Fertility preservation for transgender children and young people in paediatric healthcare: a systematic review of ethical considerations

Chanelle Warton, Rosalind J McDougall

ABSTRACT
Background While fertility preservation is recommended practice for paediatric oncology patients, it is increasingly being considered for transgender children and young people in paediatric care. This raises ethical issues for clinicians, particularly around consent and shared decision-making in this new area of healthcare.

Methods A systematic review of normative literature was conducted across four databases in June 2020 to capture ethical considerations related to fertility counselling and preservation in paediatric transgender healthcare. The text of included publications was analysed inductively, guided by the Qualitative Analysis Guide of Leuven.

Results Twenty-four publications were identified for inclusion. Four key ethical considerations emerged from this literature: access to fertility preservation, conscientious objection, decision-making capacity of children and young people, and shared decision-making.

Conclusion In the identified literature, there is consensus that transgender children and young people should not be refused access to fertility preservation services solely due to their gender identity, and that clinicians with conscientious objections to fertility preservation for this group have an obligation to refer on to willing providers. Factors that create ethical complexity in this area of paediatric care include the child’s age, mental health, and parents’ views.

INTRODUCTION
Fertility preservation and counselling are recommended medical practice for paediatric oncology populations. Fertility preservation strategies are increasingly considered in the context of paediatric transgender healthcare, as social acceptance of gender diversity and non-traditional family structures rises. Transgender young people may choose to medically transition to improve the alignment of their gender identity and physical sex characteristics. Concerns around future fertility are salient for transgender young people as some medical transition pathways inhibit fertility. While research regarding the risks and benefits of fertility preservation specifically for transgender young people is limited, data from other populations indicate that infertility can negatively influence a person’s psychosocial health.

The World Professional Association for Transgender Health and clinical guidelines thus recommend fertility counselling prior to the commencement of medical transitioning for transgender children and young people.

Counselling transgender young people and their families about fertility decision-making can be an ethically complex area for clinicians to navigate. There is a challenging mix of short-term and long-term risks and benefits to consider. Existing studies suggest that fertility concerns among transgender children and young people at presentation to a healthcare service may be neglected and the reduction of gender dysphoria prioritised. Transgender adolescents may prioritise medically transitioning to alleviate gender dysphoria over preserving their future fertility. Decision-making related to paediatric transgender fertility preservation is complicated by the urgency to transition created by gender dysphoria, the lack of medical data on the permanency of some medical transition options, the experimental nature of some fertility preservation methods, and the potential for fertility preservation and counselling to exacerbate gender dysphoria.

Further, enacting the ethical ideal of shared decision-making is complex within fertility decisions in transgender paediatric care. Shared decision-making aims to appropriately support a child or young person’s developing autonomy through active collaboration between the paediatric patient, their parents/guardians and healthcare professionals to determine a pathway of care. However, the capacity for autonomous decision-making varies greatly among children and young people, and health professionals must navigate a child’s developing autonomy to enable competent young people to participate in decision-making, while ensuring children without capacity are involved in, but not responsible for, medical choices. In addition, shared decision-making presents challenges in paediatrics given the intertwined interests of family members, or situations in which parents’ personal values differ from those of the young person.

Fertility preservation and counselling for transgender children and young people are therefore ethically complex emerging areas of healthcare. To date, there has been no systematic review of

“Transgender refers to individuals whose gender identities differ from their birth-assigned sex. Transgender is an umbrella term that includes numerous gender identities, including transgender male, transgender female, gender-queer and non-binary.”

“Gender dysphoria is the distress experienced when one’s gender identity and physical characteristics are incongruent.”

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the ethical considerations relating to fertility preservation and
counselling for transgender young people, and this paper sought
to fill that gap. In identifying and synthesising the normative
literature, we aimed to provide a resource for ethicists and
clinicians to further develop ethical practice in this area. Our
review addresses the following question: *What are the ethical
considerations relating to fertility counselling and preservation for
transgender patients in paediatric healthcare?* We first present
an outline of the current fertility preservation options for trans-
gender young people, followed by the methods used for the
systematic review. We then describe the four key ethical consid-
erations that emerged from this literature: access to fertility pres-
servation, conscientious objection, decision-making capacity of
children and young people, and shared decision-making.

In this paper, children and young people are defined as persons
under 18 years of age or under the legal age of majority.34–35 This
population has been chosen to reflect the delineation between
paediatric and adult healthcare services. Many health services
recommend a patient transition from paediatric to adult settings
at 16–18 years of age.36–37 More transgender young people are
presenting to paediatric settings for possible medical transition in
regions where social acceptance of gender diversity is increasing,
such as Australia.38 Paediatric settings were selected as the scope
for this paper given the increasing need for fertility preservation
and counselling in this age group.

### Fertility counselling for transgender children and young people

The role of fertility counselling is to support patients to consider
the impact of transitioning on their future fertility, and whether
fertility preservation is a pathway that they would like to pursue.
While the need for fertility counselling for transgender children
and young people is acknowledged, there is little specification
regarding its implementation in this context.39–40 Healthcare
professionals may therefore vary in their knowledge, approach
and comfort in communicating fertility preservation options
to transgender young people.11 12 30 31 For example, a national
survey of 284 American endocrinologists found just 36% of
respondents felt adequately trained in fertility and 75% desired
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METHODS

To investigate the ethical considerations relating to fertility
counselling and preservation for transgender patients in paedi-
atriic healthcare, a literature search was conducted in MEDLINE
(Ovid), Scopus, PubMed and PsycInfo (Ovid) databases on 1
June 2020. Databases were chosen to provide broad coverage of
social science, humanities and ethics publications in biomedical
and health-related contexts.

The following search term was used in MEDLINE:

(transgender OR “trans” OR “gender variant” OR transsexual
OR “gender diverse” OR “sex diverse” OR “non-binary” OR
“gender identity disorder” OR “gender dysphoria”) AND (“fertility
counsel*” OR “fertility preserv*” OR “preservation of fertility”)
AND (ethic* OR normative OR moral*) AND (youth* OR
adolescen* OR paediatric* OR pediatric* OR child* OR teen* OR
young OR minor)

Identical or equivalent terms were searched in the remaining
databases. Search terms were applied to titles, abstracts and
keywords across all databases. Search terms were also applied
to Medical Subject Headings (MeSH) fields in Ovid databases.
Database searches generated 60 results, of which 32 were
duplicates.

The full text of each publication was screened using the
following inclusion criteria:

- The publication presents an ethical issue, argument or principle
  related to fertility counselling and/or preservation (see definitions in
table 2). The ethical content could be a section or the entire publication.
  Such content must be explicitly identified as ethical by the publication’s authors.
- The publication discusses fertility counselling and/or preservation
  in the context of transgender young people.
- The publication is in English.

Publications that exclusively discussed transgender adults and
related interventions or had no discernable population age were
excluded. Publications that addressed ethical considerations
in the context of both transgender adults and children were
included. No restrictions were placed on publication date given
the contemporary nature of the topic. Similarly, no criterion was
applied to publication type. An inclusive approach to publication
was chosen in recognition of the value of ethical discussion in
a variety of publication types, such as letters. As is accepted
practice for reviews of normative literature,46 publications were
deemed of sufficient quality for inclusion if they were obtained
from peer-reviewed journals or book chapters from established
academic publishers.47

Following the database searches, the reference list of each
included publication was screened for relevant article titles.
Article titles were deemed relevant if they addressed at least
two aspects of the research question (e.g., fertility counselling

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Methods of fertility preservation available to transgender children and young people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fertility preservation methods</td>
<td>Prepubertal</td>
</tr>
<tr>
<td>Transgender females</td>
<td>Testicular tissuecryopreservation (TTC)*</td>
</tr>
<tr>
<td>(birth-assigned males)</td>
<td></td>
</tr>
<tr>
<td>Transgender males</td>
<td>Ovarian tissuecryopreservation (OTC)*</td>
</tr>
<tr>
<td>(birth-assigned females)</td>
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</tbody>
</table>
| *Fertility preservation methods that are experimental or in development.34–36

**Table 1** Methods of fertility preservation available to transgender children and young people

**Fertility preservation methods**

- Testicular tissue cryopreservation (TTC)*
- Ovarian tissue cryopreservation (OTC)*
- Sperm cryopreservation
- Oocyte cryopreservation

**METHODS**

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  in the context of transgender young people.
- The publication is in English.

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Following the database searches, the reference list of each
included publication was screened for relevant article titles.
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two aspects of the research question (e.g., fertility counselling


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and transgender populations). Relevant publications were then subject to a full-text screening to determine inclusion or exclusion. This process was repeated until no new relevant titles were identified.

Database searches returned 60 results, of which 43 were duplicates or did not satisfy inclusion criteria. Reference list searches returned an additional 7 eligible publications. A total of 24 publications were thus included in this review (see online supplemental figure 1). One researcher initially identified the publications for inclusion. When it was unclear whether a publication should be included, this was resolved through discussion with the other researcher until consensus was reached for that publication. Data analysis and synthesis were guided by the Qualitative Analysis Guide of Leuven (QUAGOL). QUAGOL is an iterative, systematic method of data analysis. Initially, developed as a way of analysing qualitative interview data, it has been increasingly used in reviews of normative literature. QUAGOL involves two parts, each consisting of five stages, where researchers manually draw themes from and subsequently code the literature.

### RESULTS

The 24 publications included in this review are presented in table 3. Ethics journals provided 5 of 24 publications (20.8%). The majority of publications came from other contexts: clinical or legal journals, or social science journals and books. The novelty of this area of healthcare was reflected in the publication dates of the included literature, with 19 of 24 (79.2%) publications dating from 2016 onwards. The focal demographics of the papers are presented in table 4. Ethical considerations in exclusively paediatric transgender populations were addressed in 9 of 24 (37.5%) publications.

Four key ethical considerations emerged from the literature: access to fertility preservation, conscientious objection, decisional capacity of transgender children and young people and shared decision-making.

### Access to fertility preservation

Arguments for and against the right to access fertility preservation are presented in the literature. However, there is consensus that fertility preservation should not be denied solely due to gender identity. Similarly, various authors argue for equity of access to fertility preservation services, specifically that transgender individuals deserve access to such services equal to that of others experiencing infertility. While there is consensus that access to fertility preservation should not be denied on the basis of transgender identity, the literature provides three different justifications for this position, described below.

First, a transgender young person’s right to access fertility preservation is justified by some authors on the basis of bodily autonomy or the child’s right to an open future. Clark and Virani note that “trans youth have the right to bodily autonomy, which includes decisions about... reproductive care” (p298). Quinn et al. highlight that “there is established support for fertility preservation for minors because it will ensure them an open future (that is, the possibility for biological children)” (p263). However, Clark and Virani argue that “it is not possible to preserve all open futures for all [transgender] youth. Therefore, caution must be exercised in privileging one future over another, as the harms caused by holding a particular future open may be significant” (p297).

Second, possible harms to the transgender child or young person are considered as potential arguments against offering fertility preservation. While medical risks inherent to the fertility preservation process are noted, authors suggest these risks are negligible and could be addressed through the informed consent process. Saraf and Nahata argue that while “the fertility preservation procedure itself... may potentially cause harm... Detailed discussions should occur with patients and families about potential risks vs benefits” (p318). Authors also identify the potential for social stigma and discrimination following fertility preservation as significant risks for transgender young people. De Wert et al. support that “risks [from fertility preservation] for applicants themselves are primarily social... transsexual parenthood may meet severe criticism and opposition” (p1861). However, Murphy argues that “given the vast array of parent–child relationships... it is unlikely that anyone could show that [transgender parenthood] ought to be prohibited because it poses harms to parents” (p314). Authors thus consider current and future risks associated with fertility preservation for this group, but overall suggest that these risks could be mitigated and/or do not justify denying access.

Third, the potential harm to future offspring resulting from transgender parenthood is acknowledged in the literature as a possible objection to enabling access to fertility preservation. Some authors note this harm may arise from discrimination towards the future offspring due to their parent’s transgender identity. De Roo et al. confirm this, stating “that a child having a transgender parent may experience more transient and mild harassment than those who do not have a transgender parent” (p117). De Sutter additionally cites concerns around the transgender identity of the parent potentially influencing the gender identity of the future offspring. While Hudson et al. suggest the transgender identity of a parent is not inherently harmful, Murphy argues that, “in reproductive liberty, there is enough leeway for transgender parents to have children, even if there were some kind of undesirable outcome as a result” (p314). The literature does not support denying access to fertility preservation for transgender young people as a result of the potential harms to the transgender person themselves or their future offspring.

Alongside arguments for and against the right to access fertility preservation, the potential for fertility preservation to be financially prohibitive is noted in the literature. Hudson et al. state that cost may present a “significant [obstacle] to fertility preservation for transgender adolescents” (p89). Financial barriers to accessing fertility preservation are recognised as an issue of reproductive justice. Tishelman et al.
highlight the need for further guidance around counselling families without the financial resources for fertility preservation.47

Conscientious objection
The literature explores the issue of conscientious objection among health professionals in relation to fertility preservation for transgender young people.43 The American Medical Association states that physicians in public settings cannot object to treating patients on the basis of gender identity as this violates their greater duty to treat all individuals equally.43 Despite this obligation, authors note that the personal beliefs of physicians may still act as a barrier to fertility preservation services.44 45

Mitu argues that “if clinicians believe that transpeople are unfit for parenting and should not be allowed to reproduce, this might prevent transpatients’ access to relevant information about fertility preservation.”46

While some authors suggest that a physician’s ethical entitlement to conscientiously object is outweighed by a greater duty of care, others suggest that conscientious objections should be respected. In contrast to the views of the American Medical Association, De Wert et al. argue that physicians’ conscientious objections should be respected and that these physicians are obligated to refer patients to another clinic known not to hold such objections should be respected and that these physicians are obligated to refer patients to another clinic known not to hold such objections. In contrast to the views of the American Medical Association, De Wert et al. argue that physicians’ conscientious objections should be respected and that these physicians are obligated to refer patients to another clinic known not to hold such objections.
Table 4 Focal demographic of included publications

<table>
<thead>
<tr>
<th>Demographic</th>
<th>No. (n=24)</th>
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<tbody>
<tr>
<td>Age</td>
<td>14</td>
</tr>
<tr>
<td>Paediatric</td>
<td>10</td>
</tr>
<tr>
<td>Paediatric and adult</td>
<td></td>
</tr>
<tr>
<td>Population</td>
<td></td>
</tr>
<tr>
<td>Transgender only</td>
<td>17</td>
</tr>
<tr>
<td>Transgender and DSD</td>
<td>2</td>
</tr>
<tr>
<td>Transgender, DSD, oncology and immunosuppressed</td>
<td>2</td>
</tr>
<tr>
<td>Transgender and gender non-conforming</td>
<td>1</td>
</tr>
<tr>
<td>Transgender, lesbian, gay and bisexual</td>
<td>1</td>
</tr>
<tr>
<td>Transgender, lesbian, gay and single parents</td>
<td>1</td>
</tr>
<tr>
<td>DSD, disorder/difference of sex development</td>
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Decision-making capacity of children and young people

In the included literature, age is highlighted as influencing the capacity of transgender young people to make fertility decisions. Many authors consider the circumstances in which a young person is able to consent or assent to medical procedures, including fertility preservation. Inadequate training is associated with provider discomfort and embarrassment which obstructs access to appropriate healthcare.

Decision-making capacity can be complex, Nahata et al. note the discordance between allowing young people to make decisions about their transition but not participate in fertility-related choices, stating that “it would be hypocritical to deny [a transgender young person’s] decision to refuse [fertility preservation]” (p4).

The literature highlights the potential effect of psychological comorbidities on a young person’s decisional capacity. Some authors argue that the urgency to transition created by gender dysphoria can compromise a young person’s decisional capacity. Several authors argue that transgender young people can be additionally deterred by the distressing and/or invasive nature of the preservation itself. Hudson et al. acknowledge that “the focus on parts and functions of the body typically associated with motherhood can heighten feelings of dysphoria” during fertility preservation for transgender men (p89). Authors also argue that other psychological or cognitive comorbidities can influence an individual’s ability to make fertility-related decisions.

Roles in shared decision-making

Many authors acknowledge the ethical challenges that arise for providers from shared decision-making with the transgender young person’s parents, particularly when guardians and young people disagree. Johnson et al. articulate a key question facing clinicians: given “patient wishes may be at odds with parental wishes—how to proceed?” (p192). The literature identifies the involvement of parents in decision-making as particularly ethically challenging given the young person may be dependent for care and financial resources. Some authors also acknowledge ethical challenges arising from decisional conflict between parents. Kimberley et al. argue that “dual parent consent may be unnecessarily prohibitive for adolescents who come from households with only 1 parent who is actively involved in the child’s life or in situations in which there may be interparental conflict” (p5). Authors note that navigating shared decision-making may be particularly complex for providers when parents refuse fertility preservation desired by the young person or are generally unsupportive of their child’s gender transition.

Given the significant involvement of parents in the fertility decision-making process, some authors argue that ownership of preserved tissue should be considered and established prior to fertility interventions. Eyler et al. raise the question “can the parents use the gametes without the permission of their children, either before or after they reach the age of majority?” (p155). The majority of ethical challenges identified by the literature related to the involvement of parents in shared decision-making.

Broader ethical challenges related to shared decision-making in fertility preservation for transgender young people are also raised. Authors argued that the complexities and costs associated with future methods of achieving parenthood, such as the use of assisted reproductive technologies (ART), are an influential part of shared fertility-related decisions. Some authors suggest that a young person’s value of genetic filial relations could influence their selected method of future parenthood. Hudson et al. argue that physicians “should also help [transgender youth] to explore how much [they value] the idea of a genetic relationship between [themselves] and any potential offspring as that is a salient difference between [ART and adoption]” (p89). For transgender young people who desire genetic parenthood, the literature argues that barriers to the use of preserved tissue should be discussed. Johnson et al. suggest that “families should... be informed of the future costs of reproductive medicine services” (p192), while Mitu notes that “the social stigma and discrimination against gender and sexual minorities is a challenge when accessing ART (p1122). Alongside exploration of future ART use, the lack of medical data related to the outcomes of tissue cryopreservation is identified as complicating shared fertility-related decisions.

LIMITATIONS

This paper applied search terms to abstracts, titles, MeSH fields (in relevant databases) and keywords. Publications that included ethical considerations in the body of their work but did not explicitly note this in one of the above fields may thus not have been captured.

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It is worth noting that legal precedents around parental usage vary across different jurisdictions.

"It is worth noting that legal precedents around parental usage vary across different jurisdictions."
CONCLUSION

There is an emerging body of normative literature exploring the ethical challenges involved in fertility preservation and counselling for transgender children and young people in paediatric care. This literature coalesces around four ethical considerations: access to fertility preservation by this population, physicians’ conscientious objection, the decisional capacity of transgender young people, and complexities surrounding shared decision-making particularly in relation to parents. In the included literature, there is consensus that transgender children and young people should not be refused access to fertility preservation services solely due to their gender identity, and that clinicians with conscientious objections to fertility preservation for this group have an obligation to refer on to willing providers. The ethical complexity of fertility decision-making in paediatric gender healthcare depends on the child’s age, mental health, and parents’ views. The unique potential for social opposition to transgender identities and related treatment from parents or healthcare providers may also limit access to fertility preservation by paediatric patients.

This systematic review has explicitly identified and synthesised relevant existing ethical considerations, with the aim of informing the practice of clinicians and clinical ethicists in this emerging area of healthcare. It is important to note that paediatric transgender patients’ access to fertility preservation and counselling is limited to countries where there are adequate financial resources and social acceptance. Normative literature currently available in relation to this practice thus reflects the ethical considerations specific to these geographical and social contexts. If the availability of fertility preservation and counselling for paediatric transgender patients expands, future research should aim to capture possible variations in ethical considerations that arise due to cultural context. Further research comparing the ethical considerations arising from fertility preservation and counselling for transgender young people and other paediatric populations where fertility preservation is more established, such as paediatric oncology populations, would be useful. Empirical bioethics research to understand the experiences of clinicians, parents and transgender young people in relation to the ethical aspects of fertility-related decision-making would also be highly valuable.

REFERENCES


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Contributors RJM conceptualised the study. Both authors designed the search. CW led the data collection and analysis, and wrote the first draft of the manuscript.

RJM made substantive revisions to the paper. The study was completed as CW’s research project in the Master of Public Health, supervised by RJM. Both authors finalised and approved the text.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not applicable.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement No data are available.

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J Med Ethics: first published as 10.1136/medethics-2021-107702 on 3 January 2022. Downloaded from http://jme.bmj.com/ on December 6, 2022 by guest. Protected by copyright.
Extended essay


