Access to fertility services for lesbian women in Canada

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Objective: To determine reproductive services offered to lesbian patients by Canadian fertility clinics, policies of practice, ease of access to these services, and sensitivity of clinics to this population of patients.

Design: Survey sent to assisted reproductive technology (ART) clinic directors.

Setting: Academic medical center, university–based ethics institute.

Patient(s): None.

Intervention(s): None.

Main Outcome Measure(s): The percentage of Canadian fertility clinics that will provide reproductive services to lesbian patients; services offered; the presence of clinic policies on lesbian care; and the presence on web sites of heteronormative material.

Result(s): Completed surveys were received from 71% (24/34) of clinics. All clinics surveyed provided reproductive services to lesbian patients, with the exception of one clinic. Five of 24 (21%) clinics have a written policy on care for lesbian patients; 29% (7/24) will provide services to lesbian patients without prior investigations. All clinics will offer IUI and cycle monitoring to lesbian patients. Twenty-three of 24 clinics (96%) will offer IVF services when required. Fourteen of 32 clinic web sites (44%) make mention of lesbian patients and 27% (8/30) have heteronormative information only.

Conclusion(s): Lesbians encounter several barriers to accessing reproductive services in Canada. Addressing these issues could improve experiences of lesbian women and couples seeking care at fertility clinics. (Fertil Steril 2013;100:1077–80. ©2013 by American Society for Reproductive Medicine.)

Key Words: Lesbian, donor insemination, clinic policy, assisted reproductive technology

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An increasing number of lesbian women are requesting fertility treatment from clinics worldwide. Homophobia and heterosexism faced by lesbian women is an important determinant of their ability to access these services in many countries where not only lesbians, but single heterosexual women have been denied access to fertility services. The decision to treat such patients may depend on the attitudes of the clinic staff at fertility centers. Literature addressing lesbian patient access to reproductive care is sparse and little is known about attitudes toward treating this patient population.

Some countries legislate against the treatment of certain patient populations such as unmarried women (1). In the United States, national guidelines promulgated by the American Society for Reproductive Medicine provide direction with respect to the inclusivity of provision of reproductive care. These guidelines, however, are not legally binding and access policy at US clinics varies widely (2). In Canada, where same sex marriage is legal and laws explicitly state those who wish to pursue reproductive care shall not be discriminated against on the basis of sexuality or marital status, it seems unlikely that there would be a large percentage of clinicians who would deny lesbians’ access to fertility services. Despite our current legislation, it is unknown whether access to fertility clinics for lesbians is difficult and, if it is, whether social barriers exist that may be preventing these women from obtaining services. Furthermore, if clinics are willing to see these patients in consultation, it is unclear as to what services will or will not be offered.

The purpose of this study was to investigate the policies and practices regarding lesbian patients’ access to services at fertility clinics in Canada. Our primary outcome measure was the percentage of Canadian fertility clinics that will provide reproductive assistance to lesbian patients and that
have seen these patients in the past 12 months. Secondary outcomes included a determination of the reproductive services offered and conditions under which they are offered; whether clinic policies are in place regarding care to lesbian patients; and the presence on web sites of services offered to this population as well as heteronormative material.

MATERIALS AND METHODS
The study was approved by the St. Michael’s Hospital Institutional Review Board before initiation. A confidential online survey, taking approximately 10 minutes to complete, was sent by e-mail to the medical directors of all Canadian clinics associated with the Canadian Fertility and Andrology Society. Nonresponders were sent three subsequent reminder e-mails. Databases were locked online under security code. In the survey, we asked for information on access to services, clinic policies and practices, opinions of respondents, and patient demographics. Results from an additional section seeking responses to a series of scenarios are not presented in the present article. The survey was piloted and reviewed for content validity and items were individually vetted by four physicians who participate in fertility care. Any items that were ambiguous were removed. Finally, clinic web sites were searched for the presence of lesbian-specific services (i.e., the words lesbian or same sex were used) as well as heteronormative material.

Survey results were tabulated and percentages of clinics that offer specific services/practices, and have policies for lesbian care in place were determined. The percentage of clinic web sites which mentioned lesbian/same sex couples, had overtly heterosexual depictions, mentioned donor insemination (DI), and had heteronormative DI information were determined. Examples of heteronormative language were taken directly from the web sites.

RESULTS
Completed surveys were received from 71% clinics (24/34). All clinics were willing to see partnered and unpartnered lesbian women in consultation, with the exception of one clinic. All clinics were willing to see unpartnered heterosexual women. A total of 75% clinics (18/24) do not oppose the provision of care on an individual level and 88% (21/24) do not on a policy level. A total of 96% of clinics (23/24) had seen at least one lesbian patient in consultation within the past year. Of the responding clinics, 67% (16/24) saw >25 lesbian patients per year. Regarding any ethical/moral opposition to provision of reproductive services to lesbian women at their clinic, 4% clinics (1/24) responded “yes, on a policy level” and 4% (1/24) responded “don’t know.” Similarly, regarding opposition to provision of services on religious grounds, 8% of clinics (2/24) responded “don’t know.” Only 17% clinics (4/24) have a written policy on reproductive care for lesbian patients and 54% (13/24) ask single women about their sexual orientation (Fig. 1).

Seven of 24 clinics (29%) will provide services, including cycle monitoring and IUI, to lesbian patients without prior investigations. Before treatment, 96% of the clinics (23/24) require laboratory work, 71% (17/24) require ultrasound, and 75% (18/24) require sonohysterogram/hysterosalpingogram. All clinics that treat lesbians will offer IUI and cycle monitoring. A total of 75% of the clinics (18/24) will allow use of semen from a known donor (providing that Health Canada donor sperm screening requirements were met), but only 21% (5/24) will facilitate home insemination. Of those clinics that will facilitate home insemination, all do so through cycle monitoring and education, and 4% actually provide the materials required for insemination. A total of 96% of the clinics will offer IVF services to lesbians if required.

Thirty-two clinics have web sites. Only 44% of the clinic web sites (14/32) mention lesbian couples. Of the web sites 94% (30/32) mention DI; however, 27% (8/30) of those that mention DI have heteronormative information only. Of all clinic web sites, 28% (9/32) feature depictions of heterosexual couples only (Fig. 2). Of the survey nonresponders, 50% (5/10) mention lesbian couples, 90% (9/10) provide information on DI, and 11% (1/9) of those have heteronormative DI information. Finally, 20% (2/10) of the nonresponders’ web sites featured heterosexuals exclusively.

Heteronormative refers to language or content that assumes all patients are heterosexual and serves to alienate
those in same sex relationships. Heteronormative descriptions of DI were found on 27% (8/30) of those web sites that mention DI. Examples of heteronormative descriptions of DI are as follows:

1. This type of treatment is useful for single women or couples where the male partner has no sperm or very poor sperm analysis.
2. … the treatment of infertile couples with a male factor problem with the use of anonymous donor sperm.
3. Under normal circumstances IUI uses sperm from the woman’s male partner. If she does not have a partner, or if her partner has very poor quality sperm, then insemination using sperm from screened, anonymous donors could be considered.

DISCUSSION

At present, to our knowledge there have been no studies specifically looking at barriers to accessing fertility care among lesbian women. The findings of the present study point to several hurdles Canadian lesbian women and couples encounter when seeking reproductive care. There are subtle findings of moral and ethical oppositions to providing care, along with provision of care issues. Responses from several clinics indicate a more pervasive lack of sensitive care; this is demonstrated in one way by the exclusive presentation of heterosexual information on several clinic web sites.

The opinions of fertility clinic directors indicate that provider opinions on access to services closely parallel clinic policies at Canadian fertility clinics. A total of 75% of clinic directors surveyed do not oppose the provision of care to lesbian patients and 88% of clinics do not oppose care on a policy level. Although no clinic directors admitted outright that they opposed treatment on an individual level and, only 4% of clinics did on a policy level, there are clear gaps in the numbers suggesting that more opposition exists. Clinics (4%) reported ethical/moral opposition to provision of reproductive services to lesbian women at their clinic on a policy level and an additional 4% responded that they did not know whether opposition existed. Clinics (4%) reported ethical/moral opposition to provision of reproductive services to lesbian women at their clinic on a policy level and an additional 4% responded that they did not know whether opposition existed. Similarly, regarding opposition to provision of services on religious grounds, 8% of clinics responded that they did not know. Clinics (4%) reported that they do restrict the care of lesbians. This was an unexpected finding as it is in direct violation of the Canadian Assisted Human Reproduction Act that states: persons who seek to undergo assisted reproduction procedures must not be discriminated against, including on the basis of their sexual orientation or marital status (3).

In many countries, such as the United States, clinics are legally allowed to set their own criteria for client selection or deselection (4). Stern et al. (2) in 2002 explored attitudes on access to care from a national survey of directors at 184 fertility clinics in the US. Of directors, 27.5% admitted that they would refuse lesbian couples treatment. There have been several arguments used to justify the deselection of certain women for assisted reproductive care, including lesbian women and single heterosexual women. Some of the most common reasons cited for denying lesbians access to fertility services include the absence of infertility (in single women as well), social concerns that “it goes against nature” and the traditional notion of a family, and finally, an overall concern for the protection of the welfare of the offspring (4–6). An American Psychological Association task force has reviewed the existing data and found that the development, adjustment, and well-being of children with lesbian and gay parents do not differ markedly from that of children with heterosexual parents (5). The ethical committee report of American Society of Reproductive Medicine 2009 states: there is no sound ethical basis for licensed professionals to deny reproductive services to unmarried or homosexual persons (5).

Lack of sensitivity toward care for lesbian women and couples was manifested in this study through an absence of written policy regarding their care by most fertility clinics. Lesbians are not necessarily facing infertility issues, and thus, may warrant an alternative approach to care. Our data demonstrate that most providers surveyed are disinclined to provide services, including cycle monitoring and IUI, to lesbian patients without prior investigations. Of clinics, 96% require laboratory work, 71% require ultrasound, and 75% require sonohysterogram/hysterosalpingogram. Although it is not of our opinion that patients should not undergo a complete medical work up before treatment, this patient population has often been reported to oppose the medicalization of their pursuit of pregnancy. Options to address this concern may include offering the patient to opt in or out of a pretreatment work up (after discussion of the risk of missing valuable information by opting out). Other findings revealed that there is often no inquiry into sexual orientation during the intake interview of single women, therefore potentially missing the opportunity to identify sexual orientation and counsel the patient appropriately. Finally, 25% of clinics reported low numbers of consults (<25 lesbian patients per year) with the majority of these clinics being located within or surrounding Toronto, Ontario, an area known to house the highest gay and lesbian population in Canada. The low numbers of consultations seen at these fertility centers may reflect clinic environments that are not “gay positive,” and are thus not regularly frequented by lesbian women.

The perceived medicalization of donor insemination, along with the cost of anonymous donor sperm and/or sperm processing fees, can lead many lesbian women to engage in home self-inseminations as an alternative practice (6–8). Of clinics, 79% will not facilitate home inseminations, and this is viewed by us as a positive finding. Reasons clinics should not become involved in home inseminations include the potential increased risk of infections in unscreened specimens from known donors, quality control issues with anonymous donor specimens used at home, and potential legal ramifications that could ensue between donors, intended parents, and the facilitating clinic.

Heteronormativity refers to the assumption in society that all individuals are heterosexual (7). Many studies have shown that heteronormative methods of communication in health care have been shown to create feelings of invisibility and alienation in the lesbian, gay, bisexual, and transgender communities (10). Lesbian women in three different studies reported experiencing assumptions of heterosexuality in the...
forms of verbal and published health care information and education (8–10). These assumptions affected how often they saw a provider, affected their perceived care and health outcomes, and invoked feelings of embarrassment and awkwardness.

In our study, we found that 44% (14/32) clinic web sites make mention of lesbian couples. In addition, 28% (9/32) feature depictions of couples, all of whom are heterosexual. These factors may make lesbian women feel unwelcome or out of place in these settings. Interestingly, of the “low-volume” clinics (those that see <25 lesbian patients per year), 67% make no mention of same-sex couples on their web sites. This could be interpreted as evidence of an alienated lesbian patient population avoiding clinics that do not offer information to suit their needs. In addition, 94% (30/32) web sites mention donor insemination; however, 27% (8/30) provide heteronormative information only.

All statements make the assumption that the person seeking donor insemination within a relationship has a male partner. The second and third statements presume she will only be a member of a heterosexual couple and that the treatment will solve the medical problem of infertility, rather than facilitating the creation of a family. The final statement’s use of the word “normal” implies any deviation from this model is disordered or wrong.

In the current age of ubiquitous ability to access health information online, patients are increasingly researching solutions to their health issues before presenting to a health care professional. For lesbian women, encountering only heteronormative information regarding their desired reproductive care on first point of contact can function to alienate and potentially prevent them from accessing this care at all. Reduced utilization of health care services by lesbian women due to heteronormative interactions and published materials has previously been shown (11).

Canada is one of the few nations at the forefront of protecting lesbian legal rights under the Assisted Human Reproduction Act. No lesbian woman or couple should be denied access to reproductive care on the basis of their sexual orientation. In this regard, Canada is ahead of many countries in terms of reproductive equity. However, there still exist more indirect and subtle barriers to access to care for this population. In our study specifically, we have identified four main types of barriers to access to care: [1] subtle moral/ethical oppositions to the provision of care to this population, [2] the withholding of fertility services without mandatory medicalization of the procreative process, [3] a lack of sensitivity in the provision of care, and [4] the alienation of lesbian women through heteronormative published health information.

Strengths of the study include that it was a national survey with a relatively good response rate. However, there was a potential for selection bias as the survey used for this study was provided only in English to those clinics listed on the Canadian Fertility and Andrology Society web site. Survey response bias did not appear to be present. When comparing the information presented on the web sites of survey responders to nonresponders, the nonresponders did not display a higher content of heteronormative material. The survey was self-reported leaving no way of verifying the results. Finally, although it was national, there were a small overall number of clinics on which to base results.

The findings of this study are reassuring in that almost all clinics are seeing and treating lesbian patients, falling in line with the Assisted Human Reproduction Act and ensuring that no woman or couple is denied services based on their sexual orientation. It is possible that lesbian patients may feel less medicalized when seeking fertility care if, after an informed discussion, an opt-out policy is presented for those patients who would rather not undergo full medical investigations before receiving fertility care. All clinics should consider creating a written policy for the provision of care to lesbian women to ensure the special needs of this population are being met and care is approached in a sensitive manner. Last, clinics should reevaluate their web sites and consider including information targeted toward same sex couples and reduce information or depictions that are entirely heteronormative. Taking these steps to address these issues can help improve lesbian women and couples’ experience in achieving pregnancy safely.

REFERENCES