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

Ethics Committee of the American Society for Reproductive Medicine

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This statement explores the ethical considerations surrounding the provision of fertility services to transgender individuals and concludes that the denial of access to fertility services is not justified. (Fertil Steril® 2021;115:874–8. ©2021 by American Society for Reproductive Medicine.)

Key Words: Ethics, access, fertility treatment, gender identity, fertility preservation

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KEY POINTS

- Many transgender and nonbinary persons have the same interests in having children and accessing fertility services for fertility preservation and reproduction as other persons.
- Providers should offer fertility preservation counseling to individuals before gender transition.
- Current data do not support restricting access of transgender persons to reproductive technologies, and concerns that children are harmed from being raised by transgender parents.
- Programs should ensure that transgender patients who seek fertility services are informed about the limited but reassuring data on long-term outcomes for patients and their offspring.
- Programs should treat all requests for assisted reproduction without regard to gender identity status.
- Programs are encouraged to collaborate on the collection of outcome data that explore the social and emotional wellbeing of transgender and nonbinary persons and their offspring.
- Programs should become educated on how to provide culturally competent care.

The term transgender describes a person whose gender identity, the internal sense of being male or female, differs from the gender assigned at birth. The term "nonbinary" is used to define a spectrum of gender identities that are neither exclusively masculine nor exclusively feminine.

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 in early 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, including their genitalia and secondary sexual characteristics, to bring it in line with their gender identity (1).

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, socially, and temporally. Transitioning to a different gender is complex and unique to each individual (1, 3). Transgender persons may or may not choose to alter their bodies with hormone-based or surgical treatment options. Gender-affirming surgery, which will change a person's body to conform to their gender identity, is seen as an effective adjuvant treatment. Research indicates mainly positive outcomes, resulting in relief from gender dysphoria and an improved sense of well-being (3). Some transgender persons choose not to have surgery and instead use treatments such as hormone therapy for relief of gender dysphoria (3, 4). Nonbinary people may also undergo body modifications through surgery or hormone therapy. Although increasingly covered by medical insurance, treatment for many transgender patients is still difficult to access or is denied (5).

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ASSISTED REPRODUCTIVE TECHNOLOGY AND THE CHANGING FAMILY

Transgender and nonbinary persons want to have children for the same reasons as other individuals: closeness, nurturance, and family-building. Historically, many transgender persons had children with a partner before their gender transition and shared child-rearing with the partner after transition (6). Until recently, a transition to the desired gender often meant the loss of reproductive potential. Current research reveals that many transgender persons are of reproductive age at the time of transition and many may wish to have children after transition (4, 7–9). 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, as well as options for fertility preservation before they undergo a transition (3, 4). Thus, physicians are encouraged to advise their transgender patients about options for fertility preservation and reproduction.

Patients who differ from the heteronormative family have historically been denied access to assisted reproductive technology (ART) (9). 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 (10). Although ART programs may receive requests for fertility treatment or fertility preservation from transgender persons, programs vary in their acceptance of such patients (8, 10, 11). 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 (9). Increasingly, physicians, psychologists, and ethicists have argued that the transgender patient should have access to the same options as any person who will lose or has lost his or her reproductive capacity (11, 12).

Requests for treatment from transgender and nonbinary individuals present questions about reproductive rights, the welfare of offspring, and nondiscrimination. Historically, the ethical debate over providing fertility services has depended on the balance of these values.

HISTORY AND ETIOLOGY

Many cultures throughout history have documented gender-variant behavior (1, 3). The prevalence of gender-variant persons is difficult to determine. After a review of 10 studies in 8 countries, WPATH reported the prevalence as 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 but noted that the prevalence could be much higher. A study based on surveys in the United States extrapolated that there were almost 1 million transgender individuals in the United States in 2016 (13), and there are rising numbers of young people identifying as transgender, nonbinary, or gender nonconforming (14).

Originally seen as evidence of psychopathology, gender dysphoria is currently believed to result from interactions among biological elements, genetics, prenatal infilluences, and cultural, psychosocial, and environmental factors (1, 15, 16). 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 (1–3). Most data show that the psychological health of gender dysphoric individuals is improved and comparable to that of non-gender dysphoric individuals after receiving gender-affirming treatment (15).

Recognizing that transgender people face discrimination in health care, professional organizations have begun to incorporate antidiscrimination clauses into policy and ethics documents. The American Medical Association 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 American Medical Association asserts that although 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 (17). 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 (18). Similarly, the ACOG Committee Opinion on Health Care for Transgender Individuals reiterates, "ACOG opposes discrimination based on gender identity" (19).

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 (10, 20). The current health care system is not structured for the nonbinary patient. For example, clinical documentation can be problematic because many electronic medical records only permit a male or female gender to be specified. This can lead to insensitive communication and even cause billing issues, such as when a transgender man needs a gynecologic exam. 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 (6, 9). Providers have expressed doubts about whether transgender individuals are suitable candidates for

parenthood (4, 6, 9). Although attitudes toward gay and lesbian parents have become more accepting of same-sex families, there is less acceptance of transgender parenting (21).

There have been only a handful of studies on parenting by transgender persons, and these studies have enrolled a relatively small numbers of subjects. Much of the research has focused on families in which a transgender man or transgender woman had children before gender transition. In a 2002 study, Freedman et al. (22) 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. Furthermore, few of the children displayed significant psychosocial problems, high levels of distress, or depression. The children did experience difficulties in family relationships when there were high levels of conflict between the transgender and non-transgender parent. Although a parent's gender transition is not a neutral event for a child, adaptation is better if there is an absence of parental conflict and the child is younger at the time of transition (22–24). A 12-year follow-up study of 42 French children who were conceived by donor insemination and born into families with a transgender man and his wife concluded that the children, each interviewed by 3 different mental health professionals, were healthy, well-adjusted, showed a secure attachment to their parents, and did not evidence any gender-variant behavior (25). Although limited, the available data do not support concerns that being raised by a transgender parent will necessarily result in psychopathology, identity disturbance, or impairment in psychosocial functioning (23–25).

People who identify as transgender may have more challenges but are just as committed to their families as any other person (24). Research on families in which a transgender man or transgender woman had children before gender transition has found no evidence that transgender parents have unhealthy relationships with their children (22, 23). Many transgender parents report positive relationships with their children, and research suggests that the loss of contact with the transgender parent may cause more harm than the gender change itself (22, 23). Transgender parents exhibit the same characteristics associated with good parenting, including warmth, commitment to the child, and attention to the child's needs (23, 26). 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 no credible evidence shows that a parent's sexual orientation or gender identity will adversely affect the development of the child (27).

As noted in the Committee's previous report on childrearing 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 doing so. The wide range of current family and parental types shows that children can develop normally even in families where a transgender or gender nonconforming parent may be socially stigmatized (28).

MEDICAL RISKS AND INFORMED CONSENT

Programs must ensure that transgender patients who request fertility preservation and assisted reproduction are informed about any known medical risks related to their use of hormones and current medical data on outcomes. There are currently no standard practice guidelines for physicians providing fertility preservation and reproductive care to transgender persons, although organizations such as WPATH endorse that patients should be informed about reproductive options. 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 and pregnancy 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, 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 in order to achieve pregnancy, the 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, and providers may encounter patients seeking fertility preservation and/or assisted reproduction. Fertility preservation options include sperm, oocyte, and embryo cryopreservation as well as ovarian tissue cryopreservation. Prepubertal testicular tissue cryopreservation is considered investigational. In individuals who have already initiated transition, fertility treatment may require discontinuation of exogenous hormones. Assisted reproduction may include the full range of fertility services and does not differ materially from services provided to non-transgender patients. Whether prior 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 not well-studied; however, investigators have seen preservation of normal cortical follicle distribution (29) and successful ovarian stimulation and pregnancies after testosterone use (30). Likewise, limited data on transgender women show that even those using gender-affirming hormonal medications at the time of collection maintain some degree of sperm production, with a mean 2.4 million sperm/mL (31).

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 the short-term and long-term impacts of treatment on patients and offspring.

Children and Adolescents

There may be additional ethical considerations for transgender children and adolescents receiving pubertal suppression therapy who desire fertility preservation but are

hesitant to undergo pubertal development in the gender assigned at birth. Because the only options for prepubertal children are ovarian tissue banking and prepubertal testicular cryopreservation, both of which remain experimental, the Committee recommends decisions regarding gonadectomy for fertility preservation be delayed until adolescence, when other options may be available. Postpubertal minors should receive fertility preservation counseling and be offered options of sperm banking or oocyte cryopreservation. Low utilization of fertility preservation has been noted in the adolescent population, possibly related to not wanting to delay medical transition (32). Furthermore, most states do not have specific laws regarding transgender health care for minors, which may affect access. Adolescents may have the additional barrier of needing parental consent to receive treatment, and there may be disagreements between adolescents and parents about undergoing fertility preservation (33).

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, including the Supreme Court in 2020, in the context of employment discrimination. This is an area of the law that continues to evolve. As of 2018, 21 states, the District of Columbia, and over 225 jurisdictions in the United States have antidiscrimination laws that provide express protections for transgender persons (34, 35). Denial of treatment based solely on gender identity may thus be expressly prohibited discrimination in some jurisdictions (35). In some states, there are no strong policies regarding the use of assisted reproduction or parenting by transgender persons, although there are no strong policies to protect that right (26). 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 and child custody concerns. Thus, providers should encourage transgender patients to consult the appropriate legal experts 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 bar a person from accessing fertility preservation and assisted reproductive services. Unless other factors disqualify transgender persons from fertility services and based on empirical evidence rather than stereotypes or bias, reproductive services should be offered to all interested transgender or nonbinary individuals. Professional autonomy, although 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. Treatment is best provided in consultation with a multidisciplinary team, which can include endocrinologists, specialists in transgender medicine, and mental health professionals.

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