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Commentary: Transgender People Are Not That Different after All

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The ethics consultant here faces a unique situation, loaded with ethical concerns, stemming from both the risk of transmitting HIV to the child and the transgender identity of both partners. Although both are certainly relevant to the committee's determination, I focus on the transgender identity of the partners, specifically urging the ethics consultant to consider the access given to similarly situated groups.

People with cancer and postmenopausal women have access to ARTs in ways that are not always true for transgender people. A closer look at these groups, however, demonstrates that they share critical characteristics. This overlap of similarities suggests that refusing access to ART based solely on the transgender identity of the people involved is not warranted.

When a transgender individual decides to have a child, a consultation with a fertility clinician can be advisable or necessary. Some transgender individuals take hormones, and others have limited options due to the sex of their partner or the changes they have made to their bodies. In this case study, it is the HIV status of the partner that necessitates the assistance of medical professionals. Applying for help in having children can be very taxing for transgender individuals. The mere existence of this case study demonstrates the caution with which an institution proceeds before allowing a transgender individual to utilize ART. By contrast, when an individual of childbearing age is diagnosed with cancer, it is routine for the doctor to present the patient with the option of preserving his or her reproductive capacities. As a result of the illness or treatment plan, cancer patients often lose their ability to have children; thus fertility preservation opportunities become very important.[1] In fact, cancer patients may even review these options prior to a face-to-face consultation with an oncologist, as the options are often enumerated on doctors' websites as a standard part of the treatment plan.[2]

These kinds of opportunities are not well developed for transgender patients. Many transgender patients are actively turned away from fertility clinics or remain uninformed about their options, even after meeting with a doctor, despite the technologies available to help them.[3,4,5,6,7] For transgender patients who have yet to undergo sex reassignment surgery, the options available mirror those available to cancer patients prior to chemotherapy or radiation, as both groups share similar circumstances. Both the cancer patient and the transgender individual have reproductive capacities that are not yet compromised. Additionally, both groups may lose the capacity to reproduce as a result of a medical treatment plan. Moreover, both the cancer patient and the transgender individual could preserve their fertility by reliance on various ARTs. Despite these similarities, some critics might still support restrictions on transgender access to ART. These critics might argue, for example, that children born to such parents will face harmful psychological effects, but these concerns are not based on any reliable data.[8] The existing data seem not to support the view that children do not face harm to any significant degree.[9] In any case, it is to be remembered that some cancer patients try to have children, knowing that they might not themselves survive. A child might be left with only one or no parents, and yet the prospect of this kind of harm is not usually seen as reason to prevent people with cancer from trying to have children. Ironically,

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because of the almost reflexive concern in oncology to preserve fertility, a diagnosis of cancer might actually help bolster a transgendered person's access to ART.

Postmenopausal women also seek out ARTs, after passing the age at which they can conceive and gestate naturally.[10] Although the standard used by medical professionals in giving postmenopausal women access to ART is much higher than the standard for ART access for cancer patients, the comparison still provides interesting insight into the case study at hand. The Ethics Committee of the American Society for Reproductive Medicine (ASRM) discourages the practice of ARTs for postmenopausal women, but it does acknowledge the need to consider each patient on a case-by-case basis.[11] It has said, "Postmenopausal pregnancy should be discouraged. Prospective parents and their treating physicians must carefully consider the specifics of each case before using oocyte donation, including a woman's health, medical and genetic risks, and the provision for child-rearing." Despite the discouragement, this approach does not rule out ARTs for postmenopausal woman even as it sets the default against it.

A prominent argument against postmenopausal reproduction is that there is a "natural end" to reproduction and that women should not bear children past this stage.[12] This position shares similar principles with the argument that the loss of reproduction is the "price to pay" for identifying with and transitioning to a different sex.[13] Both positions rely on that idea that a certain kind of body change must also mean the end of having children. The guidance from the ASRM to fertility clinicians does not see things exactly that way, however, because it does leave open the possibility that some postmenopausal women may be helped in their desire to have children. And if that can be true for postmenopausal women, why not also for transmen and transwomen?

As was the case with cancer patients, critics of postmenopausal pregnancy also express concerns about the welfare of children. These commentators express concerns about the children's welfare but also about the mother's welfare, namely, the risks of gestation, birth, and raising a child after a certain age.[14] By any standard, the combination of factors at play in postmenopausal reproduction should probably raise more concern for a child's welfare than does the mere fact of a transgender parent. A situation in which a child is raised by a parent of an advanced age—who faces obstacles in emotional relationships with the child and limitations on the ability to care physically for the child—is potentially more disquieting than a situation in which a child is raised by two transgender parents of a more conventional childbearing age.

Fertility clinicians are willing to extend reproductive options to certain people at risk of death and to certain women who are menopausal. As a matter of consistency, it seems that the fertility preservation of transwomen and transmen should be understood as equivalent in importance to the fertility preservation for those two groups. Not only that, but the psychological risks to children of having a trans parent do not seem obviously more dangerous than the psychological risks of having a parent die early from cancer or of having a mother of an advanced age. Treating like groups alike suggests that ethics consultants should do what they can to ensure that transpeople seeking help with ARTs get the help they want.

Notes

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10. Ethics Committee of the American Society for Reproductive Medicine. Oocyte donation to postmenopausal women. *Fertil Steril* 2004;82:S254–5.
11. See note 10, Ethics Committee of ASRM 2004.
12. See note 10, Ethics Committee 2004.
13. See note 7, McGuinness, Alghrani 2008.
14. See note 10, Ethics Committee of ASRM 2004.

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What Actually Happened

The ethics consultants met with the senior clinician to discuss the case. The social worker assigned to the infertility service was also included on the consult. During the consultation, the various parties considered whether the factors of seropositivity, transsexual history, social stigma, psychological health, and cultural or legal bias had any relevant bearing on the clinical demands of the case at hand. After much discussion, it was decided that these factors were immaterial. The senior clinician decided to move forward, and the clinical team proceeded to lay out a treatment plan for the couple. Once the infertility therapy began, however, and the multiple burdens of IVF treatment became clear, both physically and financially, the couple decided to postpone care while they discussed it further. They have not returned for treatment.

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