of those under the age of 18, the so-called mature minor. Other parts of literature focus on the elements of informed consent, such as voluntariness, and especially lack of coercion, the fullness and accuracy of informed consent and of course capacity. The modern approach was developed in the 1970s by a number of people, most notably Beauchamp and Childress. They developed what came to be called The Four Principles - autonomy, beneficence, non-maleficence, justice. Some of the literature has an excessive emphasis on autonomy and the authors are careful to point out that this is only one of the four principles. In obtaining consent, mindful of this, I first make sure that my information on the evidence I'm presenting to parents and children is as accurate as possible. This is done openly and without coercion. Only then do I consider the issues of capacity of the patient and/or parents.

28. I treat children with asthma. The standard pharmacological treatment is inhaled steroids always coupled with avoidance of environmental triggers. Other pharmacological treatments are used, particularly when there is a crisis. The children I see tend to have more severe asthma and it's sometimes difficult to have good control of the asthma with adverse effects on their quality of life, and sometimes frequent emergency department visits. In this situation I may discuss more potent inhaled corticosteroids than I would usually use in a child, with the expectation of benefit. However, these more potent drugs may have specific additional side effects, such as adrenal suppression.

29. My approach to suggesting the prescription of medications that may have troublesome side effects is to spend time describing potential benefits, potential drawbacks through the provision of full and honest information, based on what is actually known and what is contained in the medical literature, and going to great lengths to avoid any coercion.

Conclusion

30. In conclusion, what I have observed is a group of compassionate caring individuals who have become focused on one paradigm of care, without attempting to obtain robust evidence, and being led to believe in the efficacy of that paradigm not by the science, but by umbrella organizations who are not providing unbiased information or recommendations.

SWORN BEFORE ME at the City of Calgary, in the Province of Alberta, this 7th day of February, 2025.

A Commissioner for Oaths in and for Alberta

ANNA LITTLE
A COMMISSIONER FOR OATHS
IN AND FOR ALBERTA
LAWYER, NOTARY PUBLIC

IAN MITCHELL

This is **Exhibit "A"** to the affidavit of
IAN MITCHELL sworn/affirmed before me
this 7th day of February, 2025.

Anna Little

A Commissioner for Oaths in and for Alberta

ANNA LITTLE
A COMMISSIONER FOR OATHS
IN AND FOR ALBERTA
LAWYER, NOTARY PUBLIC

Canadian Paediatric Society / Société canadienne de pédiatrie

Danielle Smith
Premier of Alberta
Legislature Building
307-10800 97 Ave
Edmonton, AB T5K 2B6
premier@gov.ab.ca

February 2, 2024

Premier Smith,

We are writing in response to your recent announcement of several new policies banning or significantly curtailing access to gender-affirming care and support in healthcare and education. We are deeply concerned that implementation of these policies will not only undermine the fundamental rights of transgender children and youth in Alberta, but will lead to significant negative health outcomes, including increased risk of suicide and self-harm.

All spaces where children and adolescents spend time, including schools and all extracurricular activities, should be safe for, and inclusive of those who are transgender and gender diverse (TGD). We know that TGD youth report high levels of exposure to harassment and violence and that they are at elevated risk for adverse health outcomes, including depression, anxiety, eating disorders, self-harm, and suicide.[1] These risks may be mitigated by affirming experiences and environments, such as supportive parents, early social transition for those who express this desire, and inclusive and non-judgemental interactions with the health care system.[2] Therefore, efforts should be made to provide timely access to gender-affirming care and reduce barriers to social transitions for youth, including supporting and respecting chosen names and pronouns.

When it comes to gender-affirming medical care, current best evidence shows that younger age and earlier pubertal stage at time of presentation has been associated with lower rates of mental health conditions.[3] While some TGD adolescents may only ever desire social transition, others may be interested in medical options. For adolescents with marked and sustained gender diversity who express a clear goal of medical transition, hormone blockers may be prescribed to suppress or slow physical changes or gendered experiences. Hormonal suppression is reversible and sex steroid production will resume if blockers are discontinued.[4] Initially, the clinical objective of prescribing hormone blockers is to provide a young person with time to further explore their gender identity without pressure or distress related to ongoing development of secondary sex characteristics. An emphasis on parental support around hormone blockers is already part of the standard of care, as it is recognized that TGD youth with supportive parents have been shown to have markedly better mental health outcomes, including lower risk of suicide.[5] Should a young person continue to express gender dysphoria over time and eventually wish to pursue other gender-affirming treatments, hormone blockers may also prevent the development of secondary sex characteristics that may make medical and surgical transition riskier and more difficult. TGD adolescents who have sought and received hormonal suppression as part of a multidisciplinary approach to care report improved mental health and psychosocial functioning and lower odds of suicidal ideation.[6]

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For some adolescents with marked and sustained gender diversity, gender-affirming hormone therapy (GAHT) can be an important care component, with GAHT prescribed to promote the development of physical features that are better aligned with an individuals' experienced gender. GAHT is considered a partially reversible intervention because hormone administration over time results in both reversible and irreversible changes. Prescription of GAHT should only be provided to adolescents with a confirmed diagnosis of gender dysphoria or gender incongruence who demonstrate the capacity to understand and appreciate both the benefits and risks of these medications. When GAHT is initiated appropriately for adolescents who desire this option, it has been associated with improved well-being and mental health, decreased suicidality, and decreased body dissatisfaction.[7]

While gender-affirming surgeries are less commonly performed for adolescents, TGD youth may identify surgery as one of their transition goals. It should also be made clear that 'bottom' or 'lower' surgeries are already limited to individuals 18 years of age and older. As every individual has unique needs and circumstances, medical decisions need to be made through informed and confidential discussions between healthcare professionals and the patient/family, guided by best-available evidence to support physical and mental well-being.

Alongside the new policies restricting the care of transgender youth in the healthcare and education systems, we are also deeply concerned about your announcement to require parental opt-in for each instance a teacher intends to give formal instruction on subjects involving gender identity, sexual orientation, or human sexuality in schools. This will pose an extremely high barrier to formal education on these fundamental and universal topics for all of Alberta's children and youth. Comprehensive, evidence-based, medically accurate and age-appropriate sexual and reproductive health education has an overwhelming evidence base for its impact on positive health outcomes.[8] As such, it should be a priority for the overall health and well-being of adolescents and the downstream positive effects on the population as a whole. Open communication on issues of gender identity, gender expression, sexual orientation and human sexuality is key to improved well-being and health outcomes and can reduce risk of illness and disease, sexual exploitation and violence, stigma, misinformation, harassment, bullying, prejudice, and discrimination.[9] Comprehensive sexuality education is therefore essential to ensure that children and youth have access to accurate information and are equipped to make healthy and informed decisions.

In summary, we are deeply concerned about the proposed policies to ban access to hormone therapies for youth aged 15 and under and severely restrict access for youth aged 16-17, ban all gender-affirming surgery for those 18 and under, require parents of children 17 and under to be notified and parents of children 15 and under to give permission for name/pronoun changes in schools, exclude transgender women and girls from sport, and require parents to opt-in every time a teacher intends to give formal instruction on gender identity, sexual orientation or human sexuality. They will all have direct and real negative impacts on the physical and mental health of Alberta's children and youth. Gender-affirming medical care for youth should be a decision between the patient, their parents, and their medical care team, without intrusion by government. The health and safety of TGD youth is too important. We strongly urge you to reconsider the implementation of these policies and to ensure that initiatives impacting TGD youth are rooted in best evidence and informed by consultation with those who have lived experience, are most directly impacted, and have a robust understanding of the current evidence.

Sincerely,

Dr. Sam Wong
President, Section of Pediatrics
Alberta Medical Association

Dr. Jeff Critch
President
Canadian Paediatric Society

Dr. Ellie Vyver
Chair, Adolescent Health Committee
Canadian Paediatric Society

Dr. Raphael Sharon
Board Member, Alberta
Canadian Paediatric Society

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[1] Taylor AB, Chan A, Hall SL, Saewyc EM; Canadian Trans Youth Health Survey Research Group. Being Safe, Being Me 2019: Results of the Canadian Trans and Non-binary Youth Health Survey.2020.Vancouver, B.C.: Stigma and Resilience Among Vulnerable Youth Centre, University of British Columbia: https://apsc-saravyc.sites.olt.ubc.ca/files/2020/12/Being-Safe-Being-Me-2019_SARAVYC_ENG_1.2.pdf (Accessed February 1, 2024).

[2] Russell ST, Pollitt AM, Li G, Grossman AH. Chosen name use is linked to reduced depressive symptoms, suicidal ideation, and suicidal behavior among transgender youth. J Adolesc Health 2018;63(4):503-05. doi: 10.1016/j.jadohealth.2018.02.003

[3] Sorbara JC, Chiniara LN, Thompson S, Palmert MR. Mental health and timing of gender-affirming care. Pediatrics 2020;146(4):e20193600. doi: 10.1542/peds.2019-3600.

[4] Coleman E, Radix AE, Bouman WP, et al. Standards of care for the health of transgender and gender diverse people, Version 8. Int J Transgend Health 2022;23(Suppl 1):S1-S259. doi: 10.1080/26895269.2022.2100644.

[5] Ibid.

[6] Turban JL, King D, Carswell JM, Keuroghlian AS. Pubertal suppression for transgender youth and risk of suicidal ideation. Pediatrics 2020;145(2):e20191725. doi: 10.1542/peds.2019-1725.

[7] Allen LR, Watson LB, Egan AM, Moser CN. Well-being and suicidality among transgender youth after gender-affirming hormones. Clin Pract Pediatr Psychol 2019;7(3):302–11. doi: 10.1037/cpp0000288.

[8] UNESCO. International technical guidance on sexuality education: An evidence-informed approach. 2018: https://cdn.who.int/media/docs/default-source/reproductive-health/sexual-health/international-technical-guidance-on-sexuality-education.pdf?sfvrsn=10113efc_29&download=true (Accessed February 2, 2024).

[9] SIECCAN. Canadian Guidelines for Sexual Health Education. 2019: https://www.sieccan.org/_files/ugd/1332d5_e3ee36e39d944009956af5b86f0a5ed6.pdf (Accessed February 2, 2024).

This is **Exhibit "B"** to the affidavit of
IAN MITCHELL sworn/affirmed before me
this 7th day of February, 2025.

Anna Little

A Commissioner for Oaths in and for Alberta

ANNA LITTLE
A COMMISSIONER FOR OATHS
IN AND FOR ALBERTA
LAWYER, NOTARY PUBLIC

ASPS statement to press regarding gender surgery for adolescents

Wednesday, August 14, 2024

Many ASPS members may have read the recent article titled "A Consensus No Longer" published Aug. 12 by **City Journal**, which cites the American Society of Plastic Surgeons as the first major medical association to challenge the "consensus" of medical groups over gender surgery for minors.

The following is the ASPS statement in its entirety provided to the reporter prior to publication:

ASPS has not endorsed any organization's practice recommendations for the treatment of adolescents with gender dysphoria. ASPS currently understands that there is considerable uncertainty as to the long-term efficacy for the use of chest and genital surgical interventions for the treatment of adolescents with gender dysphoria, and the existing evidence base is viewed as low quality/low certainty. This patient population requires specific considerations.

ASPS is reviewing and prioritizing several initiatives that best support evidence-based gender surgical care to provide guidance to plastic surgeons.

As members of the multidisciplinary care team, plastic surgeons have a responsibility to provide comprehensive patient education and maintain a robust and evidence-based informed consent process, so patients and their families can set realistic expectations in the shared decision-making context.

Guided by evidence

It's important to note that, as an organization and specialty guided by evidence, the Society's stance on this issue has remained consistent: More high-quality research in this rapidly evolving area of healthcare is needed.

To that end, ASPS efforts in this area include capturing clinical data on gender surgery procedures for adults and the development of practice resources to better aid members in implementing best practices in offering gender surgery services when the highest quality evidence is available. ASPS supports transgender patients' constitutional protections and right to safe, private and humane medical care.

Further, it has always been the Society's position that members should be able to provide medical care without fear of government-sanctioned penalties and criminalization – and ASPS opposes any attempts at legal encroachment into the practice of medicine.

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- ASPS reinforces patient safety measures in the wake of reports of counterfeit Botox injections

This is **Exhibit "C"** to the affidavit of
IAN MITCHELL sworn/affirmed before me
this 7th day of February, 2025.

Anna Little

A Commissioner for Oaths in and for Alberta

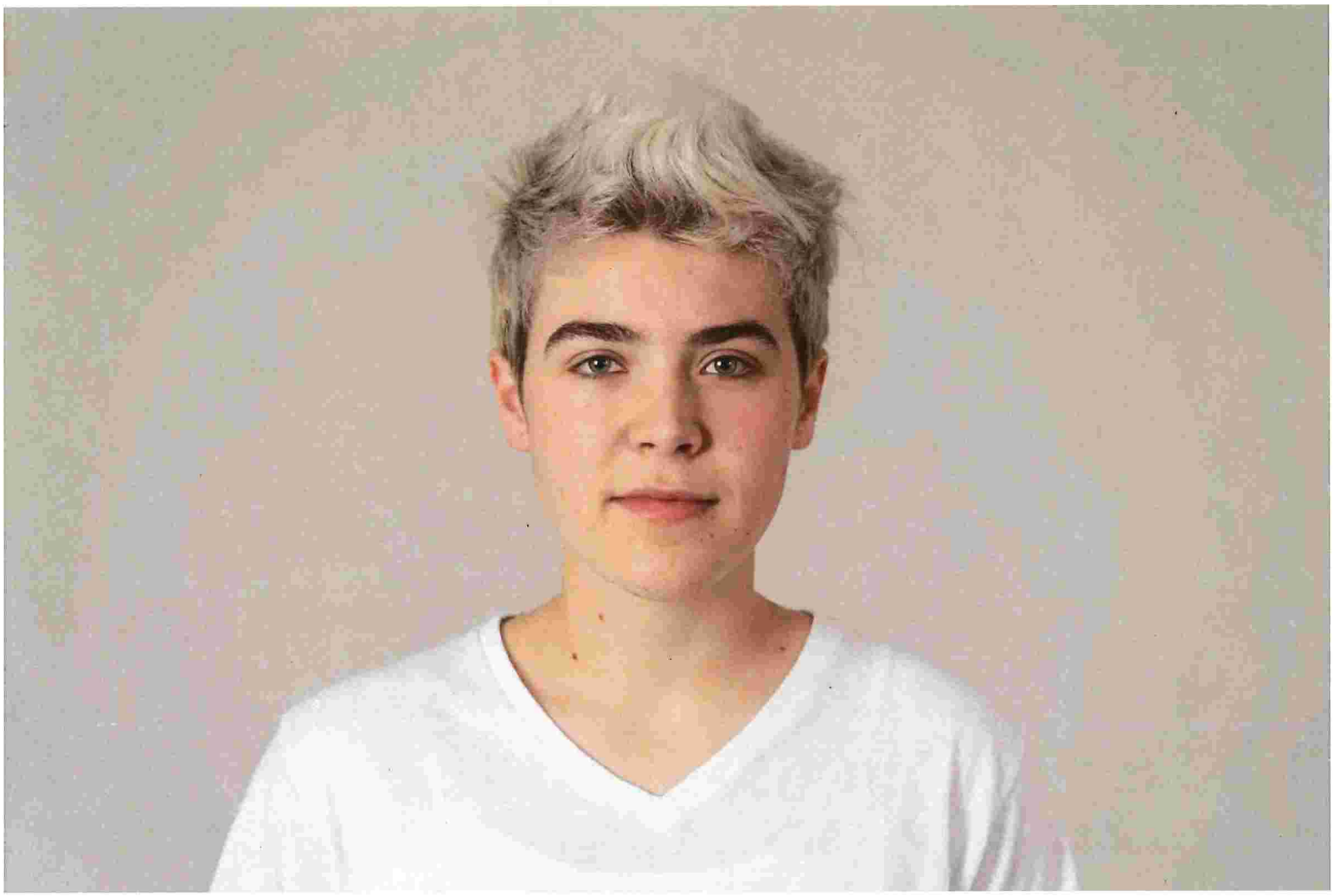
ANNA LITTLE
A COMMISSIONER FOR OATHS
IN AND FOR ALBERTA
LAWYER, NOTARY PUBLIC

Health

Expert review unlikely to shift Canada's transgender treatment model

The gender affirming-care model, which supports medical interventions in transgender youth, is dominant in Canada's medical community, despite expert concerns

by **Hadassah Alencar**
June 14, 2024



(Dreamstime)

Read: 8 min

Two months after England released an expert report discouraging medical interventions for transgender youth, most Canadian provinces have signaled they do not plan to change the gender affirming-care treatment model that is popular here.

And yet, some experts say there is inadequate research on this treatment model, which supports medical interventions that affirm a person's gender identity where it does not match their sex.

"The criticisms that have been evolving over the past number of years about the gender affirming perspective … the evidence that this is helpful is now being questioned," said Dr. Kenneth Zucker, a clinical psychologist who runs a **private practice** focused on gender dysphoria in downtown Toronto.

Dr. Hilary Cass, a former president of the UK's Royal College of Paediatrics and Child Health, was commissioned by the country's public health-care system, NHS England, to independently review the country's youth gender identity services. Her review, which took four years to complete and runs to nearly 400 pages, was **released** on April 20.

The **Cass Review** found poor evidence around medical transition for transgender minors, and recommended that puberty blockers not be routinely prescribed.

Dr. Sam Wong, a general pediatrician and head of the Alberta Medical Association's pediatrics section, largely disagrees with the Cass Review's findings. He is critical of its conclusion that medical intervention for transgender care is not based on robust medical evidence.

"To say that we don't have data on puberty blockers … it's a sleight of hand in some ways. We do have data, it's just we've been using it [to treat early puberty], and some people have moved it over to gender clinic care," he said.

Dominant model

In Canada today, the primary treatment model for transgender youth is the "gender affirming-care model." It can include several steps.

Typically, the first step — which can occur at any age — is social transition, such as adopting a new name, pronouns or clothing.

"A healthcare provider is not needed for social transition but may help a youth access resources," IWK Health, a children and women's hospital in Halifax, said in an emailed statement. "Parents are most often the ones who make these decisions for young children or support their older child/youth to access resources to socially transition."

Only after starting puberty is a patient eligible for medical treatment such as drugs or surgery. For example, a doctor may prescribe puberty blockers to stop the patient's body from developing certain characteristics — such as breasts — and later prescribe sex hormones so the patient takes on characteristics of their new gender identity.

At this stage, a patient can also undergo some gender reassignment **surgeries** to change their appearance.

Wong says pediatricians will evaluate a patient's medical, mental health and personal history to determine if they have gender dysphoria. Gender dysphoria is a mental health condition where an individual experiences psychological distress when their biological sex does not match their gender identity.

"If somebody comes in and they're six years old, and they are playing with toys of the opposite gender, or they see themselves as the opposite gender … I'll provide care for them until getting closer to puberty," said Wong, who has had three or four transgender patients.

"[T]hen I'll refer them to the transgender care clinic if they continue to have that continued gender diversity."

'Best way to help'

Gender-affirming care was not always the dominant approach to transgender treatment in Canada. This model only started to become popular in the mid-2000s, says Zucker, the clinical psychologist.

Previously, the preferred approach was the "biopsychosocial developmental model," which involved assessing a minor's biology, psychology and social environment to understand their mental health and create a treatment plan appropriate for the individual.

Social transition is not encouraged for every individual, says Zucker, who still uses the biopsychosocial developmental model in his own practice.

Rather, the goal is to help a patient feel more comfortable with their birth sex on the grounds that this enables them "to avoid the complexities of biomedical treatments such as hormones and gender reassignment surgeries," said Zucker, who led the gender identity clinic for children and youth at Toronto's Centre for Addiction and Mental Health for more than 30 years.

In 2015, Zucker was let go following **accusations** from patients, activists and clinicians that Zucker and the centre were practicing a form of "conversion therapy" — a practice that attempts to change a person's gender identity to accord with their biological sex.

Zucker denied these accusations. In 2018, the centre reached a half-million dollar **settlement** with him and issued an apology for mistakes they'd made in their review.

In Zucker's private practice today, youth are evaluated and may be encouraged to wait to see if their gender dysphoria can be resolved by treatments other than social and medical transition.

But Zucker says there is no "one-size-fits-all approach" to treatment.

"How I might approach things with a three-year-old is not going to be the same as with a 13-year-old or with a 20-year-old. So I think it's very important to take into account developmental factors in thinking about what might be the best ways to help," he said.

'Different pathways'

A 2011 **study** co-authored by Zucker found that out of 139 male children who were diagnosed with gender dysphoria, 88 per cent had desisted as an adult. Other studies also show the vast majority of children do not persist in having gender dysphoria as adults.

But a 2022 **study** found that 94 per cent of 317 transgender youth who had socially transitioned maintained their new gender identity five years later. Zucker says these findings suggest social transition can influence a child's gender identity.

"A social transition in childhood is not some kind of neutral act that occurs *in vacuo*," he said. "It is a type of psychotherapeutic intervention that likely will be associated with a very different long-term outcome."

This is why he suggests practitioners and patients spend time "exploring all options before reaching a conclusion that social transition is going to be the most helpful way in reducing gender dysphoria."

Wong disagrees that a minor's chosen gender should not be affirmed.

"I don't understand how somebody who is a clinician is able to say, 'No, you shouldn't be social transitioning'," he said. "I don't need to write a prescription for them to do social transitioning. They're doing it on their own, but I can support them with the social transitioning."

Photo by Rosemary Ketchum on **Pexels.com**

In the past 20 years, there has been an increase in adolescents with gender dysphoria who had no history of gender diverse behaviour in childhood, Zucker says.

This "suggests that there are different pathways that lead to gender dysphoria, and it may imply that one should not use the same therapeutic approach for everybody," said Zucker.

Some children who have socially transitioned under Zucker's care have stayed transgender, but others have not.

"If you adhere to a kind of born-that-way philosophy, it sort of implies that a parent doesn't think that there could be a host of factors that are contributing to why their child is feeling the way that they're feeling," he said.

Wong suggests social transitioning and early medical care can give youth time to explore their gender identity and reverse course if they so choose.

"Sometimes they just need time to figure out who they are," said Wong.

No controlled trials

The Cass Review examined the gender-affirming care model and found a lack of studies on the safety and effectiveness of medical intervention for transgender youth.

There have been no randomized controlled trials — often called the "gold standard" for scientific study — to measure the effectiveness of the gender-affirming care model. The review evaluated other studies, but determined "many were very poorly conducted," Cass said in an **interview** with The New York Times.

"I can't think of any other situation where we give life-altering treatments and don't have enough understanding about what's happening to those young people in adulthood," she said. "The critical issue is trying to work out how we can best predict who's going to thrive and who's not going to do well."

Wong agrees that transgender patients and treatments need more research — but so does a great deal of pediatric care. Up to 80 per cent of pediatric medications in Canada are prescribed **off label**, meaning use differs from Health Canada-approved guidelines.

"Gender affirming care is just one of the areas where we lacked research," he said. "Let's be honest, there's not a lot of money in pediatrics. So companies are not going to be doing a lot of research on pediatric patients. And that's been the last 100 years."

Wong also notes there is research showing puberty blockers are safe. "We've been using [it] for decades in precocious puberty," he said, referring to early puberty.

Another common critique of gender-affirming care is that existing studies are fairly short in duration, so little is known about the long-term outcomes, says Zucker.

Dr. Roy Eappen, an adult endocrinologist who has been a **vocal** opponent of medical transitions for transgender minors, says some of his concerns lie in how youth may not be able to consent to some of the irreversible consequences of medical treatments.

"I see a lot of 20-year-olds say, 'I'm never gonna have a baby.'… And then 10 years later, they're desperate to have a baby. So, I don't think we should do irreversible things without good evidence for them," said Eappen.

Medical institutions that endorse and use the gender-affirming care model say the approach is crucial because transgender children are at greater risk of committing suicide if they are not provided with this care.

The medical "evidence is such to recommend that providing medical treatment including puberty-blocking medication and hormone therapy is helpful and often life-saving," the World Professional Association for Transgender Health, a professional association devoted to transgender health, said in a published **comment** on the Cass Review.

But the Cass Review did not find evidence to support this risk.

"It has been suggested that hormone treatment reduces the elevated risk of death by suicide in this population, but the evidence found did not support this conclusion," the report says.

Health landscape

In March 2024, a month before the Cass Review was released, medical associations in every province and territory except Nunavut released a joint statement opposing government efforts to **restrict** access to medical care for transgender patients.

Both the **Canadian Pediatric Society**, a national association of pediatricians, and the **World Professional Association for Transgender Health** promote the gender affirming-care model. The latter has released a **statement** criticizing the Cass Review's findings and recommendations.

The Cass Review made international headlines, yet it was barely **reported** on and addressed politically in Canada, says Dave Snow, associate professor in the department of political science at the University of Guelph.

One of the reasons it is difficult to see a report of this nature resulting in drastic changes in Canada is that, unlike in England, each province manages their own health-care systems.

Alberta, Saskatchewan and New Brunswick are the only provinces that have plans or policies to limit transgender minors' social transition in schools or medical interventions. Alberta Premier Danielle Smith has cited the Cass Review as reason to restrict medical transition for those under 18.

Julian Haber, Photographer, Canada Strong and Free Networking Conference 2024.

"[The] Cass [Review] can provide some of the scientific impetus to say 'There's a lack of evidence in this area and that's why we're bringing in these regulations, these restrictions,'" said

Snow. "Or it could provide a model to say, 'Let's study it first, before we do anything,' or perhaps let's 'Let's pause it and then study."

A number of countries have limited medical intervention for transgender youth, including England, Finland, Sweden, Denmark and some US states. Others, such as the Netherlands, are conducting reviews on the evidence for medical transition.

Countries that support medical transition for transgender youth include Canada, Belgium, Germany, Austria and Switzerland.

Wong firmly disagrees that the gender-affirming care model should be restricted in any way.

"To have the government… pick on [transgender youth] for political reasons seems grossly unfair to me," he said.

"We as pediatricians should be allowing them to come into our office and our clinic and say, 'Here's a safe space for you to be who you want to be who you think you are. And if you change your mind or something changes, and you decide not to move forward, that's all right'."

This is **Exhibit "D"** to the affidavit of
IAN MITCHELL sworn/affirmed before me
this 7th day of February, 2025.

Anna Little

A Commissioner for Oaths in and for Alberta

ANNA LITTLE
A COMMISSIONER FOR OATHS
IN AND FOR ALBERTA
LAWYER, NOTARY PUBLIC

UNIVERSITY OF CALGARY

Cumming School of Medicine

Department of Paediatrics
Alberta Children's Hospital
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Calgary, AB, Canada T3B 6A8

20 June, 2024

Dear Dr. Wong (Sam),

Thank you very much for your work as head of the pediatric section of the Alberta Medical Association.

We were pleased to see the recent OpEd on vaccination that we are sure will be supported by 99% of your colleagues.

This letter concerns a recent article in Canadian Affairs on issues of gender transitions in children and youth. We refer to statements attributed to you that are in quotes in the article. If these are misquotes, then we apologize. We recognize how highly polarized the discussion has become, even within professional circles. The Bioethics Group in our faculty had attempted to invite Dr. Cass to speak in Calgary, but after some discussion with leaders in pediatrics and in gynecology have not proceeded with the invitation. We concluded sadly that she would have been exposed to a taxing environment.

In the interest of brevity, here we focus on comments about puberty blockers, not all the comments attributed to you. Puberty blockers are only one component of the approach to gender dysphoria. In the article, quotes attributed to you justified their use in this new situation because of their previous use in early onset puberty. However, pediatric history has shown us that successful use of a drug in one situation does not mean it will be safe and effective in another. It may be, of course, but shouldn't we ensure it is effective and safe? The context is also vastly different, between early

puberty and gender dysphoria. Use in this new context needs to be studied. That can be done in a number of ways, from simple observational studies to more sophisticated adaptive design studies. Funding need not entail large dollars from a pharmaceutical company; there could be a small-scale pilot study requiring minimal funding.

Let us be clear, we believe these young people deserve the highest level of support. What you are doing may be exactly the right thing to do. At this stage, several years after the increase in gender dysphoria was noted, it is disappointing that the prevailing attitude is that we don't need evidence, and to seek evidence is showing a lack of support for these young people and the discrimination many people still face for not being heterosexual. To continue with the theme of clarity, many components of our current approach to gender dysphoria might be wrong; are we causing harm? Neither you nor we can be sure where the truth lies.

This letter is written in the hope that you can use your leadership role to move the management of gender dysphoria into mainstream pediatric evidence-based practice. We agree with you that not all of pediatrics is evidence based, and that there may be logistical and financial barriers to evidence-based practice. However, this is the only area in pediatrics, to the best of my knowledge, where opposition to attempts to acquire evidence are the norm. A strong evidence-base is the best defence against government interference in medical practice.

Yours truly,

Ian Mitchell, Professor, Pediatrics, Cumming School of Medicine

Darrell Palmer, Pediatrician, Calgary

Roxanne Goldade, Pediatrician, Calgary

This is **Exhibit** "E" to the affidavit of
IAN MITCHELL sworn/affirmed before me
this 7th day of February, 2025.

Anna Little

A Commissioner for Oaths in and for Alberta

ANNA LITTLE
A COMMISSIONER FOR OATHS
IN AND FOR ALBERTA
LAWYER, NOTARY PUBLIC

Paediatrics & Child Health, 2024, XX, 1–2
https://doi.org/10.1093/pch/pxae070
Letter to the Editor

Letter to the Editor

Letter to the Editor: Response to the Canadian Paediatric Position Statement on transgender and gender-diverse youth

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The Canadian Paediatric Society Position Statement (CPS-PS) *An affirming approach to caring for transgender and gender-diverse youth* (1) urgently needs revision to take into account the findings of the Cass Review of Gender Identity Services in England (2). The review, commissioned by the National Health Services (NHS) England, after nine studies and comprehensive stakeholder consultations, made recommendations for the standard of care for gender-questioning children and youth.

The systematic review of 23 clinical guidelines for children and young people experiencing gender dysphoria (3,4), found that only the guidelines from Finland (5) and Sweden (6) were based on an ethical review, following a robust, transparent process linking the quality of evidence to treatment recommendations. These two guidelines recommend a cautious approach, with psychotherapy as the first line of treatment, and puberty blockers and hormones limited to the context of research.

The CPS-PS was not included in the review as it was published after the cut-off date of December 31, 2022. However, the CPS-PS relies heavily on the Endocrine Society Guidelines (7), the American Academy of Pediatrics position paper (8), and the World Professional Association for Transgender Health's Standards of Care (WPATH SOC8) (9) which Cass criticized for their non-independence and circularity (2, p. 130) and using weak evidence to make strong recommendations ((2, p. 132).

Cass also commissioned systematic reviews of social transition (10), puberty blockers (11), and masculinizing and feminizing hormones (12). Cass concluded that the evidence supporting each of these interventions was 'remarkably weak' (2, p. 13).

Cass considers social transition a psychological intervention with the potential to change a young person's gender development trajectory and thus, should involve parents and be practiced with caution. Cass recommended that puberty blockers be used only in the context of ethically approved research trials. In anticipation of this recommendation, NHS England issued a new service specification ending the routine use of puberty blockers for gender dysphoria (13). Cass recommends cautious use of cross-sex hormones but only after the age of 16 and after a thorough psychological assessment and formal independent review of each case. Each of these recommendations is based on their insufficient evidence base and potential cost–benefit ratio.

The Cass Review, based on nine studies, eight of which were systematic reviews assessing the quality of evidence, as well as extensive stakeholder consultation is the most thorough review of gender-affirming treatments in young people conducted to date. It carefully considered the meteoric rise of young people presenting with gender distress, the dramatic reversal of the sex ratio in this population, the co-occurring mental health and neurodiverse conditions, the socio-cultural and developmental contexts that may contribute to trans-identification, as well as the literature on detransition, and made prudent recommendations. The Cass Review represents the new international standard of care. Given that the current Canadian model parallels the UK's prior gender-affirming care model, the findings of the Cass Review are pivotal. Canadian youth deserve the same protection of evidence-based guidelines as children in Finland, Sweden, and the UK.

CONFLICT OF INTEREST

All authors declare no conflict of interest.

Received: June 28, 2024; Accepted: August 29, 2024

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Paediatrics & Child Health, 2024, XX, 1–2
https://doi.org/10.1093/pch/pxae066
Letter to the Editor

Letter to the Editor

Response to the Letter to the Editor on the Canadian Paediatric Society statement on gender-affirming care

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The Cass Review of Gender Identity Services in England ('the Review') is an extensive and in-depth review of gender care *in the UK* (1). We fully support and embrace the Review's focus on providing holistic, comprehensive care; providing mental health and community support for youth, parents, and caregivers when warranted; working to ensure that youth are fully informed about the ramifications (pros/cons, short- and long-term impacts) of decisions they make; and the desire to have transgender and gender-diverse youth be treated the same manner as cisgender youth. Indeed, these are the central tenets of the Canadian Paediatric Society's (CPS's) position statement, *An affirming approach to caring for transgender and gender-diverse youth* (2).

It is important to recognize, however, that there are significant limitations, biases, and inaccuracies within the Review (3–5). The Review did not follow established methodological standards for the evaluation of evidence quality, limiting the validity of its conclusions (3,4). Many studies were excluded from the systematic reviews commissioned by the Review because they did not meet the ideal methodologic standards—randomized controlled trials, blinded studies, and multi-institutional research. It is true that evidence generated via these methods is strongest, but it is not always ethical or feasible to perform such studies, and the absence of such evidence does not negate evidence generated through other commonly accepted study methodologies. Evidence generated through such methodologies is the foundation of practice across many domains of paediatrics (3), and as is true for all of paediatrics, ongoing ethically conducted, non-coercive research in the field of gender-affirming care will be important to continue to advance and enhance practice.

Furthermore, in the context of assertions regarding concerns for evidence quality, the Review has been noted to include incorrect citations of evidence (6) and inaccurate, sometimes scientifically disproven speculations (3). Even among the studies referenced by the Review and the accompanying systematic reviews, it is notable that very little evidence of harm due to current care models is documented. In fact, the Review did not cite any new primary literature that would indicate risks beyond those already acknowledged and described in the CPS position statement. That the Review asserts that the quality of evidence on which current practice is based is inadequate and then goes on to make recommendations that are based on a lower level of evidence is striking and concerning.

The CPS position statement is just that—a position statement. It did not endeavour or claim to serve as a clinical practice guideline. Rather, the position statement draws on a broad literature, including two clinical practice guidelines which, like both the position statement and the Cass Review, emphasize the importance of an individualized approach to care following a comprehensive biopsychosocial evaluation (7,8). Unlike the Review, which lacked sufficient input from content experts with experience treating transgender and gender-diverse youth, these two guidelines encompassed extensive consultation with clinical experts from around the world. Details of the development process of the World Professional Association for Transgender Health (WPATH) Standards of Care Version 8 and the 2017 Endocrine Society Clinical Practice Guideline have been emphasized again in their organizations' responses to the Review (9,10).

The Cass Review is a critique, authored by a single individual, presenting a perspective on current practices in a particular context, and it will inform care. It does not, however, purport to be 'the new international standard of care', and it should not be treated as such. The model of gender-affirming care in Canada differs in many ways from the approach that had been in place in the UK. Alternative perspectives that draw different conclusions from those in the Review regarding evidence and treatment options persist in different jurisdictions around the world.

No single perspective, including that articulated in the Review, represents the full truth when providing care in a situation with recognized unknowns, and a singular approach to

Received: August 16, 2024; Accepted: August 22, 2024

care is neither ethical nor effective in safely meeting the needs of a population. The approach to gender-affirming care for adolescents in Canada must remain grounded in the tripartite approach to evidence-based practice that guides clinical care broadly—the best available evidence, clinical expertise, and patient and family goals and values (11). This is the fundamental conclusion of the CPS position statement *An affirming approach to caring for transgender and gender-diverse youth,* and one that remains unaltered by the publication of the Cass Review.

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This is **Exhibit "F"** to the affidavit of
IAN MITCHELL sworn/affirmed before me
this 7th day of February, 2025.

Anna Little

A Commissioner for Oaths in and for Alberta

ANNA LITTLE
A COMMISSIONER FOR OATHS
IN AND FOR ALBERTA
LAWYER, NOTARY PUBLIC

Concerned Canadian Physicians

Dec 11, 2024

VIA EMAIL

Dr. Joss Reimer
President
Canadian Medical Association
1410 Blair Towers Place, Suite 500, Ottawa ON K1J 9B9

Dear Dr. Joss Reimer,

The Alberta government has announced legislation relating to pediatric gender medicine.

The proposed amendments to the Alberta *Health Professions Act* would result in three key changes:

1) Prohibition of sex reassignment surgeries in minors
2) A complete ban on the use of puberty blockers and hormone therapies for the treatment of gender dysphoria or gender incongruence in children under 16, and
3) A requirement for parental, physician and psychologist approval before puberty blockers and hormone therapies for gender reassignment and affirmation purposes can be commenced in those aged 16 and 17.

In disagreement with these changes, the Canadian Medical Association (CMA) issued a statement titled "CMA Strongly Opposes Government Efforts to Restrict Access to Care". In this statement the CMA takes the position that the gender-affirming treatments restricted by the Alberta government are "evidence-based medical care" and that restricting "the most appropriate care options for some patients has the potential to cause permanent harm". Simply put, the CMA appears to believe that medical interventions for children with gender dysphoria are evidence-based and, furthermore, that puberty is harmful to such children.

As Canadian doctors, we disagree with this stance. We and many of our colleagues believe that more caution is warranted. These interventions should not continue in Canada without challenge, especially as European countries with more experience in gender medicine are stepping back. We are disappointed that the CMA did not poll its members on this topic and has ventured to comment without broad consultation from the organization.

This field is fraught with significant gaps in evidence, limited understanding of the risks, and a confusing mix of ideology and science. Had the CMA polled its members, it might have found widespread uncertainty in this area and that many doctors are uneasy about the medical and surgical interventions being performed on minors in Canada. For example, a recent peer-reviewed article by Canadian authors concluded that "the gender affirming model of care, a

dominant treatment approach in Canada, is based on low quality evidence" and recommends that a holistic approach to assessment and psychological interventions is the most appropriate. Specifically, that the use of puberty blocking agents, cross-sex hormones, and surgical changes to a child's sex phenotype (mastectomy, tracheal shaving, etc) are higher risk interventions than psychosocial interventions and natural puberty.

In April of this year, NHS England released a report commissioned in 2020 as an independent review, to summarize and appraise practices related to the treatment of children with gender distress in the UK. This review, known as the Cass Review, made clear recommendations, citing several systematic reviews of evidence. For clarity, a systematic review is the highest level of appraisal of evidence that can be carried out to ask questions about the quality of research in a particular field. Citing a lack of robust evidence and the potential for harm, the report advised against medical and surgical interventions in minors and instead recommended psychosocial support interventions. For puberty blockers in particular, the report expressed heightened concern about interfering with psychosexual and gender identity development in children and adolescents. It further identified possible risks to neurocognitive development, bone mineral density, cardiovascular health and the unknown psychological and physical consequences of disfiguring surgeries of the face, breasts and genitals. To date, none of these risks have been adequately addressed in North American clinic settings, and follow-up studies are either lacking or remain deliberately unpublished, while other risks have been identified and ignored.

For benefits from cross-sex hormones in minors (e.g. testosterone given to girls), the Cass report again found no evidence for benefit and evidence of possible harms. Even for non-medical 'social transition', the report found neither benefit nor harm and advised caution, particularly for prepubescent children. A main concern about social transition in young children, the report claimed, is that it may result in an altered developmental trajectory with a higher risk of later medical interventions.

Reviews and guidelines from Sweden, Denmark and Norway, ahead of the Cass review over the last 3 years, expressed similar concerns and have led to significant policy shifts away from the medicalized gender-affirming care pathways.

Led by one of the world experts in pediatric gender medicine, Dr. Riittakerttu Kaltiala, Finland conducted its own review and concluded that evidence for pediatric gender medical and surgical interventions is low-quality, inconclusive and high risk. Finland recommends psychotherapy as the first line of treatment for pediatric gender dysphoria, limits hormone treatments to very few cases, and does not allow gender reassignment surgery in those under 18.

Dr. Kaltiala, concerned about the North American approach to pediatric gender medicine, wrote an opinion piece in 2023 warning that "gender affirming care is dangerous" and that some of the current approaches are based on "dangerous groupthink that results in patient harm."

Finally, let us also consider the opinions of the Canadian public. When polled by the Angus Reid Institute, a majority of Canadians expressed opposition to hormones and surgery for gender transition in children.

When it comes to the current medical approach to pediatric gender distress, we believe that the position taken by the CMA does not represent the majority view among Canadian physicians. Until the medical evidence becomes more compelling for the majority of us, it is more than reasonable to insist on the protection of children against possible harm, placing limits - guardrails - around these controversial medical interventions. In fact, without a standardized approach to assessment and diagnosis of the source of this growing clinical presentation of distress, there are no experts in the world who are able to tell which children might benefit from these interventions. Given what we know from data so far, and from a growing body of data on detransitioners and people whose gender distress resolved without intervention, we can conclude that the number of children who might be harmed from these interventions is more than 0% of those presenting to MDs with gender distress. Without this knowledge, we risk harming children and limiting their future potential as healthy, cognitively mature, sexual, and reproductive beings. This constitutes unethical medicine.

Lastly, extensive data has been collated over decades of research that indicates that the most common underlying cause of gender distress in children is the fact that many of them will develop into gay and lesbian adults at puberty and into adulthood. Those of us who are, who know, who love and who work with, LGB colleagues can only ask whether the CMA or any organizations that support gender-affirming care interventions have stopped to think about the impact this will have on our future population of Canadian lesbian, gay and bisexual adults.

We urge the CMA to consider the arguments and evidence we have provided, as well as the European approach to pediatric gender medicine. At present, international consensus points to a non-medicalized and holistic approach to pediatric patients with gender dysphoria or gender incongruence . We encourage robust research, and civil and rigorous debate on the topic. Furthermore, we express deep sympathy and empathy for the mental distress experienced by children and adolescents experiencing uncertainty about puberty, their bodies and their sexuality. Finally, we declare our prevailing belief that such children should be treated with love, respect, dignity, and with the highest standards of care available to them.

We would appreciate a meeting with you to discuss this further and hear the exact position the CMA will take on this topic after considering our letter.

Sincerely,

(Signatories listed in alphabetical order)

1. [redacted] Anesthesiology , British Columbmia
2. [redacted], Respirology, Ontario
3. [redacted], Anesthesiology , British Columbia
4. [redacted], Pediatrics, Alberta
5. [redacted], Psychiatry, Nova Scotia
6. [redacted], Vascular Surgery/Critical Care, Nova Scotia
7. Dr. Mark D'Souza, Family Medicine/Emergency Medicine, Ontario
8. Dr. Roy Eappen, Endocrinology, Quebec
9. [redacted], Family Medicine (retired), Nova Scotia
10. Dr. Roxanne Goldade, Pediatrics, Alberta
11. [redacted], Family medicine, Taber, Alberta
12. [redacted], Anesthesiology , British Columbia
13. [redacted], Anesthesiology , British Columbmia
14. [redacted], Anesthesiologist, British Columbia
15. [redacted], Pediatrics, Alberta
16. Dr. J. Edward Les, Pediatrics, Alberta
17. [redacted], Radiology/Nuclear Medicine, Newfoundland and Labrador
18. [redacted], Cardiology, New Brunswick
19. Dr. Chris Milburn, Family Medicine, Nova Scotia
20. Dr. Ian Mitchell, Pediatrics, Alberta
21. [redacted], Anesthesiology, British Columbia
22. Dr. Darrell Palmer, Pediatrics, Alberta
23. [redacted], Anesthesiology /Critical Care, British Columbia
24. [redacted], Family Medicine/Addiction Medicine, Ontario
25. [redacted], Anesthesiology, British Columbia
26. [redacted], Psychiatry, British Columbia
27. [redacted], Family Medicine, Alberta
28. [redacted], Pediatrics, Alberta
29. [redacted], Anesthesiology, British Columbia
30. [redacted] Psychiatry (retired), Nova Scotia
31. Dr. Shawn Whatley, Family Medicine/Emergency Medicine, Ontario

ASSOCIATION MÉDICALE CANADIENNE | CANADIAN MEDICAL ASSOCIATION

January 7, 2025

Dr. Pooya Kazemi
pooyakazemi@gmail.com

Dear Dr. Kazemi,

Thank you sending the letter written by you and your colleagues regarding the Alberta government's recently adopted legislation on gender-affirming treatments for pediatric transgender patients.

We appreciate the time and effort you have taken to share your perspectives and insights with us, and we recognize that there is a diversity of viewpoints within the medical profession on this, as well as many other medical issues.

As outlined in our statement, written in partnership with all provincial and territorial medical associations in Canada, the CMA's position is anchored in the commitment to ensure that all Canadians have a right to make personal choices about their health. This means ensuring all children and youth – with the support from their families and guidance of health professionals – have access to a full range of medical care options and can choose what is most appropriate based on their individual needs and the best medical evidence available. In our view, this means protecting access to comprehensive care and support options for transgender individuals, including youth.

The role of health professionals – particularly physicians – in helping families through these discussions is critical. Decisions relating to healthcare interventions for patients need to be considered carefully and seriously, without political interference that restricts what may be the most appropriate care options for an individual. It is also critical that medical standards of practice for all health conditions are able to be adapted to evolving scientific evidence without being restricted by government legislation.

The CMA is firmly of the view that government should not be involved in matters of clinical policy and setting standards of care.

Our position aligns with the statement made by Children's Healthcare Canada and the Pediatric Chairs of Canada, which states that "every child and youth, regardless of their gender identity or sexual orientation, deserves timely access to healthcare services that align with their developmental journey."

Thank you again for the letter and your ongoing work to prioritize our shared commitment to support the well-being of all Canadians.

Sincerely,

Dr. Joss Reimer
President, Canadian Medical Association