Preserving Dignity in Healthcare: Insights into LGBTQ+ Experiences with Fertility Services

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Abstract: This paper explores the concept of marketplace dignity in healthcare, focusing on LGBTQ+ consumers of private fertility services. Drawing on the three-factor dignity framework – recognition, equity, and agency – we investigate how dignity is upheld or diminished within this context. Using qualitative data from 40 LGBTQ+ service users and 8 fertility service providers, our findings reveal systemic challenges to dignity, including under-recognition, inequity, and limited agency. Notably, LGBTQ+ consumers face dehumanisation through objectification and commodification, undermining their well-being and trust in healthcare providers. While some clinics demonstrate humanisation, treating consumers as individuals with unique experiences, others prioritise financial gain over empathetic care. We highlight the urgent need for inclusivity in fertility services and contribute to marketplace dignity and LGBTQ+ reproductive health literature by centring on the experiences of marginalised groups.

Keywords: *Dignity, Fertility Services, LGBTQ+*

Track: *Social Responsibility & Ethics*

1. Introduction and Theoretical Background

Dignity is defined as the inherent worth and respect owed equally to every individual, recognising their value as a human being (Lucas, 2015). Dignity in the business discipline is primarily cited in studies focusing on workplace practices; however, Lamberton et al. (2024a; 2024b) recently developed a three-factor dignity framework to be used within the marketplace. Dignity within marketing can, therefore, be assessed through recognition/representation, equity/equality, and agency (see Table 1). This groundbreaking work aims to improve marketing's indeterminate relationship with human rights and contribute towards the Sustainable Development Goals by urging organisations to respect the dignity of all consumers (SDGs; Van Dassen & Shelton, 2024). Furthermore, it provides an opportunity for our field to focus more on preserving dignity through a "complete rethinking" of our economic structure (Banerjee & Duflo, 2019).

Primary Factor	**Definition of Primary Factor**	**Sub-factor**	**Definition of Sub-factor**
Recognition /Representation	When an organisation is committed to acting on its consumers' characteristics, achievements, and needs (Lamberton et al., 2024b) and people feel seen and heard by the organisations with which they engage (Lamberton et al., 2024a).	Under-recognition	An organisation overlooking a person or group and consequently failing to respect their dignity.
		Misrepresentation	When the depiction of a group is inaccurate and subordinate to their needs, wants, and distinctiveness.
		Unwanted recognition	An individual or group of people being seen when they do not want to be seen (e.g. overexposure).
		Voice and epistemic justice	Having a voice within an organisation but also when the voice is accepted as a basis for knowledge (e.g. valid information).
Equity/Equality	Ensure that everyone's values and lives are respected to the same extent and that nobody matters less than others in the organisation	Equity between consumers	Consumers have equal opportunities to access and benefit from resources and services without incurring significant costs.
		Equity between consumers and organisations	When people perceive that the input-output ratio they

	(Lamberton et al., 2024b).		experience does not leave them worse off than the firm.
Agency	"A feeling of control over our actions and their consequences" (Moore, 2016). It connects to equity and recognition. If someone controls the environment, they can make themselves heard and consequently act if suffering from inequality (Lamberton et al., 2024b).	Direct agency	When individuals can control their own experiences with the organisation.
		Proxy agency	In the absence of direct agency, a smaller group or individual makes decisions about a larger group.
		Collective agency	When knowledge, skills, or resources are pooled, and a group informs the organisations and their own experiences.
		Contributory agency	Not just receiving support but also providing it to those in a similar situation (e.g. peer-to-peer learning).

Table 1: Definitions of the three-factor dignity structure (and sub-factors)

The present research will focus on healthcare as a specific context within the marketplace because consumer dignity is both vital and complex in healthcare settings. Extant marketing literature on both public and private healthcare demonstrates the importance of agency and equality by advocating for co-creation in service-user and service-provider interactions (Anderson et al., 2018; Keeling et al., 2021). Furthermore, in healthcare literature, the desire for patient recognition creates practical guides for healthcare professionals to respect dignity (Bagnasco et al., 2020; Matiti & Baillie, 2011). However, the lack of direct agency through illness and vulnerability leads to discussions around the ethics of dignity and creates a preference towards empathy and compassion (Bagheri, 2012; Jones, 2015). Many healthcare organisations, therefore, still take a paternalistic view that 'the doctor knows best,' which heavily contrasts with marketing assumptions where 'the customer is always right.'

Our paper, therefore, unpacks this contrast by exploring a specific case study, LGBTQ+ consumers of private fertility services, where there are issues of systemic inequities and consumers are striving for recognition, representation, and agency. Extant marketing literature on consumers of assisted reproductive technology (ART) reveals the difficulties associated with these services and how consumers lose agency and recognition when experiencing vulnerability and survivorship (Robertson et al., 2021; Takhar, 2022; Tsigdinos,

2022). This literature concentrates primarily on heterosexual couples and individuals or does not acknowledge the sexuality of participants (e.g., Robertson et al., 2021; Yu et al., 2022). Considering that LGBTQ+ consumers experience discrimination and stigmatisation in the marketplace (Montecchi et al., 2024), especially within the reproductive market (Mimoun et al., 2022), there needs to be further understanding of how undergoing fertility treatments in clinical settings influences consumers' dignity, especially concerning equity. We therefore aim to answer the following research questions:

1) To what extent do LGBTQ+ fertility service users feel their dignity is valued in the healthcare service?
2) What factors influence the extent to which LGBTQ+ service users' dignity is either respected or diminished?

The contributions of our study are twofold. First, we contribute to the novel concept of marketplace dignity by providing a qualitative study in a healthcare setting. By doing so, we reaffirm that recognition, agency, and equity are important for establishing dignity in service settings, but also that humanisation is vital – where consumers are treated as human beings with feelings rather than as objects, financial exchanges, or commodification. Second, we contribute to the body of literature on ART by providing a much-needed LGBTQ+ perspective, which is currently lacking in academia and in practice.

2. Methodology

The reproductive market for LGBTQ+ consumers in the UK was chosen as the context of the study as it represents a fragile environment for consumers where dignity is challenged. For example, the UK is a nation of public healthcare but private clinics exist because the National Health Service (NHS) only funds ART for certain groups – heterosexual couples (without first children) receive funded ART if they can claim unsuccessful natural copulation for two years, whereas, in most areas, LGBTQ+ couples only receive funding if they can demonstrate proof of infertility. For instance by already paying for 3-6 unsuccessful rounds of ART, amassing between £15,000 and £30,000 (Moss & Parry, 2023).

Our study, therefore, used qualitative data to explore the experiences of LGBTQ+ couples who received fertility treatments from private clinics. Data were collated through either individual or paired interviews with LGBTQ+ service users (n=40) and fertility service providers (n=8) where a long interview technique was used to initiate detailed narratives (McCracken, 1988). Furthermore, if participants were still in the process of fertility

treatments, they were asked to keep a diary of their experiences (Alaszewski, 2006; Branco-Illodo et al., 2024; Zarantonello & Luomala, 2011). Of the 40 service users, 26 were cisgender lesbians, 8 were cisgender gay men, 3 were cisgender bisexual women, 2 were non-binary and queer, and one was a transgender man. Of the 8 service providers, 4 were heterosexual females, 2 were cisgender lesbians, one was a transgender man, and one was a transgender woman. In total, data comprised 30 interviews ranging between 30 and 90 minutes in length and 3 dairies, amassing 383,671 words. Data were analysed using Spiggle's (1994) approach to data analysis and interpretation.

3. Results

The findings reveal that the dignity of LGBTQ+ individuals is entwined within the overall fertility service experience. When fertility services value and respect a consumer's dignity, it leads to a positive experience, whereas disrespecting a consumer's dignity can lead to poor service experiences, complaints, disenchantment, and negative impacts on well-being. Unfortunately, the latter occurs more frequently than not within private fertility clinics in the UK. LGBTQ+ consumers repeatedly experience challenges to their recognition, equity/equality, agency, and humanisation throughout their fertility journeys.

3.1. Reducing recognition through voicelessness and epistemic injustice

As a healthcare provider, fertility clinics often provide a paternalistic approach to medicine where the consultant bases their decisions upon science and statistics without considering the wishes of the service users. This is a heteronormative approach based on statistics from heterosexual couples and 'normal' situations where there is one womb, one set of ovaries and a biological father (Mamo, 2013; Mamo & Alston-Stepnitz, 2015). LGBTQ+ consumers are, therefore, often overlooked, and the complexity of their situation (e.g., two wombs, two sets of ovaries, two potential biological fathers, and/or a surrogate) can go unrecognised. The example from Harriet (age 33) demonstrates the dangers of being under-recognised within a fertility clinic:

> We had a really, really ridiculous consultant, an older male who had a PowerPoint presentation to explain IVF and reciprocal IVF. So my, my wife is seven years older than me, so she was 38 or 39 when we went for the consultation. And so we said that we would quite like, and we'd had loads conversations ourselves and decided that together, we wanted to do reciprocal IVF because I'd always wanted to carry and my wife never wanted to carry but was more bothered about genetics and DNA and, and

> that aspect, whereas that didn't bother me at all. So we had like a great little solution. When we went into the consultation, the consultant actually said, 'Oh, we don't really want to use your old eggs' to my wife. (Harriet, age 33)

In this case, Harriet and her wife feel less dignified within the fertility clinic because the consultant does not consider the necessity of tailoring services to their wishes. Using heteronormative assumptions and consequently overlooking the requirements of LGBTQ+ consumers, he does not listen to their preferences. As a result, they remain voiceless and suffer from epistemic injustice, as their voices are not accepted as a basis for knowledge and valid information (Lamberton et al., 2024b).

3.2. The inequity and inequality of LGBTQ+ consumers

Although there are recent improvements to queering fertility services (Mamo, 2013), LGBTQ+ consumers are still experiencing inequality and inequity throughout their fertility journeys. For instance, even from the onset, the NHS only funds ART for heterosexual couples, amounting to what is known as 'The Gay Tax' for LGBTQ+ couples wishing to have biological children (Moss & Parry, 2023). Once, within the fertility service, there are still inequalities relating to the heterosexual nature of the website, the paperwork provided, and the language used by service providers. This is especially prominent for transgender consumers, such as George (age 32), who are not treated with the same equity as others:

> But the counsellor she was an odd person… it also didn't feel like she was culturally competent working with queer people. I think the idea of like, family is not biological, it's just a concept, it's not strange to queer people. And going straight to 'And could you love a child who's not biologically yours?' we were gobsmacked by that question. (George, age 32)

In this example, the values of George and his wife are not respected to the same extent as heterosexual consumers (Lamberton et al., 2024b). As a result, their dignity is disrespected, and they consequently leave the service. Although this question might be acceptable to a heterosexual couple using a donor, it is less acceptable to LGBTQ+ consumers familiar with the idea of loving children that are not biologically theirs. Equity would involve tailoring interactions so everyone feels equal, respected, and valued, and to achieve this, service providers should use different approaches depending on the situation.

3.3. *Challenges to LGBTQ+ direct agency*

When LGBTQ+ consumers experience epistemic injustice and inequity as evidenced in the examples by Harriet (age 33) and George (age 32), it affects their direct agency and ability to control a situation (Lamberton et al., 2024b). A further example from Amelia (age 31) indicates how a lack of agency can be highly detrimental not only to her dignity but also to her mental well-being.

> I got in and signed all the consent forms and everything, and I said about the sedation. He [the embryologist] said, yeah, we've got that sorted, you don't need to worry. And it was highlighted on the paperwork. And I got down to the um, theatre, and sat down in the chair, and I was like, when am I going to be sedated? Like, how does it work? And they're [the consultant was] like, oh, we should have given you that [already]. There was a pill, and it should have been given ages ago, we haven't got time. We're just going to do it [the embryo implantation]. And they just went ahead and did it, and it was just so horrible…I was just shaking on this table, and the consultant just said, kept saying, you need to stay still. But it was like I wasn't choosing to shake. It was like a fight and flight thing…It was horrible, like, really traumatic, and I ended up using the counselling service afterwards because I was just so, like, upset that that was the start of my pregnancy. (Amelia, age 31)

Amelia and other LGBTQ+ consumers of fertility services are frequently unheard, with their wishes and values being dismissed, which can result in dignity being diminished through a lack of control (Lamberton et al., 2024a; 2024b). This has long-lasting effects on consumers' mental health and well-being, which impacts feelings pre- and post-partum.

3.4.(De)humanisation through objectification and commodification

The data identify (de)humanisation, including objectification and commodification, as a novel factor influencing consumer dignity. Consumers feel more dignified when they are treated as human beings with feelings rather than as objects, financial exchanges, or commodification. Tania (age 38), for example, compares the two clinics she went to. In the first clinic, she feels coerced into an egg-sharing scheme where her gametes are commodified: "*I don't think it was very ethically fair in the way they did it really. I feel it was a financial decision because by me being an egg donor, they got to charge somebody else for a much more expensive course of treatment than me having IVF."* She much prefers the second clinic, where she was cared for and humanised:

> I just I don't I don't think they [the first clinic] cared about you as an individual really. But it's totally different to the second clinic. They you know, wanted to know, and they'd ring us when they're born and ask for a picture and just like nice, normal people that were like family orientated. (Tania, age 38)

In other instances, LGBTQ+ service users feel as if they are purely providing business; clinics do not care about the outcome, just about the money. As Amy (Age 32) explains*, "They [the clinic] just focus on the money…our rep, who we're supposed to be in contact with, she only gets in contact when we need to pay. She's been silent for ages and will return your call if you need to pay something. It's gross really."* LGBTQ+ fertility service consumers are also reduced to being bodies, ideally of a certain age and weight, as indicated through Harriet's (age 33) narrative where the consultant did not want to use her wife's *"old eggs"*. This dehumanisation occurs throughout the data, influencing the dignity felt by consumers during the ART process and their consequent evaluations of the service providers.

4. Discussion and Conclusion

In conclusion, this study underscores the critical role of dignity in shaping the experiences of LGBTQ+ consumers within private fertility services, highlighting pervasive challenges and systemic inequities. By applying Lamberton et al.'s (2024b) dignity framework our findings reveal frequent instances of epistemic injustice, inequity, diminished agency, and dehumanisation faced by LGBTQ+ service users. Our primary contribution is the addition of (de)humanisation to the dignity structure, which is a novel construct affecting outgroups and marginalised populations (van Loon et al., 2024). Practically, the experiences of LGBTQ+ consumers not only affect immediate service evaluations but also have profound and lasting impacts on consumers' mental health and well-being. Importantly, we illustrate the need for a paradigm shift in fertility service provision, advocating for a human-centred approach that treats LGBTQ+ consumers with respect, fairness, and empathy and provides them with a voice and representation within the service.

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