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ACCESS

Technologies enabling gestation offer different experiences for persons wanting to become parents (and potentially third parties). Were all to be readily available, different individuals may seek to make different choices about gestation—about *how* they bring a new human entity into being. This inevitably raises the question of who would or should have access to technologies enabling gestation, and in what circumstances. In this chapter, I explore a pivotal issue that undergirds access to these technologies. Social, legal, and clinical regulation of procreative technologies has been centred around notions of the 'biological' and the 'natural' and as such, they are structured by and re-embed these notions reinforcing conservative values in procreative regulation. This is likely to have structural impacts on the choices individuals seek to make about gestation—both in terms of the choices they *want* to make and that they *can* make.

Even before we get to thinking of legal, social, and clinical regulation, in the very development of this technology conceptions of the 'natural' are built into how they are envisaged. Technologies do not speak for themselves; they are defined by who designs them and what they designed them for. Science and scientists do not operate in a social and political vacuum. Science as an institution is not value-neutral,[1] nor does it exist in a different realm from social context: thus 'social views are always embedded or sedimented' in technologies.[2] How researchers discuss the primary motivations for their development of technologies enabling gestation are revealing of their conceptions of medical need. The technologies are brought into being as solutions to what researchers have identified as a problem in need of a medico-technological solution. In the case of uterus transplantation (UTx) most describe the importance of the procedure in relation to people born assigned female at birth

[1] Elisabeth Lloyd, *The Case of the Female Orgasm: Bias in the Science of Evolution* (Harvard University Press 2005) 242.

[2] Marilyn Strathern, 'Still Giving Nature a Helping Hand? Surrogacy: A Debate about Technology and Society' in Rachel Cook, Shelley Day Sclater, and Felicity Kaganas, *Surrogate Motherhood: International Perspectives* (Bloomsbury 2003) 281–82.

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(AFAB) who cannot experience pregnancy. Those working on UTx have positioned it the 'only treatment' for absolute uterine infertility affecting people AFAB who want to reproduce.[3] Those working on the development of artificial amnion and placenta technologies (AAPT) have stressed that they envisage the technology not as a procreative technology, but an alternative to neonatal intensive care.[4] As Kendal and I have observed elsewhere, the framing of the technology as serving *these* purposes may come to limit other uses.[5] For example, the motivations behind the development of these technologies could come to prevent transformative future uses, such as, the use of UTx to enable people who are not AFAB undertaking pregnancy. That said, some surgeons have begun turning their attention to whether uterus transplantation could be of clinical benefit to trans women,[6] which does illustrate that envisaged uses of technologies can shift over time. At the time of writing, in reading the work of those developing AAPT, it is hard to envisage the use partial ectogestation as a procreative choice (potentially in the future).[7] This is because of just how much it is insisted and reiterated that AAPT is a solution to prematurity.

In this chapter I first consider the claims made by some scholars that the right to procreate (in both a moral and legal sense) should encompass the liberty to make decisions about gestation. I argue that neither such a moral nor legal right exists, but more importantly, even if it did, it would not be absolute. The better way to approach questions of access, therefore, is not to dwell on the matter of a 'right to gestation' but instead consider how we should afford access to technologies enabling gestation appropriately bearing in mind the importance of equality of opportunity and the harms of stratified procreation. I critique the legal framework regulating assisted procreation (conception) that is contained in the Human Fertilisation and Embryology Acts 1990 and 2008 (HFE Acts 1990 and 2008) (applying across the UK) for its focus on 'biological' needs in procreation, rather than procreative needs. I argue that such an approach results in biological essentialism that has limited access to assisted procreation in ways that impact marginalized groups, and without reform, a

[3] Elliott Richards and others, 'Uterus Transplant: State of the Art in 2021' (2021) 38 Journal of Assisted Reproduction and Genetics 2251–59, 2251.

[4] Alan Flake, 'A Supportive Physiologic Environment for the Extreme Premature Infant: Improving Life Outside the Womb' (2022) 57 Journal of Pediatric Surgery 167–71, 169.

[5] Elizabeth Chloe Romanis and Evie Kendal, 'Subjective Experience, Gestational Preferences and Justice: Valuing Both Uterus Transplantation and Ectogestation' in Natasha Hammond-Browning and Nicola Williams (eds), *International Legal and Ethical Perspectives on Uterus Transplantation* (Edward Elgar 2024) 118.

[6] Benjamin Jones and others 'Uterine Transplantation in Transgender Women' (2019) 126 British Journal of Obstetrics & Gynaecology 152.

[7] ibid.

legal framework for technologies enabling gestation that builds on the premises of that which exists would come to limit access to uterus transplantation and ectogestation in concerning ways. Finally, I consider the problems of stratified access to novel technologies enabling gestation. How we facilitate access to technologies, including thinking about who they are accessible to—and who they are not—is a critical step in thinking through the implications of shifting modalities of gestation. These technologies bring new possibilities, but only where there are means for accessing technologies in ways that facilitate the realization of these possibilities.

A Right to Opt In or Out of Gestational Work?

In the ethico-legal literature on UTx, there has emerged debate about whether there is a right to gestate.[8] Amongst those debating the issue, the 'right to gestate' is seen as an extension of procreative liberty/the right to procreate.[9] In the ordinary sense of the word, however, a right to gestate seems intuitive in most cases. Where a person has become pregnant, forced termination of pregnancy (and thus the ceasing of that person undertaking gestation) would be a violation of a person's right to non-interference with their bodily integrity as well as the negative right to procreate that is recognized as a part of the right to respect for family life in the European Convention of Human Rights.[10] For clarity, the question might better be asked in this way—is there a moral or a legal right to gestation? Can a person demand access to assistive technology (like UTx) that can enable them to sustain a pregnancy? Or can a person demand access to a replacement technology (like surrogacies or ectogestation) that can undertake gestational work for them? This framing makes it clearer that the question that is being asked is one of *positive* rather than *negative* rights and that we might reach different answers when considering moral and legal rights[11] (though I do not in this case). Moreover, asking the question in this way broadens the conversation from one just related to UTx, but the full spectrum of technologies enabling gestation.

[8] John Robertson, 'Is There a Right to Gestate?' (2017) 4 Journal of Law and the Biosciences 630–36; Amel Alghrani 'Uterus Transplantation In and Beyond Cisgender Women: Revisiting Procreative Liberty in Light of Emerging Reproductive Technologies' (2018) 5 Journal of Law and the Biosciences 301–28.

[9] ibid.

[10] European Convention on Human Rights, Article 8.

[11] Gulzaar Barn, 'A Right to Gestate? Uterus Transplants and the Language of Rights' in Natasha Hammond-Browning and Nicola Williams (eds), *International Legal and Ethical Perspectives on Uterus Transplantation* (Edward Elgar 2024) 60.

Robertson argues that procreative liberty (freedom of procreative choice)[12] encompasses 'a right to gestate when gestation is essential to or a part of a person's way to have genetic offspring for rearing, just as use of IVF [in vitro fertilization] embryo freezing, sperm and egg freezing, and related activities are'.[13] He explains that these important technologies all enable individuals to procreate and thus must be encompassed under the liberty of procreative liberty. This limits the use of UTx, and within his logic also surrogacies and ectogestation, to persons who *need* such technologies to procreate. He stipulates that, '[b]ecause gestational surrogacy is essential for genetic reproduction when a woman is unfit or unable to gestate, a robust conception of procreative liberty should extent to gestational surrogacy as well'.[14] The inference is that it would not be a matter of procreative liberty for a person with a functioning uterus to be granted access to ectogestation—Robertson would presumably not have thought that this preference was encompassed within the right to procreative liberty. Moreover, if a person without a uterus or any gametes wanted UTx to procreate by sustaining a pregnancy using donor material, that would not be a matter of procreative liberty by Robertson's reasoning. Alghrani disagrees with Robertson's conception of gestation in relation to procreative liberty.[15] The inference is that if we are recognizing the value of choice in procreative activities, then *how* that procreation is facilitated will be just as critical to the concept than what entity is created. What is tricky, however, and is not addressed within her argument is what statements are made about the obligations of others where we recognize a moral right to gestation. This is pertinent in the case of all technologies enabling gestation, but most especially surrogacies and UTx.

Hall argues that there can be no such thing as a moral right to procreate as an instrument an individual can assert 'because an individual cannot reproduce on their own. Reproductive projects are necessarily collaborative, and all collaborators have the right to agree or to refuse to join the project. The hopeful parent can, at best, assert the right to *try* to reproduce'.[16] This is not to say there is not a moral right of non-interference with procreation (for example, forced sterilization is wrong) but this is wholly consistent with recognizing that there

[12] See John Robertson, *Children of Choice: Freedom and the New Reproductive Technologies* (Princeton University Press 1994) 22.
[13] Robertson, 'Is There a Right to Gestate?' (n 8) 631.
[14] ibid 632.
[15] Alghrani (n 8) 307–08.
[16] Georgina Antonia Hall, 'Reproduction Misconceived: Why There is No Right to Reproduce and the Implications for ART Access' (2022) Journal of Medical Ethics <doi:10.1136/jme-2022-108512> accessed 1 September 2024 (emphasis added).

is straightforwardly no *right* to use the body of (or materials resulting from) another for one's procreative purposes. A person assigned male at birth (AMAB) cannot demand that their partner assigned female at birth (AFAB) facilitate a pregnancy as much as a person AFAB morally cannot demand that their partner AMAB inseminate them. There can be no moral *positive right* to UTx and surrogacies because of what this means that individuals can demand of the bodies of others.[17] Just as there is no right to gestation in cases where individuals seek to interfere with the abortion choices of others (eg to prevent individuals having an abortion and thus continue facilitating gestation and birth so that they can parent the resulting entity),[18] there is no right to demand another individual act as a surrogate (which would be very similar co-opting to the prevention of abortion) or to donate their uterus. As Barn argues:

> A positive right to UTx that involved forcible redistribution of reproductive materials or coerced access to reproductive means would of course be straightforwardly in conflict with other people's negative rights and therefore unsustainable.[19]

These are rights to bodily integrity—but there is no positive right to become pregnant, nor to have gestation facilitated by another person. Ectogestation, however, is distinguishable from surrogacies and UTx in the sense that a right to (ecto)gestation would not be demanding work of other bodies (parts from them or the performance or pregnancy), but this is not to say that it would not be demanding work of others at all (eg professionals managing machines). This distinction might still be material in that a right to make a choice about gestation in the sense of whether to facilitate it oneself or to opt for a machine does not transgress the bodily boundaries of another person. The question of resources and implications becomes more material where the potential interference with the negative rights of other individuals is less pertinent. If one accepts that there is a positive right to other forms of procreative assistance (like IVF), one should accept that there should be a positive right to ectogestation. Essentially if one accepts a moral right to procreate, then one *must* accept a moral right to ectogestation. However, I agree with Hall that there can be no moral right to procreate because it requires bodily resources of others, in the case of ectogestation this is *still* the case because I cannot demand the use of

[17] Barn (n 11) 71.
[18] See Chapter 7.
[19] Barn (n 11) 71.

another person's genetic material for the purposes of my procreation (whether that is facilitated by my body or by a machine)—I need their agreement, which they might provide to me directly or to a clinic if they are donating their material. It might be fair to say that I have a right to try, however, since this would encompass situations where I have the agreement (or active collaboration) of another person to use their genetic material. This argument is limited to procreative possibilities in the present of course, we might need to ask different questions about whether there is a right to procreate in instances where procreative possibilities as we know them are no longer in anyway limited to biosex. For example, where persons can generate their own gametes (through in vitro gametogenesis (IVG)) and facilitate pregnancy (because they were born with a uterus or a bioengineered uterus) or using a machine.[20] In these instances no bodily resources are being demanded of another person at all, only potentially state assistance (in a publicly funded health system).

Hall explains that clinicians and the state are collaborators in the procreative project when an individual needs procreative technological assistance to reproduce. She then argues that since they are collaborators they are free (morally) to 'refuse or restrict access to treatment, when asked to join the project' though the grounds for appropriate refusal are debateable.[21] By this logic, the state would be free to restrict or refuse access to ectogestation on the basis of whatever criteria it deems appropriate (Hall concedes that we can debate what the right criteria might be, but the argument is that they are entitled to introduce access criteria because there is no moral right to procreate). While Hall's framing of procreation as collaborative is generally appropriate within the confines of reproductive biology as we know it,[22] the framing of the state or clinicians as collaborators affords them too much power and legitimates intrusion into decisions that we ought to shield from external interference and public–political interference.[23] Furthermore, it ignores the socio-political realities of the ways that states design and weaponize procreative policies to the detriment of marginalized groups.[24] In legal terms, state involvement is

[20] See Elizabeth Chloe Romanis and Alan Brown, 'Legal Parenthood, Novel Reproductive Practices, and the Disruption of Reproductive Biosex' Modern Law Review <doi.org/10.1111/1468-2230.12914> accessed 1 September 2024.

[21] Hall (n 16).

[22] Romanis and Brown (n 20).

[23] This point is not that we must or need to fund every instance of procreative assistance, but that decisional privacy about procreation without state interference must be respected. This is analogous to the argument that Jackson makes about why we should not interrogate the fitness to parent of people seeking fertility treatment: see Emily Jackson, 'Conception and the Irrelevance of the Welfare Principle' (2002) 65 Modern Law Review 176–203, 178.

[24] See Dorothy Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty 20th Anniversary Edition* (Vintage Books 2017).

relevant because—where assistance is publicly funded—there might be claims that the state ought to support it. We can acknowledge this dimension of procreative decision-making without actively encouraging the framing of the state as a 'collaborator' in procreative projects.

Alghrani's argument is not only that there is a moral right to gestation, but also a *legal* right. In making this claim she subsumes a 'right to gestate' under a 'right to procreate' within 'the right to respect for family life' in the European Convention for Human Rights.[25] There are, however, two errors in Alghrani's construction of the legal right to gestate.

First, in Strasbourg jurisprudence there is no right to procreate—only a right *to respect for decisions about procreation*. Because the right to respect for private life protects decisions related to identity, procreation does readily come under its scope.[26] In *Dickson v United Kingdom*,[27] the case on which Alghrani relies to establish a right to procreate, the European Court of Human Rights (ECtHR) reiterates, on the basis of established precedent, that article 8 encompasses 'a right to respect for *their decision to become genetic parents*'.[28] Eijkholt, however, warns against the dangers of equating the right to respect for private life to a *positive right* to procreate, since in its substance is requires nothing more than an individual right to 'respect' *for decision-making about procreation*. Claiming there is a right to procreate 'obscures the degree of protection that can be expected'.[29] Individuals can make private choices about procreation; they cannot demand that the state subsidize or facilitate their access. Although there are circumstances where the ECtHR has interpreted the right to respect for private life as encompassing positive obligations, they have yet to do so in the context of a 'right to decisional privacy about procreation'.[30] The ECtHR considered it unnecessary in *Dickson* to make a determination about whether there is a positive or a negative right to procreate as the decision was actually one about whether there was excess public interference into a private matter: decision-making about procreation in the particular context (which concerned a married couple seeking artificial insemination because the husband was incarcerated).[31] Even where the ECtHR does recognize that there are positive obligations in relation to the right to respect for private life, they will

[25] Alghrani (n 8) 310.
[26] Pieter Dijk and others, *Theory and Practice of the European Convention on Human Rights* (4th edn, Intersentia 2006) 66.
[27] *Dickson v United Kingdom*, Application No 44362/04 (2007).
[28] ibid [66] (emphasis added).
[29] Marleen Eijkholt, 'The Right to Found a Family as a Stillborn Right to Procreate?' (2010) 18 Medical Law Review 127–51, 142.
[30] ibid.
[31] *Dickson* (n 27) [71].

never be absolute. Positive obligations mean that states must create a framework that contains the appropriate safeguards for such practices to go ahead. They would be permitted under such a framework to derogate from the right to respect for private life in contexts where interference is in accordance with the law, and:

> necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.[32]

As such, states are permitted where they have such a justification to put in place legal frameworks that enable access to assisted procreation, but restrict its use to some circumstances, or specifically prohibit it in others, where such provisions are related to the conditions for permissible derogation in the convention. The decision in *Dickson* means that where assisted procreation is made available to some individuals, it should be made readily available to all unless a refusal is justified by way of the permissible derogations afforded to member states. Consequently, a right to privacy around decisions about assisted procreation will always be a *qualified* right.

Second, ECtHR jurisprudence when it refers to a right to respect for procreative decisions is referring specifically to the right to decisions about whether to become a genetic parent,[33] not about gestation. Convention jurisprudence, therefore, exemplifies reasoning on the point of the nature of procreation that resembles more what Robertson (rather than Alghrani) constructed as encompassed within a right to procreate (decisions only about genetic parenthood). Though unlike Robertson, the ECtHR has never encompassed means of gestation as falling within the realms of procreative decision-making that must be respected as a matter of private life. Prohibitions on surrogacies across members of the Council of Europe are not considered, in themselves, violations of the right to private life. In cases where individuals have sought to claim that their home state refusing to recognize them as the parent of their child is a violation of their right to respect for private life have consistently failed.[34] It is notable that in the same cases it is often found that non-recognition of parenthood is a violation of the right to respect for private life of resulting children.[35] This is

[32] Art 8(2).
[33] *Evans v United Kingdom*, Application No 6339/05 (2007) [72].
[34] *Labassee v France*, Application No 65941/11 (2014); *Mennesson v France*, Application No 65192/11 (2014); *DB and others v Switzerland*, Application Nos 58817/15 and 58252/15 (2022).
[35] ibid.

likely because decisions about technologies enabling gestation are not wholly a private matter. As Eijkholt explains—the involvement of a third person like a surrogate or a uterus donor could transform procreative arrangements into 'not quite private ones'.[36] We cannot simply collapse the matter of gestation into the existing jurisprudence on procreation, which is explicitly referring to matters of assisted conception where it references a right to respect for decisions about procreation. This is crystal clear in that there has never been a decision that stipulates that decisions to access surrogacy must be respected.

Despite the above, I am not arguing that we should not facilitate access to technologies enabling gestation. Rather I am illustrating, in agreement with Barn, that rights-based justifications to their access encompass complications.[37] Even if we were to determine that there is a moral or legal right to procreate, we are still left with questions about what obligations this imposes on, for example, the state (in moral and legal terms) to facilitate the realization of that right. As a consequence, determinations about rights hardly move the debate about access to technologies enabling gestation along that much. Moreover, that there may be no moral or legal right to certain experiences over others in assisted procreation does not mean that we should not respect the choices people make in valuing some experiences over others. Even if there is no legal right to procreation, there would be a violation of a person's right to respect for private life (or right to non-discrimination) if the *conditions* that are placed on access to procreative technologies systemically exclude some groups and not others.[38] Involuntary childlessness 'can provoke a life crises at a deeply existential level, threatening one's sense of identity, purpose and role functioning, and may require a complete revision of life goals'.[39] It is also the case that how one becomes a parent can matter to individuals and can be a part of the procreation, and their identity in relation to that, that they imagine for themselves. We do not have to recognize a right to procreate (and as a constituent part of this the right to gestate or the right to gestation) in order to recognize that facilitating access to technologies enabling gestation can be a moral and social good that can meaningfully help people to lead the lives that they envisage for themselves. The issue at hand is, therefore, not about whether there is a right to gestation, rather about how we afford access to technologies

[36] Eijkholt (n 29) 143.
[37] Barn (n 11) 72.
[38] See Kirsty Horsey and Emily Jackson, 'The Human Fertilisation and Embryology Act 1990 and Non-Traditional Families' (2023) 86 Modern Law Review 1472–88.
[39] Bernadette Bartlam and Susan Birch, 'Review: A Right to Parenthood' (1998) 2 Journal of Child Health Care 36–40, 36.

enabling gestation appropriately bearing in mind the importance of equality of opportunity and the harms of stratified procreation.

Access, Procreative Need, and Biological Need

Procreative needs are broader than 'biological' needs in procreation. An individual's (or couple's) biological needs in procreation encompass what has been traditionally understood as 'infertility', which the World Health Organization defined as 'a disease of the male or female reproductive system defined by a failure to achieve a pregnancy after 12 months or more of regular unprotected sexual intercourse'.[40] This might result, for example, from a person AMAB not producing (good-quality) sperm, a person AFAB not producing (good-quality) eggs, or 'abnormalities' in the uterus or endocrine system that make a pregnancy difficult to establish or sustain.[41] A person's (or couple's) biological needs in procreation, thus, encompass interventions that enable procreation to occur (eg hormone therapy, or donor material). Procreative needs do not relate *only* to individuals' biological needs because what are framed as matters of fertility reflect only the cis-heteronormative nuclear model of procreation (family-building). They also encompass broader social and psychosocial factors—for example, sexuality, identity, economic circumstances. These factors can mean that not everyone can or wants to reproduce sexually. Attending to biological needs and *not* to broader procreative needs is a matter of propagating biological essentialism: that procreation is the result of biological factors only, rather than a range of socio-cultural factors. Assisted procreation makes transcending the 'biological' possible. Where we use technology only as a mirror to the 'biological', this is perpetuating the notion of the 'biological' as inviolable.

Assisted procreation is highly regulated activity in England and Wales and many jurisdictions, though there are some notable exceptions (the United States, for example, is referred to as 'the wild west' of assisted reproduction).[42] The framework in England and Wales, while not directly imposing specific rules on who can and cannot procreate, does impose conditions that could

[40] World Health Organization, 'Fact Sheet: Infertility' (nd) <https://www.who.int/news-room/fact-sheets/detail/infertility> accessed 21 June 2024.
[41] ibid.
[42] I Glenn Cohen, 'The Right(s) to Procreate and Assisted Reproductive Technologies in the United States' in David Orentlicher and Tamara K Hervey, *The Oxford Handbook of Comparative Health Law* (OUP 2021) 1009.

indirectly limit some people from procreating. For example, there are provisions that enable clinics to make decisions about who should be able to access procreative services.[43] Moreover, where there are new procreative developments, those developing technology will develop criteria for access based on what 'problem' they envisage their technology to be addressing. In this section, I argue that what is deemed permissible in assisted procreation (in both social and legal terms) is constructed around notions of the 'biological' and thus a matter of medical need. This narrow lens of constructed need limits recognition of the *procreative* needs of individuals. It is likely, I argue, that without significant reform, and a change in the approach to law-making, that technologies enabling gestation will be subject to significant restrictions—tying their use to medically constructed notions of need (that reflect the 'biological') in ways that exclude marginalized persons.

'Biological need' and legal limitations

That access to procreative technologies should be underpinned by *need* is in the fabric of the legal framework. In a publicly funded health system, a notion of 'need' might not be thought so problematic in determining or prioritizing access to resources. However, the lens through which 'need' is interpreted and constructed should always be subject to careful, critical interrogation (for who it includes and who it excludes). Since its inception, the legal framework, with its origins in the HFE Act 1990), had the cis-heteronormative nuclear family in mind. As Horsey and Jackson note, since assisted conception was stigmatized and highly controversial at the time it was assumed necessary to subject access to strict controls.[44] In the 1990 Act, there were no provisions allowing for same-sex family recognition in the attribution of parenthood and included provisions that expressly required clinics consider the need for a child to have a father and mother when considering whether to provide procreative services (effectively signalling that single people and same-sex female couples should not be assisted to procreate).[45] Essentially, assisted procreation was envisaged as a means of enabling traditional families to procreate where there were biological limitations preventing sexual procreation. Speaking to the social stigma surrounding assisted procreation, the provisions of the Act assumed

[43] Michael Thomson, 'Legislating for the Monstrous: Access to Reproductive Services and the Monstrous Feminine' (1997) 6 Social & Legal Studies 401–24, 410.
[44] Horsey and Jackson (n 38) 1472.
[45] ibid 1473.

and enabled the 'invisibility' of the assistance (eg with donor anonymity).[46] This was mirrored in the discussions of surrogacies. The Warnock Committee, an inquiry set up in 1982 to investigate the regulate human reproduction in the UK, made recommendations[47] which (though only some were accepted)[48] resulted in the Surrogacy Arrangements Act 1985. While they made recommendations about regulation, most of Warnock's members hoped that surrogacies would just go away by constructing a regulatory regime that did not make surrogacies appealing.[49] In making surrogacies more legally complex, surrogacies might be thought to be limited to people who *need* (have a 'compelling medical need' for) assisted gestation, rather than those who might want to outsource gestation.

Reforms introduced in the HFE Act 2008 did make some space for families outside of the heteronormative nuclear model of the family in introducing the recognition of female same-sex parents[50] and in changing provisions referring to the need for a 'father' to requiring clinics to consider whether a child resulting from fertility treatment would have a supportive parenting environment.[51] To some extent, these provisions move on from the concept of 'medical need' in the construction of assisted procreation because they are accounting for circumstances in which people wanting to build their families together may not be biologically limited in their ability to procreate, but their specific needs are not served by biological possibilities (eg two people AFAB may both be capable of becoming pregnant, but would not be able to procreate together). However, there remain aspects of the legal framework that maintain assumptions of the 'biological' that could or can limit access to persons wanting to reproduce outside of the cis-heteronormative nuclear family model. Furthermore, that the 2008 Act has changed the letter of the law does

[46] Per the Human Fertilisation and Embryology Authority (Disclosure of Donor Information) Regulations 2004 persons conceived from donated material after 1 April 2005 are entitled to request identifying information about their donors from the Human Fertilisation Authority when they turn 18. However, it is notable that children must know they are donor conceived to know they can apply for information about the donor. There is inevitably some difference between the children of heterosexual and same-sex couples: see Andrew Bainham, 'Arguments about Parentage' (2008) 67 Cambridge Law Journal 322–51.

[47] Department of Health and Social Security, *Report of the Committee of Inquiry into Human Fertilisation and Embryology* (Cmnd 9314, 1984).

[48] Margaret Brazier, 'Regulating the Reproduction Business?' (1999) 7 Medical Law Review 166–93, 169.

[49] ibid 179.

[50] Notably, however, this recognition is simply extending the nuclear family to the inclusion of female same-sex parents, rather than any kind of radical reform—see Julie McCandless and Sally Sheldon, 'The Human Fertilisation and Embryology Act (2008) and the Tenacity of the Sexual Family Form' (2010) 73 Modern Law Review 175–207.

[51] For commentary see Marie Fox, 'The Human Fertilisation and Embryology Act 2008: Tinkering at the Margins' (2009) 17 Feminist Legal Studies 333–44, 337.

not necessarily mean that notions of 'biological need' have not been baked into assisted procreation in other ways. Guidelines, for example, build notions of the 'biological' into access criteria—for example, in relation to age and assisted conception.[52] Moreover, decisions about what is and is not funded across the jurisdiction, or at a local level, in the health service can reflect notions of 'biological need'. It was only in 2022 that funding for same-sex couples for fertility treatment was introduced[53]—before this, in order to establish a 'fertility issue', lesbian couples had to go through several rounds of intrauterine insemination before they could be considered for NHS-funded treatment.[54] Finally, where new technologies become available, it is often the case that they are restricted to their clinically envisaged use—for example, mitochondrial replacement techniques, legally regulated in the UK since 2015—have been restricted to cases of 'medical necessity'.[55]

There remain several barriers to access to procreation embedded within the legal framework that limit access to assisted procreation generally for marginalized groups. It is hardly surprising that this is the case given the endemic marginalization of 'non-traditional' procreative arrangements in the evolution of the law (including that pre-dating the HFE Acts).[56] These barriers, still embedding the concept of 'biological need' for assistance to some extent, may come to limit who can access technologies enabling gestation.

First, who is envisaged as a person that can become pregnant in the legal framework may come to limit access to UTx for procreative purposes. The limitations of current transplantation techniques mean that the organ is not connected to a person's fallopian tubes (if they have them).[57] A pregnancy can thus only be established by IVF. Even if the science were to change here, it is likely that for people AMAB, a pregnancy from UTx could only be achieved by IVF. As a consequence, provisions relating to who can become pregnant in assisted conception are relevant. Hammond-Browning observes that the HFE

[52] National Institute for Health and Care Excellence, 'Fertility Problems: Assessment and Treatment [CG156]' (2017) <https://www.nice.org.uk/guidance/cg156/chapter/Recommendations#access-criteria-for-ivf> accessed 20 May 2024 [1.11.1.4]

[53] Lowenna Waters, 'Discriminatory NHS Rules on IVF for Lesbian Women to be Scrapped' (2022) *The Standard* <https://www.standard.co.uk/news/uk/nhs-discriminatory-rules-ivf-lesbian-women-to-be-scrapped-b1013565.html> accessed 20 May 2024.

[54] ibid.

[55] Human Fertilisation and Embryology (Mitochondrial Donation) Regulations 2015, Reg 5 (a). For critique see Romanis and Brown (n 20).

[56] Sarah Cooper, *Analysis Gender in Healthcare: The Politics of Sex and Reproduction* (Palgrave Macmillan 2022) 171–74.

[57] Dominique de Ziegler and others, 'Assisted Reproductive Technology Strategies in Uterus Transplantation (2019) 112 Fertility and Sterility 19–23, 20.

Acts prohibit the transfer of human embryos into a person who is not AFAB.[58] There is no express prohibition in either Act (1990 or 2008) stipulating that it is an offence to implant embryos in the uterus of a male person (whether that is a uterus they were born with or that has been transplanted into them). Rather, the legislation directs that 'no person shall place in a woman— (a) an embryo other than a permitted embryo . . . or (b) any gametes other than permitted eggs or permitted sperm'.[59] In the next sub-section (that defines permitted eggs as from a woman's ovaries, and permitted sperm as from a man's testes), it is specified that ' "woman" and "man" include respectively a girl and a boy (from birth)'.[60] This can be interpreted either as saying that it is only permitted embryos/gametes can then *only* be implanted into women AFAB (explicitly prohibiting the practice of using such material in men AMAB and, potentially, people AFAB who have changed their legal gender to male). Hammond-Browning stresses that anything other than this interpretation is difficult to foresee.[61] If this first interpretation is adopted, a person AMAB could have a uterus transplant, but they could not lawfully become pregnant. However, the provision can be interpreted as merely omitting to acknowledge the realities of male pregnancies (it does not explicitly say *only* women).[62] Per this interpretation, persons AMAB could be supported to become pregnant after uterus transplantation because it is not strictly prohibited. Horsey and Jackson note that this provision is not a direct prohibition on trans women and cis men undertaking pregnancy, it was simply that it was taken for granted that only people AFAB could become pregnant.[63] In any event, the law as written is clearly not friendly to procreation outside of the cis-heteronormative because it exists in a regulatory gap. This creates considerable uncertainty[64] that could come to affect access to UTx for people AMAB if it is not altered. The overall construction of the provision still is revealing—it seems deliberate in its intention maintain some preservation of 'biological procreation' even where procreation is technologically assisted. Such normative judgments underpinning regulatory structures could come to

[58] Natasha Hammond-Browning, 'UK Criteria for Uterus Transplantation: A Review' (2019) 126 British Journal of Obstetrics and Gynaecology 1320–26, 1322.
[59] Human Fertilisation and Embryology Act 2008, s 3(2).
[60] ibid s 3ZA(6).
[61] Natasha Hammond-Browning, 'Author's Reply Re: Uterine Transplantation in Transgender Women: Medical, Legal and Ethical Considerations' (2018) 126 British Journal of Obstetrics & Gynaecology 546, 546.
[62] Elizabeth Chloe Romanis, 'Male and Nonbinary Pregnancy in the Law: Ontic Injustice and/or Invisbilization' (forthcoming).
[63] Horsey and Jackson (n 38) 1475.
[64] Alan Brown, 'Trans Parenthood'; Horsey and Jackson (n 38).

impact on ideas about where and when people can access technologies that defy the 'biological'—such as ectogestation.

Second, there are indirect barriers to access to assisted procreation that may come to impact access to technologies enabling gestation. Many jurisdictions have 'child welfare' requirements within their domestic law surrounding assisted procreation that could become a barrier to subversive uses of assisted gestation even if there were no longer direct prohibitions. Legislation in England and Wales dictates that:

> [a] woman shall not be provided with treatment services unless account has been taken of the welfare of any child who may be born as a result of the treatment (including the need of that child for supportive parenting), and of any other child who may be affected by the birth.[65]

Thomson argues that this section 'embodies dominant contemporary gender definitions. The doctor defines which women exist within these definitions, therefore also defining those—the monstrous—who fall outwith'.[66] In this way, the provision could be understood as directly reinforcing 'biologically' constructed biosexed roles. Moreover, the provision, O'Donovan notes, is a 'threshold requirement' for access to embryo implantation,[67] and thus it can easily be used to discriminate against individuals. In UTx, since it will involve IVF to establish a pregnancy, clinics are mandated to consider the welfare of a potential future child that might be delivered from a UTx pregnancy. Similarly, the provision is not explicit that it applies only where gestation takes place inside a person's body, and so it is foreseeable that this could also be used to determine whether persons should be assisted with procreation by ectogestation (by way of an analysis of the potential future welfare of a child born from these person/s having treatment).[68]

McGuiness and Alghrani have questioned whether this 'welfare clause' could be and is 'being used as a smoke screen to hide prejudices regarding the parental fitness of prospective patients', and stipulated that this might particularly impact on gender/sex minorities seeking to become parents through

[65] Human Fertilisation and Embryology Act 1990, s 13(5), as amended by HFEA 2008, s 14(2).
[66] Thomson (n 43), 410–11.
[67] Laura O'Donovan, 'Why Uterine Transplantation Requires Us to Rethink the Role of the Preconception Welfare Principle (2022) Journal of Law and the Biosciences <doi.org/10.1093/jlb/lsac028> accessed 1 September 2024 1–32, 16.
[68] Natasha Hammond-Browning, 'A New Dawn? Ectogenesis, Future Children and Reproductive Choice' (2018) 14 Contemporary Issues in Law 349–73, 357.

assisted procreation.[69] Historically, this provision has been used to discriminate against single women and same-sex female couples (the need of a child for supportive parenting read, before amendment in 2008, the need of a child for a father).[70] Dunne has explained that one of the principal aims of the sterilization of trans and nonbinary people across Europe was to 'protect any future child from the potential dangers of having a trans parent, in particular a parent who has played a non-normative role (eg woman producing sperm in the child's conception)'.[71] It is easy to imagine similar notions can be projected into the 'welfare clause' when applied to novel technologies enabling gestation—especially when used outside of the reproductive binary eg trans women or, more so, cis men gestating.

In addition, O'Donovan has raised concerns about the child welfare principle being used to determine priority-setting for UTx,[72] suggesting that this could lead to an indirect discrimination policy that prioritizes some people over others. Some have noted that there might come a point where demand for a uterus to gestate outstrips supply, and difficult decisions must be made about how to prioritize need for uteri.[73] It is not hard to imagine the need to determine priority being used to reinforce 'the traditional "goal-standard" model of the nuclear family'[74] in determining that women AFAB without uteruses are in greater need. In a recent focus group study with reproductive rights advocates in England, this was raised by several participants who had concerns that people deemed '*deserving recipients*' would be the exclusive recipients of any donor organs. For example, people with Mayer-Rokitansky-Küster-Hauser Syndrome (born AFAB with a deformed or absent uterus and/or vagina) may be afforded priority over trans women because '*it starts to go down this really bizarre deserving/non-deserving, moral/immoral path*'.[75] The concern would be that if biosexed roles in procreation continue to be reinforced,

[69] Sheelagh McGuiness and Amel Alghrani, 'Gender and Parenthood: The Case for Realignment' (2008) 16 Medical Law Review 261–83, 268.

[70] For discussion of this reform, see McCandless and Sheldon (n 50); Rachel Anne Fenton, D Jane Rees, and Sue Heenan, ''Shall I Be Mother?' Reproductive Autonomy, Feminism and the Human Fertilisation and Embryology Act 2008' in Jackie Jones and others (eds), *Gender, Sexualities and Law* (Routledge 2011) 241–54, 250.

[71] Peter Dunne, 'Transgender Sterilisation Requirements in Europe' (2017) 25 Medical Law Review 554–81, 569.

[72] O'Donovan (n 67) 28–30.

[73] Elizabeth Chloe Romanis and Jordan Parsons, 'Directed and Conditional Uterus Donation' (2022) 48 Journal of Medical Ethics 810–15, 812.

[74] Susie Bower-Brown, 'Beyond Mum and Dad: Gendered Assumptions about Parenting and the Experiences of Trans and/or Non-Binary Parents in the UK' (2022) 18 LGBTQ+ Family: An Interdisciplinary Journal 233–40, 233.

[75] Elizabeth Chloe Romanis, 'The Equality-Enhancing Potential of Novel Forms of Assisted Gestation: Perspectives of Reproductive Rights Advocates' (2023) 37 Bioethics 637–46, 644.

it can be reasoned that people AFAB without a uterus are in greater need than trans women or cis men. The Canadian Assisted Human Reproduction Act 2004 contains some key principles that underpin the scheme of regulation. These principles include a similar declaration to that of the English 'Welfare Clause',[76] however, this is qualified by another principle that declares that 'persons who seek to undergo assisted reproduction procedures must not be discriminated against, including on the basis of their sexual orientation'.[77] While this may go some way to preventing some of the problems described, in not making explicit that discrimination on the basis of gender/sex, it still leaves open the possibility of people seeking to subvert the biosex binary in procreation being denied treatment depending on the social context.

While complete ectogestation is unlawful,[78] were it to become possible and lawful in itself, some of the barriers discussed above determining who can use it and in what circumstances raise normative questions. The welfare provisions will still apply because assisted conception is inevitably a prerequisite to the beginning of gestation facilitated by machine. Since the regulation of assisted procreation has long been premised on constructed notions of need that reflect the 'biological' and on 'welfare reflections' that can easily reflect conservative values, would use of ectogestation be limited to people or couples where one is unable to sustain a pregnancy?

Clinical gatekeeping

Partial ectogestation has been identified as a technology enabling gestation that is important in facilitating procreative choices. For example, those who cannot sustain a complete pregnancy for health reasons,[79] and some scholars have advocated for partial ectogestation as a procreative choice beyond health needs.[80] Access to partial ectogestation (where there is no assisted conception) would

[76] Assisted Human Reproduction Act 2004, s 2(a) stipulates that 'the health and well-being of children born through the application of assisted human reproductive technologies must be given priority in all decisions respecting their use'.

[77] ibid s 2(e).

[78] See discussion in Chapter 1.

[79] Jennifer Hendricks, 'Not of Woman Born: A Scientific Fantasy' (2012) 62 Case Western Law Review 399–445, 408; Amel Alghrani, *Regulating Assisted Reproductive Technologies: New Horizons* (CUP 2018), 131; Hammond-Browning (n 68) 351; Elizabeth Chloe Romanis, 'Artificial Womb Technology and the Choice to Gestate Ex Utero: Is Partial Ectogenesis the Business of the Criminal Law?' (2020) 28 Medical Law Review 342–74, 351–53.

[80] Anna Nelson, 'Should Delivery by Partial Ectogenesis Be Available on Request of the Pregnant Person?' (2022) 15 International Journal of Feminist Approaches to Bioethics 1–26; Romanis, 'Artificial Womb Technology' (n 79) 354.

not be regulated by the existing legal framework in the HFE Acts. Procreation, however, is subject to considerable regulation beyond this framework. Partial ectogestation involves ending a pregnancy,[81] and as such the provisions that regulate termination of pregnancy in the Offences Against the Person Act 1861 and Abortion Act 1967 are applicable. Any 'unlawful procurement of miscarriage' is a crime: miscarriage is defined as ending of an 'established pregnancy'[82] and thus, *any* unlawful ending of an established pregnancy (and not just those that result in fetal death) is a crime.[83] Pregnancies can lawfully be ended in circumstances deemed lawful codified in the Abortion Act 1967 (AA 1967)—on 'socio-medical grounds' before twenty-four weeks,[84] where continuing the pregnancy poses greater risk to the pregnant woman's life than termination,[85] where termination is necessary to prevent grave permanent injury to the pregnant woman, or where there is a substantial risk that the fetus has 'such physical or mental abnormalities so as to be seriously handicapped' if born.[86] As I have argued elsewhere, for a pregnant person wanting to opt out of gestation, the law here poses a barrier and potentially places on pregnant people not facing an immediate serious risk to health or any risk to life an obligation to undertake gestational work (remaining pregnant) in place of ectogestation where it is available.[87] The construction of the AA 1967 is such that pregnant people must 'convince a doctor that they require intervention into their pregnancy' to end it—and this is the case whether the question is one of abortion or ectogestation.[88] This aligns with the approach in medicine more broadly in that although people are entitled to be informed about reasonable options,[89] doctors must only inform patients of those interventions that they believe are clinically appropriate:[90] and even then patients cannot *demand* one course of action over another.[91] Until there is a change in the law, therefore, partial ectogestation is permissible only when undertaken for clinical reasons. This aligns with the envisaged uses of the technology of those developing the technology.

[81] Romanis, 'Artificial Womb Technology' (n 79) 335.
[82] *R (On the Application of Smeaton) v Secretary of State for Health* [2002] EWHC 610 (admin).
[83] Romanis, 'Artificial Womb Technology' (n 79) 358–59.
[84] Abortion Act 1967, s 1(1)(a).
[85] ibid s 1(1)(b).
[86] ibid s 1(1)(c).
[87] Romanis, 'Artificial Womb Technology' (n 79) 363.
[88] Abortion is discussed in Chapter 7.
[89] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.
[90] *McCulloch v Forth Valley Health Board* [2023] UKSC 26.
[91] *R (Burke) v General Medical Council* [2005] EWCA Civ 1003.

It remains to be seen whether partial ectogestation is a procreative choice that would appeal to people—it does, after all, involve major surgery and encompasses risk, therefore, to the pregnant person and to their wanted fetus. There are imaginable circumstances, however, where for some the risk profile of partial ectogestation compared to a complete pregnancy might be such that intervention is desirable to some. That this decision, essentially one of *how* a procreation is facilitated, is confined to the medical profession might be thought problematic for the extent that it disregards the inevitable sociopolitical elements of such a decision in subsuming it only as a clinical question. It is easy to see how some reasons might readily become more palatable to health professionals than others. We can look to technological interventions in birth as an example, while caesarean rates generally are rising, it has been a long journey for, and there is still much resistance to, recognition of the importance of 'maternal-request caesarean section'[92] even though, in many cases, from the birth-givers perspective their request is often motivated by clinical need.[93]

In the case of other technologies enabling gestation, clinical gatekeeping may also limit access, limiting who can experience pregnancy. Surrogacy UK, a not-for-profit professional organization supporting surrogacies in the UK, have long-endorsed surrogacies in instances where it is necessary for intended parents, and they have encouraged a broad socially attentive definition of necessity to encompass that need for assistance with gestation cannot be defined in purely 'biological' terms.[94] There are some people who are not biologically infertile but do not have the ability to gestate, such as male same-sex couples, or people who may be capable of becoming and sustaining a pregnancy, but they have crippling tokophobia. Access criteria have been developed for UTx, though they vary by provider. It is notable that, as UTx remains, at most centres performing the procedure, an experimental surgery, that drawn up access criteria reflect notions of risk specific to the risk profile of the technology as experimental. As Koplin and Kendal have acknowledged there are ethical

[92] Updated guidance in 2023 in the UK is more supportive of request caesarean that it previously had been: National Institute of Health and Care Excellence, 'Caesarean birth - NG192' (2021) <https://www.nice.org.uk/guidance/ng192> accessed 28 November 2023, [1.2.25] and [1.2.29].

[93] Elizabeth Chloe Romanis, 'Appropriately Framing Maternal Request Caesarean Section' (2022) 48 Journal of Medical Ethics 554–56; Rebecca Brown and Andrea Mulligan, '"Maternal Request": Caesarean Sections and Medical Necessity' (2023) 18 Clinical Ethics 312–20.

[94] Law Commission of England and Wales and Scottish Law Commission, 'Building Families Through Surrogacy: A New Law: Volume II: Final Report' (Law Com No 411, Scot Law Com No 262, March 2023) <https://s3-eu-west-2.amazonaws.com/cloud-platform-e218f50a4812967ba1215eaecede923f/uploads/sites/30/2023/03/2.-Surrogacy-full-report.pdf> accessed 12 June 2024 [6.101].

complexities baked into determinations of who is eligible for UTx.[95] In the UK, criteria have been based on a 'variety of psychosocial and medical factors',[96] which has sparked considerable debate.[97] For example, it has been indicated that UTx recipients should be AFAB, have their own ovum, have a supportive partner, and must not yet be a parent (among other things).[98] Hammond-Browning critically reflects on these criteria,[99] most of which the team have defended in some way as clinically necessary or a matter of fairness.[100] I do not have the space to delve into the assessment of each of these criteria (though I will note, agreeing with Hammond-Browning, that a person already being a parent, especially if they were unable to gestate that child, undermines the goal of the procedure in helping people have a *pregnancy experience* not just to have a child).[101] The point I wish to make is that these are not wholly clinical criteria. Many are, in fact, socio-political judgments on whether someone's self-described need for the experience of gestation is sufficient to be classified as a clinical need. It is easy to see how such normative questions, which are obviously socio-political, might feature in clinical decisions about access to complete ectogestation.

The gatekeeping I have described is exacerbated by the point of scarcity of resources and how need is, often within publicly funded healthcare, constructed as a hierarchy.[102] How those needs constructed as clinical necessity are weighed against those considered more personal preference is a complex matter fraught with ethical judgement. In UTx, where demand is likely to outstrip supply of donor material,[103] how do we determine whose need for

[95] Julian Koplin and Evie Kendal, 'Ethical Issues in Uterine Transplantation' (2020) 34 Korean Journal of Transplantation 78–83, 82.

[96] Laura O'Donovan and others, 'Ethical and Policy Issues Raised by Uterus Transplants' (2019) 131 British Medical Bulletin 19–28, 24.

[97] Natasha Hammond-Browning, 'UK Criteria for Uterus Transplantation: A Review' (2017) 126 British Journal of Obstetrics & Gynaecology 1320–26; Benjamin Jones and others, 'Re: UK Criteria for Uterus Transplantation: A Review' (2019) 126 British Journal of Obstetrics & Gynaecology 1507–08; see also Ryan Tonkens, 'Gatekeeping Uterus Transplants: A Proposal for Eligibility Criteria and the Fair Allocation of Wombs' in Natasha Hammond-Browning and Nicola Williams (eds), *International Legal and Ethical Perspectives on Uterus Transplantation* (Edward Elgar 2024).

[98] Benjamin Jones and others, 'Uterine Transplantation: Past, Present and Future' (2016) 123 British Journal of Obstetrics and Gynaecology 1434–38.

[99] Hammond-Browning (n 97).

[100] Jones and others (n 97).

[101] Hammond-Browning (n 97) 1323.

[102] See Evie Kendal, 'Commentary on Romanis' Assisted Gestative Technologies' (2022) 48 Journal of Medical Ethics 450–51, 450.

[103] There is system of opt-out for organ donation in England and Wales (also referred to as 'deemed consent') per the Organ Donation (Deemed) Consent Act 2019 and the Human Transplantation (Wales) Act 2013. However, the uterus is on the list of organs excluded from the deemed consent model

a uterus to experience is greatest? What normative judgments about who should be undertaking pregnancy (and who should not) might filter into these assessments? Mitra argues that 'if reproductive justice is to be achieved one has to think of ways for uterus allocation that would neither selectively target gendered bodies nor selectively deprive access for some on the basis of their sexuality and gender'.[104] Similarly, in the case of partial ectogestation or ectogestation, where presumably the technology is expensive and there is limited availability, what needs will be considered most significant when assessing whether to support individuals to avoid or opt-out of gestational work? How will these relate to gendered stereotypes?

It has consistently been the case that procreative technologies are limited to 'certain groups that have specific needs that *are* recognized, whereas other groups of people with other different needs may be excluded'.[105] Who is perceived as the appropriate user of novel technologies is co-constructed between notions of the 'biological' and of social judgement influencing whether a 'medical need' is recognized. It remains the case that in assisted procreation, 'individuals must explain their reproductive choices (or choices around reproduction) in clinical terms to ascertain social acceptance'.[106] People who opt for technological assistance, for example, are often ridiculed—for example birthing people who opt for a maternal request caesarean section are labelled 'too posh to push'.[107] Equally, people who refuse to birth in a hospital (they want to birth at home with or without medical support) are also criticized for being 'bad mothers'.[108] While this critique comes from different directions, the essence is always that pregnant people are expected to conform to the recommendations (and often control of) medical professionals.

per The Human Tissue (Permitted Materials: exceptions) (England) regulations 2020. See Nicola Williams, Laura O'Donovan, and Stephen Wilkinson, 'Presumed Dissent? Opt-out Organ Donation and the Exclusion of Organs and Tissues' (2022) 30 Medical Law Review 268–98; Romanis and Parsons (n 73) 810–15.

[104] Sayani Mitra, 'Transplanting the Uterus: A Reproductive Justice Perspective' in Solveig Lena Hansen and Silke Schicktanz (eds), *Ethical Challenges of Organ Transplantation* (Transcript Publishing 2021) 293.

[105] Romanis, 'The Equality-Enhancing Potential' (n 75) 644.

[106] ibid.

[107] For critique see Elizabeth Chloe Romanis, 'Addressing Rising Cesarean Rates: Maternal Request Cesareans, Defensive Practice, and the Power of Choice in Childbirth' (2020) 13 International Journal of Feminist Approaches to Bioethics 1–26, 17.

[108] For critique see Anna Nelson and Elizabeth Chloe Romanis, 'The Medicalisation of Childbirth and Access to Homebirth in the UK: COVID-19 and Beyond' (2021) 29 Medical Law Review 661–87.

Stratified Access

Roberts has argued that procreative 'technologies rarely achieve their subversive potential' because of a constellation of barriers erected to their use.[109] In this section, I argue, that without due attention to the *extra-legal* barriers surrounding procreative technologies, technologies enabling gestation are likely to exacerbate existing disparities in procreative decision-making and pregnancy care. I am not taking the position that because of potential disparities technologies enabling gestation should never be permitted. Räsänen claims that it is not immediately apparent that disparities are always and necessarily unjust (he suggests further thought must be directed to the issue)—'if pregnancy outcomes are "good enough" for everyone, then the fact that some people have access to even better outcomes might not be a problem for justice'.[110] I am not taking this approach either, as the access issues I highlight are absolutely justice concerns given that they disproportionately impact some marginalized groups more than others. My position is that we need to centre the reality of disparities in procreative and pregnancy care in reflections about how to facilitate access to technologies enabling gestation so that such disparities can be addressed. One element of this has been explored thus far in this chapter—in that we must not understand procreative needs as wholly 'biological' needs—as to do so limits use to cis-heteronormative nuclear families. In this section, I note that the access issues related to socio-economic status, class, and race where procreative technologies are not publicly funded.

Notably, most scholars who have written strongly in defence of a technology enabling gestation, have also written strongly in favour of public funding. Kendal advocates for 'state-sponsored' ectogestation,[111] and Wilkinson and Williams advocate for state funding of UTx.[112] The matter of state funding in principle does not go far enough. As Cooper notes, 'the purchase and supply of [assisted reproductive technologies] on the NHS *at a regional level* houses a myriad of considerations that are inextricably linked to the subsequent determination of access'.[113] Decisions about what procreative assistance to fund and for whom is the subject of a lottery across much of the UK. In a recent study, Jones and others found that the accessibility of various forms of assisted

[109] Roberts (n 24) 248.
[110] Joona Räsänen, 'Who Should Have Access to Assisted Gestative Technologies?' (2022) 48 Journal of Medical Ethics 447, 447.
[111] Evie Kendal, *Equal Opportunity and the Case for State Sponsored Ectogenesis* (Palgrave 2015).
[112] Stephen Wilkinson and Nicola Williams, 'Should Uterus Transplants be Publicly Funded?' (2016) 42 Journal of Medical Ethics 559–65.
[113] Cooper (n 56) 170 (emphasis added).

procreation was much greater in areas in England with the 'most advantaged local authorities in terms of average household income and level of deprivation'.[114] There are lesser opportunities, therefore for individuals living in more deprived areas and experiencing involuntary childlessness to pursue assisted procreation.[115] That funding for procreative assistance is better in areas where people are more likely to be able to afford to pay for it themselves exemplifies that procreative technologies, more often than not, benefit more socio-economically privileged individuals. Moreover, it is not just the direct financial costs of procreative technologies that must be considered when we consider who can afford to access them—for example, travel costs, the necessary time off work etc.[116] Disparities are concerning in the context of assisted conception because it affects who is enabled to reproduce at all, but also in the context of technologies enabling gestation, because it affects decisions about the bodily work involved in procreating. Cavaliere warns that even in publicly funded health systems that appropriately recognize the importance of funding procreative technologies, 'it is unlikely that all biologically and socially infertile women would be granted free access to ectogenesis' because resource allocation decisions are inevitable.[117] The same must be true of UTx.

While the conceptualization of legal rights adopts a neoliberal stance—people can procreate how they want but they cannot demand that the state help them—this ignores the socio-political dimensions of procreation—who is routinely excluded from procreating and doing so in a way that enables them to have the meaningful experiences they seek, or without the burdens they seek to avoid. Where ectogestation is reserved for the privileged[118] (because they pay for the service directly or live in areas where it is more likely to be funded), there risks a widening of the gap that exists in pregnancy outcomes. In the UK, and many other western high-income economies, entrenched obstetric negligence, violence, and racism is evident in maternal morbidity such that Black women are five times more likely to die as a result of poor care during

[114] Bobbie Jones, Nitzan Peri-Toten, and Anna Mountford-Zimdars, 'Geographic Opportunities for Assisted Reproduction: A Study of Regional Variations in Access to Fertility Treatment in England' (2023) 26 Human Fertility 494–503.

[115] ibid.

[116] Romanis, 'The Equality-Enhancing Potential' (n 75) 645.

[117] Giulia Cavaliere, 'Gestation, Equality and Freedom: Ectogenesis as a Political Perspective' (2020) 46 Journal of Medical Ethics 76–82, 78.

[118] Suki Finn and Sasha Isaac, 'Evaluating Ectogenesis via the Metaphysics of Pregnancy' in Robbie Davis-Floyd (ed), *Birthing Techno-Sapiens: Human Evolution and the Future of Reproduction* (Routledge 2021).

pregnancy and birth.[119] It is not hard to imagine technologies enabling gestation creating a world in which richer, privileged people, more likely to be educated and white, are able to access ectogestation, and UTx where pregnancy is important to them (and will likely receive good care). All while people with lesser resources who are structurally marginalized by socio-economic status, class, and race (often directly and indirectly as a result of state policies) do not have access to these choices. Technologies enabling gestation make even starker the realities of the procreative disparities that already exist in contemporary conditions.

An analysis attentive to stratification can help make visible how 'state policy, cultural norms directly or indirectly privilege and valorize the reproductive work of certain groups while vilifying the capabilities of others'.[120] UTx could result in the reinforcement of the bioromanticism of *some* pregnancies, while ectogestation is seen as a mechanism to control (and, in extreme cases, replace) others. Horn argues for the importance of looking to contemporary and historical instances of procreative coercion to ensure due attention is paid to 'the harms that might accompany the pursuit of an intended project of . . . technology to improve decision-making in reproductive care'.[121] There may be 'concerns about women from lower socio-economic backgrounds losing even greater degrees of privacy and bodily control as the process of gestation is seen as more publicly owned' (irrespective of location because there is the possibility of it being facilitated by machine).[122] Pregnancy is a fleshy, embodied business. A clear conceptual distinction between *pregnancy* and gestation, I would argue, must be maintained, in law and beyond, in order to reinforce the point that pregnancy as a bodily state cannot be subject to the same interference as gestation facilitated by machine. This speaks to the importance of proper regulation of surrogacies to ensure that intended parents recognize and respect the bodily boundaries of the surrogate: while the surrogate is pregnant, the fetus is a part of them. Some decisions, therefore, must always be the surrogates: decisions about termination, for example, or about birthing.[123]

[119] Birthrights, 'Systemic Racism, Not Broken Bodies: An Inquiry into Racial Injustice and Human Rights in UK Maternity Care' (2022) <https://www.birthrights.org.uk/wp-content/uploads/2022/05/Birthrights-inquiry-systemic-racism_exec-summary_May-22-web.pdf> accessed 28 November 2023.

[120] Stephanie Paterson, Francesca Scala, and Marlene Sokolon, 'Introduction' in Stephanie Paterson, Francesca Scala, and Marlene Sokolon (eds), *Fertile Ground: Exploring Reproduction in Canada* (McGill-Queen's University Press 2014) 8.

[121] Claire Horn, 'Ectogenesis, Inequality, and Coercion: A Reproductive Justice-informed Analysis of the Impact of Artificial Wombs' (2023) 18 BioSocieties 523–44, 532.

[122] Claire Horn and Elizabeth Chloe Romanis, 'Establishing Boundaries for Speculation about Artificial Wombs, Ectogenesis, Gender, and the Gestating Body' in Chris Dietz, Mitchell Travis, and Michael Thomson (eds), *A Jurisprudence of the Body* (Palgrave 2020) 249.

[123] This is not the same as saying the surrogate is the parent—see Chapter 6.

An important element of stratified access is not just a case of affording access to technologies, but who potentially is pressured or encouraged to utilize technologies that do not speak to their preferences.[124] A number of commentators have raised concerns about the use of ectogestation to facilitate the 'policing of pregnancy' and specifically the coercive power of law.[125] Pregnancy, and pregnancy experiences, as Howard explains, are 'an issue of class, race, religion, relationship status, ethnicity, and ability, among other intersections of identity and oppression'.[126] Cavaliere warned of the dangers of ectogestation coming to label some individuals as 'substandard gestators' where their behaviours do not align with societal expectations.[127] The effect could be exacerbated by UTx in the construction of pregnancy as a meaningful experience that people struggle to these lengths to achieve. Some scholars have suggested that ectogestation could be an important mechanism for fetal protection,[128] for example, for enabling 'fetuses that could have become the victims of maternal alcohol or drug use during pregnancy to have a safe and healthy place for fetal development'.[129] Such an approach, however, is likely—Horn argues—to result in coercive uses of ectogestation[130] (made possible by fetal extraction). Though Horn argues this would be more the result of social pressure and result in some legal change to facilitate (she notes that 'it is improbable' that fetal extraction for gestation ex utero would be lawful).[131] However, the case law relating to disputes about how to proceed where a pregnant person is refusing medical intervention in their pregnancy tells a different story. I have argued elsewhere that it is not wholly implausible that compelled fetal extraction and partial ectogestation could come before the courts.[132] Pregnant people are consistently found to be lacking capacity to refuse surgical intervention in birth where it is considered necessary by medical professionals[133] and decisions seemingly indicate that

[124] Horn (n 121) 531.

[125] ibid; Cavaliere (n 117); Elizabeth Chloe Romanis, '"The Law is Very, Very Outdated and Not Keeping Up with the Technology": Novel Forms of Assisted Gestation, Legal Challenges, and Perspectives of Reproductive Rights Advocates in England and Wales' (2023) 10 Journal of Law and the Biosciences <doi.org/10.1093/jlb/lsad027> accessed 1 September 2024.

[126] Grace Howard, *The Pregnancy Police: Conceiving Crime, Arresting Personhood* (University of California Press 2024) 4.

[127] Cavaliere (n 117) 79.

[128] Räsänen (n 110); Gregory Pence, 'What's so Good about Natural Motherhood? (In Praise of Unnatural Gestation)' in Scott Gelfand and John Shook (eds), *Ectogenesis: Artificial Womb Technology and the Future of Human Reproduction* (Rodopi 2006) 82.

[129] Räsänen (n 110) 447.

[130] Horn (n 121) 531–39.

[131] ibid 536.

[132] Romanis, '"The Law is Very, Very Outdated . . . ' (n 125).

[133] *Re S (Adult: Refusal of Medical Treatment)* [1992] 3 WLR 8; *Re MB (Caesarean Section)* [1997] EWCA Civ 1361; *Re AA* [2012] EWHC 4378 (COP); *Guys and St Thomas NHS Foundation Trust v R* [2020] EWCOP 4; *NHS Trust v JP* [2019] EWCOP 23.

the threshold of capacity for decision-making in this context *may* be lower than in others.[134] Where a person is found to be incapacitated, medical interventions can be lawfully performed where they are in the best interests of the individual. The hyper-medicalization of pregnancy and birth, that is legally supported, should be cause for concern—could there be a case where a pregnant person is found to be incapacitated and that it is in their best interests to have their pregnancy ended (and gestation continued ex utero)?

As I have argued in this chapter, without social and legal reform there is the danger that technologies enabling gestation are inaccessible to marginalized groups who *want* to use them, especially those considered to be seeking procreation beyond the cis-heteronormative 'biological' family. A related issue is the transformative gender-rupturing potential of the technologies that these technologies may possess; this is discussed in Chapter 5.

[134] Samantha Halliday, 'Court-authorized Obstetric Intervention: Insight and Capacity, A Tale of Loss' in Camilla Pickles and Jonathan Herring (eds), *Childbirth, Vulnerability and Law: Exploring Issues of Violence and Control* (Routledge 2019) 179.