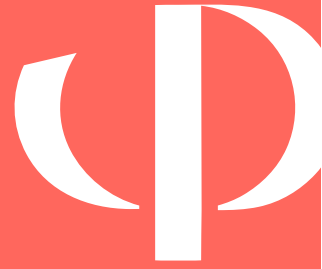


LGBTQ Issues in Philosophy



SPRING 2016

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FROM THE EDITOR

Kory Schaff

CALIFORNIA STATE UNIVERSITY, LOS ANGELES

The APA's Committee on LGBTQ Philosophers is pleased to publish the spring edition of its *Newsletter on LGBTQ Issues in Philosophy*, featuring three articles on public health issues in the LGBTQ community.

Melissa Ballengee Alexander examines the impact of an important but overlooked New Jersey court case that found the advertisement of conversion therapy services violates the state's consumer fraud laws. In the case of *Ferguson v. JONAH* (2015), a jury returned the verdict against a faith-based organization advertising its services for SOCE ("sexual orientation conversion efforts"). Alexander argues that this legal victory is an important step in protecting the right to health for members of the LGBTQ community against so-called conversion therapies and encouraging broader legal reform in which LGBTQ individuals are accepted and treated as equals under the law.

Amanda Roth investigates some bioethical considerations of "queer reproduction" in the health-care system, where LGBTQ individuals and couples continue to face financial obstacles to, and issues of access concerning, reproductive health care due to heterosexist bias, health insurance companies, and other institutional agents. In particular, queer women who want to start a family confront the "medicalization" of reproduction: "what underlies the typical infertility treatment paradigm for queer women is heterosexism—taking the heterosexual-couple case to be the default and failing to recognize and appropriately respond to the ways in which queer women's sexuality makes a medically relevant difference."

Timothy Murphy briefly surveys some philosophical arguments from philosophers John Finnis and Margaret Somerville opposing same-sex marriage on the grounds that the state should suppress public displays of immoral behavior as well as protect the interest of children. Murphy argues that such views not only depend on incoherent claims about Natural Law, they are also confounded empirically by experience and evidence that shows there is no "moral evil" perpetrated by society's acceptance and celebration of LGBTQ individuals and families.

Finally, the committee would also like to announce the search for a new editor of this newsletter. After serving in his appointment for two years, Kory Schaff is stepping

down to make way for new talent and interests. If you are interested in applying for the position of editor of the *APA Newsletter on LGBTQ Issues in Philosophy* starting in 2017, please contact Kory Schaff (kschaff@calstatela.edu) or the committee chair, Ásta Sveinsdottir (asta@sfsu.edu).

ARTICLES

Victim to Victor: A Right to Health Perspective on Ferguson v. JONAH

Melissa Ballengee Alexander

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One day before the landmark United States Supreme Court decision recognizing a constitutional right to same-sex marriage in *Obergefell v. Hodges*, a less widely reported New Jersey case vindicated another important right for the LGBT community. On June 25, 2015, in *Ferguson v. JONAH*, a jury returned a verdict finding that a faith-based organization advertising and selling conversion therapy services violated New Jersey's consumer fraud act. The jury concluded that the faith-based organization, JONAH, and other defendants acting therewith "made misrepresentations in connection with the advertisement, sale or subsequent performance of the JONAH program and engaged in unconscionable commercial practices."¹

Sexual orientation change efforts (SOCE), also known as "conversion," "reparative," "reorientation," or "ex-gay" therapy, seek to change a person's sexual orientation or gender identity. Conversion therapy rests on two premises: (1) homosexuality is a mental illness or disorder, and (2) same-sex attraction can be changed through therapy. Mainstream health professional organizations reject both premises.

I. RECENT RAPID LEGAL REFORMS RELATING TO CONVERSION THERAPY

While progress on same-sex marriage has enjoyed more press, legal reforms limiting conversion therapy have been gaining ground since 2012. In that year, California made national headlines as the first state to ban state-licensed professionals from providing conversion therapy to minors.² New Jersey followed suit a year later.³ Since then, certain medical providers, patients, and parents have challenged these statutory bans as an unconstitutional

restriction of free speech, a violation of the free exercise of religion, or a violation of due process.⁴ So far, however, courts have rejected these arguments as unfounded. Applying differing legal standards, the Ninth Circuit and Third Circuit United States Court of Appeals have upheld the constitutionality, respectively, of California and New Jersey's statutes limiting conversion therapy.⁵

In the past year, progress on curtailing conversion therapy has accelerated rapidly. In May 2015, U.S. Congressman Ted Lieu (D-Los Angeles) introduced the first federal bill seeking to limit conversion therapy nationwide, the Therapeutic Fraud Prevention Act.⁶ That same month, Oregon joined California and New Jersey in prohibiting state-licensed professionals from providing such therapy to minors.⁷ Approximately twenty other states are considering similar legislation to restrict conversion therapy.⁸ Then, in June 2015, the *JONAH* verdict was announced.

The *JONAH* case appears to have precipitated a trend toward more consumer protection-oriented attacks on sexual orientation change efforts. Shortly after the *JONAH* verdict, in August 2015, Illinois became the fourth state to restrict conversion therapy and the first state to expressly provide a private right of action for consumer fraud based on the so-called therapy.⁹ Then, on February 10, 2016, four members of Congress asked the chairman of the Federal Trade Commission (FTC) to regulate conversion therapy as part of the FTC's mandate to restrict "unfair or deceptive acts or practices in or affecting commerce."¹⁰ Later that same month, three human rights organizations jointly filed a complaint with the FTC asking the commission to investigate and take enforcement action to stop an organization, People Can Change, Inc., from advertising and providing conversion therapy services.¹¹ The FTC complaint alleges that the organization's advertisements constitute unfair, deceptive, and fraudulent business practices.¹²

Despite the recent wave of state and federal action seeking to use consumer protection laws to address harms caused by deceptive conversion therapy practices, there is little legal scholarship evaluating the relative merits of this approach.¹³ This article begins to fill that gap by analyzing the strengths and weaknesses of utilizing consumer protection laws as an accountability measure for conversion therapy from a right to health perspective. Specifically, the article provides some preliminary thoughts regarding how consumer protection litigation builds capacity of rights-bearers to claim the right to health.

II. CONSUMER PROTECTION LITIGATION AS A MECHANISM FOR IMPLEMENTING THE RIGHT TO HEALTH

The General Comment on the right to health describes four criteria utilized to evaluate the right to health: availability, accessibility, acceptability, and quality of care.¹⁴ Consumer protection litigation is not likely to materially increase available care nor to make care more accessible; however, it is likely to impact the acceptability and quality of care. The following section describes how.¹⁵

A. UNDERMINING DIGNITY: THE EXPRESSIVE HARM OF A "SAME SEX ATTRACTION DISORDER" DIAGNOSIS

At the most basic level, sexual orientation change efforts rest on the insidious premise that being LGBT or having same-sex attraction is a disorder. This pernicious diagnosis undermines the dignity of the LGBT community. It perpetuates and reinforces stigma and discrimination and threatens the spiritual well-being of individuals who experience such attractions. Consumer protection litigation against conversion therapy providers attacks this harmful diagnosis directly by proving in court to a jury of peers that "same-sex attraction disorder" ("SSAD") is a false diagnosis, unsupported by credible medical professionals.

In fact, the nation's leading medical associations reject the notion that being LGBT or having same-sex attractions is an illness or disorder. The American Psychiatric Association removed homosexuality from its *Diagnostic and Statistical Manual of Mental Disorders (DSM)* more than forty years ago. Today, respected medical professional organizations describe such behavior and attractions as normal variants of human sexuality and gender.¹⁶

There is enormous vindication in a jury verdict recognizing SSAD as a fraudulent diagnosis. Such an affirmation reinforces the notion that same-sex attraction is not an illness to be cured but rather a normal, if less prevalent, way to experience sexuality and gender. Such expressive recognition directly counters the original expressive harm and increases respect for the human dignity of the LGBT community. Treating people who experience same-sex attractions as disordered is not an appropriate way to render quality care.¹⁷ Because labeling same-sex attraction as a disorder by itself causes expressive harm, undermines dignity and respect, and exacerbates any internal discordance, consumer protection litigation discrediting this unsupported premise furthers the right to health and improves the quality of care.

B. POOR QUALITY CARE: THE DANGER OF FALSE HOPE AND BREACH OF TRUST

Similarly, consumer protection litigation also helps improve the quality of care by proving in court that specific conversion therapy services are not effective, as claimed. Conversion therapy rests on the tenuous premise that same-sex attraction can be changed by therapeutic efforts. Yet leading medical and mental health organizations uniformly agree that there is no competent and reliable scientific evidence supporting the efficacy of conversion therapy.¹⁸ In fact, these organizations warn that such treatment may, in fact, pose a risk of harm.¹⁹ As the American Psychological Association concluded after careful study, "efforts to change sexual orientation are unlikely to be successful and involve some risk of harm."²⁰

The notion that same-sex attraction is not a choice for some individuals is almost as fundamental to dignity, respect, and self-worth as the premise that such attractions are not disordered. Many individuals struggle with the fact that they experience same-sex attractions and view such

preferences as contrary to their deeply held beliefs.²¹ Conversion therapy providers take advantage of this discordance for profit.

It is cruel and inhumane to give individuals false hope that therapy will enable them to be someone other than who they are.²² The best approach to care is to help people find self-acceptance.

Consumer protection litigation allows individuals who were victimized by false claims of effective conversion therapy to seek recompense for any deceptive or misleading business practices that cause them injury. Most states' consumer protection laws provide multiplier damages and attorneys' fees to a prevailing plaintiff. This removes at least some of the economic incentive to pedal false hope based on dubious science, thus, hopefully, improving the quality of care.

Moreover, by focusing on deception and economic harm, consumer protection litigation enables a plaintiff to recover damages without having to explore the intricate biases of a juror's view of sexual orientation rights more generally. After all, a juror who questions the merits of LGBT rights can still conclude that it is wrong for a therapist to promise results that cannot be delivered and to take money from a patient for services that are ineffective. In this way, consumer protection litigation focuses on the common ground between those who support LGBT rights and those who are more skeptical. By building a bridge, such litigation recognizes common humanity and appropriate care.

C. THE VALUE OF ACTIVE PARTICIPATION AND EMPOWERMENT

Consumer protection litigation also empowers the recipient of conversion therapy, who actively participates in vindicating his or her rights and, in so doing, transitions from victim to victor. In this regard, litigation may even be superior to legislative or regulatory reform because litigation develops the capacity of the rights-holder to claim his or her rights.²³ It empowers rights-holders personally to take action to improve the quality and acceptability of care.

Individual legal action also provides immediacy of relief. Most, if not all, states already have consumer protection laws.²⁴ Accordingly, through consumer protection litigation, many individuals harmed by conversion therapy can pursue damages and other relief without waiting for further legislative change.

Consumer protection litigation also offers potential redress to a wider range of participants. The legislative efforts to date have focused on state-licensed professionals providing conversion therapy to minors. While there is reason to be particularly concerned about this especially vulnerable group (at added risk of coercion and still trying to form a secure sense of identity), there must also be an avenue for adults who are harmed to seek relief. The sense of having a "disorder" reinforced by conversion therapy, as well as the false hope of a cure, can be devastating for adults as well as minors. Similarly, non-licensed providers can cause as much (or more) harm as licensed providers. Consumer protection

litigation augments legislative and regulatory reforms by expanding both the group of people who have a legal remedy and the providers who can be called to account.

Consumer protection litigation offers a meaningful accountability measure to help implement the right to health. In particular, it enables a consumer who has been harmed to actively challenge conversion therapy practices today, without having to wait for legislative or regulatory reforms.

D. PUBLIC TRIALS CAN INCREASE TRANSPARENCY AND MOBILIZE POLITICAL WILL

Such litigation also tends to generate publicity, shining the light on degrading and inhumane conversion practices and helping to mobilize public opposition (which, in turn, contributes to legislative and other reform measures). For example, in the *JONAH* case, the trial brought to light that the conversion therapy providers were making some men undress and stand naked in a circle and making other men undress and touch their genitals in front of the counselors. Exposing specific, seemingly absurd practices helps to galvanize public opposition to conversion therapy.

Increasing public awareness of the lack of credible scientific support for conversion therapy and of the harm such deceptive practices have caused certain individuals can have a multiplier effect. Personal narratives, as developed and told in litigation, build broader bases of support for the cause. As more people learn of the harm caused by conversion therapy and relate to the individuals injured thereby, more people will support broader legal reforms. Consumer protection litigation can be used effectively, as it was in the *JONAH* case, to sway public opinion, creating a multiplier effect for progress realizing the human rights at issue.

III. LIMITATIONS ON CONSUMER PROTECTION LITIGATION AS AN IMPLEMENTATION STRATEGY

While consumer protection litigation is a promising new tool to empower rights-holders and to combat at least the most egregious conversion therapy providers, it also has significant limitations.

A. A REMEDY AFTER HARM ACCRUES, BUT LITTLE PREVENTION

First, consumer protection litigation only offers a remedy *after* harm occurs. At best, it provides some relief for the economic harm caused by deceptive conversion therapy practices. However, it fails to *prevent* such harm from occurring in the first place, at least directly.²⁵

B. THE INEFFICIENCY (UNSUSTAINABILITY?) OF A CASE-BY-CASE APPROACH

Second, consumer protection litigation is extremely inefficient.²⁶ It only addresses harm caused to individual plaintiff(s) by the particular provider(s) sued.²⁷ Each case is expensive and time consuming to try, and damages tend to be relatively low.²⁸

Moreover, no single case is likely to stop other providers. After all, a consumer protection claim turns on the particular representations and practices of a particular provider to a particular consumer. Such representations and practices typically vary by provider.²⁹ Each case demonstrates only that a particular representation and/or program was ineffective and deceptive, rather than that conversion therapy as a whole is deceptive.

Each suit also requires a plaintiff who is willing to testify that he or she attempted conversion therapy and failed, with invasive, personal discovery of his or her mental health and sexual preferences made public. Many individuals harmed by conversion therapy may be unwilling to give up their privacy or subject themselves to the additional trauma of such litigation. Even for those who are willing to litigate, there is a personal cost.

Each case also requires an attorney who is willing and able to wage an expensive and time-consuming battle for litigation involving relatively low actual damages and a politically sensitive topic. While a prevailing plaintiff can recover reasonable attorneys' fees, an unsuccessful attorney will recover nothing and could be out-of-pocket significant expenses as well as time. Accordingly, such cases really require policy-motivated attorneys donating their time, at least initially, in the hope of reform. This is a difficult model to sustain, especially on a larger scale. The inefficiency of consumer protection litigation limits its utility for widespread reform, justice or accountability.

C. THE POSSIBILITY OF EVADING WITH BETTER DISCLOSURES: IS INFORMED CONSENT ENOUGH GIVEN EXISTING STIGMA AND DISCRIMINATION?

Third, providers may be able to avoid liability by making more complete and more accurate disclosures. For example, a savvy provider could literally quote the conclusions of the American Psychological Association and federal report in its literature and have participants sign that they understand that the medical establishment does not endorse a conversion-therapy approach. Without question, this would be a step forward. Better disclosures might deter some participants, and those who are not deterred would at least have a more accurate understanding of the likelihood of success and possible risks.

However, improved disclosures would still fail to address important concerns about capacity and/or voluntariness of consent for conversion therapy. As long as society, families, and certain religious organizations stigmatize and discriminate against individuals based on sexual orientation, an individual experiencing same-sex attraction may be desperate for any possible solution, no matter how unlikely or risky.³⁰ Improving disclosures without addressing the structural violence currently impeding truly informed consent is a woefully inadequate solution. Providers will continue to be able to prey on vulnerable individuals seeking change—needing counseling on self-acceptance—but instead receiving further reinforcement that same-sex attraction diminishes self-worth. Improved disclosures would also do nothing to combat the expressive injury caused to the LGBT community as a whole by allowing

“professionals” to continue labeling homosexuality as a disorder. Because complete and accurate disclosure is only part of the larger problem with conversion therapy, consumer protection litigation is progress but not a panacea.

IV. CONCLUSION: CONSUMER PROTECTION LITIGATION IS A PROMISING, IF IMPERFECT, SUPPLEMENT TO OTHER STRATEGIES

The recent trend toward increased consumer protection litigation to combat abusive conversion-therapy practices appears likely to aid accountability and improve the quality and acceptability of care. By countering the expressive harm of labeling same-sex attraction a “disorder” with an expressive verdict that labels such a diagnosis “fraudulent,” consumer protection litigation improves dignity and respect for the LGBT community. By demonstrating that conversion therapy is ineffective, consumer protection litigation undermines the credibility of deceptive providers and encourages individuals with same-sex attraction to instead seek self-acceptance. Such litigation empowers former victims and generates publicity that builds momentum for broader legal reform. Overall, conversion therapy consumer protection litigation helps to implement the right to health.

However, such litigation has limitations. It primarily punishes deceptive practices that have harmed individuals without directly preventing them. It is inefficient and may ultimately lead to better disclosures rather than a change in practices. So, while the trend in consumer protection litigation is an exciting, promising development in vindicating rights, it should be viewed as a supplemental strategy until (or in addition) to legislative and regulatory reform on conversion therapy.

NOTES

1. See Order Granting Permanent Injunctive Relief and Awarding Attorney's Fees, *Ferguson v. JONAH*, No. L-5473-12 (N.J. Super. Ct. Law Div. Dec. 18, 2015).
2. Cal. Bus. & Prof. Code §§ 865.1, 865.2.
3. N.J. Stat. Ann. §§ 45:1-54, 55.
4. Setting aside the specific constitutional arguments, many who support conversion therapy argue that for an individual whose deeply held beliefs conflict with his or her same-sex urges, prohibitions on licensed conversion therapy unfairly limit treatment options. They contend that depriving such individuals of the ability to seek the desired therapy in a professionally based, ethically directed setting is unfair—driving treatment underground and to untrained providers. Without addressing whether (or under what circumstances) conversion therapy might be ethical, it is certainly worth taking seriously the risk of driving sexual orientation-change efforts underground to unmonitored, untrained, or illegal providers.
 Because this article focuses on consumer protection litigation, such difficult questions are largely beyond its scope. This risk should be mitigated somewhat, however, by the fact that California, New Jersey, Oregon, and Illinois all limit the prohibition on conversion therapy to minors. Consequently, individuals desiring such therapy can still obtain it in a professional setting as long as they are willing to wait until they reach the age of majority.
5. *Pickup v. Brown*, 740 F.3d 1208 (9th Cir.), cert. denied, — U.S. —, 134 S.Ct. 2871, 189 L.Ed.2d 833 (2014); *King v. Governor of the State of New Jersey*, 767 F.3d 216 (3rd Cir. 2014) (NJ statute does not violate licensed counselor's constitutional rights); *Doe v. Governor of the State of New Jersey*, 783 F.3d 150 (3rd

Cir.), *cert. denied*, 577 U.S. – (Feb. 29, 2016)(NJ statute does not violate minor’s First Amendment right to receive information nor parent’s due process right to direct upbringing of their child).

Thus far, the Supreme Court has declined to grant certiorari in the conversion therapy cases appealed to it. This may change eventually, as there is a circuit split regarding at least two constitutional issues raised by the *Doe* case. First, are state statutes that prohibit licensed professionals from providing conversion therapy to minors regulating conduct or speech? The Ninth Circuit held conduct, finding no First Amendment protection. The Third Circuit held speech, finding at least some First Amendment guarantees implicated (but not violated).

To the extent the statutes are properly considered “professional speech” (upon which this article takes no position), there is an additional circuit split regarding the appropriate standard of review for “professional speech.” The Third Circuit recognizes the longstanding tradition of states regulating professionals and then analogizes professional speech to commercial speech, deciding that such speech should be subject to intermediate scrutiny. Under intermediate scrutiny, limits on professional speech are permissible when they “directly advance” a “substantial government interest” and are “not more extensive than is necessary to serve that interest.” Other circuits considering professional speech have applied a lower standard of review: rational basis scrutiny (often citing *Casey*). Under this approach, restrictions on professional speech are permissible as long as they are rationally related to a legitimate state interest.

6. HR 2450-114th Congress (2015-2016), available at <http://www.congress.gov/114/bills/hr2450/BILLS-114hr2450ih.pdf>
7. Ore. Stat. Ann., Ch. 79, §1 (2015).
8. See *Active Laws & Legislation: The Details*, National Center for Lesbian Rights, available at <http://www.nclrights.org/bornperfect-laws-legislation-by-state/>
9. Ill. Stat. Ann. § 405-48-20 (2016).
10. FTC Letter, February 10, 2016, from Patty Murray, Cory Booker, Jackie Speier and Ted Lieu to Chairman Edith Ramirez, available at http://www.huffingtonpost.com/entry/congress-ftc-gay-conversion-therapy_us_56bb6402e4b0c3c5504f9574
11. Also in February 2016, New York Governor Mario Cuomo announced regulations banning public and private health insurers in the state of New York from covering conversion therapy and prohibiting state mental health facilities from conducting the practice on minors. See Eugene Scott, “New York Gov. Cuomo Announces Regulations to Prevent Gay ‘Conversion Therapy,’” CNN, February 6, 2016, available at <http://www.cnn.com/2016/02/06/politics/andrew-cuomo-conversion-therapy-new-york/>
12. *Human Rights Campaign v. People Can Change, Inc.*, FTC Complaint, available at <http://hrc-assets.s3-website-us-east-1.amazonaws.com/files/assets/resources/FTC-ConversionTherapy-Complaint-Final.pdf>
13. Most recent academic scholarship on conversion therapy has focused on the First Amendment professional speech issue, the tension between parent and state over controversial medical treatment for a child, or concerns over limiting religion in counseling. Outside the context of conversion therapy, there is more scholarship on the value of consumer protection litigation to health. In fact, under the Affordable Care Act, the federal government has started to provide block grants to the states for, among other uses, consumer protection litigation support.
14. General Comment 14: The Right to the Highest Attainable Standard of Health, adopted by the Committee on Economic, Social, and Cultural Rights on May 11, 2000. UN document E/C.12/2000/4.
15. Of course, this assumes that the decision in *Ferguson v. JONAH* can be replicated in other cases in other states. With the *JONAH* precedent and in light of many states’ broad consumer protection laws, similar rulings seem likely. However, until more cases succeed, especially in states without any legislative restrictions on conversion therapy, replicating success is not certain.
16. See Organizational Positions on Reparative Therapy (quoting positions of 14 leading professional organizations), available at <http://www.hrc.org/resources/the-lies-and-dangers-of-reparative-therapy>; see also American Psychological Association, “Being Gay Is Just as Healthy as Being Straight,” May 28, 2003, <http://www.apa.org/research/action/gay.aspx>; and World Psychiatric Association, Position Statement, excerpts available at <http://www.buzzfeed.com/patrickstrudwick/gay-cures-are-harmful-and-don-t-work-says-worlds-largest-body#.rc89rMDNo>

17. Therapy providers who begin from the premise that someone attracted to the same-sex is disordered also risk alienating those individuals from needed therapy or other healthcare. To the extent consumer protection litigation decreases the number of providers who proceed in this manner, such litigation seems likely to increase the acceptability of therapy and other care to this population in ways that further the right to health.
18. See Organizational Positions on Reparative Therapy (quoting positions of 14 leading professional organizations), available at <http://www.hrc.org/resources/the-lies-and-dangers-of-reparative-therapy> and World Psychiatric Association, Position Statement (acknowledging “lack of scientific efficacy of treatments that attempt to change sexual orientation and highlight[ing] the harm and adverse effects of such ‘therapies,’”), excerpts available at <http://www.buzzfeed.com/patrickstrudwick/gay-cures-are-harmful-and-don-t-work-says-worlds-largest-body#.rc89rMDNo>
19. *Id.* Given the premises upon which conversion therapy is based, it is surprising that there is not more definitive scientific proof that conversion therapy causes serious harm. Perhaps, as overall societal (and familial) stigma and discrimination for same-sex attraction decreases, credible evidence will be easier to obtain reliably.
20. American Psychological Association, *Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation* (2009), available at <https://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf>
21. Of course, without existing stigma and discrimination, the prevalence of such internal dissonance may decrease.
22. Conversion therapy’s false promises and ineffective care can also cause a broader breach of trust with the medical profession, which undermines recipients’ trust in the medical establishment more generally.
23. Overall, however, legislative or regulatory limitations on conversion therapy provide superior protection for at least two reasons. First and foremost, they apply prospectively, before an individual is harmed. Second, they tend to apply more broadly (to all minors—rather than just the plaintiffs and to all state-licensed providers rather than just the defendants). Accordingly, when this article discusses the right to health benefits of consumer protection litigation, it views those benefits largely as until (or in addition to) legislative or regulatory reform.
24. However, not all states’ consumer protection laws are broad enough to allow a claim for any unspecified unfair and deceptive business practice.
25. Over time, it could decrease the number of providers and thereby decrease the number of people at risk of being harmed.
26. Even without further regulation or legislation, state regulators could address some of the most egregious representations and practices of state-licensed providers more efficiently than consumer litigation if they had the political will to do so.
27. Class action treatment could theoretically address part of this problem and may be worth exploring for all former patients of a particular provider who were harmed by similar deceptive advertisements and practices. However, an attempt to address multiple providers through class action litigation may be more difficult. After all, different providers advertise and provide services differently. Moreover, what each patient was told, knew and experienced varies, likely making it challenging to prove that any purported class is “similarly situated.”
28. Damages are typically only the amounts paid for the conversion therapy, a relatively small amount even when trebled. Attorneys’ fees are the real deterrent to providers, as such cases are complicated and can accrue seven-figure attorneys’ fees, costs, and expenses, as was the case in *JONAH*.
29. There are myriad possible ways to approach conversion therapy, and especially among unlicensed providers, practices vary widely.
30. While largely beyond the scope of this article, the right to health views spiritual well-being as an integral part of health. Religious

organizations (as well as families and societal structures) can greatly improve health. So, while some religious institutions have historically played an ignominious role in conversion therapy, it is important to acknowledge that religious organizations can and often are essential partners in realizing the right to health.

So This Lesbian Couple Walks into a Fertility Clinic. . . Bioethics and the Medicalization of Queer Women's Reproduction

Amanda Roth
SUNY-GENESEO

So this lesbian couple walks into a fertility clinic. . . . What ought they to expect? It's not the setup for a joke, but rather a genuine issue of bioethical concern I have in mind here: What happens when queer women intend to become parents through reproduction and enter a clinical context in order to do so?¹ Perhaps surprisingly, the answer is not that they will be turned away as unfit for parenthood—though not so long ago this would have been a prevailing experience. As of 2001, 74 percent of ART clinics in the United States took female-female couples as patients, and we might expect this percentage to be even higher today.² Indeed, both the ASRM and ACOG have affirmed an ethical duty of fertility services providers not to discriminate on the basis of sexuality.³

The above paints an overly rosy picture of the situation of queer reproduction in the United States. Even if overt discrimination has waned, inequality in access to reproductive assistance for insurance/financial reasons remains a serious problem,⁴ and there may be gatekeeping occurring that can discourage same-sex couples from pursuing treatment.⁵ Still, it is remarkable that the dominant paradigm queer women encounter in the U.S. reproductive clinical setting is so similar to that offered to heterosexual couples. In a sense this seems an obvious victory for LGBTQ+ equality. But I'll suggest, in another sense, the current situation is also a bioethical quandary—for the context of heterosexual entrance to a reproductive medicine clinical setting contrasts with the context of queer women's entrance into such settings. Once these contextual differences are taken into consideration, it is not so obviously appropriate that women in same-sex and different-sex relationships receive similar treatment.

My main concern in what follows is that queer women often experience an *infertility* treatment paradigm through medicalized reproduction within the fertility clinic, whether or not there is evidence of infertility and often whether or not such treatment was sought. This situation ought to raise significant queer and bioethical concern. The medicalization of reproduction, after all, is not risk and cost free, as feminist critics of reproductive technology have long pointed out. Here, though, there is a more specific objection at hand. Unlike most straight women seeking fertility assistance (after multiple failed attempts

at "natural" conception), queer women in the typical case are not entering the clinic because they tried and failed to become pregnant, and in many cases, thus, they are not unable to conceive without medical intervention. Thus the use of medical/technological intervention to achieve pregnancy is *prima facie* questionable in the average queer context in a way it is not in the average straight context. Further, given that in some cases queer women express resistance and opposition to the medicalized paradigm—but sometimes cannot escape it given various background constraints—the ethical questions here are pointed. Most worrisome of all, I will suggest that what underlies the typical infertility treatment paradigm for queer women is heterosexism—taking the heterosexual-couple case to be the default and failing to recognize and appropriately respond to the ways in which queer women's sexuality makes a medically relevant difference.

I. LESBIAN INFERTILITY?

Before putting forth the critique of the medicalization of queer reproduction, we must take up a prior question: What exactly does *infertility* consist of? Above I imply that members of same-sex couples are not—*qua* members of a same-sex couple—infertile. Yet is this obvious? What does it mean to be infertile anyway? As Julien Murphy points out in a 1999 paper, it cannot merely be a matter of an individual having a physical abnormality that prevents pregnancy such as low sperm motility or blocked fallopian tubes.⁶ Many recognized cases of infertility in male/female couples, after all, are designated "unexplained infertility"; no diagnosis is at hand, yet pregnancy cannot be achieved through intercourse. Further, in some cases both individuals in a different-sex couple might be capable of reproducing with other partners, but are unable to conceive together. Couldn't we, then, hold analogously that same-sex couples *are* infertile? Murphy suggests that a diagnosis of "temporary" or "relational" infertility might solve various discrimination-related problems faced by queer people seeking to reproduce.⁷ Such a diagnosis, she claims, could discourage restriction of services only to heterosexual couples and lead to increased insurance coverage for such services by putting lesbian couples on the same footing as heterosexual couples—both could claim a legitimate medical need for services.⁸

These considerations make a vital point about symmetry. A common objection to reproductive assistance for same-sex couples has been that it is one's choice of partner—not any *medical* abnormality—that prevents reproduction. But as Murphy points out, this is equally true for some infertile different-sex couples. Yet no one suggests that women in such different-sex couples ought simply to find new partners with whom they can reproduce or otherwise denies the propriety of such a couple receiving fertility services. It is easy to see, then, why the notion of universal lesbian infertility might be *prima facie* appealing from the point of view of queer women circa the late 1990s.

Murphy appears cautiously optimistic about the strategy of lesbian relational infertility, but I am less sanguine. In some cases it is doubtful whether Murphy's hypothesized benefits were ever likely to materialize. For instance, Murphy connects the need for same-sex couples to go

through second-parent adoption to secure parental rights to the lack of a medical diagnosis of infertility. But, as has become clear with the success of the marriage equality movement, the issue of second-parent adoption has little to do with a diagnosis of infertility, and almost everything to do with marriage.⁹ More important still, the massive shift in attitudes toward LFBQ families in the last two decades has significantly increased the ability of queer women to receive fertility treatment (so long as they can afford it). In fact, many clinics currently advertise toward same-sex couples and offer procedures, such as reciprocal IVF, specific to them.¹⁰ This undermines Murphy's case for a lesbian infertility strategy by altering the strategic calculus. As Murphy admits, there are costs to the strategy she considers and while two decades or longer ago the benefits might have been worth the costs, they no longer are.

Ironically enough, the greatest weakness of the lesbian infertility strategy in the current climate is that, increasingly, clinics already do treat queer women as if they are infertile! Hence, queer reproduction has in the past two decades or so become significantly medicalized—in great contrast to the “traditional” lesbian approaches of the early days of the lesbian baby boom.¹¹ However, as I will attempt to show, this is no solution to anything, but rather is a distinct queer/bioethical problem in itself.

II. MEDICALIZATION OF QUEER REPRODUCTION

Suspicion of reproductive technology is far from new—this perspective dominated feminist approaches to ART during the 1980s and early '90s.¹² The worry I am putting forth, however, is somewhat different both in spirit and application. I do not object to reproductive technologies generally, nor to any particular form of ART, and I am sympathetic to the notion that these technologies have been an overall boon to liberating the family from its traditional heteronormative constraints. My worry is about recent medicalized practices in regard to queer women's reproduction, specifically, which, I will argue, are primarily the result of heterosexism on the part of fertility specialists.

IN THE CLINIC

My interest in this issue arose given my own experience entering—and quickly exiting—a reproductive endocrinology clinic when my wife and I decided to become parents. Though we intended our visit to a fertility specialist as merely a consultation to explore options and obtain information, it was clear that the provider had other plans. No room was made for the question of *choosing* much of anything; though we preferred a self/home insemination, an in-clinic intrauterine insemination (IUI), which places sperm into the uterus, was treated as a foregone conclusion, and a self-insemination was dismissed as something the provider knew nothing about. Before such a procedure would be performed, I was required to undergo various testing. Two weeks and one low 21-day progesterone result later, a third intervention—the use of Clomid to stimulate ovulation—was immediately strongly recommended, despite months of natural methods of tracking cycles indicating consistent and predictable ovulation. Little room was made for questions here as the recommendation was given over the phone and accompanied by no reference to any risks of fertility drugs.¹³

I never returned to the clinic, reasoning that the level of intervention being required/recommended was much too high for someone who had never attempted conception. In particular, we wanted to avoid a multiple pregnancy, so it seemed absurd to begin fertility medications without first confirming I would be unable to conceive without them. More than this, it seemed to us that such aggressive treatment was not appropriate for our case. Unlike the typical heterosexual patient entering the clinic, we had no evidence of infertility and had never attempted to conceive. The proper comparison case was not the average different-sex couple encountered in the clinic—for whom immediate use of fertility drugs *might* be reasonable—but the typical woman just beginning to attempt to conceive, who has never her fertility.¹⁴ Why, we wondered, should I take on a vastly different treatment protocol than the typical woman about to try to conceive simply given my sexuality?

In talking with other queer people, it became clear this was not an isolated experience—clinics often failed to differentiate in sensible ways between same-sex and different-sex couples. One friend related a puzzling experience of a clinic not permitting her to undergo IUI until her female partner, who would be uninvolved in the process physically/biologically, underwent basic STI testing, as is required for different-sex couples (presumably because the male partner typically provides the sperm being used.) Another acquaintance was advised by a specialist to save time and money by beginning with IVF, again despite no evidence of a fertility problem. Queer parenting and message boards and social media offer similar stories and worries. Many indicate fear that fertility specialists will “pump women full of drugs,” denigrate self-insemination, and dismiss natural methods of predicting ovulation.

The small bioethics literature on this topic supports the above points. Ross et al. report that one of the recommendations offered by queer women for improving assisted reproductive services is to avoid offering and pressuring queer women into fertility interventions when they have no known fertility difficulties.¹⁵ Donovan finds in a pilot study of four lesbian women in the UK that the women experienced their bodies being “medically problematized” as they were presented with “more and more investigative tests and use of drugs at what seemed to them quite an early stage in their [reproductive] attempts,” even though their goal for entering the clinic was to gain access to donor sperm.¹⁶ Markus et al. raise similar concerns about automatic aggressive medicalization of queer women's reproduction; it begins with a case study of a same-sex couple with no known fertility problems who are advised during preconception counseling with a specialist to “pursue pregnancy using ultrasound to detect follicle growth, followed by a human chorionic gonadotropin trigger shot and then intrauterine insemination in the clinic.”¹⁷ In addition, clinics themselves are sometimes forthcoming about the aggressiveness of their protocols. One clinic's website aimed at LGBTQ people describes the usual approach to female-female couples this way: “Combination of ovulation induction with oral medications, like Clomid, and two precisely timed donor inseminations, assures perfect timing and the highest success rates at the Fertility Institute.”¹⁸

Not only do specialist providers often take very aggressive approaches, but anything less is portrayed as a non-option. Haimes and Wenier point out cases of the bioethics literature portraying self-insemination as problematic and dangerous.¹⁹ Indeed, the same clinic's website mentioned above also takes a distinctively negative tone about self-insemination, claiming that the usual methods of detecting ovulation and timing insemination will lead to non-optimal cervical mucus and few sperm surviving. But the idea that self-(intravaginal or intracervical) insemination is dangerous is absurd.²⁰ Further, one wonders in the face of such negativity about self-insemination how so many queer women of past generations have managed to reproduce, given that medicalized options for queer women have become widely available in the past two decades or so.

A recent article in *New York Magazine* describes more of the same. In this case, on the advice of a reproductive endocrinologist, the couple pursued IVF in one woman (after many previous failed cycles) and simultaneously pursued IUI in the second partner. Though the second partner had never before attempted to conceive and had no known fertility troubles, the provider assured the couple that it would probably "take a little while" for her to conceive and so the chances of a double pregnancy were "slim." The result: both partners conceived that month and they delivered their children four days apart.²¹

It is worth pointing out that the immediate use of fertility drugs in queer women without known fertility problems appears to contradict current recommendations. Amato and Jacobson, for instance, addressing an audience of clinicians likely to treat same-sex couples, recommend three to six inseminations before moving on to further testing (e.g., an HSG) or the use of fertility medications.²² Even in light of this much more conservative approach, however, there is room to object to the background assumption of medicalization. Consider an online ASRM fact sheet on same-sex reproduction which is divided by timeline, pointing to issues or questions that might arise "Before conception," "During the fertility work-up," or "After a successful cycle."²³ No room is made here for approaches that are not medically assisted, and it is presumed that any queer woman patient *will* be undergoing basic the "work-up."²⁴

In my view, the appropriateness of the "work-up" and related testing is worth questioning along with the quick escalation to the use of fertility drugs. For as stated earlier, the context of queer reproduction contrasts with straight reproduction in ways that potentially make different approaches within the clinic apt. Current guidelines recommend that male-female couples pursue fertility intervention only after failure to conceive for one year (or six months, in the case of women over age 35).²⁵ Thus different-sex couples encounter the clinic only after establishing with *prima facie* evidence that medical intervention is likely to be required to achieve pregnancy. In light of that evidence, immediate medicalization and aggressive treatment is perhaps warranted.²⁶

But notice that women in same-sex couples rarely attempt to conceive *before* consulting with a fertility specialist.

Rather than failed attempts at conception, the motivations leading queer women to the clinic often include the seeking of detailed information about insemination timing and frozen sperm lifespan; a need for physician involvement in conception in order to receive donor sperm from their chosen bank or in order to protect themselves and any known donor legally when it comes to parental standing; a desire for or curiosity about medicalized approaches to queer reproduction, such as IUI or IVF, which can be more effective per cycle than simple insemination. The point is that the typical female-female couple entering the clinic is not analogous to the typical male-female couple entering that context; suspicion of infertility is rarely what brings queer women into the clinic, and thus *treatment* of infertility is perhaps not an appropriate outcome for these women. Yet, often, that is what they get.

HETEROSEXISM AT WORK

What is happening here? Why are queer women so often treated in such aggressive ways within the clinical context? The answer I suggest is heterosexism on the part of providers in conceptualizing queerness and its supposed relation to infertility.

Consider the case presented in *The New Yorker*. Why would a fertility specialist here expect conception to "take a while" and express surprise when a successful pregnancy results after one insemination? The surprise here is telling. For it *would* be surprising if a heterosexual couple seen in a fertility clinic conceived on the very first (unmedicated) insemination attempt—because such a couple, having failed to conceive after twelve attempts, would reasonably be suspected to be infertile. But no such expectation applies to the second partner, who had never before attempted conception. In fact, as a woman with no known fertility problems, pursuing IUI and using donor sperm (hence ruling out any male-factor infertility possibility), one could reasonably predict a quite good chance of pregnancy occurring quickly. For instance, Gnoth et al., found that of couples using the NFP method to conceive through intercourse, 38 percent conceived during their first cycle trying, with cumulative probabilities of conception approaching 70 percent by attempt number three.²⁷ In this vein, would the provider in question have cast it as unexpected for a typical *straight* woman with no known fertility problems to conceive through intercourse on the first attempt? Surely not. Why, then, is queer women's fertility regularly treated as suspect?

Though the queer context and straight context of entrance into a fertility clinic are dissimilar, the conceptualization and treatment of queer and straight women as patients is essentially identical. Queerness stands in as a proxy for infertility, and queer women are thus slotted in to the very same protocol applied to women in different-sex couples, despite their quite different situation and, in some cases, despite their resistance and objections. In other words, the conceptualization of and treatment advised for queer women is heterosexist; the straight woman entering the clinic and her background context are treated as the default, and the queer woman's difference is ignored.

III. A BIOETHICAL PROBLEM OF QUEER PROPORTIONS

As a bioethical matter, the most obvious concern here is overtreatment, meaning: a) inhibition of patient autonomy over their own reproductive process, b) treatment that proceeds without informed consent, and c) treatment that is not indicated given a reasonable evaluation of the risk/benefit.

To return to my own story, as it happened I never returned to a clinic (or any other) in an attempt to avoid (a)-(c). Consistent with (a), I found the immediate “strong-arming” approach of the clinic alienating and, like many women, objected to the expectation that I would “largely surrender . . . [my] decision-making capacity and bod[y] to the doctors.”²⁸

Given my background in bioethics as well as my wife’s background in health IT, we were able to navigate our situation and ultimately resist what was quite bad medical advice. These sorts of failures, however, are extremely problematic in what they mean in the typical case for patients’ ability to give informed consent. Without an accurate picture of options and risks/benefits—as occurs when self-insemination is depicted as doomed to fail or the increased chance of multiples when using fertility medications is not mentioned—how can consent to treatment be informed?

Finally, even assuming a patient’s truly informed consent, we must question whether the relevant risk/benefit ratio—risks including ovarian hyperstimulation syndrome, multiple pregnancy (and its associated increase in morbidity and mortality for fetuses and pregnant women), and potentially other pregnancy complications—can justify the treatments in question.²⁹ Again, such interventions are not so casually made available to straight women en masse and for good reason. Is it acceptable for queer women to take on such risks simply because of their sexuality?

It was concerns along all of these dimensions that led my wife and I to flee the clinic, which turned out to be a very apt decision. One month later, after completing one cycle of unmedicated self-insemination, I was pregnant . . . with twins. This, just weeks after having been essentially advised to begin treatment for infertility.³⁰

IV. QUEER WOMEN’S REPRODUCTION GOING FORWARD

Given the critique I have put forth above, one might wonder what alternative I have in mind. In my own case, self-insemination was easy, successful, inexpensive, and otherwise satisfying. Is that the suggestion I have in mind for all queer women?

Not necessarily—though I certainly want to resist the common assumption that self-insemination is dangerous, difficult, or ineffective and promote knowledge of what is, after all, the way thousands of queer women have become parents for decades. Still, some same-sex couples will not feel comfortable inseminating on their own or will require the involvement of a physician for logistical

or legal reasons. Consider, then, as another possibility the recommendation from a group of CNM-midwives who suggest that primary care clinicians supervise the process of donor-insemination, whether at home or in the clinic, and that referral to a fertility specialist be reserved only for cases of suspected infertility.³¹ In contrast to the undermining of autonomy some women experience in the fertility clinic context, such an approach combined with traditional fertility monitoring methods of predicting ovulation has the additional benefit that “[m]any couples . . . find . . . [it] quite empowering, because they become the authority on their own fertility.”³² A 2006 Canadian guide aimed at primary care providers takes a similar approach, offering a flow chart for determining when to oversee inseminations in the family clinic, how to counsel patients about home insemination, and when to refer patients to a fertility clinic (after three to five failed inseminations or when required to do so by Canadian law in regards to some types of donation).³³

I think there is much to appreciate in these recommendations. Shifting the majority of queer women’s reproduction to primary care providers, after all, would lead to fewer interventions, which, in turn, means fewer side effects and negative health outcomes. Women themselves (or insurers) would face much lower costs. And fertility-related medical resources would be conserved for those who are actually infertile.

In addition, as I suggested above, if the assumption that sexual identity need be entangled with infertility is inherently heterosexist, it should be resisted. Consider Donovan’s analysis of the conception of donor insemination as a treatment for infertility as heteronormative: “The naming of DI as a treatment for infertility belies the fact that it does not ‘treat’ anything and can only work if the woman is fertile. Such naming implies and imposes the presence of a male who has fertility problems that need to be by-passed by the use of donated sperm.”³⁴ Shifting the reproduction of same-sex couples to primary care providers would help to break the problematic association between queerness and infertility.

On the other hand, there are a number of important worries about Markus et al.’s and Steele and Stratmann’s suggestion. First, hearkening back to Murphy’s argument, there is a cost to repudiating the notion that queerness equals infertility when legitimacy and insurance coverage tends to be tied to the notion of medical need. To deny that queerness is a kind of infertility is to give up one important way of arguing for equity in insurance coverage.

Relatedly, there is a significant worry that breaking the link between queerness and infertility will disadvantage queer people in relation to straight people in a different manner, when we recognize how much of heterosexual fertility treatment may not be “needed” either. I have been discussing the situation of different-sex couples in a manner that implies that all such couples entering the clinic will require medical assistance to conceive, and so interventions like IVF are reasonable. But this, surely, is not always the case—consider male-factor infertility cases in which the female partner is perfectly able to conceive without medical

intervention, but simply through the use of donated sperm. Such couples are routinely offered IVF as a solution to their fertility problem in the same way that female-female couples are immediately offered interventions. Breaking the association between queerness and infertility, however, could delegitimize such interventions in the queer case, but not the heterosexual case. Thus, it might not make sense to attempt to sever the queer-infertility connection until many typical heterosexual “overuses” of medicalized reproduction are reflected upon and questioned, lest queer people be disadvantaged relative to heterosexual people when it comes to ART access.

A final worry has to do with what such a protocol would mean for the small percentage of women in same-sex relationships who are infertile, and thus will require medical assistance to conceive.³⁵ Shifting queer reproductive treatment to self-insemination or primary care providers will presumably lead to a longer time to achieve pregnancy, higher costs, and more stress for these women in comparison to beginning the attempt to conceive with fertility treatment. Relatedly, some queer women reason that with tens of thousands of dollars, years of pregnancy attempts, and significant emotional distress at stake, it makes sense to take an aggressive approach—even to begin with IVF—regardless of any suspicions of infertility.³⁶

In the same vein of thought, what if queer women are not similarly situated to typical straight women beginning their attempts to conceive? What if the analogy I have been relying on throughout the paper breaks down? Achieving pregnancy without medical assistance, after all, is simply a more difficult endeavor for the typical same-sex couple in terms of logistics, financial costs, and the need for detailed knowledge of fertility and reproduction. It may turn out that when women in same-sex couples follow a low-intervention protocol (i.e., three to six well-timed unmedicated inseminations) their failure rate will still be significantly higher than that of women in different-sex couples attempting to conceive naturally. Thus, we may see a higher percentage of women in same-sex relationships requiring fertility treatment in the end anyway. If so, why not begin with the more effective higher intervention approaches for any queer woman who wants them?

These are important concerns, and it is indeed vital to take them seriously in light of the critique I am putting forth and the potential drastic change in reproductive protocols for queer women it supports. Rather than offering a clear response to these concerns, I want to leave them for further careful reflection and debate. What I am aiming for here, then, is less a conclusion about what to do about queer’s women reproduction and more the beginning of a conversation about an issue that does not seem to get much bioethical attention at all.

Further, I take it that what we ought to conclude about queer women’s reproduction should be influenced by relevant empirical data regarding the success of self-insemination vs. provider-overseen insemination vs. fertility treatment; whether the picture of queer reproduction I have painted above is representative; what queer women want in terms of reproductive treatment; what options they are

presented with when receiving care and how they decide amongst those options; and what costs—financial and health-related—they bear. These are issues that largely go untouched in the current bioethics literature. But without such knowledge, it is hard to see how we can come to any conclusion on these issues.

V. CONCLUSION

I am a member of a queer parents social media group with thousands of participants, in which members introduce their families and say something about how they came to be parents. Most indicate that they employed fertility treatments and, unsurprisingly, multiples are common. It is wonderful that all of these individuals/couples have been able to create the families they want. And scrolling through story after story of assisted conception with a happy ending can seem like a powerful confirmation of the appropriateness of current treatment protocols.

Yet, if my argument holds, there is something quite worrisome about what these queer women’s stories represent, both in terms of bioethics and in terms of the queer values and politics relevant to reproduction. If I am correct that the aggressive use of fertility treatments in female-female couples is a result of heterosexism, then we in the queer community ought to be highly skeptical of this approach. Further, at stake is the role of “traditional” queer values that emphasize women’s control of their bodies, autonomy, resisting the medical establishment, and doing-it-yourself.³⁷ We must decide what we want the future of queer reproduction to be.

Additionally, from a bioethics perspective, what is perhaps most disturbing of all is how little we know and are attempting to discover about the queer reproductive clinic patient. Consider again the analogy between same-sex and different-sex family-making. What would the bioethics community’s reaction be if the kind of stories typical in the queer community appeared in the straight community with similar frequency—for instance, if straight women en masse were routinely steered to medical intervention *before* they had ever attempted conception and if intercourse was depicted as a dangerous or ineffective approach to achieving pregnancy? No doubt, this would be perceived as a crisis—an absurd overuse of medical resources, the unnecessary bearing of risk on a massive scale, and a substantial failure to prioritize the autonomy and informed consent of patients. Is it hyperbolic to suggest that something similar might be currently occurring in regard to queer women’s reproduction in the United States?

NOTES

1. I will use “queer” throughout to refer to any same-sex attraction, behavior, or relationships, and thus to include many different specific sexual identities, as well potentially as some trans identities.
2. Paul Amato and Mary Casey Jacob, “Providing Fertility Services to Lesbian Couples: The Lesbian Baby Boom,” *Sexuality, Reproduction, and Menopause* 2, no. 2 (June 2004): 83–88, citing Stern et al., “Access to Services at Assisted Reproductive Technology Clinics: A Survey of Policies and Practices,” *American Journal of Obstetrics and Gynecology* 184 (2001): 591–97.
3. ASRM Ethics Committee, “Access to Fertility Treatment by Gays, Lesbians, and Unmarried People: A Committee Opinion,” *Fertility*

- and *Sterility* 100, no. 6 (2013): 1524–27; ACOG Committee Opinion No. 385, “The Limits of Conscientious Refusal in Reproductive Medicine,” *Obstetrics and Gynecology* 110 (2007): 1203–08.
4. Bernadette Blanchfield and Charlotte Patterson, “Racial and Sexual Minority in Women’s Receipt of Medical Assistance to Become Pregnant,” *Health Psychology* 34, no. 6 (2014): 571–79.
 5. Katherine Johnson, “Excluding Lesbians and Single Women: An Analysis of U.S. Fertility Clinic Websites,” *Women’s Studies International Forum* 35 (2012): 394–402.
 6. Julien Murphy, “Should Lesbians Count as Infertile Couples? Antilebian Discrimination in Assisted Reproduction,” in *Embodying Bioethics: Recent Feminist Advances*, ed. Anne Donchin and Laura Purdy, 103–20 (Lanham, MD: Rowman & Littlefield, 1999), 111.
 7. Ibid.
 8. Ibid., 103–06.
 9. See Nancy Polikoff, “A Mother Should Not Have to Adopt Her Own Child: Parentage Laws for Children of Lesbian Couples in the Twenty-First Century,” *Stanford Journal of Civil Rights and Civil Liberties* 5 (2009): 201–68.
 10. Reciprocal IVF refers to cases in which one partner provides the egg and the other gestates the resulting embryo.
 11. Laura Mamo, *Queering Reproduction: Achieving Pregnancy in the Age of Technoscience* (Durham, NC: Duke University Press, 2007); Amy Agigian, *Baby Steps: How Lesbian Alternative Insemination Is Changing the World* (Middletown, CT: Wesleyan University Press, 2004).
 12. Jennifer Parks, “Rethinking Radical Politics in the Context of Assisted Reproductive Technology,” *Bioethics* 23, no. 1 (2009): 20–27.
 13. The serious risks to fertility drugs are ovarian hyperstimulation syndrome and multiple pregnancies, the chance of which rises to about 8 percent or more. ASRM Practice Committee, “Use of Clomiphene Citrate in Infertile Women: A Committee Opinion,” *Fertility and Sterility* 100, no. 6 (December 2013): 345.
 14. Catherine Donovan, “It’s Not Really Seen as an Issue, You Know, Lesbian Infertility, It’s Kind of ‘What’s That?: Lesbians’ Unsuccessful Experiences of Medicalised Donor Insemination,” *Medical Sociology* 3, no. 1 (2008): 22.
 15. Lori Ross, Leah Steele, and Rachel Epstein. “Lesbian and Bisexual Women’s Recommendations for Improving the Provision of Assisted Reproductive Technology Services,” *Fertility and Sterility* 86, no. 3 (2006): 735–38.
 16. Donovan, “It’s Not Really Seen as an Issue, You Know, Lesbian Infertility, It’s Kind of ‘What’s That?’,” 19.
 17. Elizabeth Markus et al., “Lesbian Couples Seeking Pregnancy with Donor Insemination,” *Journal of Midwifery and Women’s Health* 55, no. 2 (2010): 124–32.
 18. <http://www.gayandlesbianfertility.com/faqs>
 19. Erica Haimes and Kate Weiner, “‘Everybody’s Got a Dad...’: Issues for Families in the Management of Donor Insemination,” *Sociology of Health and Illness* 22, no. 4 (2000): 494.
 20. IUI, on the other hand, requires specially prepared sperm and sterile instruments, thus it is recommended that it is only performed by a medical professional. However, many women are indeed bypassing the clinic for this procedure as well. Jillian Keenan, “Beyond the Turkey Baster,” *Slate*, August 26, 2013. http://www.slate.com/articles/double_x/doublex/2013/08/intrauterine_insemination_at_home_midwives_are_performing_iuis_without_formal.html
 21. Alexa Tsoulis-Reay, “My Wife and I Are (Both) Pregnant,” *New York Magazine*, 2016. <http://nymag.com/thecut/2016/01/dual-pregnancy-c-v-r.html>
 22. Amato and Jacobson, “Providing Fertility Services to Lesbian Couples.”
 23. ASRM, “Counseling Issues for Gay Men and Lesbians Seeking Assisted Reproductive Technology,” 2015. https://www.asrm.org/uploadedFiles/ASRM_Content/Resources/Patient_Resources/Fact_Sheets_and_Info_Booklets/Counseling%20issues%20for%20gay%20men%20and%20lesbians%20FINAL%204-23-12.pdf
 24. See also Amato and Jacobson, “Providing Fertility Services to Lesbian Couples.”
 25. https://www.asrm.org/Infographic_Year_of_Unprotected_Sex/
 26. Or perhaps not. Perhaps intervention for different-sex couples is too quick or aggressive as well. See, for instance, Kamphuis et al., “Are We Overusing IVF?,” *BMJ* 348 (2014) doi: [10.1136/bmj.g252](https://doi.org/10.1136/bmj.g252).
 27. Gnoth et al., “Time to Pregnancy: Results of the German Prospective Study and Impact on the Management of Infertility,” *Human Reproduction* 18, no. 9 (2003): 1959–66.
 28. Boyd et al., *Autonomous Motherhood? A Socio-Legal Study of Choice and Constraint* (Toronto: University of Toronto Press, 2015), 193.
 29. ASRM Practice Committee 2013, 345; Esme Kamphuis et al., “Are We Overusing IVF?”
 30. Sadly I lost those twins in the second-trimester—an instance of one of the many possible complications of multiple pregnancies.
 31. Markus et al., “Lesbian Couples Seeking Pregnancy with Donor Insemination,” 124.
 32. Ibid., 126.
 33. L. S. Steele and H. Stratmann, “Counseling Lesbian Patients about Getting Pregnant,” *Canadian Family Physician* 52 (2006): 605–11.
 34. Donovan, “It’s Not Really Seen as an Issue, You Know, Lesbian Infertility, It’s Kind of ‘What’s That?’,” 16.
 35. There is debate over whether the infertility (in the form of PCOS) is more prevalent in queer women versus straight women. See R. Agrawal et al., “Prevalence of Polycystic Ovaries and Polycystic Ovary Syndrome in Lesbian Women Compared with Heterosexual Women,” *Fertility and Sterility* 82, no. 5 (2004): 1352–57; H. A. Smith et al., “A Comparison of Polycystic Ovary Syndrome and Related Factors between Lesbian and Heterosexual Women,” *Women’s Health Issues* 21, no. 3 (2011): 191–98; P. De Sutter et al., “PCOS in Lesbian and Heterosexual Women Treated with Artificial Donor Insemination,” *Reproductive Biomedicine Online* 17, no. 3 (2008): 398–402.
 36. One vial of frozen sperm plus shipping costs \$500–\$1,000+, while a medicated in clinic IUI can easily top \$3,000 per cycle all told.
 37. Mamo, *Queering Reproduction*; Agigian, *Baby Steps*; Amanda Roth, “(Queer) Family Values and ‘Reciprocal IVF’: What Difference Does Sexual Identity Make?,” *Kennedy Institute of Ethics Journal* (forthcoming).

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The Moral World of Critics of Homosexuality and Same-Sex Marriage Today

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Certain commentators have argued against homosexuality and same-sex marriage on philosophical grounds. Worth mention in this camp are John Finnis, with his conceptually dense objections to homosexuality, and Margaret Somerville and John Finnis, again, for arguing against same-sex marriage, both of them invoking betrayals to the meaning of marriage as well as harm to children.

In one sense, both these parties make some effort to carve out a space for gay and lesbian people, but it's a confining space. Finnis concedes that the power of the state should not intrude so far as to try and prevent *all* sex between men or sex between women; he has said that "truly private" sex ought to remain beyond the "supervision" of the state.¹ But that sexual space comes at a cost: no publicly visible homosexuality so far as possible. Finnis gets to that outcome by making the case that the state should suppress so far as possible any activities which enable two men or two women to find one another, to protect them against their own "unfortunate" sexual inclinations. He argues that the law should prohibit—and I will use his language here—advertising of homosexual services, marketing homosexual services, maintenance of places of resort for homosexual activity, promotion of "homosexualist" lifestyles via education, and promotion of "homosexualist" lifestyles via public media of communication. As far as the public square is concerned, practically speaking, then, there ought to be no evidence that people are other than heterosexual.

Even at the time he wrote this, Finnis saw ahead of him the possibility that more states would decriminalize sex between men and sex between women, which happened in parts of the United Kingdom starting in 1967. Even so, he recommended against striking down laws that criminalize sodomy on any legal theory that would also require legal toleration of the practices mentioned above. Whether the law criminalizes "sodomy" or not, the only real space Finnis would leave to gay and lesbian people, then, is the closet in all its deforming power.

For her part, Margaret Somerville would open greater social space to gay and lesbian people than Finnis. She calls for social and legal respect and acknowledges the wrong that is discrimination based on sexual orientation. But in her account the social space available to gay and lesbian people does not extend to the confines of marriage. Civil unions? Yes. Marriage? No. Somerville maintains that because of the symbolic dimensions involved in the transmission of life and because of the needs of children, gay men and lesbians should be excluded from marriage, properly speaking, and its implicit right to conceive and raise children.² Civil unions are a kind of consolation prize to gay and lesbian people, but those unions are distinct from marriage and should not, as a matter of ethics or law,

entitle couples to children: civil unions do not entail, as she sees things, the right to found a family; that privilege belongs to the marital state.

For both Somerville and Finnis, however, gay and lesbian people might have a role in raising children if—and pretty much only if—no other people are willing to adopt children needing parents. Finnis goes so far as to say that such adoption should be only allowed when necessary to avoid the utter abandonment of children. With a similar view, Somerville also opens the door for same-sex couples to adopt. On her view, gay and lesbian couples shouldn't bring children into existence as their own children, but they can come forward to take care of children when no one else will, when all else fails. Second-class children are entitled to second-class parents, evidently.

Many parts of the world are governed by standards far removed from these recommendations. Homosexuality is legal in large swaths of the world, visible social support is available to many people queer in their sexual identities, and online communications facilitate interactions of all kinds. Young people embrace gay and lesbian identities at an earlier age, not to mention that more and more people decline to be identified as male or female in any bifurcated way, as if all people must be replaceable versions of "males" and "females." Gay and lesbian people can more and more easily adopt children too, and not only as parents of last resort. These changes leave critics of homosexuality and/or same-sex marriage as living dissenters to their times. Having made their case, these critics have seen courts and legislatures only expand the social options available to many gay and lesbian people.

Wondering how he might experience living as a dissenter to social practices he fundamentally opposes, I asked John Finnis as much by letter. I got no reply. When it comes to experiencing the effects of her views, Somerville says she feels the hurt gay and lesbian people experience when we encounter her view that the law should exclude same-sex couples from marriage. Really, she does, or at least that's what she says in her 2015 book, *Bird on an Ethics Wire*, but don't expect any apologies anytime soon.³

As I've said, Somerville has long defended the view that the law should exclude same-sex couples from marriage, and even in the face of decisions by her adopted Canada to legalize same-sex marriage, she doesn't back down from that view. Far from it: in her accounts, Somerville presents herself as speaking on behalf of children themselves, children whose well-being is overlooked in the rush to have children any old which way by anyone wanting them for any reason. Children for gay and lesbian couples? "It's not natural," she once told me at a conference in Sweden. Somerville goes so far as to maintain that children have the right not to be born to same-sex couples. Better that children should not exist at all than to be born to same-sex couples, maybe especially married same-sex couples. But as I say, she's not indifferent to the outcome. Of the impact of her views, she says: "I genuinely regret the hurt it inflicts." Rather than revise her views in order to avoid that hurt, however, she simply stands on her views and advocates "for children's human rights" with "moral regret."

As a matter of moral logic, this is the kind of world these commentators live in: they believe that homosexuality and/or same-sex marriage are fundamental moral evils, and yet the arc of history has only enlarged the possibilities for people of the same sex to have sex together, to form relationships, and even to marry and have children. These commentators live under a state of moral siege. The world does not heed their counsel; on the contrary, more and more people's lives are morally despoiled by the alleged intrinsic disvalues of homosexuality and the society-damaging, children-damaging claims by gay, lesbian, bisexual, and queer people to full status equality with others. It is hard to avoid the conclusion that they ought to see whole societies rotted out by values and social practices that betray sexuality in its fundamentals, with only more of that moral rot on the way. In fact, as far as I can tell, these commentators exhibit little sympathy for the people they understand as morally compromised in their relationships with one another or with children; instead, they exhibit only a kind of moral rigor mortis.

It's pretty clear that yet another formal defense of a Natural Law-like view of human sexuality won't stem the philosophical tide in favor of gay, lesbian, bisexual, and transgender people. It's not for want of understanding restrictive definitions of sexuality and marriage that many societies have passed over those views. If I may hazard a guess, it's because those definitions sacrifice too much humanity to tendentious interpretations of human relationships. In the name of purifying sexual practices, critics condemn homosexuality across the board no matter the value of that sexuality for some people, no matter that the sexuality is transient or abiding, no matter the value of relationships built on that sexuality, no matter the value of identities built on that kind of sexuality, no matter the legal and governmental excesses tolerated in the name of constraining that sexuality, and no matter the hypocrisies involved when institutions and states selectively permit what they formally prohibit. In the name of purifying marriage, some critics condemn same-sex marriage no matter the value of that kind of relationship for some people, no matter that opposite-sex marriage enfolds relationships that overlap in kind with same-sex relationships, and no matter the value of same-sex marriage for existing children and for children yet to come. Ultimately, it's a better moral philosophy that works to order society to the benefit of gay, lesbian, bisexual, and queer people than a moral philosophy that sacrifices too many prospects for well-being and happiness on a moral bed of Procrustes. It's a better moral philosophy that imagines and works to identify and undo invidious differences of status equality than a moral philosophy that treats some interpretations of sexuality and marriage as opportunities for deepening status inequality.

NOTES

1. John Finnis, "Law, Morality, and Sexual Orientation," *Notre Dame Law Review* 69 (1994): 1049–76. See also John Finnis, "Opposing 'Death with Dignity' and 'Same-Sex Marriage': Faith or Reason?," Address at the University of Notre Dame Australia, June 6, 2013. Available at www.nd.edu.au/news/media-releases/2013/187 [podcast].
2. Margaret Somerville, "The Case Against 'Same-Sex Marriage'." This is a brief presented on April 29, 2003, before the Standing

Committee on Justice and Human Rights, Canada. Margaret Somerville is Samuel Gale Professor of Law and Professor in the Faculty of Medicine at McGill University's Centre for Medicine, Ethics, and Law.

3. Margaret Somerville, *Bird on an Ethics Wire: Battles about Values in the Culture Wars* (Montreal and Kingston: McGill-Queen's University Press, 2015), 3.

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The *APA Newsletter on LGBTQ Issues in Philosophy* invites members to submit papers, book reviews, and professional notes for publication in the fall 2016 edition. Submissions can address issues in the areas of lesbian, gay, bisexual, trans, gender, and sexuality studies, as well as issues of concern for LGBTQ people in the profession. The newsletter seeks quality paper submissions for anonymous review. Reviews and notes should address recent books, current events, or emerging trends. Members who give papers at APA divisional meetings, in particular, are encouraged to submit their work by the appropriate deadlines.

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