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Features

Familial Discordance Regarding Fertility Preservation for a Transgender Teen: An Ethical Case Study

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ABSTRACT

A 16-year-old adolescent who identifies as transgender wishes to consider fertility preservation prior to the use of gender-affirming hormones. The adolescent's parents are divorced, and one parent supports fertility preservation while the other does not. This case explores the minor's future reproductive autonomy and parental decision making in a field where there is limited evidence of known harms and benefits to the use of fertility preservation in the transgender population and about future potential regret from lack of consideration of fertility preservation during the prime window of opportunity. This case is created from a composite of cases seen at multiple institutions.

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CASE

Kasey is a 16-year-old born with XY chromosomes and male genitalia, who identifies as transgender. Diagnosed with gender dysphoria at age eight, Kasey's preferred pronouns are *they, them,* and *theirs.* Kasey has been socially transitioned since age nine and began taking puberty blockers at age 10. Kasey's father, Keith, is a registered nurse. He and Kate, Kasey's mother, are divorced. Kasey has been under the regular care of a psychologist and pediatric endocrinologist since the age of eight and was advised that decisions for gender-affirming hormones would be discussed at age 16. (Gender-affirming hormones induce characteristics of the desired sex and reduce characteristics of the natal sex.) Kasey is excited about the prospect of hormones and has had many long conversations with Kate about Kasey's desires and future goals to one day be in a committed, romantic relationship and a parent. Kate is in agreement with and supportive of Kasey's choices, but Keith is not. During visits with the physicians involved in Kasey's care, Keith asked to see medical evidence about the side-effects of hormones in teens and young adults and potential adverse effects. Keith was displeased with the lack of evidence available.

In the process of discussing the impact of hormones, Kasey learned her fertility might be

impacted. The family was advised of fertility preservation options that could store Kasey's gametes—sperm—for future use. However, since Kasey has been on puberty blockers from an early age, she would have to cease taking the blockers to see if sperm production would resume. Kasey is very interested in this option, as she has always wanted to be a parent, and although Kasey is not sure of her sexual orientation yet, she currently feels more attracted to people who identify as female. Kasey hopes one day that her stored sperm could be used during in vitro fertilization to create a biological child with a woman she loves. Keith does not support attempts at fertility preservation, believing it to be a waste of the family's limited financial resources. Kasey's physician mentions that there are no known charity or special needs funds available to cover some of the costs, but offers to look into it. Keith thinks the consideration of fertility and preservation is too much to consider with all of the other decisions that have to be made. Should Kasey be permitted to pursue fertility preservation despite Keith's concerns?

DISCUSSION

This case involves a tension between parental decision making and a minor's future reproductive autonomy. Kasey is interested in fertility preservation, believing she will want to be a biological parent in the future, whereas Keith thinks fertility preservation is a waste of limited resources. It is important to note that Keith is not just opposed to fertility preservation, but he is also generally unsupportive of Kasey's gender-affirming treatments. Kate, in contrast, agrees with all of Kasey's treatments, including fertility preservation. This issue of parental discord is also a factor in this case, and generally courts have ruled that the custodial parent has the final say in health matters pertaining to the minor.[1] There are also additional options for mediation, such as allowing a neutral third party to make a decision.

We may question whether Keith's opposition to fertility preservation is due to his broader disagreement with Kasey's gender-affirming treatment. When making medical decisions for their children, parents are supposed to act in the child's best interest. While Keith may have some justifiable concerns about hormone treatment, the harms associated with not undergoing this treatment (for example, psychiatric comorbidities and life-threatening behaviors) may be greater than the harms of the treatment.[2] Youth and adults with persistent gender dysphoria have significant potential for suicide or self-harm if they do not receive the services needed to resolve the dysphoria, and while infertility can greatly impact quality of life, it is not life-threatening.[3] Furthermore, hormone treatment is considered to be standard of care: numerous professional medical societies support gender-affirming treatment for transgender youth, and a growing number of insurance companies cover this treatment.[4] Keith's lack of support for Kasey's gender-affirming treatment will likely adversely affect Kasey's well-being. The healthcare team may want to consider having a one-on-one conversation with Keith about Kasey's treatment overall and also try to tease out whether Keith's views on fertility preservation are part of his general opposition to gender-affirming treatment.

Keith's opposition to fertility preservation may be a barrier to Kasey's receiving it, because, in most states, minors need parental consent for the use of hormones and to have fertility preservation.[5] In contrast, if Kasey were seeking other reproductive services, such as contraception, these could be obtained without parental consent in most cases in most states.[6] This raises the question of why fertility preservation should be treated differently than other reproductive services. While abortion is the exception to these reproductive services, due to its controversial nature, fertility preservation for minors has wide support in the medical and bioethics literature, at least for cancer patients.[7] Presumably the same arguments supporting fertility preservation for minors with cancer would apply to transgender individuals. Yet the same dilemma arises in the oncofertility realm when clinicians discuss fertility preservation for children and their parents oppose it.[8]

One of the main factors that differentiates fertility preservation from other reproductive services is cost. Whereas various reproductive services are typically relatively inexpensive and covered by insurance, fertility preservation can be quite expensive and is generally not covered by insurance. The cost of collecting a semen sample, testing the sample to assess suitability for storage, and the yearly storage fees vary by state, but are estimated to be $500 for initial collection and testing and $300 for yearly storage fees.[9] To date, there are no charity programs of-

fering financial assistance for gamete cryopreservation in the case of a transgender individual. Thus, it is a stark reality that the costs alone may prohibit Kasey's parents from consenting for the procedure. Some individuals have pursued crowd-funding campaigns to cover the cost of fertility preservation, but this has not been widely adopted.[10] Further, some reproductive clinics allow payment plan options that may make such procedures more affordable, but would require the "patient" to be at least 18 years old if the parents are not willing to sponsor the loan.

Without Keith's consent and financial support, it seems unlikely that Kasey will be able to undergo fertility preservation since she probably cannot afford fertility preservation on her own. In our healthcare system, the positive right to particular medical treatments is limited, sometimes based on financial resources. Given that fertility preservation, like much of reproductive medicine, is often seen as "elective," it does not receive the same degree of priority as other treatments, even those treatments that are not lifesaving but dramatically improve the quality of life.[11] Decades of data indicate that infertility can negatively impact psychosocial health.[12] Limited studies have been conducted on the potential regret and impact on quality of life among older transgender adults who did not use fertility preservation and are now infertile.[13] However, we know that some transgender individuals, like Kasey, value biological parenthood.[14] Although some research reports low utilization of fertility preservation by transgender adolescents, another study found that 40 percent of transgender individuals chose to undergo some form of fertility preservation before gender-affirming treatment.[15] Further, among those studies that report low use of fertility preservation, there were high rates of youth saying they intended to adopt children.[16] This suggests transgender youth may have different perceptions of parenthood and family composition than cisgender populations. (*Cisgender* denotes persons whose experiences of their gender correspond with the sex they were assigned at birth.)

While fertility preservation for transgender teens is relatively new, in the oncology realm there is established support for fertility preservation for minors because it will ensure them an open future (that is, the possibility for biological children).[17] Here, fertility preservation would also allow Kasey an open future, thereby enhancing her reproductive autonomy. This is particularly important for Kasey, not only because she has expressed an interest in fertility preservation, but also the goal of being a biological parent. Other avenues for parenthood, such as the use of a gestational surrogate or adoption of an infant, are often challenging for all populations due to high costs and state laws in the United States. While it should not be so, our society often makes it challenging for people who are "different," whether as a cancer survivor, member of a same-sex couple, or transgender individual, to adopt.[18] Unlike in the oncology world, the actual risk of infertility from gender-affirming hormones is less well known, and recent research documents report inconsistent risks and outcomes.[19] As such, it is challenging for a careprovider to give definitive, evidence-based information about Kasey's risk of infertility.

At 16, Kasey is probably mature enough to make her own reproductive decisions. There is consensus in the medical literature that minors should be included in both discussions and decisions regarding their healthcare, appropriate to their understanding and maturity.[20] Furthermore, as treatment decisions become more subjective, minors' involvement should increase.[21] Reproduction is seen as a deeply personal endeavor, one that is best made by individuals themselves rather than by proxy. The private nature of reproductive decision making underpins why minors are legally permitted to make most of their own reproductive decisions. Transgender reproductive decisions do not always reflect a minor's wishes due to parental discord, lack of finances, or decisions made at one developmental age that do not remain true in adulthood.[22] Since Kasey is actively involved in decision making regarding her gender-affirming care, it may seem unfair to minimize her role in or exclude her from decisions regarding fertility preservation.

The next step for Kasey, her parents, and the healthcare team is to have a frank discussion of fertility threats and options with all parties present. Kasey should be allowed to express her values and goals for biological parenthood, and Keith should also be able to state his concerns. The American Academy of Pediatrics (AAP) recommends that careproviders attempt an arbitrative model of handing family discordance, as it offers the potential to maintain "family cohesiveness by respecting the authority of parents

and the developing autonomy of children."[23] Along the lines of the AAP recommendation, a recent commentary suggests a pediatric clinician's primary obligation is to the child.[24] Since Kasey is a minor and needs both financial support and consent from her parents for fertility preservation, it may not be appropriate for a healthcare provider to encourage Kasey to pursue preservation over her parents' objections. However, depending upon the divorce agreement, Kate may have the legal authority to make medical decisions for Kasey without Keith's consent. If Kate and Keith have a divorce agreement that requires shared decision making, Kate could appeal to the justice system to win final decision-making authority for Kasey on behalf of maintaining her health and well-being.[25]

If Keith remains opposed to fertility preservation or if he and Kate conclude that even though they are supportive of it, they cannot afford it, Kasey still has some other options for biological parenthood. First, Kasey could delay her treatment until she reaches the age of 18 and can make such decisions without parental consent. However, as previously mentioned, delay of treatment for gender dysphoria often has devastating consequences for youth, with high rates of suicide and other self-harm injuries as well as substance use and abuse.[26] Second, Kasey could pursue emancipated minor status to pursue fertility preservation, although she would still need the finances for such treatment. Crowdsourced funding and community-based fundraising could allow Kasey to obtain the needed funding. Third, Kasey could go off hormone therapy as an adult in an attempt to create a biological child. Yet, the worry with this course of action is that the effects of cross-sex hormones on Kasey's future fertility remain unknown.[27] Transmen have carried pregnancies by pausing their hormone therapy. (A *transman* is a man who was assigned female gender at birth.) A pause in hormonal therapy to re-initiate sperm production may also be a viable option for transwomen who wish to pursue biological parenthood.[28] (A *transwoman* is a woman who was assigned male gender at birth.) This option should be discussed by the healthcare team if Kasey is unable to access fertility preservation treatment.

CONCLUSION

Healthcare teams who are presented with parental discordance over a transgender adolescent's desire for fertility preservation are limited by parental consent and financial support. Healthcare teams should have multiple conversations with minors and their parents to discuss options and hopefully reach a satisfactory solution for all. Reaching an acceptable solution for the parents and the child should be the primary goal of the healthcare team. However, it can be reasoned that the patient's satisfaction has priority over the parents' satisfaction. More research is needed on transgender youths' ability to regain or preserve fertility in adulthood if they are unable to access preservation services as minors.

BLINDING OF THE CASE

Details of this case have been altered to protect the identity of the patient and family.

NOTES

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