



Uterus transplantation in and beyond cisgender women: revisiting procreative liberty in light of emerging reproductive technologies

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ABSTRACT

Whilst internationally a growing body of literature is emerging on uterus transplantation as the latest advance in assisted reproductive technology, much of this has been devoted to responding to the ethical questions raised by this procedure in the context of its immediate purpose, to restore fertility in cisgender women. Very few have addressed whether it can be claimed that there is a right to gestate under the umbrella of procreative liberty, nor whether such a right, if it does exist, applies not only to cisgender women, but also transgender and gender variant individuals and cisgender men. In honour of Professor Robertson, I advance the debate further by examining the arguments put forward in his last paper and whether the right to gestate extends beyond cisgender women.

KEYWORDS: gestation, uterus transplantation, procreative liberty, reproduction

INTRODUCTION

Forty years on from the birth of Louise Brown, the world's first 'test tube baby',¹ reproductive medicine continues to revolutionize reproduction and propel us into

¹ TIME MAGAZINE, *The Test Tube Baby*, 1978; Peter R. Brinsden, *Thirty Years of IVF: The Legacy of Patrick Steptoe and Robert Edwards* 12 HUM. FERTIL. 137–143 (2009).

unchartered territories.² Looking back 40 years and knowing what we know now about the subsequent developments in assisted reproduction, Louise's birth after in vitro fertilization (IVF) using her married parents' gametes and following gestation in her mother does not seem so earth shattering. Other more dramatic and controversial developments were to follow, the most recent of which is uterus transplantation that raises the prospect that soon either mother or father may gestate a baby. This speculation has been raised in response to the success of uterus transplantation,³ which follows on from the transplantation of other reproductive tissue (including ovaries⁴ and testes⁵). The world's first child born following a uterine transplant first occurred in Sweden in 2014, to treat absolute uterine factor infertility in cisgender women,⁶ which for many years has been regarded as untreatable.⁷ In December 2017, it was reported that the first successful uterine transplant had been performed in the USA⁸ and clinical trials of uterine transplantation are now underway in the USA,⁹ Europe,¹⁰ Asia,¹¹ and have received ethical approval in the UK.¹²

Whilst internationally a growing body of literature is emerging on UTx, much of this has been devoted to responding to the clinical and ethical questions raised by this procedure in the context of its immediate purpose, to restore fertility in cisgender women.¹³ Very few have addressed whether it can be claimed that there is a right to gestate under the umbrella of procreative liberty, nor whether such a right,

² For regulatory dilemmas thrown up by earlier advances in assisted reproductive technologies, see Robert LEE & Derek MORGAN, *HUMAN FERTILISATION AND EMBRYOLOGY: REGULATING THE REPRODUCTIVE REVOLUTION* (2001). Margaret Brazier, *Regulating the Reproduction Business*, 7 *MED. L. REV.* 166 (1999). Roger Brownsword, *Regulating Human Genetics: New Dilemmas for a New Millennium*, 12 *MED. L. REV.* 14–39 (2004).

³ Mats Brannstrom et al., *Live Birth After Uterus Transplantation*, 385 *LANCET* 607–16 (2015).

⁴ Human ovarian tissue transplantation has resulted in the birth of over 70 children worldwide—see Sherman Silber, *Ovarian Tissue Cryopreservation and Transplantation: Scientific Implications*, 33 *J. ASSIST. REPROD. & GENET.* 1595–603 (2016). See also Valerie K. Blake, *Ovaries, Tissues and Uteruses Oh My! Regulating Reproductive Tissue Transplants*, 19 *WILLIAM & MARY J. WOMEN & L.* 353–93 (2013).

⁵ G. Vince, *Man Fathers Child After Testicular Transplant*, *NEW SCIENTIST*, Feb. 28, 2001.

⁶ The term *cisgender* (from the Latin *cis-*, meaning 'on the same side as') can be used to describe individuals who possess, from birth and into adulthood, the male or female reproductive organs (sex) typical of the social category of man or woman (gender) to which that individual was assigned at birth. Hence, a cisgender person's gender is on the same side as their birth-assigned sex, in contrast to which a transgender person's gender is on the other side (trans-) of their birth-assigned sex—see B. Aultman, *Cisgender*, *TRANSGENDER Q. STUD.* 61–62 (2014).

⁷ Mats Brännström, *Uterus Transplantation and Beyond*, 28 *J. MATER SCI: MATER MED.* 70 (2017), at 75.

⁸ Denise Grady, *Woman With Transplanted Uterus Gives Birth, the First in the U.S.*, *THE NEW YORK TIMES*, Dec. 2, 2017.

⁹ Bridget Kuehn, *US Uterus Transplant Trials Under Way*, 317 *JAMA* 1005–7 (2017).

¹⁰ Samantha Huet et al., *Uterus Transplantation in France: for Which Patients?* 205 *EUR. J. OBSTET. GYNECOL. REPROD. BIOL.* 7–10 (2016).

¹¹ Nobuhi Suganuma et al., *Uterus Transplantation: Toward Clinical Application in Japan*, 16 *REPROD. MED. & BIOL.* 305–13 (2017). *Womb Transplants: First 10 British Women Given Go-Ahead*, *THE GUARDIAN*, Sept. 29, 2015.

¹² Benjamin P. Jones et al., *Uterine Transplantation: Past, Present and Future*, 123 *BJOG* 1434–38 (2016).

¹³ For some of the literature written on uterus transplantation in cis women, see Stephen Wilkinson & Nicola Williams, *Should Uterus Transplants be Publicly Funded?*, 42 *J. MED. ETHICS* 559–65 (2016). Also see the three responses to the article: Amel Alghrani, *Yes, Uterus Transplants Should Be Publicly Funded!*; J. Balayla, *Public Funding of Uterine Transplantation*; Mianna Lotz, *Commentary on Nicola Williams and Stephen Wilkinson: Should Uterus Transplants Be Publicly Funded?* *J. MED. ETHICS* (2016). John Robertson J., *Other Women's Uterus: Uterus Transplants and Gestational Surrogacy*, 3 *J. L. & BIOSCI.* 68–86 (2016). Nicola Williams, *Should Deceased Donation be Morally Preferred in Uterine Transplantation Trials?*, 30 *BIOETHICS* 415–24 (2016);

if it does exist, applies not only to cisgender women, but also transgender and gender variant individuals and cisgender men.¹⁴ In 2016, Professor John Robertson published an insightful paper on uterus transplantation.¹⁵ The focus of his paper was whether this procedure will be a safe and effective therapy for cisgender women with uterine insufficiency. Comparing UTx and gestational surrogacy, Robertson argued ‘if UTx becomes safe and effective, the case for offering UTx to all women with UFI is strong’.¹⁶ In a published response to the paper, I highlighted that whilst Robertson had described UTx in that paper as a technology ‘less dramatic in scope, but important for affected women’¹⁷ than other ART innovations, two controversial questions surrounding UTx were not dealt with in this paper: firstly, whether cisgender women could argue there is a positive ‘right’ to gestate under the umbrella of procreative liberty that grounds a claim on the public fisc to subsidize their attempt to gestate via UTx, and secondly, the possibilities UTx raises in the future to widen the reproductive options of transgender and gender variant individuals and cisgender men who may seek access to UTx and thus the prospect it raises for widening who may experience gestation.¹⁸ In light of Robertson’s standing as a prolific writer on procreative liberty, I asserted that it would be interesting to know Robertson’s perspective on both issues, should science conquer this last frontier.

In one of the last pieces of work written by Robertson, published posthumously, he responded to this invitation, providing his views on whether there is a right to gestate in such novel contexts.¹⁹ There he noted that my ‘provocative comment’ had spurred on his thinking about whether procreative liberty implies a right to gestate.²⁰ He conceded that ‘if a high priority is given to enabling persons to have and rear their own genetic offspring; safety and efficacy have been established; and there is no other alternative for having genetic offspring, a rare case of male pregnancy as an aspect of procreative liberty might arise’.²¹ Robertson thus perceived a distinction between gestation for the sake of the experience and gestation that was tied to genetic reproduction—only in the latter did he regard gestation part of procreative liberty.

In honor of Professor Robertson who greatly influenced my thoughts on procreative liberty and given his significant contribution to the bioethics field, I would like to explore and advance the debate further by picking up where he left off and examining the arguments put forward in his last paper. In a bid to move the debate

STEPHEN COLEMAN, THE ETHICS OF ARTIFICIAL UTERUSES: IMPLICATIONS FOR REPRODUCTION AND ABORTION (Michelle Bayefsky & Benjamin Berkman, eds, 2004). *The Ethics of Allocating Uterine Transplantation*, 16 *CAMB. Q. HEALTHCARE ETHICS* 350–365 (2015). Ariel Lefkowitz, Marcel Edwards & Jacques Balayla, *Ethical Considerations in the Era of the Uterine Transplant: An Update of the Montreal Criteria for the Ethical Feasibility of Uterine Transplantation*, 100 *FERTIL. STERIL.* 924–6 (2013).

¹⁴ Although note the following ethical paper by Robert Sparrow, *Is it ‘Every Man’s Right to Have Babies if He Wants Them? Male Pregnancy and the Limits of Procreative Liberty*, 18 *KENN. INST. ETHICS J.* 275–99 (2008).

¹⁵ Timothy F. Murphy, *Assisted Gestation and Transgender Women*, 29 *BIOETHICS* 389–97 (2015).
 John Robertson, *Other Women’s Wombs: Uterus Transplants and Gestational Surrogacy*, 3 *J. L. & BIOSCI.* 68–86 (2016).

¹⁶ *Id.* at 85.

¹⁷ *Id.* at 69.

¹⁸ Amel Alghrani, *Uterus Transplantation: Does Procreative Liberty Encompass a Right to Gestate?* 3 *J. L. & BIOSCI.* 636–41 (2016).

¹⁹ John Robertson, *Is There a Right to Gestate*, 4 *J. L. & BIOSCI.* 630–6 (2017).

²⁰ *Id.* at 636.

²¹ *Id.* at 636.

forward, this paper assumes, at least for the sake of argument, that UTx will one day become sufficiently safe treatment for enabling gestation in cisgender women, transgender, and gender variant individuals and cisgender men, so as to restore, realign, and enhance reproductive function. I will then address the following three arguments: firstly, I revisit the concept and meaning of procreative liberty in the context of UTx as a new emerging reproductive technology. I question Robertson's argument that a right to gestate is encompassed within the notion of procreative liberty only when tied to genetic reproduction. I concur with the argument that cisgender women have a *prima facie* negative claim to UTx, which I agree with and which remains relatively uncontroversial, in the sense that there is no obvious counterargument of sufficient weight to override such a right. In this paper, having outlined why I agree with this, I would like to explore the more controversial question of whether individuals in countries where there is a universal healthcare system, such as the UK, could have a positive claim on the public fisc to be subsidized in their attempt to have children via UTx. Whilst it has been pointed out that UTx is hardly necessary to have children, since parenthood might be achieved via alternate routes such as adoption or surrogacy, the question addressed in this article is more fine grained: In a publicly funded healthcare system is there a right to expect the state to subsidize one's interest in gestating children?

The second question I address is whether transgender, non-binary, and other gender plural individuals can also assert a right to gestate under the concept of procreative liberty. In the absence of persuasive evidence to the contrary, this paper assumes these individuals have the same procreative liberties as cisgender individuals. Transgender women may seek UTx as a way of expressing and consolidating both a maternal and feminine identity, namely a parental identity that aligns with gender identity and thus in this context, uterus transplantation has the potential to realign reproductive capacity. Again, the question here is not necessarily one of having children; transindividuals may already be parents and have had children prior and post to any gender affirming treatment, depending on what type of surgeries and hormonal therapies they may have chosen, if any. The question is one of securing an experience imagined as important to one's (gender) identity and hoped-for parental bonds and whether this is enough to impose a public duty, correlative to an individual right to uterus transplantation. Here I examine Robertson's concession that the claim of a transgender woman desiring a uterus transplant so she could have the woman-specific experience of gestation does exist, but that it is 'weak'.²²

The case of transgender men and whether they may have a right to gestate under the umbrella of procreative liberty is also considered. Whilst some European countries mandate sterilization as part of legal gender recognition, in the UK, it is not necessary for transgender individuals to have had, or desire to have, any bodily interventions such as hormones or surgeries that may render them sterile in order to obtain a Gender Recognition Certificate and thus this potential legal barrier to a transgender men gestating does not exist in the UK.²³ Transgender men who have successfully conceived and gestated after using testosterone in both the UK and USA have made media headlines

²² *Id.* at 636.

²³ See Francis R. Whittle, *Trans Equality Policy Review United Kingdom*, University of Westminster, Apr. 2018, at 3.

worldwide and ‘many of the news reports on pregnancies of transgender men having children sensationalize what for transmen, as for all parents having children, should be a personal and intimate experience’.²⁴

The third and final argument I address is that of cisgender men asserting a right to uterus transplantation—in this context uterus transplantation may be sought as an ‘enhancement’ of reproductive function. Whilst this may be justified by recourse to arguments that procreative liberty encompasses alternate and novel means of founding a family, again some may claim that this is not necessarily about having children; but rather choosing a procreative experience not now available to men. The argument that will be addressed here is why should the state recognize any duty to subsidize the experience of gestation, which may be regarded as unnecessary to any man as a way of having children. Here I examine Robertson’s argument that there is ‘a strong presumption against such a right... just because women reproduce through pregnancy does not mean that men should be able to do so as well.’²⁵ Again this seems to contradict his previous argument that gestation should be allowed when it is the only means of genetic reproduction, especially in the context of a single male or a cisgender man in a same sex relationship that may not have recourse to a gestational carrier. In light of the global advances being made into uterine transplantation, as a dramatic new reproductive technology and the speculation this may open up the gestational experience beyond cisgender women, application of procreative liberty analysis to this debate renders this both a significant and timely paper.

PART I. UTERINE TRANSPLANTATION TO RESTORE FERTILITY IN WOMEN: IS THERE A RIGHT TO GESTATE?

Procreative liberty

Procreative liberty denotes freedom in activities and choices related to procreation.²⁶ Robertson argued it is respected because of the centrality of reproduction to personal identity, meaning and dignity.²⁷ Robertson formulated one of the most popular and cited defenses of this right in his book, *Children of Choice*, where he described procreative liberty as ‘... the freedom to decide whether or not to have offspring. To deny procreative choice is to deny or impose a crucial self-defining experience, thus denying persons respect and dignity at the most basic level.’²⁸ Because of this importance, the right to procreate is widely recognized as a prima facie moral right that cannot be limited except for very good reason. Robertson’s writings on the importance of procreative liberty have been elaborated upon in a wealth of literature and have served to help shape and support the claims of many who seek to procreate in alternate ways. Similarly, myself and moral philosopher Harris have argued that ‘whilst there is no widespread agreement as to the nature and scope of this right; it is clear that it must apply to more than

²⁴ Alexis D. Light et al, *Transgender Men Who Experienced Pregnancy After Female-to-Male Gender Transitioning*, 124 OBSTET. GYNECOL. 1120–27 (2014).

²⁵ Robertson *supra* note 19, at 635.

²⁶ John Robertson, *Embryos, Families and Procreative Liberty: the Legal Structure of New Reproduction*, 59 S. CAL. REV. 939–1041 (1986).

²⁷ JOHN ROBERTSON, *CHILDREN OF CHOICE* 30 (1994).

²⁸ *Id.* at 4.

conventional sexual reproduction and that it includes a range of the values and liberties which normal sexual reproduction embodies or subserves'.²⁹

Robertson acknowledged that not everything involving procreation implicates procreative liberty.³⁰ In light of the recent successful clinical trials which suggest uterine transplantation (UTx) may soon be a feasible method of family formation for cisgender women, the question is raised as to whether this procedure should be available as a form of treatment to alleviate uterus factor infertility and whether, under notions of procreative liberty, it can be claimed there a right to *gestate*. Robertson rightly noted that in order to answer the question of whether procreative liberty includes a right to *gestate*, one must first answer the question of what counts as 'reproduction'. He argued that reproduction is having or rearing offspring with one's own genes. A non-genetic conception of procreation would extend to obtaining and rearing a child who might not have any genetic connection at all, which he viewed as morphing into a claim of a right to adoption—a right to rear a child—without a genetic connection at all. Robertson argued that the interest in rearing children may be protected on some other theory of human flourishing, but it does not follow from procreative liberty, as it is not per se a reproductive interest. Harris concedes that perpetuating one's genes is part of traditional sexual reproduction, thus 'it is thus natural to see the freedom to create closely genetically related individuals as a plausible dimension of reproductive liberty, not least because so many people and agencies have been attracted to the idea of genetic relatedness and have linked the procreative imperative to the genetic imperative'.³¹ Despite disagreements within academia on the importance of genetic relatedness,³² the argument of procreative liberty as advanced by Robertson was that gestation as a means to genetically procreate and found a family clearly falls under the umbrella of procreative liberty. However, Robertson added the important caveat that 'this does not mean that gestation *tout court*—gestation unrelated to one's own genetic reproduction—should be covered'. He states:

...procreative liberty should include a right to *gestate* when gestation is essential to or part of a person's way to have genetic offspring for rearing, just as use of IVE, embryo freezing, sperm and egg freezing, and related activities are. They all enable a person to reproduce, ie, produce genetically related offspring.³³

Robertson argued that if there is a right to *gestate*, it is only when it is integral to the gestator's own genetic reproduction. Thus, it would not extend to cases in which a cisgender woman without eggs or a uterus wants a UTx so that she might receive donor gametes/embryo and *gestate* the child that she will then rear, since the woman would not be genetically reproducing. This focus on the genetic link is reflected elsewhere in UK law, for instance a couple who seek to found a family via surrogacy can only attain

²⁹ Amel Alghrani & John Harris, Should the Foundation of Families Be Regulated?, 18 *Child and Family Law Quarterly* 191–210, 191 (2006).

³⁰ Robertson, *supra* note 19, 636.

³¹ Alghrani & Harris, *supra* note 29.

³² For more on genetic relatedness, see Danielle Griffiths, *The (Re) Production of the Genetically Related Body in Law, Technology and Culture: Mitochondria Replacement Therapy*, 24 *HEALTHCARE ANAL.* 196–209 (2016).

³³ Robertson *supra* note 19, 631.

legal parenthood if one of the parties is genetically linked to the child.³⁴ This is also reflected in International law, for instance the interpretation accorded to Article 8 of the European Convention of Human Rights.³⁵

Here I would like to further probe this argument that a right to gestate only exists when necessary for the gestator's genetic reproduction. It is not clear why uterus transplantation should be limited to those who are able to use their genetic material to procreate. Egg donation has become increasingly common and some women who are not able to provide their own genetic material may still feel that they have a biological connection when they use donor eggs, primarily because of the gestational experience. Limiting uterus transplantation to individuals who can use their genetic material will result in the unfair exclusion of certain groups or individuals, for instance those with certain types of infertility, cancer survivors who do not have viable gametes and post-menopausal cisgender women.³⁶

The UK courts have acknowledged that parenthood can be separated into genetic, gestational, and social/psychological parenthood³⁷ and explicitly noted that whilst genetic parenthood is important, it was by no means an essential component of parenthood. Whilst in the great majority of cases, cisgender women will combine all three,³⁸ gestation was explicitly acknowledged as a method of attaining parenthood.³⁹ In the UK, such importance is placed on gestation, that it is the woman who gestates the child who is regarded as the child's legal 'mother' irrespective of biological connection.⁴⁰ Only with her consent and a number of other requirements can legal motherhood be relinquished and transferred via a parental order.⁴¹ To interpret procreative liberty as encompassing the right to gestate only where intended for means of genetic parenthood and exclude those who require a third party's gametes from the ambit of UTx seems absurd, since they have already enlisted the aid of a third party, the uterus donor. In *Re G*, Baroness Hale noted that acknowledging gestational motherhood facilitates certainty and convenience, but also recognizes a deeper truth: 'that the

³⁴ The Human Fertilisation and Embryology Act 2008, section 54 (1)(b). See also the case of *B v C (Surrogacy - Adoption)* [2015] EWFC 17 which concerned an application for an adoption order in respect of the child A by his biological father B where B had entered into a surrogacy arrangement with his own mother.

³⁵ On this latter point, see the 2017 Grand Chamber judgment in *Paradiso and Campanelli v Italy* (Application No. 25358/12). This case concerned a married Italian couple, who had entered into commercial surrogacy arrangement with a surrogate in Russia. Due to a clinical error, neither parent had a genetic connection to the child the surrogate gestated an embryo obtained from unknown ova and sperm donors. Measures taken by the Italian authorities resulted in the separation of on a permanent basis of the child and the applicants. The Grand Chamber found that no Article 8 family life, *de facto* or otherwise, arose between the applicant's and their child.

³⁶ In the USA, more than 60,000 young adults are diagnosed with cancer each year. Cancer treatment can affect fertility and practice guidelines from a number of professional organisations, including the American Society of Oncology highlight the need to address and counsel fertility with their at risk patients—for more, see Joanne Frankel Kelvin, *Fertility Preservation in Young Adult Patients with Cancer*, 31 *ONCOLOGY* 530, 534–38 (2017).

³⁷ *Re G* [2006] UKHL 43, [paras 33–35] per Baroness Hale.

³⁸ *Id.* at para 36.

³⁹ *Id.* at para 34.

⁴⁰ The Human Fertilisation and Embryology Act 2008, section 33 provides 'The woman who is carrying or has carried a child as a result of the placing in her of an embryo or of sperm and eggs, and no other woman, is to be treated as the mother of the child.'

⁴¹ For a discussion on parental orders and law surrounding surrogacy in the UK, see A. Alghrani A. & D. Griffiths, *Surrogacy Regulation In The UK: the Case For Reform*, 29 *CHILD & FAM. L. Q.* 165–86 (2017).

process of carrying a child and giving birth... brings with it, in the vast majority of cases, a very special relationship between mother and child, a relationship which is different from any other'.⁴² The exclusion of those who are infertile from discussions on uterus transplantation runs counter to Lady Hale's acknowledgement that there are now different avenues to parenthood. It has even been argued that a gestational relationship with a child is a better indicator that the interest of the child will be served, and thus more moral relevance should be attached to the gestational, rather than to the genetic connection when deciding who has the right to parent a biologically related newborn.⁴³ Gheaus positions the gestational procreator's right over the genetic on account of two features of gestation; firstly, the fact gestation is unavoidably burdensome and secondly, gestation is typically the context in which the relationship between parent and child starts—thus the intimate relationship between gestator and child is likely to start before birth.⁴⁴ Whilst acknowledging Gheaus arguments, it need not be a competition as to which parent has made a greater contribution to the procreative enterprise, but rather it suffices to state that gestation is equally accepted as a method of attaining parenthood. Thus, the argument that procreative liberty only extends to those who seek to gestate a genetically related child is unconvincing in the context of uterus transplant technology.

Furthermore, any claims that procreative liberty should be limited to genetic reproduction to prevent speculative harm to other persons are tenuous, since there is no evidence to support theories that the welfare of children raised by parents to whom they do not share a genetic link fare any less well off. What little evidence there is on the topic seems to indicate the contrary. A longitudinal study by Golombok's follow-up study which examined children at 3 years old indicated that the absence of a genetic or gestational link between the mother and the child did not impact negatively on parent-child relationships.⁴⁵ The study found that families without a genetic or a gestational link 'reflected higher levels of warmth and interaction between mothers and their 3-year-old children in the assisted reproduction families than in the comparison group of families with a naturally conceived child'.⁴⁶

Thus, the answer to the first question this paper set out to answer is that procreative liberty does extend to a right to gestate. Whilst Robertson regards this right to gestate as part of one's procreative liberty when desired for genetic reproduction, this is where he and I differ for the reasons outlined above. I now turn to the question of whether the right to gestate is a positive or negative right in countries such as the UK, where other fertility treatment is publicly funded.

Procreative liberty as a negative right to gestate

Robertson argued that procreative liberty at a minimum should entail a negative liberty right to engage in activities necessary to achieve the goal of procreation, without interference by the state or others unless the reproduction harms unconsenting others in

⁴² *Re G* [2006] UKHL 43.

⁴³ Anca Gheaus, *Biological Parenthood: Gestational, Not Genetic*, 96 AUSTRALIAN JOURNAL OF PHILOSOPHY 225–40 (2017).

⁴⁴ *Id.*

⁴⁵ Susan Golombok et al., *Non-Genetic and Non-Gestational Parenthood: Consequences for Parent-Child Relationships and the Psychological Well-Being of Mothers, Fathers and Children at Age 3*, 21 HUMAN REPRODUCTION 1918–24 (2006).

⁴⁶ *Id.* at 1922.

specific ways.⁴⁷ He acknowledged that one could also argue for a positive right of procreative liberty, such that the state or insurers are obligated to provide the resources or means to enable genetic reproduction to occur.⁴⁸ The former view that procreative liberty entails a negative right against state interference is reflected in international legislation such as the Universal Declaration⁴⁹ and the European Convention of Human Rights (ECHR),⁵⁰ which protects the right to a private and family life and the right to marry and found a family as a universal right. Robertson's interpretation of procreative liberty as protecting one's right to genetic reproduction correlates with the interpretation by the ECHR to the 'right to a private and family life' under Article 8,⁵¹ as supporting a right to procreate using one's genes, but as a negative right against state interference, as opposed to a positive right to state assistance.

This is evidenced in the case of *Dickson v United Kingdom*,⁵² where Article 8 was successfully relied upon to challenge the English prison authority's refusal to allow Kirk Dickson and his wife artificial insemination facilities. Dickson was a prisoner serving a minimum life sentence of 15 years for murder. He had met his partner via a prison penal network when she was also in prison. She was subsequently released and the couple in their desires to procreate applied for artificial insemination facilities, which they had offered to pay for themselves. The UK Secretary of State refused this request firstly on the basis their relationship had not been tested in a normal environment, secondly that the child would be without the presence of a father for an important part of his/her childhood, and lastly, that there was a legitimate and public concern that the punitive and deterrent elements of imprisonment would have been circumvented if artificial insemination were allowed. Upon appeal, the Grand Chamber agreed with the applicants that the refusal of artificial insemination facilities breached their right to respect for a private and family life as guaranteed by Article 8. The court held that 'the refusal of artificial insemination facilities concerned their private and family lives which notions incorporated the right to respect for their decision to become genetic parents'.⁵³ The court accepted that whilst it was legitimate for the authorities to concern themselves as a matter of principle with the welfare of any child, the policy in operation was structured so as to exclude 'any real weighing of the competing individual and public interests and prevented the required assessment of the proportionality of a restriction, in any individual case'.⁵⁴ Thus, it was held to be a violation of Article 8.

⁴⁷ Robertson, *supra* note 19, at 631.

⁴⁸ *Id.*

⁴⁹ Article 16 (1) of the United Nations Universal Declaration of Human Rights 1948 (the UN Declaration) provides that 'Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family'.

⁵⁰ The Human Rights Act 1998 was introduced into UK law in October 2000 and incorporated the rights set out in the European Convention on Human Rights (ECHR) into domestic British law.

⁵¹ In theory, this is further supported by Article 12 which provides that 'men and women of marriageable age have the right to marry and found a family, according to the national laws governing the exercise of this right', although in practice, the ECHR has dealt with claims to genetic reproduction under Article 8. For instance see *Evans v UK* [2007] 2 F.C.R. 5.

⁵² *Dickson v UK* [2007] 3 F.C.R. 877. For a commentary of the case, see Marleen Eijkholt, *The Right to Procreate is not Aborted*, 16 MED. L. REV. 284–93 (2008).

⁵³ *Id.* at para 66.

⁵⁴ *Id.*

Similarly, in *Hadley v Amicus Healthcare Ltd & Others: Evans v Midland Fertility Services & Others* [2003],⁵⁵ a joint case that arose following disputes between gamete progenitors as to the fate of their embryos following separation, the judge Nicholas Wall LJ held that whilst Article 12 was not engaged in the case before him, in any event ‘... the right to found a family through in vitro fertilisation can only, put at its highest, amount to the right to have access to *in vitro* fertilisation treatment. Self evidently it cannot be a right to be treated successfully. Furthermore it is a right which is qualified by availability, suitability for treatment and cost.’⁵⁶ What can be gleaned from these cases is that any outright prohibition on uterus transplantation to *restore* fertility and natural function in cisgender women lacking a functioning uterus so as to permit genetic reproduction would engage Article 8.⁵⁷ Whilst Article 8(2) allows for derogation in the interests of ‘public safety’ and ‘for the protection of health and morals’, any such prohibition must be justified, competing individual and public interests fairly balanced and any restriction must be ‘necessary in a democratic society’ and ‘in accordance with the law’. Member States are accorded a certain margin of appreciation in their interpretation and incorporation of the rights contained in the Convention; however, the court in *Dickson* stated the breadth of this ‘varies and depends on a number of factors including the nature of the activities restricted and the aims pursued by the restrictions.’⁵⁸ The Grand Chamber in *Dickson* explicitly stated that

... where a particularly important facet of an individual’s existence or identity is at stake (such as the choice to become a genetic parent), the margin of appreciation accorded to a state will in general be restricted.⁵⁹

Thus, *Dickson* implies that any decision to prohibit an individual accessing assisted reproductive technology to genetically reproduce ought to be thoroughly considered and fairly weighted. The Grand Chamber in *Dickson* avoided answering whether Article 8 grounded a negative or positive obligation, stating ‘the core issue in the present case is precisely whether a fair balance was struck between the competing public and private interests involved’.⁶⁰ Eijkholt argues that the judgement seems to suggest that the choice to become a genetic parent would be of such vital importance, that a request for access should not be interfered with and seems to be considered in the sense of a negative right.⁶¹ Thus, the claim of a negative right to coital or non-coital reproduction where gestation is concerned is persuasive. In the absence of convincing reason to the contrary, it seems clear that for women suffering from uterus factor infertility there is a negative right to gestate, certainly where genetic reproduction is concerned.

⁵⁵ *Hadley v Amicus Healthcare Ltd & Others: Evans v Midland Fertility Services & Others* [2003] EWCH 2161 (Fam). For a commentary of the case see Amel Alghrani, *Deciding the Fate of Frozen Embryos* 13 *MED. L. REV.* 244–256 (2005).

⁵⁶ *Id.* at para 261.

⁵⁷ *Dickson*, supra note 51, at para 66.

⁵⁸ *Id.* at para 77. See also *Smith v UK* (2000) 29 *EHR* 493, para 88.

⁵⁹ *Id.* at para 78.

⁶⁰ *Id.* at para 71.

⁶¹ Marleen Eijkholt, *The Right to Procreate is Not Aborted*, 16 *MED. L. REV.* 284–93 (2008), at 291.

Procreative liberty as a positive right to gestate

The controversial question is whether a positive right to gestate should also be recognized when financial support or services are needed. Arguments that individuals should be allowed to claim a positive right to uterus transplantation as an avenue to genetic reproduction may be met with outrage given that it is estimated the procedure will cost in excess of £50,000 per operation: 10 times that of IVF.⁶² Given the substantial cost of the procedure, some commentators have tackled the thorny question of whether in countries with a publicly funded system, such as the UK, a case can be made for the public funding of UTx.⁶³

In their paper on whether there should be public funding of uterus transplantation to help cisgender women overcome uterus factor infertility, rather than arguing the case for why it should, Wilkinson and Williamson instead focused upon arguments on why the state *should not* fund UTx. They address three arguments against publicly funding of UTx. The first suggests that UTx should not be publicly funded because doing so is inconsistent with governments' obligations to prevent climate change and environmental pollution. This is dismissed on the grounds that, if that is its concern—then the state should (for example) tax *all* human reproduction rather than singling out those who are pathologically infertile for especially negative treatment. Much the same goes for UTx. They thus agree with the view put forward by Karnein and Iser that 'the burden of reducing overpopulation has to be distributed equally and cannot be shouldered by those in need of ARTs and reproductive donation alone.'⁶⁴

Their second argument focuses on the claims that UTx does not treat a disorder and is not medically necessary and thus should not be publicly funded. This claim is based on two assumptions: one, that whilst infertility enjoys official status it is not a real disease as it is only harmful to people *with certain desires* and secondly infertility is a *social* problem that is mistakenly viewed as *medical* instead. They provide the following quote in support by Pemberton, which encapsulates this skepticism:

In the 1960s, those unable to conceive were referred to as the 'involuntary childless'. Today, this has been reframed within the discourse of biomedicine as 'infertility', and it reflects an increasing tendency for medicine to step in to manage and provide solutions to social problems. This, of course, does not detract from the upset that childlessness can bring. But, this is grief based on a sense of failure because of an 'abnormality' that is culturally determined. I am not arguing that the infertile should not be free to seek assistance with conception if they choose it. My issue is whether they are entitled to treatment under the NHS. While childlessness is distressing, it is not associated with long-term disability, morbidity or mortality. It is not a disease. Rather, it is about people unable to have something that they want. This is not what the NHS is there to remedy.⁶⁵

The authors rightly refute such claims noting how many pathological conditions are only harmful in the presence of certain desires; thus, the fact that the major harms

⁶² See <http://wombtransplantuk.org/everything-you-need-to-know-about-uterine-transplantation> (accessed June 14, 2018).

⁶³ Wilkinson & Williams, *supra* note 13.

⁶⁴ Susan Golombok et al., *Reproductive Donation in the Context of Environmental and Global Justice* in REGULATING REPRODUCTIVE DONATION 84–104 (2015).

⁶⁵ Max Pemberton, *Finger on the Pulse*, THE TELEGRAPH, May 6, 2011; Wilkinson & Williams, *supra* note 13.

associated with infertility are dependent on the desire to have children does not mean that infertility cannot be a pathological condition. Secondly, they highlight that many pathological conditions are only (directly) harmful in certain social contexts and may even be beneficial in others. I agree with both arguments presented by the authors that neither of the first two arguments considered provide strong reasons why procreative liberty should not ground a positive right to gestate. It is here we depart company. Their third and final argument, the one with which the authors support, asserts that funding for UTx should be denied because of the availability of alternatives such as adoption and surrogacy.⁶⁶ If procreative liberty encompasses the ability to access reproductive technologies to facilitate genetic reproduction, adoption does not provide this alternative.

Arguments that posit surrogacy as a viable alternative to justify claims against state funding are also tenuous. For a cisgender woman lacking a functioning uterus, the only way genetic motherhood can be achieved is through surrogacy. Surrogacy may go against the religious, cultural, or personal reasons of some women⁶⁷ and as Robertson pointed out in his paper, there are many for whom surrogacy is not a viable option.⁶⁸ Surrogacy, as a path to parenthood, is far from unproblematic; it can be an emotionally draining method of founding a family and in the UK the practice is shrouded in legal uncertainty.⁶⁹ Even if this uncertainty was removed by 'better regulation', it is still not a 'sufficiently good' alternative to justify not offering UTx, as research demonstrates that many attach a great importance to the experience of gestation and pregnancy to have offspring.⁷⁰ Brannstrom cogently sums up the advantages of UTx over surrogacy:

The advantages of a model for a successful uterine transplantation compared to gestational surrogacy are obvious for the infertile couple - apart from the joy of experiencing a pregnancy, they would not be dependent on a third party during gestation and would have full control over maternal lifestyle-influences on their offspring. Furthermore, the genetic mother, instead of the surrogate, would take the physiological risks involved with any pregnancy. Issues such as maternal bonding during gestation, the definition of motherhood and the risk of economic pressure being a factor in recruitment of the surrogate carrier, would be abolished. Also, the prospected child would not have to deal with the possible conflict of having two mothers.⁷¹

UTx allows cisgender women suffering from uterus factor infertility the opportunity to experience gestation, pregnancy, and childbirth akin to their fertile female

⁶⁶ Wilkinson & Williams, *supra* note 13.

⁶⁷ A point also noted by Professor John Robertson in J. Robertson, *supra* note 15, at 70.

⁶⁸ *Id.*

⁶⁹ Surrogacy arrangements are not enforceable in the UK—see The Surrogacy Arrangements Act 1985. Also Amel Alghrani, Danielle Griffiths & Brazier Margaret, *Surrogacy Law: From Piecemeal Tweaks to Sustained Review and Reform*, in LAW IN SOCIETY: REFLECTIONS ON CHILDREN, FAMILY, CULTURE AND PHILOSOPHY: ESSAYS IN HONOUR OF MICHAEL FREEMAN 425–55 (Alison Diduck, Noam Peleg & Helen Reece, eds, 2015).

⁷⁰ See Jim G. Thornton, Helen M. McNamara & Imogen A. Montague, *Would You Rather be a 'Birth' or a 'Genetic' Mother? If So, How Much?* 20 J. MED. ETHICS 87–92 (1994). See also Vered H. Eisenberg & Joseph G. Schenker, *Pre-embryo Donation: Ethical and Legal Aspects*, 60 INT'L J. GYNECOL. & OBSTET. 51–57 (1998); MARY B. MAHOWALD, GENES, WOMEN AND EQUALITY 129 (2000).

⁷¹ Mats Brannstrom, Caiza A. Wranning & Randa El Akouri, *Transplantation of the Uterus*, 28 Mol. CELL ENDOCRINOL. 177–84 (2003).

counterparts who conceive ‘naturally’⁷² or without assistance. If UTx presents the only way a cisgender woman can have a genetically related child and surrogacy is not an option for whatever reason, uterus transplantation clearly falls within the parameters of procreative liberty and within the scope of Article 8 of the ECHR.

But delineating whether it is a positive or negative right is inherently conflated with political questions surrounding the expense of the procedure. The costs of UTx may evoke strong sentiments and objections as to why public taxpayers should be burdened with funding such treatment,⁷³ especially in an era of austerity. Writing from the USA, Robertson noted similar constraints, stating:

The transplant procedure for the recipient is highly expensive and intrusive, and possibly doubly so if a living donor is used. This will give pause to insurance and public funders, who might decide that it is too costly to include in infertility benefits. This position, however, would conflict with a notion of equal access to technologies to overcome infertility, such as coverage for IVF and diagnostic and corrective procedures to enable production of gametes, when they are determined to be safe and effective.⁷⁴

The public funding of a very expensive treatment such as uterus transplantation and whether there is an entitlement to it exposes a much broader problem with regard to the distribution of medical resources in general. Whilst a discussion of allocation of resources is beyond the scope of this paper, some immediately obvious observations on this issue in regard to uterus transplantation can be briefly made.

Firstly, there must be some consistency/rationale behind which treatments will be publicly funded and which will not. It is conceded that publicly funded healthcare systems, such as the UK National Health Service (NHS) has a limited budget and therefore some form of rationing policy must operate.⁷⁵ A discussion of the range of factors that must be considered in answering the allocation question when determining UTx has been explored by Bayefsky and Berkman, where they address factors such as (1) the motivation to seek treatment, (2) allocation by age, (3) child-rearing capacity, and (4) the amount of infertility treatment required.⁷⁶ They present a set of eligibility and ranking criteria, which they acknowledge are not exhaustive but are intended to spark discussion about how uteruses can be allocated in a just manner.

The argument that uterus transplantation should not be publicly funded as it is not life-saving treatment is weak since numerous treatments are publicly funded that are not life saving, consider kidney transplantation, which will significantly improve a patient’s quality of life, and yet dialysis is a life-preserving alternative. Cornea transplants to restore the sight of people with clouded vision and orthodontic treatment such as braces to help align teeth are but a few examples of well-accepted therapies performed

⁷² Heather Widdows & Fiona MacCallum, *Disparities in Parenting Criteria: An Exploration of the Issues, Focusing on Adoption and Embryo Donation*, 28 J. MED. ETHICS 139–42 (2002).

⁷³ See Wilkinson & Williams, *supra* note 13.

⁷⁴ Robertson, *supra* note 19, at 633.

⁷⁵ For more on the UK healthcare system, see Konstantina Grosios, Peter B. Gahan & John Burbidge, *Overview of Healthcare in the UK*, 1 EPMA J. 529–34 (2010). For the future of UK healthcare, see Hugh E. Montgomery et al., *The Future of UK Healthcare: Problems and Potential Solutions to a System in Crisis*, 28 ANN. ONCOL. 1751–55 (2017).

⁷⁶ Michelle J. Bayefsky & Benjamin A. Berkman, *The Ethics of Allocating Uterine Transplantation*, 16 CMB. Q. HEALTHCARE ETHICS 350–365 (2015).

only to improve a patient's quality of life, not to preserve it. The Warnock Committee commissioned by the UK government in 1978 to consider the legal and ethical issues generated by IVF reported in 1984 and specifically acknowledged that there are many other treatments not designed to satisfy absolute needs (in the sense the patient would die without them), which are readily available on the NHS. The Committee noted that medicine is no longer exclusively concerned with the preservation of life, but also the quality of life and remedying the malfunctions of the human body. An inability to have children is on this analysis, a malfunction that should be considered in exactly the same way as any other. The committee concluded that consequently 'infertility is a condition meriting treatment'.⁷⁷

Secondly, if a state accepts that there is or should be a public commitment to treating infertility and thus publicly funds IVF, again it is arbitrary to fund IVF to assist couples having difficulty in *conceiving*, but not UTx, which will assist women having difficulty *gestating*. In the UK, the majority of fertility services (some 60%) are provided by the private sector, with the NHS providing the public funding for remaining 40%.⁷⁸ As the judge in *Hadley v Amicus Healthcare Ltd & Others* alluded to, provision is qualified.⁷⁹ The National Institute for Health and Care Excellence (NICE) provides best practice guidance and recommends in the context of access to IVF that the state funds provision of three cycles of IVF in women aged under 40 years who have not conceived after 2 years of regular unprotected intercourse or 12 cycles of artificial insemination. However, NHS funding comes through Clinical Commissioning groups (CCGs) and despite the NICE guidance, provision is dependant on local CCG's who make the final decision about who can have NHS-funded IVF treatment in their local area.⁸⁰ CCGs may impose stricter criteria than those recommended by NICE as a pre-requisite to being eligible for IVF funding: such as the recipient must not have children already from both their current and any previous relationships, that they are a healthy weight, non-smoker and further age restrictions may be imposed (for example, some CCGs only fund treatment for women under 35). In 2017, Fertility Network UK data revealed 13 areas of England have restricted or completely halted IVF treatment since the start of 2017, with a further 8 consulting on taking similar steps.⁸¹ The figures also revealed that the number of CCGs in England offering three full cycles of IVF has fallen by 46%, from 50 in 2013⁸² to 27 in 2017. The cutbacks have been taken in a bid to save money and have resulted in a postcode lottery, with variance on provision based on geographical location. Unsurprisingly, many individuals/couples seeking fertility treatment resort to private fertility centers, with a reported 6 out of every 10 IVF cycles funded privately in

⁷⁷ The Report of the Committee of Inquiry into Human Fertilisation and Embryology, 1984, Cm 9314 ('The Warnock Report') at para 2.4.

⁷⁸ HFEA Innovation in Regulation, Feb. 2017, at 4, <https://ifqlive.blob.core.windows.net/umbraco-website/1796/innovation-and-regulation-plan-post-consultation-tagged.pdf> (accessed June 15, 2018).

⁷⁹ *Hadley v Amicus Healthcare Ltd & Others: Evans v Midland Fertility Services & Others* [2003] EWCH 2161.

⁸⁰ In the UK, The Health and Social Care Act 2012 introduced major structural changes to commissioning and procurement of NHS services. Previous Primary Care Trusts responsible for commissioning were dissolved and their functions devolved to GP commissioning groups called Clinical Commissioning Groups.

⁸¹ Sarah Marsh, *IVF Cut Back in 13 Areas of England to Save Money, New Data Shows*, THE GUARDIAN, Aug. 6, 2017.

⁸² Karen McVeigh, *NHS Denying Women Fertility Treatment to Save Money, Watchdog Warns*, THE GUARDIAN, Oct. 23, 2014.

2014.⁸³ The cost of private treatment can vary, but each cycle typically costs between £6000 and £10,000, with top London clinics charging £15,000 or more.⁸⁴ The lack of public funding of fertility treatment has attracted much criticism; Susan Seenan, the chief executive of Fertility Network UK, argues infertility can have a serious and lasting impact and denying people help is ‘a short-sighted and false economy’.⁸⁵ It is against this background that decisions must be made as to whether the state should also be obliged to fund much more expensive fertility treatments such as UTx.

Thirdly, if difficult decisions must be made about how to prioritize limited funding in the face of rising demand, any rationing system must operate on a fair and transparent basis. In the UK, NICE provides one way in which treatments can be rationed is by examining the increase in health likely to accrue as a result of introducing a new treatment—the so-called incremental cost effectiveness ratio. This is measured by the cost per quality adjusted life year (QALY). Thus, whether a uterus transplant will be publicly funded could depend on the QALY assessment.

Lastly, it is fair and right that use of resources is debated and what the rightful limits of society’s obligations are, especially when we are living in a climate in which there are daily new reports of the fact that there are insufficient medical resources to meet the demand. Consequently, some kind of rationing is required and inevitable in all healthcare systems. This is not a problem unique to the UK, the appropriate allocation of public resources to assisted reproduction technologies (ARTs) is a contentious issue in most developed economies. Access to reproductive technologies must compete with other claims on scarce healthcare resources and the nature of its outcomes are different from those of most other health services and thus according priority on a fair basis is no easy feat.⁸⁶ Devlin and Parkin outline the characteristics of ARTs that make them ‘unusual’ as health services and the particular challenges encountered by economists and policy makers in using the tools of economic evaluation to assess ‘value for money’ of ARTs. They note how the recurrent theme internationally is one of uneven allocations of public (or third-party) resources to ARTs within health systems (including those in which public funding applies to an otherwise comprehensive range of services) and a greater reliance, across health systems, on private, out-of-pocket sources of funds than for most other healthcare services. The consequence is unequal access to ARTs. Further the tendency of ARTs to be distributed by willingness and ability to pay has been described by some as a covert form of eugenics.⁸⁷

It is clear that limited medical resources necessitate a constant reappraisal of the value in those conditions treated and funded. Clear delineation of where one’s procreative rights lie on that spectrum and whether there is a positive right to gestate is essential for such discussions. Desires to procreate should not be minimized as simply individuals lacking capacity to fulfill one of many basic desires they have. A cisgender woman born with uterus factor infertility may rightly regard herself as suffering from a

⁸³ Donna Ferguson, *IVF and the NHS: The Parents Navigating Fertility’s Postcode Lottery*, THE GUARDIAN, May 10, 2014.

⁸⁴ *Id.*

⁸⁵ Marsh, *supra* note 81.

⁸⁶ Nancy Devlin & David Parkin, *Funding Fertility: Issues in the Allocation and Distribution of Resources to Assisted Reproduction Technologies*, 6 HUM. FERTIL. S2–6 (2003).

⁸⁷ *Id.*

disability and regard her condition of lacking a uterus as no different to someone born lacking a functioning leg who requires surgery to try and restore him or her to full mobility so as to live a full and fulfilling life.

Discussions regarding positive rights cannot escape the context they are being discussed in. One cannot escape from the reality that the political scenery and state of the publicly funded healthcare systems such as that in the UK (the NHS) are quite different in 2018, to when the Warnock Committee deliberated in the late 70s in the context of IVF. In the UK, a government recession followed by a program of unprecedented cuts has seen the NHS wilfully starved of funds, and as Kamal notes ‘the NHS is now in the worst crisis in its history and is rapidly approaching breaking point’.⁸⁸ Whether public funding for some fertility treatment such as IVF will continue in the coming years is unclear. Whether it could sustain the cost of even more expensive fertility treatment such as uterus transplantation is even more uncertain. It may well be the case, that as with the majority of IVF provision, this will fall to the private sector which may further exacerbate health and social inequalities, in that this advance may only be available to those individuals/couples in a position of economic strength who can afford to fund such treatment privately. Whilst in theory resource issues should not determine nor cloud the question of whether or not there is a positive right to gestate, the reality is that if the state does not have enough resources to fund everything, then in a universal healthcare system, resources may not affect a negative right to gestate, but will inevitably affect a positive right to gestate. Thus, I would concur at this point with Robertson that ‘in addition to recognition as a negative right, there is a strong argument that UTx should be included in coverage generally of reproductive services if it meets the safety and efficacy standards of other covered procedures.’⁸⁹

PART II

As emerging reproductive technologies such as uterus transplantation promise more avenues in which individuals can actualize their procreative rights, and in light of the UK courts acknowledgment that ‘... families are formed in different ways these days and the law must attempt to keep up and to respond to developments...’⁹⁰ it is not clear why discussion should be confined to cisgender individuals. In the absence of persuasive evidence to the contrary, this paper assumes that transgender, non-binary, and other gender plural individuals have the same procreative liberties as cisgender individuals. In discussing this topic, the paper refers to the explanation of the term ‘trans-identity’ offered by the UK House of Commons Women and Equality Committee Report on Transgender Equality (2015–2016), which is as follows:

Each of us is at birth assigned a sex (male or female), based on our physical identities. Most peoples gender identity (the gender with which they associate themselves) and gender presentation will not differ from that typically associated with their assigned sex. Trans people, however, have a gender identity, which differs to that of their assigned (birth) sex. Trans identities take a wide variety of forms. Trans identity can be ‘non binary’ in

⁸⁸ *Id.*

⁸⁹ Robertson, *supra* note 19, at 631.

⁹⁰ *Re G (Children)* [2014] EWCA Civ 336, [para 30] per LJ Black.

character, located at a (fixed or variable) point along a continuum between male and female; or 'non-gendered', i.e. having no identification as neither male nor female.⁹¹

Research thus far conducted on families where a parent is transgender or gender variant shows that these children do not fare any less well than children reared in other family units.⁹² Notwithstanding this, the discrimination transgender individuals have faced in the context of actualizing the procreative rights both pre and post gender-affirming treatments have been well documented.⁹³ In the context of discussions regarding procreative liberty, whilst the rights of many groups in this context have been examined,⁹⁴ transindividuals are a group who have until recently been neglected in such discourse. Mitu has written on how much of the discourse in the transgender movement has centered on the acceptance of the transgender identity and the social and medically assisted parts of the gender affirming process:

Studies of human reproduction, reproductive health, and reproductive practices have focused on cissexism (a belief that transsexuals' identified genders are inferior to, or less authentic than, those of cissexuals). Transgender reproduction is almost invisible in transgender studies as well as in studies of reproduction, which mainly have focused on whether transgender people should be offered assisted reproduction services and/or fertility preservation before starting medical aspects of a transition.⁹⁵

Mitu argues that 'with transgender people's long-term life plans in view, which are likely to include parenting, stronger advocacy is required both to educate this population regarding options for reproduction and to change laws, insurance policies, and, above all, social and clinical norms to facilitate transgender people's reproductive choices.'⁹⁶ Respecting transgender individuals' procreative choices necessitates informing and counseling those individuals who opt for gender affirming treatment on their reproductive preservation options prior to and post treatment, for instance, the possibility of having their gametes frozen and stored for later use and fertilization via IVF.⁹⁷

Whilst objections that transgender individuals have in some way forfeited their rights to procreate and that this is the 'price to pay' for undergoing gender affirming

⁹¹ Women and Equalities Committee, *Transgender Equality*, HC 390 2016 – 16, 1 Jan. 2016. 1.1

⁹² Rebecca L. Stotzer, Jody L. Herman & Amira Hasenbush, *Transgender Parenting: A Review of Existing Research*, THE WILLIAMS INSTITUTE 1–28 (2014).

⁹³ Thomas Stocks, *To What Extent Have the Rights of Transgender People Been Underrealized in Comparison to the Rights of Lesbian, Gay, Bisexual, and Queer/Questioning People in the United Kingdom?* 16 INT'L J. TRANSGENDER. 1–35 (2015). Sheelagh McGuinness & Amel Alghrani, *Gender and Parenthood: The Case for Realignment*, 16 MED. L. REV. 261–83 (2008). House of Commons, Women and Equalities Committee, *Transgender Equality* (2015–16) HC 390.

⁹⁴ Whether infertile heterosexual couples, single women, those in same sex relationships, prisoners and HIV discordant individuals should be assisted in their desires to procreate have all attracted attention and academic debate.

⁹⁵ Khadija Mitu, *Transgender Reproductive Choice and Fertility Preservation*, 8 AMA J. ETHICS 1119–25, at 1119 (2016).

⁹⁶ *Id.* at 1125

⁹⁷ For more on this, see McGuinness & Alghrani, *supra* note 93.

treatment have been persuasively rejected by academics such as Sutter,⁹⁸ this notion that loss of fertility is the ‘price to pay’ for transitioning remains endorsed by some countries who mandate that transgender individuals are sterile or ‘continuously non-reproductive’⁹⁹ as a pre-condition to gender recognition. In 2017, across the Council of Europe, 20 countries continue to enforce a sterilization requirement.¹⁰⁰ In its landmark 2017 opinion, *AP, Garçon, and Nicot v France*,¹⁰¹ the court held that, by conditioning gender recognition on submission to ‘a sterilization operation or medical treatment creating a high probability of sterilization’ France had violated the applicants’ right to a private and family life under Article 8 of the ECHR. Dunne noted that whilst this judgement follows recent decisions reached by national courts in Germany,¹⁰² Sweden,¹⁰³ and Italy¹⁰⁴ and is a welcome affirmation of transgender rights, statements from the ECtHR as well as the highest courts in Germany and Sweden’ reveal a general assumption that, irrespective of disproportionality, transgender sterilization requirements do pursue valid aims.¹⁰⁵ Dunne argued that from the existing case law, policy debates and literature, three central justifications become apparent as justifying the conditioning of gender recognition on sterilization: legal certainty, child welfare, and natural reproduction. Critiquing all three, Dunne persuasively sets out how none pursue valid aims. He rightly contends that sterilization requirements rely upon a weak, discriminatory and logically inconsistent framework.¹⁰⁶ Whilst such blatant discrimination against transgender and gender variant individuals such as compulsory sterilization in certain jurisdictions is now being addressed, it is imperative that debates and discussions surrounding emerging ARTs such as UTx are not confined to cisgender individuals and discourses also include transgender, non-binary and other gender plural individuals.

Uterus transplantation in transgender women: the final step in re-alignment

Soon after the world’s first birth via uterine transplant, media headlines were quick to publicize that this raised the prospect that the procedure may also be possible in transgender women so as to enable gestation.¹⁰⁷ Robertson acknowledges, ‘transgender persons have the same right to have genetic offspring that other persons have’.

⁹⁸ Petra De Sutter, *Gender Reassignment and Assisted Reproduction: Present and Future Options for Transsexual People*, 16 HUM. REPROD. 612–14 (2001), at 612. Petra De Sutter, *The Desire to have Children and the Preservation of Fertility in Transsexual Women: A Survey*, 6 INT’L J. TRANSGENDER. 1–12 (2001).

⁹⁹ Term used in German legislation that previously required that the transperson is ‘continuously non-reproductive’. (TSG (1980) Second Section, SS 8. 1 (iii)).

¹⁰⁰ Peter Dunne, *Transgender Sterilisation Requirements in Europe*, 25 MED. L. REV. 554–81 (2017).

¹⁰¹ (ECtHR, Apr. 6, 2017).

¹⁰² Federal Constitutional Court of Germany, 1 BvR 3295/07 (Jan. 11, 2011).

¹⁰³ Stockholm Administrative Court of Appeals, *Socialstyrelsen v NN*, Mål nr 1968–12 (Dec. 19, 2012).

¹⁰⁴ *Id.*

¹⁰⁵ Dunne, *supra* note 100.

¹⁰⁶ *Id.*

¹⁰⁷ Dina Fine Maron, *How a Transgender Woman Could Get Pregnant*, SCIENTIFIC AMERICAN, June 15, 2016. L. Leah Samuel, *With Uterus Transplants a Reality, Transgender Women Dare to Dream of Pregnancies*, STAT Reporting from the Frontiers of Health and Medicine, Mar. 7, 2016. Uterus transplantation into transwomen has been explored in the following papers: A. Alghrani, *Assisted Reproductive Technologies and Family formation: Womb Transplant Technology and the Allocation of Family Responsibilities*, in TAKING RESPONSIBILITY: LAW AND THE CHANGING FAMILY (C. Lind, H. Keating & J. Bridgman, eds, 2010). Murphy, *supra* note 14. A. Alghrani, *supra* note 18.

Transgender women could use sperm stored prior to any gender affirming surgery to create an embryo with a donated egg, which she could then gestate in a transplanted uterus. Without a uterus transplant, genetic reproduction would only be possible via a gestational carrier such as a surrogate. Uterus transplantation overcomes this and holds the potential to further widen the reproductive options for transgender women. Transgender women may desire to gestate for non-genetic reproduction and regard gestation as a way of expressing and consolidating both a maternal and feminine identity, namely a parental identity that aligns with gender identity.¹⁰⁸ Thus in this context, uterus transplantation has the potential to realign reproductive capacity. Again, the question here is not necessarily one of having children; transgender women may already be parents and have had children both prior to gender affirming surgery transitioning and post, depending on what type of surgeries and hormonal therapies they have chosen.¹⁰⁹ The question is one of securing an experience imagined as important to one's (gender) identity and hoped-for parental bonds. Here I examine Robertson's claim that in this context, that the claim of a transgender woman desiring a uterus transplant so she could have the woman-specific experience of gestation does exist under procreative liberty, but that it is 'weak'¹¹⁰ and only if no other carrier is available and where it represents the only avenue for genetic reproduction. He supported this view with the claim that 'the medical and technical hurdles to enable her to overcome her phenotypic male anatomy and accommodate a functioning uterus might simply be too high. Still, if safety and efficacy could be shown, she might have a claim to do so only if no other carrier were available.'¹¹¹

There are of course additional safety concerns when considering uterine transplantation into a transgender women. Consider for instance, the *Montreal Criteria for the Ethical Feasibility of Uterine Transplantation* developed in 2012 to guide clinicians and researchers in ethically carrying out uterine transplants.¹¹² Since their inception, these criteria have helped set a standard for the ethical execution of this novel procedure and have encouraged further discussion and consideration of the concerns that surround uterine transplant. Nevertheless, the *Montreal Criteria* require that the recipient be a cisgender female. The justification for this is premised on safety and efficacy concerns and the fact that to date, only cisgender female recipients have been used in animal and human trials of uterine transplants. Medical issues concerning uterine transplant with a non-cisgender female recipient include the creation of adequate uterine vascularization de novo, the necessity for appropriate hormone replacement to sustain implantation and pregnancy, and the placement of the uterus in a non-gynecoid pelvis.¹¹³ These unique considerations mean that uterine transplant in cisgender men and transgender women fails to meet the first stipulation of Moore's Criteria for Surgical Innovation, which requires that novel surgical procedures have an adequate research

¹⁰⁸ Murphy, *supra* note 14.

¹⁰⁹ Sutter, *Gender Reassignment and Assisted Reproduction*, *supra* note 99. Damien Riggs, Jennifer Power & Henry V. Doussa, *Parenting and Australian Trans and Gender Diverse People: An Exploratory Survey*, 17 INT'L J. TRANSGENDER. 59–65 (2016).

¹¹⁰ Robertson, *supra* note 19, at 636.

¹¹¹ *Id.*

¹¹² Ariel Lefkowitz, Marcel Edwards & Jacques Balayla, *The Montreal Criteria for the Ethical Feasibility of Uterine Transplantation*, 25 TRANSL. INT. 439–47 (2012).

¹¹³ *Id.*

background. It is on this basis that the *Montreal Criteria* exclude non-cisgender female recipients.¹¹⁴

But let us suppose that such safety concerns are overcome. It is not clear why the claim of transgender women to gestate is regarded as ‘weak’ or any weaker than that of cisgender women. Uterus transplantation offers the same promise of a solution for transgender women wishing to gestate a child as it does for cisgender females with uterus factor infertility. In the UK, the Gender Recognition Act 2004 offers full legal gender recognition if the individual has been diagnosed with gender identity disorder, has lived in the acquired gender for 2 years, and has sworn a statutory declaration that they intend to live permanently in the acquired gender.¹¹⁵ Whilst this latter element is dubious, since cisgender individuals do not have to make such declarations that they are going to live permanently in their assigned gender,¹¹⁶ it is clear that this statutory framework does not endorse the notion that transgender individuals have in some way ‘chosen’ to be infertile and that this negates their rights to ARTs. This notion is also inconsistent with the legislative stance adopted in the Human Fertilisation and Embryology Act 2008 which governs fertility treatment and contains provisions that grants parental recognition to same sex couples¹¹⁷—the UK Government does not accept that a same sex couple has somehow waived away any rights to parent by the mere fact they have elected to be in a relationship where biological reproduction is not possible. Section 9 of the Gender Recognition Act 2004 provides that ‘where a full gender recognition certificate is issued to a person, the person’s gender becomes for all purposes the acquired gender (so that, if the acquired gender is the male gender, the person’s sex becomes that of a man and, if it is the female gender, the person’s sex becomes that of a woman)’. Thus, if uterine transplants were offered as clinical treatment in cisgender women, and providing it was scientifically feasible and safe to perform this procedure in transgender women who have a full gender recognition certificate, they too may also claim a right to gestate utilizing this technology.

Murphy in an insightful paper on the topic of assisted gestation in transgender women also argues that if transgender women are treated the same as cisgender women in the full moral sense ‘[i]t is not simply ‘frivolous’ for transgender women to assert any interest in gestation’.¹¹⁸ Murphy addressed the possible objection that might be raised against gestation by transgender women that it could alter the social meaning of sexed bodies and argues that this line of argument fails to substantiate a meaningful objection to gestation by transgender women because social meanings of sexed bodies do not remain constant. In any case, one could reasonably expect little social impact from transgender women who gestate their own children, since in that case the social identity of the parent (female) would align with female-typical behavior (gestation).¹¹⁹

¹¹⁴ *Id.*

¹¹⁵ Section 2 of the Gender Recognition Act 2004. For an interesting discussion of the Gender Recognition Act 2004 and the broader political context, read SALLY HINES, *GENDER DIVERSITY, RECOGNITION AND CITIZENSHIP* (2013).

¹¹⁶ For criticism of the Gender Recognition Act and calls that it is updated, see the Women and Equalities Committee, *Transgender Equality*, HC 390 2016-16, Jan. 14, 2016, at 3–4.

¹¹⁷ See The Human Fertilisation and Embryology Act 2008, ss 42–45.

¹¹⁸ Murphy, *supra* note 14, at 392.

¹¹⁹ *Id.* at 396.

Thus, under the umbrella of procreative liberty, if it can be argued cisgender women can claim a right to gestate, it is unclear why the same would not apply to transgender women, certainly in jurisdictions such as the UK which grants transgender women who have obtained legal recognition the equivalent rights as their cisgender female counterparts.

Uterus transplantation in transgender men

A transgender man is someone who identifies as a man, but whose sex assigned at birth was female. Born with female reproductive organs, transgender men may undergo gender-affirming surgery. As noted in the previous section, whilst some European countries mandate sterilization, in the UK, it is not necessary for transgender individuals to have had, or desire to have, any bodily interventions such as hormones or surgeries that may render them sterile in order to obtain a Gender Recognition Certificate and thus this potential legal barrier to a transgender man gestating does not exist in the UK.¹²⁰ Obedin-Maliver and Makadon highlight how the largest survey on this subject in the USA showed that most transgender men have not undergone gender-affirming surgery, which leaves many with the capacity to bear children.¹²¹ For transgender men who wish to conceive and gestate with functioning natal reproductive organs, the main concerns are related to whether they use or have used testosterone and if so, the duration of use and timing in relation to pregnancy and the effect this may have on the fetus. The role of testosterone in influencing the genesis of obstetrical complications remains unclear. Whilst the literature suggests that high (endogenous) androgen levels in pregnant women are associated with reduced birth weight,¹²² Obedin-Maliver and Makadon draw attention to small study which showed that ‘pregnancy, delivery, and birth outcomes’ did not differ according to prior testosterone use, though testosterone levels and birth weight were not measured during pregnancy.¹²³ Transgender men have successfully conceived and carried a pregnancy after using testosterone.¹²⁴ Obedin-Maliver and Makadon rightly note how some of these cases have attracted worldwide media attention and ‘many of the news reports on pregnancies of transgender men having children sensationalize what for trans men, as for all parents having children, should be a personal and intimate experience.’¹²⁵

One example of this is the global media attention Thomas Beatie, a transgender man in Oregon, USA, received when he decided to gestate after discovering his

¹²⁰ Whittle, *supra* note 23, at 3.

¹²¹ Jaime M. Grant et al. *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*. Washington: The National Center for Transgender Equality and the National Gay and Lesbian Task Force, 2011; Juno Obedin-Maliver & Harvey J. Makadon, *Transgender Men and Pregnancy*, 9 *OBSTET. MED.* 4–8 (2016).

¹²² Sven M. Carlsen, Geir Jacobsen & Pal Romundstad, *Maternal Testosterone Levels During Pregnancy are Associated with Offspring Aiz at Birth*, 155 *EUR. J. ENDOCRINOL.* 365–70 (2006). Kristin M. Voegtline et al, *Sex-Specific Associations of Maternal Prenatal Testosterone Levels with Birth Weight and Weight Gain in Infancy*, 4 *J. DEV. ORIG. HEALTH DIS.* 280–84 (2013).

¹²³ Sven A. Ellis, Danuta M. Wojnar & Maria Pettinato, *Conception, Pregnancy, and Birth Experiences of Male and Gender Variant Gestational Parents: It’s How We Could Have a Family*, 60 *J. MIDWIFERY WOMEN’S HEALTH* 62–69 (2014).

¹²⁴ A. D. Light, *supra* note 24.

¹²⁵ *Id.*

partner could not become pregnant following a hysterectomy.¹²⁶ With the use of donor insemination, Beatie successfully gestated and gave birth to a healthy daughter and later publicly discussed his pregnancy on the Oprah Winfrey Show.¹²⁷ Fascination and horror in the notion of a pregnant man dominated headlines, with some commentators suggesting Beatie had forfeited his 'right' to become pregnant and that pregnancy negated Beatie's maleness and rendered his pregnancy illegitimate.¹²⁸ In a commentary about Beatie's pregnancy, Blaze demonstrated there were also pejorative responses within television:¹²⁹ David Letterman called Beatie an 'androgynous freak show', while other network presenters described the pregnancy as 'disgusting' and 'useless'.¹³⁰ Von Doussa, Power, and Riggs¹³¹ argue that the Beatie case reflects the fact that whilst attitudes have become more accepting of same-sex parenthood, there is less cultural acceptance for parents who are transgender or gender or whose gender is not clearly defined as either male or female.¹³² Transindividuals who wish to parent have to overcome these difficulties in negotiating parenthood within a society in which parenting is culturally constructed in highly gendered terms. In a survey conducted by Ellis, Wojnar, and Pettinato of eight subjects whose sex assigned at birth was female and who carried a pregnancy to term while identifying as male or gender variant at the time of conception and through delivery,¹³³ they noted both internal and external struggles for the parents. Internal challenges were typified by the conflict between one's identity as male and/or gender variant and social norms that define a pregnant person as a woman and a gestational parent as mother. External challenges centered on the external world and involved a constant tension about needing to 'manage others' perceptions and either disclosing or not disclosing what they were experiencing.¹³⁴ Their recommendations were focused on providing affirming and inclusive care for transgender men who may gestate a child, beginning with preconception and counseling and continuing through the postpartum period.

On whether transgender men have a right to gestate under the umbrella of procreative liberty, Murphy has argued Thomas Beatie's (now) multiple pregnancies and child births have not led to an identifiable social harm rooted in changed social meaning of sexed bodies, let alone a harm of a magnitude that would justify imposing moral or legal obstacles to prevent assisted gestation by transgender men.¹³⁵ Murphy further states: 'It is hard to see that this outcome would change even if more transgender men

¹²⁶ James Macintyre, *Married 'Man' Claims to Be Five Months Pregnant*, THE INDEPENDENT, Mar. 27, 2008. Thomas Beatie, *Labor of Love: Is Society Ready for This Pregnant Husband?*, THE ADVOCATE, Apr. 8, 2008. J. Bone, *Thomas Beatie, A Married Man Who Used To Be A Woman Is Pregnant With A Baby Girl*, TIMES ONLINE, Mar. 26, 2008.

¹²⁷ American talk show hosted by Oprah Winfrey.

¹²⁸ Damien W. Riggs, *What Makes a Man? Thomas Beattie, Embodiment, and 'Mundane Transphobia'*, 24 FEMINISM & PSYCHOL. 1–15 (2014).

¹²⁹ Alex Blaze, *Hate Starts Rolling in for Thomas Beatie, 2004–2015*, THE BILERICO PROJECT (2008).

¹³⁰ *Id.*

¹³¹ Henry V. Doussa, Jennifer Power & Damien Riggs, *Imagining Parenthood: the Possibilities and Experiences of Parenthood Among Transgender People*, 17 CULTURE HEALTH & SEX. 1119–31 (2015).

¹³² Bente D. Spidsberg, *Vulnerable and Strong – Lesbian Women Encountering Maternity Care*, 60 J. ADV. NURS. 478–86 (2007).

¹³³ Ellis et al., *supra* note 123.

¹³⁴ *Id.*

¹³⁵ Murphy, *supra* note 14, at 396.

followed his example. As far as the world at large is concerned, transgender men will be outwardly fathers to their children.¹³⁶

In the UK a transgender man who gestates his own child will be regarded as the child's mother on the birth registration certificate because the law continues to ascribe legal parenthood based on sexual characteristics at birth. Thus, the legal 'mother' is defined by the Human Fertilisation and Embryology Act 2008 as 'the woman who is carrying or who has carried a child as a result of placing in her an embryo or of sperm and eggs...'¹³⁷ As Whittle notes, 'the gestational parent is consistently assumed to be female and referred to as "she" and as a "mother" throughout this and other legislation'.¹³⁸ The Gender Recognition Act 2004 provides that 'the fact that a person's gender has become the acquired gender under this Act does not affect the status of the person as the father or mother of a child.'¹³⁹ The explanatory notes that accompany the legislation state this provision was to ensure the continuity of parental rights and responsibilities for transgender parents. Yet, there is no clear provision for transgender parents who conceive after having legally transitioned. Thus, a transgender man who has obtained a gender recognition certificate and is legally recognized as male, who later conceives and gives birth to a child, is regarded as the legal 'mother' of the child. Indeed, this is the situation that transpired in 2017 in the UK, when Hayden Cross, who had undergone gender-affirming treatment and for 3 years had been legally recognized as male, was registered as his child's 'mother'.¹⁴⁰ Cross was fearful gender affirming treatment he was undergoing would limit his fertility but was declined NHS treatment to facilitate fertility preservation and thus he placed his treatment on hold and resorted to an informal donor, which resulted in the successful conception and the birth of his daughter. For him he wanted to gestate to genetically reproduce and stated 'having a biological child has always meant a lot to me'.¹⁴¹ When he registered his daughter's birth, he was named on the birth certificate as his daughters 'mother' (despite his male legal gender) and the child was deemed legally fatherless. Whittle argues that there is no acknowledgment that someone might not *want* to be registered as a 'mother' if they are a man or non-binary and highlights how transgender individuals who give birth fall between the gaps in all existing UK legislation on legal parenthood—at all times, the definition of 'male' and 'female' and 'mother' and 'father' are cisgender normative and assume that the individuals in question will have the reproductive capacities of cisgender males/females.¹⁴² In the context of non-alignment between the sex assigned at birth and gender identity, it has been argued that transparent identity is a multidimensional, multidetermined, non-binary and fluid identity, and that institutional forms and legislation relative to parenting and birthing must acknowledge the diversity of parental identity and designation.¹⁴³ This is even more so in the context of new reproductive technologies such as uterine

¹³⁶ *Id.*

¹³⁷ Section 33(1)

¹³⁸ Whittle, *supra* note 23, at 5.

¹³⁹ Section 12.

¹⁴⁰ Chris Baynes, *Britain's First Pregnant Man Gives Birth to Girl*, THE INDEPENDENT, July 8, 2017.

¹⁴¹ *Id.*

¹⁴² Whittle, *supra* note 23, at 4–5.

¹⁴³ Marie-Pier Petit, Danielle Julien & Line Chamberland, *Negotiating Parental Designations Among Trans Parents' Families: An Ecological Model of Parental Identity*, 4 PSYCHOL. SEX. ORIENT. & GENDER DIVERS. 282–95 (2017).

transplantation that continue to expand possibilities for how individuals may exercise their procreative liberty.

PART III—‘BIRTHED BY DAD’ UTERINE TRANSPLANTATION IN CISGENDER MEN

The third and final issue I now address is the prospect that science may soon also discover how to achieve pregnancy in cisgender men. There are crucial distinctions between transgender women and cisgender men gestating via UTx to be factored in: for instance, the former will most likely be in receipt of estrogen and other ‘female’ hormones and thus their testosterone may be significantly lowered. Professor Brännström who led the world’s first successful UTx procedure in Sweden has asserted that it could one day be technically possible to transplant a uterus into a cisgender man, combined with the use of hormone therapy to enable a pregnancy to succeed.¹⁴⁴ The baby would be delivered via cesarean section and the uterus removed shortly after successful delivery. This controversial prospect was also noted by the media, which featured headlines such as ‘Scientists are Now Attempting to Figure Out How to Get Men Pregnant’¹⁴⁵ and ‘Will Uterine Transplants Make Male Pregnancy Possible?’¹⁴⁶ Cisgender men who may seek to utilize such technology could be same-sex male couples, one of them donating the gametes whilst the other gestates the baby, involving both in the reproductive process. Single men may also wish to opt for this procedure. As single and same-sex male couples require a gestational surrogate to gestate a child to procreate, this would avoid the expensive and legally uncertain route of commissioning a surrogate.¹⁴⁷ In theory, it would seem if there were a right to gestate that applies to cisgender women and transgender individuals, in the absence of harm to resulting children it would by extension apply to cisgender men. In support of procreative liberty as encompassing founding a family through alternate and novel means, Savulescu argued:

‘Experiments in reproduction’ are as important as ‘experiments in living’ as long as they don’t harm the children who are produced. For this reason, reproductive freedom is important. It is easy to grant people the freedom to do what is disagreeable to us; freedom is important only when it is the freedom for people to do what is disagreeable to others.¹⁴⁸

Robertson’s accounts of procreative liberty center on respect for individual autonomy and individual’s decisions concerning how they procreate and found a family. The State should respect this liberty and Joel Feinberg argues in *The Moral Limits of the Criminal Law*¹⁴⁹ it should only ‘prohibit conduct that causes serious private harm, or the unreasonable risk of such harm, or harm to important public institutions and practices’.¹⁵⁰ Phrased slightly differently, Harris has argued that in all democracies, the

¹⁴⁴ Martin Hutchinson, *Womb Transplant Baby ‘Within Three Years’*, BBC NEWS, July 1, 2003.

¹⁴⁵ Micaiah Bilger, *Scientists are Now Attempting to Figure Out How to Get Men Pregnant*, LIFE NEWS.COM, June 20, 2016.

¹⁴⁶ Denise Grady, *Will Uterine Transplants Make Male Pregnancy Possible?*, NEW YORK TIMES, Nov. 16, 2015.

¹⁴⁷ The Surrogacy Arrangements Act 1985 (as amended by section 59 Human Fertilisation and Embryology Act 1990) renders surrogacy arrangements unenforceable in the UK.

¹⁴⁸ Julien Savulescu, *Deaf Lesbians, ‘Designer Disability’ and the Future of Medicine*, 325 BRIT. MED. J. 771 (2002), at 772.

¹⁴⁹ JOEL FEINBERG, *THE MORAL LIMITS OF THE CRIMINAL LAW* (1984).

¹⁵⁰ *Id.*

‘democratic presumption’ is that individual choices will not be interfered with unless good and sufficient grounds can be produced for so doing.¹⁵¹ On the basis of this democratic presumption, the burden falls on those wishing to rebut such a presumption to prove that allowing the exercise of such a right would cause demonstrable harm. This becomes important in the context of a right to gestate since some countries such as the UK have legislation in place, which would render it unlawful and a crime for a man to place an embryo into a cisgender male body with the intention to implant.¹⁵² This legislative prohibition was drafted at a time when uterus transplantation was still restricted to research in animals and not yet possible in cisgender women, and if procreative liberty extends to a right to gestate it is not clear that prohibiting gestation in cisgender men or transgender men is justified in the absence of substantiation of the serious harms it may cause.

In 2008, before the world’s first successful human uterus transplant and when ‘the idea that men might become pregnant’ was more speculative than it is now, Sparrow wrote a paper on whether ‘it is every man’s right to have babies if he want them?’¹⁵³ He was discussing suggestions that in the future it might be possible for cisgender men to become pregnant and conceded that given the role played by the right to procreative liberty (what he refers to as reproductive liberty in his paper) in other debates about reproductive technologies, it will be extremely difficult to deny that this right extends to include male pregnancy. However, he asserts that:

... this conclusion constitutes a *reductio ad absurdum* of the idea of reproductive liberty as it is currently used in bioethics. Any notion of a right to reproductive liberty that extends as far as a man’s right to gestate has lost contact with the facts about the biology of reproduction and its significance in a normal human life that made it plausible to defend the existence of such a right in the first place.¹⁵⁴

Sparrow therefore advises that the extent of this purported right in other contexts in which it is deployed needs revisiting. He argues that notions of procreative liberty have gone awry in this context for the following reasons: firstly, the argument for procreative liberty relies for its force on facts about the normative role reproduction plays in the human life cycle. Given the role that reproduction plays in human flourishing, the harms of infringing and frustrating this right for those unable to reproduce, or who need assistance so as to do so, are clear. However, as gestation and pregnancy is simply not a normal part of cisgender men’s lives, he states ‘it is not a tragedy when a man cannot become pregnant—no matter how much he wishes to be pregnant’.¹⁵⁵ Thus, Sparrow argues barriers to male pregnancy do not constitute restrictions of procreative liberty in the same way, as do barriers to women becoming pregnant. Sparrow’s argument relies upon procreation conceived of as ‘legitimate’, state-sanctioned, heteronormative reproduction, or what might be termed repronormativity.¹⁵⁶ Whilst it is true that one may not

¹⁵¹ Alghrani & Harris, *supra* note 29.

¹⁵² See The Human Fertilisation Act 1990 (as amended by the Human Fertilisation and Embryology Act 2008).

¹⁵³ Sparrow, *supra* note 14.

¹⁵⁴ *Id.* at 276.

¹⁵⁵ *Id.* at 287.

¹⁵⁶ For more on repronormativity see Anna L. Weissman, *Repronormativity and the Reproduction of the Nation-State: The State and Sexuality Collide*, 13 J. GLBT FAM. STUD. 277–305 (2016).

traditionally regard a cisgender male not being able to get pregnant as a human tragedy, this may be because it is not yet possible and people do not have sympathy because someone cannot do the impossible. For instance, I may not sympathize with someone unable to teleport. But in a world where cisgender men can get pregnant/people can teleport, we may think differently and see it as a tragedy. Furthermore, rights are not based on whether something is perceived as a tragedy or not. I would not regard it a tragedy if a sexist political commentator was banned from appearing on television and making sexist comments, but it might interfere with his/her fundamental human right to free speech as protected under the European Convention of Human Rights.¹⁵⁷

Sparrow's second argument is that rights cannot be summoned into existence *ex nihilo*, whether an activity falls within a right depends in part on a set of substantive judgements about what sorts of projects can contribute to a meaningful life and the interests that found rights must be capable of being described in ways that can communicate their importance to others. That the application of a right always involves these sorts of judgements about the merits of the claim that some particular project falls within it, otherwise one would have no way of adjudicating when rights conflict. He goes on to state 'the problem with grounding a male right to pregnancy in a more general right to self-determination, then, is that in the context of the normal reproductive life cycle for men, it is a frivolous claim.'¹⁵⁸ He argues that because pregnancy is not a reasonable expectation in men, men who wish to become pregnant are not capable of establishing that this desire should be granted the same moral weight as women's desires to become pregnant. This he claims accounts for the primary source of the intuition that defending 'men's right to have babies' is just plain silly.

Again this is not convincing. Just because the importance of a right can be explained does not result in adjudication between conflicts of rights being possible. For instance, the right to privacy might conflict with the right to free speech. We can explain that both are important. But the fact that they are important does not help us adjudicate conflicts between those rights.¹⁵⁹

As Sparrow deems that pregnancy is not a reasonable expectation in cisgender men, he argues no negative right to male pregnancy exists and laws prohibiting men from becoming pregnant would not interfere with a project that is entitled to the same level of respect granted to conventional reproduction. The rights rhetoric Sparrow deployed here clouds the issue. Whether cisgender men have the right to get pregnant depends upon what theory of rights one adopts. If one adopted a choice theory of rights or broad interpretation of procreation liberty, then as Sparrow concedes, one could say thwarting a man's decision to get pregnant, would interfere with his rights.

Sparrow's analysis can be summed up as follows: without some naturalistic and gendered account of parenthood, bioethics has opened the door to entirely degendered accounts of rights and duties in parenthood. He seems to favor a view that parental sex implies moral limits to the ways in which people should have children, at least as far as state subsidy is concerned. Acknowledging that fertility clinicians help same-sex

¹⁵⁷ Article 10 ECHR.

¹⁵⁸ *Supra* note 14, at 288.

¹⁵⁹ For a UK case which illustrates these competing rights, see *PJS (Appellant) v News Group Newspapers Ltd* [2016] UKSC 26.

couples bypass their relational infertility,¹⁶⁰ Sparrow's line of argumentation remains that individuals may still only have children in male-typical or female-typical ways, even if the parental roles of same-sex couples vary from the norm. Sparrow also argues against the use of public funds to support research into technology to enable cisgender men to gestate (since he sees no right, there is no public duty to support research).

Similar to Sparrow, Robertson argues there is a strong argument against men having a right to gestate under the auspices of procreative liberty and argues 'the desire alone to experience what women feel in carrying and delivering a child would not be a strong enough reason to undergo the burdens and costs, not to mention the use of a scarce organ, simply to have a gestational experience unnecessary for his reproduction. Just because women reproduce through pregnancy does not mean that men should be able to do so as well. Not all whims or even strong desires about passing on genes merit protection as part of procreative liberty.'¹⁶¹ As noted earlier, Robertson's view is based on the view that procreative liberty should include a right to gestate when tied to genetic reproduction. Thus, he does concede that a man might have a stronger claim to gestate if there were no partner or surrogate available, stating:

...if a high priority is given to enabling persons to have and rear their own genetic offspring; safety and efficacy have been established; and there is no other alternative for having genetic offspring, a rare case of male pregnancy as an aspect of procreative liberty might arise.¹⁶²

However, he argues that even then it would not be 'strong enough to justify the gender conflation that might then occur'.¹⁶³

This is similar to the objection raised above in the context of transgender women, that speculative social harms rooted in changed social meaning of sexed bodies will occur. As Murphy argued in response to such arguments, these fail because social meanings of sexed bodies do not remain constant and because the change in this case would not elicit social effects significant enough to justify restricting gestation only to cisgender women.¹⁶⁴ As Murphy plausibly points out: 'The social meaning of sexed bodies has changed and continues to change in a variety of ways, without the sky falling.'¹⁶⁵ Thus, in the absence of plausible justification to the contrary, it seems that cisgender male gestation would also fall under the ambit of procreative liberty, certainly according to the definition of procreative liberty provided by Robertson and where desired to enable genetic reproduction.

CONCLUSION

Reproductive science continues to propel us into uncharted territories and tests the very essence of principles such as the right to procreative liberty. The controversial

¹⁶⁰ Julien S. Murphy, *Should Lesbians Count As Infertile Couples? Anti-Lesbian Discrimination in Assisted Reproduction*, in *QUEER FAMILIES, QUEER POLITICS: Challenging Culture and the State* 182–200 (M. Bernstein & R. Reinmann, eds, 2001).

¹⁶¹ Robertson, *supra* note 19, at 636.

¹⁶² *Id.* at 636.

¹⁶³ *Id.*

¹⁶⁴ Murphy, *supra* note 14.

¹⁶⁵ *Id.* at 396.

possibility of uterine transplantation once more reminds us how reproductive technologies are increasingly allowing us to separate genetic, gestational and social parenthood.¹⁶⁶ Such a possibility necessitates a reconsideration of laws that ascribe legal parental status based on the sex assigned at birth. As scientists around the world continue in their endeavors to emulate the success of Sweden and the USA, the prospect of uterus transplantation not only to restore fertility in women, but also to restore, realign and enhance reproductive capacity in transgender and non-binary individuals and cisgender men, provides an interesting context within which to test the boundaries of notions of procreative liberty. This paper has sought to originally contribute to the debate by elaborating on Robertson's final paper and in so doing, examining the idea of a right to gestate as a fundamental component of procreative liberty.

I have questioned Robertson's argument here that procreative liberty only supports a right to gestate when sought for genetic reproduction, for as the English courts have acknowledged gestation is an acceptable avenue to parenthood which brings with it a very special relationship between gestational parent and child, 'a relationship which is different from any other'.¹⁶⁷ The exclusion of those who are infertile from discussions on uterus transplantation serves to unfairly exclude individuals who are infertile and unable to produce their own gametes. I argued that procreative liberty does extend to a right to gestate and in countries such as the UK, where other fertility treatment is publicly funded it could be regarded as a positive right.

Robertson argued that procreative liberty entails respecting peoples' procreative choices and that the presumption must be in favor of the liberty to access reproductive technologies and other means of founding families to genetically reproduce, unless good and sufficient reasons can be shown against so doing. In this context, those who would exercise procreative liberty so that they can gestate a child do not have to show what good it would do, rather those who would curtail freedom have to show not simply that it is unpopular, or undesirable, but that it is seriously harmful to others, or to society and that these harms are real and present, not future and speculative. I have argued that Robertson did not provide sufficient or robust enough reasons to rebut this presumption when discussing the possibility of gestation by transgender individuals and non-binary individuals or cisgender men. In light of emerging uterus transplant technology, convincing arguments why procreative liberty should not extend to gestation by others besides cisgender women, if there are any, are yet to be made.

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¹⁶⁶ Gena Corea, *The Mother Machine*, in *THE ETHICS OF REPRODUCTIVE TECHNOLOGY* 220–32 (K. D. Alpern, ed, 1992) at 226.

¹⁶⁷ *Re G* [2006] UKHL 43, [paras 33–35] per Baroness Hale.