Access to fertility services by transgender persons: an Ethics Committee opinion

Ethics Committee of the American Society for Reproductive Medicine

American Society for Reproductive Medicine, Birmingham, Alabama

This statement explores the ethical considerations surrounding the provision of fertility services to transgender individuals and concludes that denial of access to fertility services is not justified. (Fertil Steril® 2015;104:1111–5. ©2015 by American Society for Reproductive Medicine.)

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KEY POINTS

- Transgender persons have the same interests as other persons in having children and in accessing fertility services for fertility preservation and reproduction.
- While current data are sparse, they do not support restricting access by transgender persons to reproductive technologies and do not support concerns that children are harmed from being raised by transgender parents.
- Providers should offer fertility preservation options to individuals before gender transition.
- Programs should ensure that transgender patients who seek fertility services are informed about any distinctive medical risks and the lack of data about long-term outcomes for patients and their offspring.
- Programs should treat all requests for assisted reproduction without regard to gender identity status.
- We encourage programs to collaborate on the collection of outcome data.
- Programs without sufficient resources to offer care have an ethical duty to assist in referral to providers equipped to manage such patients.

INTRODUCTION

The term transgender describes a person whose gender identity, the internal sense of being male or female, differs from the gender assigned at birth. Transgender persons report intense and persistent discomfort with their primary and secondary sex characteristics or their birth sex, often described as "being trapped in the wrong body." This distress can appear as early as childhood (1). The American Psychiatric Association's Diagnostic and Statistical Manual has termed this emotional distress gender dysphoria, while noting that gender nonconformity is itself not a mental disorder (2). Transgender persons describe an enduring wish to change their physical appearance, often including genitalia and secondary sexual characteristics, to bring it in line with their gender identity (1, 3, 4).

Transgender persons may wish to transition from female to male (transgender man or FTM) or male to female (transgender woman or MTF). The term transgender includes people who are at different stages of gender transition physically, emotionally, and temporally (1, 4, 5). Transitioning to a different gender is complex and unique to the individual (1, 4, 5). Transgender persons may or may not choose to alter their bodies hormonally or surgically (3, 4). Gender reassignment surgery, which will change a person's body to conform to their gender identity, is now seen as an effective, safe treatment and is increasingly covered by medical insurance. Research indicates mainly positive outcomes, resulting in relief from gender dysphoria and an improved sense of well-being (3, 5-8). Some transgender persons, however, choose not to have surgery and instead use treatments such as hormone therapy for relief of gender dysphoria (4, 5).

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ART AND THE CHANGING FAMILY

Transgender persons want to have children for the same reasons as others: intimacy, nurturance, and family. Historically, many transgender persons had children with a partner before their gender transition and shared rearing with the partner after transition (9–13). Until recently, transition to the desired gender meant the loss of reproductive potential. Current research reveals that many transgender persons are of reproductive age at the time of transition, and confirms that many may wish to have children after transition (13–16). The World Professional Association of Transgender Health (WPATH) and the Endocrine Society recommend that all transgender persons be counseled about the effect of treatment on their fertility and options for fertility preservation before they undergo transition (5, 15). Thus, physicians are encouraged to advise their transgender patients about options for fertility preservation and reproduction (5, 8, 13, 18).

Patients who deviate from the heteronormative family have historically been denied access to assisted reproductive technology (ART) (16, 17). The wish of gay, lesbian, and transgender persons to have children has been stigmatized by providers and policy makers who have assumed harmful effects for the children (17). Although there is growing acceptance of the use of ART by gay and lesbian patients, some providers express discomfort about providing fertility services for transgender patients (18). Although ART programs may receive requests for fertility treatment or fertility preservation from transgender persons, programs vary in their acceptance of such patients (14, 19–22). Resistance to providing treatment is typically grounded in either concern for the welfare of the patient or concern for the welfare of the offspring, or both. Some programs believe it unacceptable to treat any transgender persons. Some programs may provide services only for FTM (transgender male) patients with female partners, because of reservations about treating all transgender patients (16, 21, 22). It has been standard for the past 10 years In Belgium, France, and the Netherlands, for example, to provide donor insemination for couples with a transgender man and female partner who wish to have children (22). Increasingly physicians, psychologists, and ethicists have argued that the transgender patient should have access to the same options as any person who will or has lost his or her reproductive capacity (19–21, 23).

Requests for treatment from transgender individuals present questions about reproductive rights, the welfare of offspring, nondiscrimination, and professional autonomy. The over arching ethical issue is whether it is acceptable to help transgender persons to reproduce. If it is ethical to provide such services, the second question is whether programs have a duty to treat all transgender persons, regardless of their gender identity.

HISTORY AND ETIOLOGY

Many cultures throughout history have documented gender variant behavior (1, 3, 5, 7). The prevalence of gender-variant persons is difficult to determine, but after a review of 10 studies in eight countries, WPATH estimated the prevalence from 1:12,000 to 1:45,000 for male-to-female individuals and 1:30,400 to 1:200,000 for female-to-male individuals (14). Others have suggested the prevalence is higher (1, 5).

Because gender variance was viewed historically as evidence of psychopathology, transgender persons were encouraged to undergo treatment, with a variety of interventions including medication and shock treatment (3, 7). There is no evidence however that psychological or psychiatric methods can bring about change of a transgender identity (1). While the etiology of gender dysphoria remains poorly understood, biological elements, genetics, prenatal influences, hormonal imbalances, and environmental factors may all be factors (1, 3, 4, 7). The American Psychological Association, the American Psychiatric Association, and WPATH, among other organizations, have concluded that there is no single explanation for gender-variant behavior and that gender dysphoria, by itself, does not constitute a mental disorder (1, 2, 5). Research has found that transgender persons can be highly educated, stably employed, sustain long-term partnered relationships, and do not exhibit mental disorders more often than any other group (8, 13, 24, 25).

Recognizing that transgender people face discrimination in health care, professional organizations have begun to incorporate anti-discrimination clauses into policy and ethics documents. The American Medical Association (AMA) policy position on lesbian, gay, bisexual, and transgender (LGBT) issues explicitly opposes discrimination in health care, physician education and training, and the physician workplace, based on gender identity. With respect to the physician-patient relationship, the AMA asserts that while generally a physician is free to decline to undertake the care of a patient, physicians who offer their services to the public may not refuse to accept patients because of sexual orientation or gender identity (26). The Code of Professional Ethics of the American Congress of Obstetricians and Gynecologists (ACOG) states that the principle of justice requires strict avoidance of discrimination based on sexual orientation or perceived gender (27). Similarly, the ACOG Committee Opinion on Health Care for Transgender Individuals reiterates, “ACOG opposes discrimination based on gender identity” (28).

Literature and research surrounding the experience of transgender patients in health-care settings suggests that many continue to face stigma and confusion by providers, often in the form of insensitivity to preferred gender pronouns, displays of discomfort, and substandard care (29). Suggestions for improving relations between transgender patients and health-care providers include consultation with organizations devoted to supporting transgender individuals and increased education that highlights cultural competency with this community.

OFFSPRING WELFARE AND THE FAMILY

Many persons who oppose reproduction by transgender persons do so out of concern for the well-being of the

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