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METHODOLOGY

Queering bioethics: A queer bioethical inventory of surrogacy

La queer bioethics : *un inventaire de* queer bioethics *de la maternité de substitution*

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Summary Queer bioethics is a latterly explicated field of bioethics developed by Lance Wahlert and Autumn Fiester, focusing on gender nonconformity and sexual diversity. Queer bioethical inquiries often involve people identifying as lesbian, gay, trans, queer or intersex (= LGBTQI) to name some of the established identity categories of such nonconformity and diversity. Topics of queer bioethical interest can include, for example, issues discussed in mainstream bioethics as gender reassignment or sex affirmation of trans- and intersex people respectively, or reproductive justice for same-sex couples accessing assisted reproduction technology. Further, however, queer bioethics interrogates the basis on which certain socio-medicalized views on gender and sexuality are justified in medical ethics, wishing to critically renegotiate these justifications to allow more human flourishing. This is also a call for dismantling the cis- and heteronormative bioethical foundations of public health. This article offers an introduction to queer bioethics accompanied by the queer bioethics inventory (QBI) formulated by Wahlert and Fiester for bioethical methodology, by focusing on the case of surrogacy in Finland. The case is selected neither because it is the most queer bioethically appalling nor because it is a rare one. On the contrary: the case has nothing explicitly to do with LGBTQI people, and allowing surrogacy as treatment is not globally uncommon. To subject a seemingly non-queer, common bioethical practice, for a queer bioethical analysis reveals the need for queer bioethics.

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Résumé La *queer bioethics* est un domaine de bioéthique expliquée récemment développé par Lance Wahlert et Autumn Fiester, centré sur la non-conformité entre sexes et la diversité sexuelle. Les enquêtes bioéthiques transgenre impliquent souvent des personnes qui s'identifient comme lesbiennes, gays, trans, transgenre ou intersexué (= LGBTQI) pour nommer certaines des catégories d'identité établies de cette non-conformité et diversité. Les sujets d'intérêt *queer bioethics* peuvent comprendre, par exemple, les questions abordées dans la bioéthique générale comme la réaffectation des sexes ou l'affirmation du sexe des personnes trans- et intersexuées respectivement, ou l'égalité de reproduction pour les couples de même sexe accédant à la technologie de reproduction. Par ailleurs, la *queer bioethics* interroge la base sur laquelle certains points de vue sociomédicaux sur le genre et la sexualité sont justifiés dans l'éthique médicale, désireux de renégocier de manière critique ces justifications pour permettre un plus grand épanouissement humain. Il s'agit également de démanteler les fondements bioéthiques cis-et hétéronormatif de la santé publique. Cet article offre une introduction à la *queer bioethics* accompagnée de l'inventaire de la *queer bioethics* (QBI) formulé par Wahlert et Fiester pour la méthodologie bioéthique, en se concentrant sur le cas de la maternité de substitution en Finlande. Le cas est choisi ni parce qu'il est le plus transgenre bioéthiquement épouvantable ni parce qu'il est rare. Au contraire : le cas n'a rien explicitement à voir avec les gens LGBTQI, et permettre la maternité de substitution comme traitement est assez courant. Soumettre une pratique bioéthique commune apparemment non-transgenre pour une analyse *queer bioethics* révèle la nécessité de la *queer bioethics*.

Introduction

This article offers my treatment on introducing, applying and further developing the concept of queer bioethics, by drawing from the case of surrogacy in Finland. A Northern European country with globally high-ranking, reproductive healthcare and relatively balanced economic equality — both important factors in bioethical analyses of surrogacy work — Finland banned surrogacy in 2007 after allowing it for decades as an infertility treatment for married couples to whom having a child was physically impossible due to malfunctions or the absence of a uterus. In 2011, the Finnish National Advisory Board on Social Welfare and Health Care Ethics ETENE [1] formulated a statement recommending the reinstatement of surrogacy as a legal treatment. Following an established bioethical trend, the board deemed it as the most unproblematic form of surrogacy, most notably compared to what it called commercial surrogacy. Despite recommending surrogacy to be a legal treatment in certain isolated cases, however, their bioethical contemplation viewed surrogacy in general as ''problematic to human dignity'' [1, p. 2] and recognized issues of equality and non-discrimination in receiving this infertility treatment. Based on this statement and on wider bioethical research, I formulate what I call the conditions for ethical surrogacy and interrogate them via feminist and queer bioethical analyses, focusing on the latter.

I begin this article by discussing the current formulation of queer bioethics, in addition to briefly exploring what I consider its moral theory potential that should be developed further. Next I will discuss the case of surrogacy by giving the example from Finland and analyze its bioethical ramifications by using the queer bioethics inventory [2]. I will also offer non-exhaustive, feminist bioethical remarks.

The case of surrogacy in Finland was selected for the inventory neither because it is the most queer bioethically appalling nor because it is a rare one. On the contrary: the case has nothing explicitly to do with LGBTQI people, and allowing surrogacy as treatment is not globally uncommon. To subject a seemingly non-queer, common bioethical practice for a queer bioethical analysis reveals the need for queer bioethics: By offering a queer bioethical analysis of a general bioethical issue rather than a specifically LGBTQI — one this article aims to highlight how so-called mainstream bioethics fails to acknowledge infringements of bioethical justice when it comes to gender nonconformity and sexual diversity. It also aims to highlight how the metaethical hetero- and cisnormative component can negatively affect professional bioethical analysis.

Heteronormativity refers to the systematic assumption of heterosexuality, from which seemingly follows the unproblematic legitimacy of organizing bioethical practices accordingly. Cisnormativity refers to the assumption that there are two distinct (if not indeed categorical/essential), gender binaries of male and female, from which seemingly follows the unproblematic legitimacy of organizing bioethical practices accordingly [2—4]. Hetero- and cisnormativity are also often accompanied by the assumption that gender can be divided into social (gender) and biological (sex), whereas a queer approach to sex promoted in this article

is that it is physiology that is also gendered socially, not through so-called objective discovery.[1]

Queer bioethics: what is it, what could it be?

Bioethics can be defined as a field of philosophy invested in ethical inquiry of social sciences and bio-sciences, using both theoretical and pragmatic tools. According to its founders Lance Wahlert and Autumn Fiester [2,3, p. 2–3], queer bioethics is a latterly explicated field of bioethics focusing on questions related to lesbian, gay, bi, trans, queer or intersex people, henceforth to be referred with the abbreviation LGBTQI.[2] Topics of queer bioethical interest can include ethical transition treatment for trans people; bodily integrity of intersex babies; reproductive justice for same-sex couples or queer hospice care. However, Wahlert and Fiester[3] [2, p. S62] crucially point out, whilst interest in LGBTQI healthcare aims to highlight important gaps and bring into relief serious LGBTQI issues, such work can inadvertently reinforce both the marginalization of sexual minorities and the cultural norms related to sexuality, gender identity and the conventional family. To ensure that positive outcomes for LGBTQI patients are essentially paired with real ethical sustainability and decreased marginalization, Wahlert and Fiester [2,4] advocate for queer bioethics as a methodology of scholastic, bioethical and critical scrutiny. They set queer bioethics to address both the needs of LGBTQI persons in a healthcare environment but also to consider the perspectives, histories and feelings of such parties. Further, they set queer bioethics to be used as a moral theory.

Historically in the West, sexual and gender diversity has been officially oppressed by criminal and then psychiatric bio-power in the Foucauldian sense,[4] still dominating LGBTQI discourse in several countries. There has been only a few select moments in history of bioethics when queer persons have been at the center of bioethical discourse — a famous example is the HIV/AIDS crisis in the 1980s — and those moments have not been very queer-affirming [2, p. S56–7]. Crucially, from looking at queer presence in the history of bioethics, from psychiatric labeling to reproductive debates, it is important to note that mere inclusion of LGBTQI persons in healthcare cases, policies and research does not in itself solve the problem of marginalization and stigma [3,4,6,7]. This notion will be exemplified later in the analysis section of this article.

Queer bioethics can be defined as a specific field of bioethics targeting questions, both historic and present, of sexuality and gender with a norm-critical approach. It identifies LGBTQI people as specific bioethical agents, which Wahlert and Fiester also refer to as the injection of queer personhood [3, p. iii]. Queer bioethics has two simultaneously operating prongs. On the one hand, it focuses on LGBTQI – specific questions, interrogating how and why gender and sexuality are produced and reproduced, critically deconstructing them with the analytical tools of hetero- and cisnormativity. On the other, it also interrogates why and explains how questions of gender and sexuality are questions of humanity per se and life as we (think we) know it. As recent scientific advances have broadened our understanding of, for example, the non-binary number of chromosomes affecting gendered physiology, or of how many so-called biological parents one can have (cf. the three-parent baby technique) [8], it is becoming unequivocally apparent that past-century sexual and reproductive ethics need a queer injection simply to be able to compute contemporary, bioethical debates.

Wahlert and Fiester [3, p. iii–iv] define queer bioethical aims:

- to place sexuality and gender identity in the core of ethical discussions brought about by advances and renegotiations of normality in biology and medicine;
- to place the so-called less powerful central stage;
- to challenge the status quo and the presumptive legitimacy of the normative;
- to challenge our complacency in the face of injustice and discrimination in medical encounters, systems and policies;[5]
- last but not least, they define queer bioethics to serve as a moral theory.

Queer bioethics, indeed, has moral theory potential. I suggest it could join forces with feminist bioethics and underlying feminist philosophy to laudably interrogate the notion of bioethical normality; its construction, reconfigurations and effects on practices, politics and bodies. As a moral theory, queer bioethics could re-evaluate the classic bioethical principles by looking at cases of gender and sexual diversity to see if there is a need to revise the respect of autonomy, nonmaleficence, beneficence and justice.[6] Do LGBTQI biodiscourses (i.e. practices and legislation) respect the classic principles of bioethics? If there are infringements on these principles more likely when LGBQTI issues are concerned, as both Wahlert and Fiester and this article[7] suggest, then why do those infringements persist? So, queer bioethics can be bestowed with both a theoretic and practical aim. Several cases need to be analyzed with its methodology,

[1] Some scholars of gender and sexual diversity only use the term sex, some only the term gender. Albeit for some purely a terminological question, it is important to note that terminology reflects the background theory one subscribes to [5].

[2] There are several variations of this string of letters, constantly under negotiation. In relation to bioethics, the form LGBT has most often been used, even as a term LGBT bioethics and LGBT healthcare [cf. 1].

[3] See also [4; cf. 7].

[4] Albeit my treatment does not subscribe to Foucauldian tradition, there are laudable analyses on gender and sexual diversity to be found there, suggesting perhaps the rise of, or at least interest in formulating, LGBTQI biopolitics [cf. 3,5].

[5] Emerging queer bioethics as a theory and methodology does not mean that these topics would have not been challenged in so-called mainstream bioethics before its arrival [see e.g. 6, 9] or that no such work could be done without calling it queer bioethics or using the queer bioethics inventory [see e.g. 10].

[6] On these principles see [11]; on their feminist reconfigurations, see [12].

[7] See also [6,9,10].

while simultaneously inquiring its moral theory potential further. The latter needs to be completed with metaphysical and epistemic inquiries into bioethical background philosophies.[8]

I suggest the fundaments of queer bioethics as a moral theory include making appeals to responsibility and social and global justice; treating gender and sexuality as diverse phenomena and making this a necessary condition in all analyses, and disputing the gender binary and heteronormativity as necessary conditions. Last but not least, queer bioethics should build on a relational concept of autonomy.[9]

Queering methodology

Lance Wahlert [7] describes queer bioethical methodology as examination of the pressing ethical issues that lie at the intersection of gender identity, sexuality and bioethics. In its core are bioethics-related challenges facing LGBTQI persons, questioning their encounters within the medical system. An integral part of queer bioethical methodology is the appraisal of canonical bioethical concerns bearing in mind queer perspectives, which is precisely what this article is set to do. In queering bioethics, Wahlert wishes to introduce the traditional queer-theoretical concept of queering into medical ethics. Queering medical ethics/bioethics means that in addition to asking ''What'', i.e. attending to the previously mentioned concerns (queer as a noun), queer bioethics also asks ''How''. Using queer as a verb means the employment of methodologies from queer activism, queer theory and queer identity and putting them it into ethical practice in medicine [7].

Wahlert [7] sees queer bioethics to improve medical practice for LGBTQI people, or ''the queer in the clinic'' as he refers to the LGBQTI bioethical patient zero, in three different realms. In terms of clinical practice, queer bioethics ushers in appreciation of queerness as central or valuable to a clinical situation; demands an acknowledgment of queer populations as worthy, (e.g. equal visitation) and creates a greater tendency not to generalize or to stigmatize. In clinical outreach, queer bioethics can shed light on the need of population-specific resources beyond the clinic referring to, for e.g., social services for LGBTQI persons that should be integrated into clinical practice. Continuity of care for LGBTQI persons must be guaranteed, thus replacing the attitude of suspicion with clinical comfort. Wahlert contends that queer bioethical analyses can enrich clinical training by offering ways for integration of queer patients and families into the canonical fold, with an ethical mindfulness of the complications of queerness in clinical encounters [7]. An integral tool is the queer bioethics inventory (Appendix 1).

As introduced earlier, and as documented in practice by, for example, Dean, Victor and Guidry-Grimes [4], mere inclusion of LGBTQI persons does not solve problems of discrimination or extend bioethical justice to questions of gender and sexual diversity. Acknowledging that even the most sympathetic and well-intentioned cases that include either LGBTQI or queer-related content can decrease bias about sexuality and gender nonconformity in medicine, Wahlert and Fiester [2, p. S62] have developed an inventory to approach such bias methodologically. The queer bioethics inventory is a set of questions ''to better scrutinize the efficacy, legitimacy and impartiality of cases we use in bioethics'' [2, p. S62]. The inventory is intended for both clinical and theoretical use to better attend the needs of LGBTQI parties in the clinic and in bio-sciences by not merely dwelling on the presence of queer people in bioethical cases but to offer a decidedly queer analysis.

Next I will offer a decidedly queer analysis of surrogacy by subjecting a statement of surrogacy ethics to the applicable questions of the queer bioethics inventory. I will accompany my analysis with feminist bioethical remarks crucial for studying surrogacy.[10]

A queer bioethical inventory: the case of surrogacy in Finland

This section of the article discusses surrogacy in relation to the queer bioethics inventory. I discuss mainstream bioethics' ethical guidelines for surrogacy from a queer bioethics point of view by using Finland as an example. As introduced, a Northern European country with globally high-ranking reproductive healthcare and relatively good economic equality, both important factors in bioethical analyses of surrogacy work, Finland banned surrogacy in 2007 after allowing it for decades as an infertility treatment to married couples for whom having a child was physically impossible due to malfunctions or the absence of a uterus. In 2011, the national ethics advisory board ETENE [1] formulated a statement to reinstate surrogacy as treatment. The board deemed it as the most unproblematic form of surrogacy, most notably compared to so-called commercial surrogacy. In general, despite noting that ''families where the woman does not have a uterus have described their experiences of human suffering'', they viewed surrogacy to be ''questionable in terms of human dignity'' [1, p. 2] and recognized issues of equality and non-discrimination in receiving this infertility treatment, However, they neither discussed the equality and non-discrimination issue in more detail nor acknowledged the gross human dignity and equality problems in global surrogacy arrangements.

Once again, the case I use for my analysis has nothing explicitly to do with LGBTQI, and allowing surrogacy as treatment only is one of the most common surrogacy practices globally.[11] To subject a seemingly non-queer, common bioethical practice for a queer bioethical analysis reveals

[8] Albeit these projects falling outside the scope of this article.
[9] On this concept, see [12].
[10] Albeit I do not offer a full feminist bioethical analysis of surrogacy here.
[11] Allowing and regulating surrogacy as treatment is often referred to as altruistic surrogacy. The other globally prominent surrogacy practice is to allow accruing various level of financial gain from the practice, often referred to as commercial surrogacy. There are poignant remarks to be made on both of these practices, especially about the role of the surrogate in the latter practice which has been feverishly debated in feminist bioethics for decades now (for a recent inquiry, see [13]), only some of which to be addressed in this article.

the need for queer bioethics. Under the scrutiny of the queer bioethics inventory, several issues of equality and non-discrimination can be addressed that remained hidden by the mainstream bioethical analysis offered in the statement. The demand for equality and non-discrimination can also be perceived as the fulfillment of bioethical justice, one of the classic principles of bioethics.

In its statement recommending surrogacy to be reinstated as a treatment, ETENE [1] proposed that surrogacy may be an ethically acceptable option for married couples for whom having a child is physically impossible due to malfunctions or the absence of a uterus. Further, it deemed all surrogacy treatments should be subject to a permit, and ''surrogate motherhood'' should be based on ''a genuine desire to help'', deeming all commercial surrogacy by default as unethical [1, p. 1—2]. As a result of the total ban, all surrogacy arrangements by Finns are reproductive tourism: Finnish citizens travel aboard to adjacent countries such as the Ukraine where surrogacy services can be commissioned (by married couples), and then face problems when trying to return to Finland with the child. In my non-governmental organization work for LGBTQI families, it has been brought to my attention that suspicion of surrogacy arrangement has been considered grounds for losing custody of the child at least for the duration of investigation into the child's origin, especially in the LGBQTI context.

ETENE's statement [1, p. 3—4] follows a common construction in mainstream bioethics when regulating what is viewed as ethical surrogacy, arranged in Table 1.

Before addressing these conditions with the queer bioethics inventory, I will address some feminist bioethical concerns.

Conditions for ethical surrogacy: feminist bioethical concerns

The first condition, that surrogacy should only be used as an infertility treatment for married couples for whom having a child is physically impossible due to malfunctions or the absence of a uterus, sets about a peculiar construction of treatment by proxy. Infertility treatment for married couples for whom having a child is physically impossible due to malfunctions or the absence of a uterus suggests confused reproductive agency: her uterus is the cause for their treatment. Polemically put, is it her womb or their womb?

Further confusing this treatment by proxy is the implication that the surrogate is the treatment to a married couples' infertility. Is a woman without a uterus in a heterosexual marriage ethically entitled to use another woman's womb? As it has been discussed in feminist bioethics in detail, it seems that constructing surrogacy as treatment is questionable in terms of female reproductive autonomy, especially if the woman's choice of becoming a surrogate is not the most important factor in defining the ethical sustainability from motive point of view. This type of argumentation assumes that women cannot be trusted to make decisions on surrogacy without strict (cis- and heteronormative) control and that despite how the surrogates feel about surrogacy, there are problems imposed on their human dignity. For example, ETENE states that:

> *From the perspective of the child and the couple wishing for a child, human dignity would seem to be respected, while from the perspective of the woman consenting to act as a surrogate, surrogacy may be seen as problematic from the viewpoint of human dignity, at least in the legal sense, regardless of how the woman feels about it herself [1, p. 2].*

Albeit legal and ethical problematics obviously persist despite subjective experience, it is condescending, paternalistic and bioethically curious to override women's informed consent so harshly, evoking curious gendered form of consent.

The third and fourth conditions evoking motherhood submerge another issue feminist bioethics has written extensively on. To add to that discussion, I would like to point out that the treatment model poses ambivalent, bioethically unconventional demands to the surrogate: as quoted above, on the one hand, the surrogate's feelings cannot override the human dignity problems so that the decision to become a surrogate would be a question for her to decide autonomously. On the other hand, however, it is formulated as her ethical duty to navigate and disseminate something as emotionally volatile as motherhood in her surrogacy, without there being a clear bioethical definition on what motherhood as an ethical condition entails.

It is my feminist bioethical stance that we must critically analyze the treatment practice on the surrogate motherhood regard. I suggest it is often left unchecked in the treatment model due to it being deemed as

Table 1 Conditions for ethical surrogacy.
Les conditions pour une maternité de substitution éthique.

It must only be used as an infertility treatment for married couples for whom having a child is physically impossible due to malfunctions or the absence of a uterus
It requires a permit (strictly under medical/governmental control)
It involves ''surrogate motherhood'' (as opposed to viewing the surrogates as reproductive workers) ''Surrogate motherhood'' must be motivated by ''a genuine desire to help'' (often interpreted only by banning the surrogate from gain while simultaneously allowing other agents, such as the clinic that would provide the procedures needed for the surrogacy arrangement, to accrue gain)
That equality and non-discrimination should be taken into account when formulating surrogacy practices and legislation (without offering solutions on how this should be done)

an altruistic practice. Evoking motherhood and altruism do not juxtapose with the stereotypical female role of selfless mother-nurturer, which seemingly means the altruistic surrogate poses less bioethical problems than a commercially-motivated one, which however, I hope to have shown to be inaccurate.

Most urgently, we must seek new ways to theorize and tackle commercialism in surrogacy by not focusing on the commercialist motivation of the surrogate — especially surrogates in the Global South tend to get either demonized as purveyors of so-called commercial motherhood or patronized as mindless victims by white, middle-class academic feminism — but to analyze surrogacy as work and discuss the just distribution of the profits gained from this reproductive work. Most definitely, the key commercial players in the current, global reproductive game are not the surrogates. Hence, it is ethically dubious and moral hedging to not place the transnational healthcare companies in the hot seat when deciding on the morality of commercial surrogacy practices. Conditioning surrogacy as motherhood and simultaneously linking unethical commercialism to the surrogate's motives shows insufficient understanding of how motherhood is used to manipulate women in bioethical settings.[12]

Targeting surrogate motives as the defining elements of commercialism also displays insufficient regard to social and global justice: many women work as surrogates for various reasons, some because it is the best choice out of bad ones, but still, albeit controversially, offering many of them ways to improve their otherwise destitute lives.[13] Such disregard accentuates the lack of global solidarity. Banning surrogacy in countries with high reproductive healthcare and relatively low income differences benefits the extremely exploitative mechanics of reproductive tourism as colonialism. Setting the so-called altruistic motive as the only one possible for the ethical surrogate, she is categorically excluded from benefiting from her reproductive work. What are the ethical justifications making the surrogates the only ones not entitled to benefit from their reproductive work as others (the brokers, the clinics, the stock holders of multinational healthcare companies) so obviously are entitled to these profits from their reproductive work?

Taking into account the confused treatment by proxy, austere demands to volatile emotional content without ethical scrutiny, confused commercialism and the lack of global-scale comparative analyses when formulating its ethical conditions, I suggest it is safe to now say that surrogacy as treatment is a more problematic practice than initially met the mainstream bioethicist's analytical eye [cf. 1]. Surely commercial surrogacy has severe problems, but the treatment scenario is also neither unproblematic nor in fact uncommercial per se.

Conditions for ethical surrogacy: a queer bioethics inventory

I will next subject the conditions for ethical surrogacy — Table 1 of this article — to queer bioethical scrutiny by using the queer bioethics inventory — Appendix 1 of this article.[14] One of the issues raised by Wahlert and Fiester's inventory is to analyze whether the case in question honors the diversity of families and relationships across and within the LGBT(QI) population or does it prioritize heterosexual marriage. If married couples are the only possible receivers of surrogacy treatment, the case does not honor the diversity of families. Assuming heterosexual, cis-gender married couples as the only allowed subjects results in not only prioritizing heterosexual marriage, but also neglects other forms of heterosexual kinship and parenting.

The queer bioethics inventory invites us to look at cases by de-queering or queering them. When looking at conditions for ethical surrogacy, the latter is more appropriate, especially as Finland now allows same-sex marriage, (which it did not at time ETENE drafted its statement). In the treatment model, could a female couple be placed in the position of the intended parents, as they now could qualify as a married couple for whom having a child is physically impossible due to malfunctions or the absence of a uterus? I remain skeptical. The reason is that currently, female couples already report discrimination in access to assisted reproductive treatment although they have had the legal right to it since 2007.

In 2016, the National Non-Discrimination and Equality Tribunal of Finland examined whether the medical directors of hospital districts had committed discriminatory conduct prohibited in the Non-Discrimination Act by giving an order to their respective hospital districts that single women and female couples should be excluded from the assisted reproductive treatments provided for by the public healthcare services. The tribunal considered that the medical directors of hospital districts had given to their respective hospital districts discriminatory orders and prohibited them from continuing discrimination. The Tribunal also considered a specific case of client[15] who they deemed had been discriminated against based on her sexual orientation. She had been completely denied assisted reproductive treatment in public healthcare. Conclusively, the Tribunal found that the medical directors of hospital districts had been neglecting their duty to promote equality as provided by the Finnish Non-Discrimination Act. The tribunal imposed a conditional fine on each of the medical directors of hospital districts to

[12] It is used very similarly in both commercial and altruistic surrogacy practices; most grossly in the former, it used as a controlling discourse keeping surrogates at bay, [cf. 13].

[13] To make myself perfectly clear, I am not at all suggesting that commercial surrogacy would not include forms that grossly exploit women. What I wish to suggest is that this exploitation is not due to women being able to accrue gain from their reproductive work per se but to how the surrogacy business operates. Even if one would accept that allowing surrogacy as treatment and banning all financial gain from women offers an ethically sufficient solution to this problem, which I think it does not, the treatment model seldom offers solutions e.g. on should the surrogate, often a close member of the family in the altruistic model, be entitled to a somehow defined, special position in the child's life for his/her best interest. There is documentation on the possibility and perils of exploitation in the altruistic model, too [e.g. 17, p. 1259—61].

[14] [2, p. S62].

[15] Curiously, the patient is referred to as the client in the original [15], which reads as another manifestation of confused commercialism in assisted reproduction service settings even in countries with universal healthcare.

enforce compliance with its injunction [15].[16] This goes to show again that mere inclusion of LGBTQI persons does not solve problems of discrimination or extend bioethical justice to questions of gender and sexual diversity.

When queering and de-queering bioethical cases, it is also crucial to detect differences within the LGBTQI positions. As reproductive agents, including as intended parents or surrogates, gender nonconforming people's reproductive autonomy is often disrespected in several legislative and treatment practices. So, even if a female couple could theoretically qualify for surrogacy as an infertility treatment similar to married couples for whom having a child is physically impossible due to malfunctions or the absence of a uterus, neither are the former as likely to receive it as a cis straight couple with a similar medical complaint would be, nor does it seem even theoretically possible to allow male couples or a trans person with that agency.

On the latter note and crucially for queer reproductive rights and justice, Finland is one the countries to demand chemical sterilization of transsexual people who wish to obtain a new legal gender status, which has been critiqued for decades now. However, chemical sterilization is not in all cases a permanent infringement on positive reproductive rights. In October 204, the first known case of a Finnish transsexual man expecting a child came into public awareness. Globally, the first ever known case was Thomas Beatie's in the U.S. 2008 [16]. Beatie, who had transitioned from female to male and was now legally male and pregnant, was the first to report the problems such families face during and after his pregnancy. Albeit not very common cases and requiring special sensitivity and expertise, queer manifestations of reproductive rights such as pregnant trans men who are also fathers-to-be should not be labeled as curiosities in mainstream bioethics and as freaky cases with shock value in public media. Instead, their cases should be subjected to analyses of reproductive justice, and they should be respected as reproductive agents whose services require non-canonical bioethical treatment and thinking. Queer bioethics can help to spearhead, organize and evaluate such treatment and thinking. This requires the resources to further develop queer bioethical theory, approaches and services. To offer a thought experiment on such creating such services, surrogacy could be offered as treatment for those suffering from childlessness caused by chemical sterilization as trans men react very differently to the possibility of pregnancy. Similarly, trans women can greatly suffer from the lack of a uterus, causing human suffering brought about by childlessness which was suggested [8] in certain isolated cases to be relieved via surrogacy treatment. Hetero- and cisnormative metaethics demarcate this suffering from being considered as equal.

Beatie makes a direct reference to surrogacy in his book [16]: he describes how he took on the reproductive work of pregnancy when his wife Nancy had to have a hysterectomy, calling himself as their own surrogate. In the transgender imagination and in the context of queer bioethics, it is possible to be both male and pregnant without it posing a system failure to the bioethical analysis. Such analyses are possible when hetero- and cisnormativity are dismantled as necessary conditions in ethical sense-making.

When looking at the Finnish surrogacy case from the viewpoint of inclusion—asking the queer bioethics inventory question of Does the case omit, exclude or dismiss? — it is apparent that the case does not honor the diversity of families either inside or outside LGBTQI. Especially men, either as couples or as single parents, are simply invisible. As mentioned, cis men who wish to parent with men are very much affected by the lack of a uterus. Yet they are not candidates for this the treatment by proxy—uterus that the straight married couple are (and perhaps now, a female couple could theoretically be). Even if it is agreed that men are excluded based on their gendered physiology, what strikes as most troubling in terms of this dismissal is that when ETENE [1, p. 2] recognizes that involuntary childlessness causes human suffering, and that equality and non-discrimination are key factors in considering surrogacy, the statement no way acknowledges the suffering of those involuntarily childless individuals, who are not a part of a (straight) married couple and whose suffering could be greatly relieved by allowing surrogacy arrangements. Overall, in terms of equality, the treatment practice of surrogacy is not ideal when trying to decrease non-discrimination as the justifications of the treatment model are built on biased value components.

Going back to the questions of the queer bioethics inventory, obviously, the answer to the question, 'Are both queer and non-queer subjects treated as equally important and valid?' is a negative one. To conclude on a final bullet point of the inventory, it has become apparent that there is a heteronormative value hierarchy giving priority to some voices over others, which not only applies to surrogacy, but as my analysis has shown, to bioethics more generally.

Conclusion

Crucially, the hetero- and cisnormative value hierarchy — the metaethical heteronormative component — detected in the case of surrogacy in Finland is so entrenched in the value system per se that it remained invisible in the ethical analysis by professional bioethicists. This often is not because of malevolence or discriminatory motivations (although in some cases, it most definitely can be), but I suggest, is due to a lack of bioethical imagination

[16] The National Non-Discrimination and Equality Tribunal is an impartial and independent judicial body appointed by the Finnish Government. The Tribunal supervises compliance with the Non-Discrimination Act and the Act on Equality between Women and Men (Equality Act) both in private activities and in public administrative and commercial activities. However, the mandate of the Tribunal does not cover matters related to work life issues outside the scope of the Equality Act, private life, family life or practice of religion.
The function of the Tribunal is to give legal protection to those who consider they have been discriminated against or victimized. The person being discriminated or, with his or her consent, the Non-Discrimination Ombudsman or an association promoting non-discrimination may submit a matter to the Non-Discrimination and Equality Tribunal for consideration. Only the Ombudsman for Equality or a central organization of employers' associations or of central labor market organization may submit a matter falling under the scope of the Equality Act to the Non-Discrimination and Equality Tribunal for consideration. Cf. http://yvtltk.fi/en/index/tribunal.html.

reaching beyond hetero- and cisnormativity which never has and never will be a final frontier of human opulence.

To envision bioethics attuned to expanding justice and eradicating discrimination from a queer point of view, we must continue to seek demedicalizing theories of gender and sexual diversity. LGBTQI healthcare cases, policies and research must be subjected to queer bioethical inventory. Crucially these inventories must be paired with legislative analysis and reform to dismantle unjust cis- and heteronormativity in legislation, including gaining an understanding on how the complex and subtle, albeit also obvious, entanglements between medicine and law actually govern gender in a specific context. From a larger point of view of philosophical gravitas, queering bioethics and bioethical justice requires deconstructing cis- and heteronormativity as the necessary conditions in metaphysical, epistemological and ethical sense-making.

Appendix A. The queer bioethics inventory [2, page S62]

The Queer Bioethics Inventory

Given that even the most sympathetic and well-intentioned cases that include either LGBT persons or queer-related content can play into (rather than redress) long-standing biases about sexuality and gender nonconformity in science and medicine, this inventory provides a set of questions to better scrutinize the efficacy, legitimacy, and impartiality of the cases we use in bioethics. While by no means exhaustive, the list of questions helps us to better attend to the unique needs of LGBT parties in the clinic and in the biosciences by dwelling, not merely on the presence of queer people in bioethics cases, but (perhaps more importantly) on the need for decidedly non-normative and truly queer forms of analysis.

- Does the case in question honor the diversity of families and relationships across and within the LGBT population; or, alternatively, does it prioritize heterosexual marriage or the heteronormative family of origin?
- Has the case implicitly or explicitly made value judgments about types of sexual relationships: same-sex, cross-sex, monogamous, open, or promiscuous?
- Has the scenario of the case conflated "safe" or "safer" sex with monogamy or abstinence?
- Does the case patronize the LGBT individual by pitying (or overly sentimentalizing) the queer subject?
- Are the queer roles in the case mere LGBT stereotypes or overgeneralizations?
- Has the case infantilized the queer parties? Could the case substitute an adult, straight, gender-conforming male or female and still be coherent?
- Does the case omit, exclude, or dismiss important characters—such as partners, lovers, or caregivers?
- Is there a heteronormative value hierarchy in the case that gives priority to some voices over others?
- Does the case allow itself to be "dequeered" and still have ethical or clinical relevance? If not, does the queer nature of the case justify or disqualify it as worthy of legitimate study?
- Are both the nonqueer and queer subjects treated as equally important and valid?
- Does the case function as a type of bioethical voyeurism, overly scrutinizing the sexual or lifestyle choices of queer persons beyond clinical or ethical relevance?
- Have unsympathetic and immaterial details about the queer subjects been included, resulting in bias against them?
- Does the case respect the queer person's choice and rationale to remain closeted or protective of queer health information?
- Are non-normative bodies appreciated as legitimate, appropriate, and neutral?

Disclosure of interest

The author declares that she has no competing interest.

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