doi:10.1017/S096318011100079X

Commentary: The Questions We Shouldn't Ask

Lance Wahlert and Autumn Fiester

Clinical ethics consults take as a given that the moral standing of the consult itself—the act of calling for and conducting an ethics consult—is beyond reproach. Our working assumption is that bioethicists are always justified in asking about the moral permissibility of fulfilling patients' requests or meeting their demands. In this consult, then, the pressing ethical issue seems to be whether we ought to provide IVF services to this HIV-discordant trans couple. But "ought we to assist?" is not only the wrong question; it is a question that wrongs the subjects of the consult.

Although an ethics consult was called in this case, what is striking here is the complete ordinariness of the patients' request: because HIV has become a chronic, clinically manageable illness and IVF has become the standard protocol to address fertility-related concerns of discordant couples,[1] it is clinically and ethically commonplace to use ART to avoid putting the seronegative partner (and the fetus) at risk for HIV transmission. This best-practice standard is both highly effective and clinically uncontroversial.[2] We have to ask what aspect of this case deems it ethically problematic, warranting an ethics consult in the first place. Using the helpful term coined by Tod Chambers in his work on the genre of clinical ethics cases, we need to ask what is the source of the case's "reportability"[3]—the break in the clinical routine that merits our moral attention.

Parsing this case for its reportability, there are only two features to explore: (1) what is being requested and (2) who is making the request. The former has already been shown to be an ethical non-starter, because the request fits squarely within the standard of care for this patient population. That only leaves the latter: this case must hinge on the who-is-asking component, and that conclusion will lay bare the real ethical controversy of this case. If a heterosexual, gender-normative, HIV-discordant couple came to a fertility clinic to request IVF, there would be no hesitation and certainly no ethical second-guessing of the patients' request. In other words, there would be no ethics consult.

An ethics consultant might justify the extra attention paid here by the mere fact that this is an unusual request; it is not a routine occurrence that a MTF transwoman wants to impregnate a FTM transman who will be the couple's gestational carrier, so the out-of-the-ordinary configuration of the couple itself justifies asking about the moral permissibility of assisting. And after all—this argument and the colloquialism goes—there's no harm in asking. When it comes to clinical ethics consultations, the received view is that there isn't anything problematic in asking about the moral permissibility of a clinical action. This stance would likely see ethical reinforcement in the fact that these reflections couldn't have burdened this couple, because the consult took place without their knowledge.

But all of this speaks to the core ethical problem in the case: clinical ethics takes it as a given that there is a right—even an obligation—to engage in a searching inquiry into the clinical choices of some types of patients, even when what those patients want is an ordinary request in other patients' hands. The troubling moral problem here is not the patients' IVF request but our insistence on a thorough, discriminating evaluation of that request. It is simply not true that any and all questioning of patients' clinical choices is fair game; if we subjected a heterosexual couple to this kind of minute inquiry, they would be highly offended—with cause.

The moral charge that would be leveled against us would be impertinence. They would accuse us of prying, a presumptuous and intrusive overstepping of appropriate clinical boundaries. Inside the standard of care for infertility treatment, there is no legitimate space to inquire about whom to treat, the quality of a couple's relationship, their parenting skills, their emotional stability, or the duration of the desire to parent.

In everyday parlance, the name for this level of searing examination is scrutiny, and it is not value neutral. In fact, its pernicious character might best be explained by examining the suspicious gaze that drives this scrutiny. We coin the phrase "the suspicious gaze" to describe the stance of skepticism and mistrust that providers unwittingly take toward particular categories of patients. The suspicious gaze manifests itself as a systematic type of apprehension and doubt about what particular patients say they want, the rationale they give for wanting it, and their future satisfaction and contentment when they actually get it. The suspicious gaze impugns the patient's credibility, reliability, and stability. As captured in the proverb "consider the source," even the most ordinary of clinical requests seem to necessitate a closer look when these patients make them; in others words, these requests demand scrutiny.

The demand for an ethics consult in this clinically unremarkable case inadvertently betrays the existence of the suspicious gaze toward trans patients. In fact, we believe that whereas the suspicious gaze is especially intense, and the level of scrutiny particularly high, in the arena of childbearing (with its overlapping layers of gender identity, sexuality, procreation, parenting, and coupledom), both the gaze and the scrutiny are found in most areas of trans healthcare. This is but just one instance of the global stance providers take toward transpersons—prior to, during, and after transition.

Consider the very process required for a transperson to transition, hormonally or surgically, from one sex to another: they are without exception subjected to an invasive and prolonged level of scrutiny before clinical providers, assuming their gate-keeping role, will approve and then afford the means to transition.[4] Trans individuals must secure clinical approval to become the sex they maintain they always already were, and it is clinicians who will or will not grant passage from one gender or heteronormative category into another. The transperson is required to give personal and intimate testimonial to secure permission from the provider, whose default position is always one of skepticism. The burden of overcoming clinical doubt is always placed on the trans individual, and so the trans clinical narrative of scrutiny, surveillance, suspicion, and (ultimately) permission or denial is built into the very fabric of that patient-provider relationship. This unique trans clinical narrative appears in every arena of trans clinical care, mirroring the original request-scrutiny-approval pattern. The underlying, and ethically problematic, implication of this pattern is that there is a legitimate, justifiable rationale to question the clinical requests of transpersons; there is an inherent, unacknowledged assumption among providers that transpersons are unreliable, unstable, and maybe even self-deceived when making clinical choices. The suspicious gaze that is generated through the transition process of transpersons permeates all aspects of their future clinical care, and it is merely amplified in the reproductive realm, with all that is at stake there.

Returning now to the case, we have more clarity about why the very question "ought we to assist?" wrongs the patients involved. The question itself is a species of clinical accusation or indictment in the

absence of cause. The question reveals an unjustified, demeaning assumption about the couple before us, that merely by virtue of being transgender, they may be unfit for parenthood. This ethics consult is an implicit demand for these individuals to prove themselves worthy of the right to procreate that all others have by default.

What assumptions about this couple's ability to parent might the clinical team be making here? If transpersons have an unstable gender, will they be unstable parents? Will they raise unstable children? More specifically to this case, if a FTM transman wants to bear a child, has he essentially backed out of his previous, as we might phrase it, "clinical agreement" to be a full-fledged man? Likewise, has an MTF transwoman broken the contract of her clinical agreement by curtailing estrogen treatments such that he can impregnate a partner? The dilemma of trans parentage, thus, is not really about who should access IVF treatment; it is really a dilemma generated by the constellation of the suspicious gaze coupled with the overarching trans clinical narrative that marks these patients as second class as adult agents.

Whereas some might make the case that transpersons can form committed couples, make loving parents, and raise happy and healthy children, these are all irrelevant to the ethics of this scenario. Other persons seeking IVF treatment (such as married heterosexuals, single women, and partnered straight persons) are not scrutinized about either the health of their relationships or the potential quality of their future children's lives. Transpersons should be held to the same standards, and therefore we should not even entertain asking such questions about trans partners. Not only does this case reveal the bias of heteronormativity; it also bears the mark of transphobia.

Notes

1. According to protocol at leading fertility practices.
2. Based on clinical evidence.
3. Chambers, *Fiction of Bioethics*.
4. Based on a quick review of the process.

doi:10.1017/S0963180111000806

Commentary: Crossing Cultural Divides: Transgender People Who Want to Have Children

Timothy F. Murphy

In this case, clinicians called for an ethics consultation to discuss a request they found unusual: two transgender people in a relationship wanted help in having a child.[1] In the course of committee meetings like these, clinicians and academics will typically discuss the request with one another, and if their expertise were to fall short, they might seek counsel outside their ranks.[2] Moreover, when requests to clinicians involve clashes of culture, experts typically recommend broad deference to views that differ from those of the clinicians. In a case recently discussed in the pages of this journal, an ethics committee was advised to bend over backward to accommodate the religious views of a son making decisions on his mother's behalf, never mind that doing so left his mother worse off than she might otherwise have been and never mind that at least one religious scholar offered the son a religious interpretation that could have spared his mother considerable pain and discomfort.[3]

In the case at hand, the cultural divide in question is as deep as any to be found between conflicting religious interpretations; it involves two people who have abdicated the sex assigned to them at birth. This transgender man and transgender woman are looking