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.

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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

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for assisted reproductive treatments to have a child. The further twist that one of the people in this case has an HIV infection is scarcely an issue any longer. Fertility clinicians now have a long history of success in sperm washing, which protects women and their fetuses from a semen-borne HIV infection.[4] No, the novelty of this case lies in the fact that transgender people want to become parents. Mostly to this point in history, transgender men and women have become parents before they transition to new sex identities, but as more people transition earlier—sometimes even as early as adolescence[5]—it can be expected that transgender men and women will make fewer detours into relationships that do not map onto their felt gender identity and—accordingly—will look for opportunities to have children only after their transition. This kind of request has already popped up from time to time.

In 2000, the reproductive clinic at the University of Bristol was approached by a couple asking for help in having a child. In that instance, one of the members of the couple was a transgender man, and the couple was also looking for insemination by donor. The people at the clinic involved with this request published a case report that amounts to a crash course on transgenderism.[6] The authors first reviewed the basics of cross-sex identities: definitions, manifestations, and clinical management guidelines. In that review, one of their key concerns was whether or not transgender people are mentally stable. Looking at some of the evidence in the literature, they find that people with gender identity disorders who transition to the desired gender fare better than those who do not, although they report that transgender women are somewhat less stable than transgender men.

That's the parental side of things; what about the effect of transgender parents on children? The clinicians involved in the Bristol case found no reason to object in principle to offering reproductive assistance to transgender men and women on this basis. They specifically mention the 1978 Green study that to this day stands virtually alone as the only meaningful study of children with transgender parents.[7] The Bristol team did not come to the conclusion, however, that every transgender person should be helped. They left the door open to turning some people away on the grounds that some would-be parents will be unstable and, therefore, undesirable as parents. Even so, they set the default in favor of helping transgender men and women seeking assisted reproductive treatments. As I mentioned, the children of transgender parents are not well studied, but there is no obvious evidence that these children fall anywhere but within the spectrum of effects that other parents have on their children.[8] If there is a case to be made against transgender men and women as parents, it will have to turn on issues other than the stability of parents and the welfare of their children, barring unforeseeable new research findings.

The conclusions of the Bristol clinicians a decade ago hasn't stopped clinicians elsewhere from declining to provide this kind of assistance. In the United States, Tracey Langondino—a transgender man—reported being turned away by one clinic and being offered only limited help from another.[9] The degree of caution expressed in hesitance about helping transgender men and women have children is sometimes expressed as concern about the future children, and that indeed is how the Bristol clinicians saw things: "Our paramount consideration was that an unborn child should receive good and effective parenting." Of course, people who do not need the assistance of clinicians to have children may have children for any reason important to them. They do not have to pass any

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kind of test in order to conceive children or otherwise prove that they can reasonably ensure the welfare of their children. Against this background, it is striking that only a tiny fraction of the people who want children are evaluated for their adequacy as parents, namely those seeking help with ARTs.

Transgender people wanting ARTs face scrutiny not only because they have to pass through decision-making processes presided over by clinicians. They face additional scrutiny because—let's not forget—they are mentally disordered by the canons of psychiatric medicine.[10] In a sense, to raise questions about whether transgender people should have children is to raise questions about the legitimacy of the diagnosis gender identity disorder (GID). In important ways, psychiatry faces challenges about keeping gender identity disorder on the books, at least in its current conception.[11] Transpeople reject the view that they are disordered, and some jurisdictions have extended legal protections on the basis of gender identity. Paradoxically, body modification that goes forward in the name of treating the symptoms of GID also undercuts the validity of GID, because after these modifications, transgender people usually go on to live fairly ordinary lives, so where's the harm that justifies the designation as disorder in the first place? Why, after all, do people have to have certain body parts in order to participate in male or female genders? It is therefore unclear that unconventional gender identities must be a barrier to parenthood.

By itself GID does not undercut someone's ability to understand the nature and consequences of having children, as other psychiatric disorders might. Clinicians unfamiliar with transgender people may want to stop and pause before offering clinical services to them, but—given the degree of access afforded to others—it is unclear that requests for ARTs must trigger additional scrutiny. If ethics consultations or convened ethics committees do take place, the people involved should ordinarily work to give as much benefit of the doubt to transgender people as they do to patients whose religious and cultural views shape their requests of medicine.

Notes

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