

# 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; ■: ■-■. ©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).

Received August 13, 2015; accepted August 14, 2015.

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Fertility and Sterility® Vol. ■, No. ■, ■ 2015 0015-0282/\$36.00  
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<http://dx.doi.org/10.1016/j.fertnstert.2015.08.021>

## 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 overarching 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

intended offspring and question whether access to fertility services serves the needs of the children of transgender persons (13, 16, 22). Providers have expressed doubts about whether transgender individuals are suitable candidates for parenthood (8-21). Some have argued that the psychosexual development and mental health of the offspring will be at risk (9, 20). These arguments parallel earlier, now disproved, arguments against providing fertility services to gay and lesbian persons (23).

There has been only a handful of studies about parenting by transgender persons, and these studies have enrolled relatively small numbers of subjects. Much of the research has focused on families where a transgender man or transgender woman had children before gender transition. In a small 1978 study, Green examined 16 children, mean age of 11 years, who were living with at least one transgender parent. In most cases, the children had been aware of the parent's gender transition and lived with the parent during the transition. Green's work focused on psychosexual development. These children did not appear to differ in gender identity, gender role, or sexuality from children raised in heterosexual families (10). Green's second study in 1998 looked at 18 children who had either continued to live with the transgender parent or maintained regular contact with the parent. None of these children exhibited gender variant behavior or disturbances in gender identity. The children typically showed acceptance of their parents' gender change and a wish to preserve a close relationship with the parent (11). In a 2002 study, David Freedman *et al.* examined the gender development, mental health, and family and peer relationships of 18 British children of transgender parents, most of whom had been born before their parents' gender transition. None of these children exhibited gender dysphoria. Further, few of the children displayed significant psychosocial problems, high levels of distress, or depression. The children did experience difficulties in family relationships because of high levels of conflict between the transgender and nontransgender parent (9). Thus, it appears that while a parent's gender transition is not a neutral event for a child, there are protective factors that contribute to resilience and successful coping (9, 12).

The most recent data comes from a 12-year follow-up study of 42 French children, conceived by donor insemination, born into families with a transgender man and his wife. The research concluded that the children, interviewed by three different mental health professionals, are healthy, well-adjusted, show secure attachment to their parents, and do not evidence any gender-variant behavior (30). Thus, the data available do not support the fear that being raised by a transgender parent will necessarily result in psychopathology, identity disturbance, or impairment in psychosocial functioning (9-12, 30).

The security of a child's attachments to his or her parents and the capacity of the parent to be warm and responsive to the child's needs are strong determinants of a child's well-being (17). Research on families where a transgender man or transgender woman had children before gender transition has found no evidence that transgender parents have unhealthy relationships with their children (9-12). Not

only do most transgender parents report positive relationships with their children, research suggests the loss of contact with the transgender parent may cause more harm than the gender change itself (9-12). Transgender parents exhibit these same characteristics associated with good parenting including warmth, commitment to the child, and attention to the child's needs (30-34). There is no evidence that being transgender prevents parents from establishing caring and responsive relationships with their children. The American Academy of Child and Adolescent Psychiatry affirms that "there is no evidence to support that parents who are...transgender are per se deficient in parenting skills, child-centered concerns, and parent-child attachments compared with heterosexual parents" (35).

As noted in the Committee's previous report on *Child-rearing ability and the provision of fertility services*, it is difficult to make accurate predictions about parental child-rearing, and providers should be extremely careful in making them. A wide range of family types and parents can ensure that child welfare and children can develop normally in families where a parent is socially stigmatized (36).

## MEDICAL RISKS AND INFORMED CONSENT

Programs must also ensure that transgender patients who request fertility preservation and assisted reproduction are informed about any known medical risks and the lack of medical data on outcomes. There are currently no practice guidelines for physicians providing fertility preservation and reproductive care to transgender persons, and it is beyond the scope of this document. However, further research is needed to provide evidence-based and patient-centered care and to understand the medical and psychosocial risks and impacts for parent and offspring during treatment, the perinatal period, and on future health.

Providers should offer psychological counseling by a qualified mental health professional to assist transgender persons with questions about disclosure to offspring and others, of the use of donor gametes, disclosure of the parents' transgender status, as well as to provide support for the bio-psycho-social impacts of treatment. Additional areas of counseling exploration might include the impact of discontinuing hormone therapy, impact of fertility treatments on gender dysphoria, and the need for emotional support and resources. Further research is needed on the psychosocial and counseling needs of transgender patients receiving reproductive care.

Exogenous hormones and gonadectomy have well-recognized impacts on fertility. Providers may encounter patients seeking fertility preservation and/or assisted reproduction. Fertility preservation options include sperm, oocyte, and embryo cryopreservation. Ovarian tissue and prepubertal testicular cryopreservation remain experimental. Reproduction in transgender persons who have initiated transition will often involve discontinuation of exogenous hormones. Long-term exogenous hormone use may be associated with a number of risks (4, 5, 15). Assisted reproduction may include the full range of fertility services and do not differ materially from those provided to non-transgender

patients. Whether long-term hormone exposure confers any unique medical risk to the patient undergoing assisted reproduction procedures or any long-term impact on gametes and/or offspring is currently unknown. Consistent with the principles and practice of informed consent, patients should be provided information that is material to their decision making to proceed with or forgo fertility treatment, including that there remain uncertainties and gaps in knowledge as to short-term and long-term impacts of treatment on patients and offspring.

There may be additional ethical considerations for children and adolescents on pubertal suppression therapy who desire fertility preservation, but are hesitant to undergo pubertal development in the gender assigned at birth. Since the options of ovarian tissue banking and prepubertal testicular cryopreservation remain experimental, the Committee recommends that decisions regarding gonadectomy for fertility preservation be delayed until adulthood.

## LEGAL CONCERNS

Although transgender persons experience discrimination, a majority of federal and state civil rights laws do not include express protections against discrimination based on gender identity or transgender status. Several courts and federal agencies have determined that transgender people are protected from discrimination by laws that prohibit sex discrimination. Currently, 17 states, the District of Columbia, and over 100 counties or cities in the United States have anti-discrimination laws that provide express protections for transgender persons (37). Denial of treatment based solely on gender identity thus may be prohibited discrimination in some jurisdictions (37). No states prohibit reproduction or parenting by transgender persons, although there are no strong policies to protect that right (34). A few courts have ruled that a parent's transgender identity alone should not be a determining factor in custody decisions. Transgender parents face many complex legal issues, including legal recognition of their gender, questions about validity and recognition of their marriages, recognition of their legal relationship to their child, and child custody concerns. Thus, providers should encourage transgender patients to consult appropriate professionals to become informed about the legal issues involved in becoming a parent through ART.

## CONCLUSION

The Committee concludes that transgender identity/status by itself should not automatically bar a person from accessing fertility preservation and assisted reproductive services. Unless other factors disqualify transgender persons from fertility services, based on empirical evidence rather than stereotype or bias, we find no ethical basis to deny reproductive services to transgender individuals. Professional autonomy, while a significant value in deciding whom to treat, is limited in this case by a greater ethical obligation, and in some jurisdictions, a legal duty, to regard all persons equally, regardless of their gender identity. Programs without sufficient resources to offer care have an ethical duty to assist in referral to providers equipped to treat such patients.

Treatment is best provided in consultation with a multidisciplinary team, which can include endocrinologists, specialists in transgender medicine, and mental health professionals.

**Acknowledgments:** This report was developed by the Ethics Committee of the American Society for Reproductive Medicine as a service to its members and other practicing clinicians. While this document reflects the views of members of that Committee, it is not intended to be the only approved standard of practice or to dictate an exclusive course of treatment in all cases. This report was approved by the Ethics Committee of the American Society for Reproductive Medicine and the Board of Directors of the American Society for Reproductive Medicine.

This document was reviewed by ASRM members and their input was considered in the preparation of the final document. The following members of the ASRM Ethics Committee participated in the development of this document. All Committee members disclosed commercial and financial relationships with manufacturers or distributors of goods or services used to treat patients. Members of the Committee who were found to have conflicts of interest based on the relationships disclosed did not participate in the discussion or development of this document.

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