

Uterus transplants and the insufficient value of gestation¹

The recent success of uterus transplants, resulting in some live births, provides us with another treatment for a kind of infertility.² For some, this might seem exactly like other forms of fertility treatment ethically speaking, albeit one that might be more expensive. Others have raised ethical concerns grounded on the medical risks of this treatment for donor, recipient, and child.³

However, in this article I argue that uterus transplants are distinct from other fertility treatments not only in their degree of medical risk and financial cost but, also, in the way that they make

¹ With thanks to participants at the Ethics of Uterus Transplantation Symposium, University of Lancaster, and particularly to Rosamund Scott for her insightful commentary on that occasion; and at the Institute for Experimental Medicine seminar series, University of Kiel. I am also grateful for helpful and detailed critiques from Christopher Nathan, Carolyn McLeod, and an anonymous reviewer for this journal.

² M. Brännström, L. Johannesson, H. Bokström, N. Kvarnström, J. Mölne, P. Dahm-Kähler, A. Enskog et al. Livebirth after Uterus Transplantation. *The Lancet* 2015; 385 (9968): 607-616. This article considers such transplants as a treatment for women's infertility, rather than considering their role in enabling cis-gender men to gestate children, or as an option for transgender women where it is for reasons other than to gestate a child. On the former, see R. Sparrow. Is it "Every Man's Right to Have Babies if He Wants Them"? Male Pregnancy and the Limits of Reproductive Liberty. *Kennedy Institute of Ethics Journal* 2008; 18 (3): 275-299. For a response, and a consideration of the latter, see T. F. Murphy. Assisted Gestation and Transgender Women. *Bioethics* 2015; 29 (6): 389-397. What follows would have implications in these other contexts, especially in the rejection of normal functioning arguments, which would support the ethical irrelevance of assigned sex at birth in the context of uterus transplants.

³ For instance, R. M. Farrell & T. Falcone.. Uterine Transplant: New Medical and Ethical Considerations. *The Lancet* 2015; 385 (9968): 581-582; R. Catsanos, W. Rogers & M. Lotz. The Ethics of Uterus Transplantation. *Bioethics* 2013; 27: 65-73.

pressing a question that has hitherto been neglected, namely, what is the value of gestation and how should we respond to that value?⁴

Some may find the above an odd way to approach the provision of fertility treatment. They might think that uterus transplants ought to be assessed as one way to meet a medical need — of treating infertility — rather than attending to, let alone evaluating, the reasons why people desire to gestate. First, then, I outline the reason why uterus transplants draw our attention to the question of the value of gestation.⁵ Second, I argue that any justification of the provision of uterus transplants would have to be based on the value of gestation, rather than on claims that it meets medical need or promotes normal functioning.

The remainder of the article then assesses the very limited prospects of success for such a justification. I argue that it would be difficult to justify state funding, although we might not have sufficient reason to ban uterus transplants. However, there is more to assessing the ethics of a treatment than merely asking whether it should be banned or if state funding can be justified. We can also inquire whether accessing some treatment should be easy or hard, as well as exactly how hard. I argue that this is the moral terrain of uterus transplants: we have reasons to refrain from enabling these transplants, especially against a background of gender inequality and given the limited value of gestation. One way to refrain from enabling a treatment is not to provide state funding but that is not the only way, as I explore in the final section of this article.

⁴ There are some exceptions, discussed in section 2. For example, Anca Gheaus uses the experience of pregnancy to defend a right to keep one's biological child, in: *The Right to Parent One's Biological Baby*. *Journal of Political Philosophy* 2012; 20 (4): 432-455. Tina Rulli describes a possible exemption from a duty to adopt based on the value of pregnancy in: *Preferring a Genetically-Related Child*. *Journal of Moral Philosophy* 2016; 13(6): 669-698.

⁵ This article considers a range of values that gestation could have, from contributing to a life's flourishing, to increasing wellbeing, to the value of pursuing a project, or of having a certain kind of experience. With thanks to a referee for pointing out this diversity.

1. Uterus transplants and the question of gestation's value

Uterus transplants highlight the issue of the value of gestation because the particular good that they provide is the experience of pregnancy, and they provide it in contexts where it cannot be achieved in any other way.⁶ First, there are other ways for people to become parents, including surrogacy and adoption.⁷ In cases where a woman has saved eggs or has functioning ovaries, surrogacy would enable her to have a biological child, just as uterus transplants could.⁸ These alternatives to uterus transplants are, and will likely continue to be, practically easier and less risky. Not only are uterus transplants still experimental but, as with any transplant, patients face the general risks of surgery, the particular risks of rejection and infection, and the need to take immunosuppressant drugs.⁹

Second, uterus transplants do not provide a clearly ethically superior option compared to the existing alternatives of surrogacy and adoption. In a world where there are children without parents, adopting is a morally superior choice to creating another child.¹⁰ Further, there are forms of surrogacy that most would find morally permissible or, at the least, no more morally impermissible than uterus transplants. As instances where surrogacy may be found morally permissible, suppose, to illustrate, that the surrogate has sufficiently attractive alternatives open

⁶ See Catsanos et al., *op. cit.* note 3.

⁷ For some doubts that surrogacy is an adequate alternative see S. Wilkinson & N. J. Williams. Should Uterus Transplants be Publicly Funded? *Journal of Medical Ethics* 2016; 42, 559-565, at pp.560-562. But for a compelling response see M. Lotz. Commentary on Nicola Williams and Stephen Wilkinson: 'Should Uterus Transplants Be Publicly Funded?' *Journal of Medical Ethics* 2016; 42: 570-571.

⁸ I use 'women' here and throughout rather than a gender neutral term, both because using 'persons' or 'people with uteruses' would obscure the background gender inequalities that are, I argue, essential to assessing the ethics of uterus transplants and because the scope of this paper is restricted as outlined in footnote 2. Further, at present, uterus transplants are being performed only on women.

⁹ I return to the details of these risks in sections 2 and 3.

¹⁰ Some might even see it as morally required; for a discussion, see Rulli *op. cit.* note 4.

to her, that there are no extreme inequalities in wealth, and where the surrogate acts as such for friends and family.¹¹ As to those who find surrogacy always morally impermissible, consistency in argument ought to lead them to think much the same about uterus transplants. For instance, for those who make arguments that surrogacy is a product of gender inequality, consistency should lead to thinking much the same about living donors of uteri and perhaps about the women who have transplants — on which more later.¹² To illustrate, regarding the donors, women may feel pressured to provide a uterus, lack other options, or, when encouraging donations from family members, one may be exploiting a socially ingrained gendered expectation that women be self-sacrificing. Alternatively, as another example, it would also be surprising if those who object to surrogacy's 'unnaturalness' did not find these transplants similarly unnatural.

Thus, what uterus transplants provide that alternatives do not is the experience of pregnancy — and not some less risky or more ethical option. Admittedly, that uterus transplants enable the experience of pregnancy is not unique to this form of reproductive technology. Assisted reproductive technologies such as in vitro fertilisation (IVF) also provide this experience, where adoption and surrogacy do not. Indeed, what this article has to say about the value of gestation would have some relevance to these other cases too. However, unlike uterus transplants, IVF might be justified compared to surrogacy or adoption on grounds other than the fact that it provides the experience of pregnancy. For instance, IVF is likely to be cheaper than surrogacy and avoids some ethical worries around using a surrogate, unlike uterus transplants. So, too, IVF could provide an easier way for people to have children than our current adoptive system with its long vetting process, whereas uterus transplants are a far more

¹¹ For a possible counter-argument, beyond the scope of this article to address, that regards uterus transplants as relieving surrogates of a burden, see J. A. Robertson. Other Women's Wombs: Uterus Transplants and Gestational Surrogacy. *Journal of Law and the Biosciences* 2016: 68-86, at pp. 76-78.

¹² Note, a move to dead donors of uteri may eliminate some of the former concerns.

complicated procedure. Hence, uterus transplants are a form of fertility treatment that particularly requires getting to grips with the value of the experience of pregnancy.

2. Why not medical need or normal functioning

While uterus transplants enable gestation, some might respond that regardless the value of gestation is not the reason *why* these transplants should be funded or even available. Instead, the appropriate justification for such a treatment is that it meets a medical need.¹³ Infertility is commonly regarded as a disease or a disability.¹⁴ While some have pointed to difficulties with understanding infertility as a disease in general, the conditions that uterus transplants could treat appear to be clear cut instances of disease or disability.¹⁵ Women born without wombs, whose reproductive systems are damaged through disease, or who have their wombs removed for the sake of treating cervical cancer all appear to have a clear absence of normal functioning of a kind that constitutes disease or disability on the bio-statistical approach, where to be healthy is to have statistically normal function for one's reference class. For women of childbearing age,

¹³ On this view, see Catsanos et al. *op. cit.* note 3, p. 67.

¹⁴ The WHO and HFEA define infertility this way, e.g. see <http://www.who.int/reproductivehealth/topics/infertility/definitions/en/>

¹⁵ For a discussion questioning whether infertility is a disease see E. McTernan. Should fertility treatment be state funded?. *Journal of Applied Philosophy* 2015; 32: 227- 240, section 2. On the opposing side, see Wilkinson & Williams, *op. cit.* note 7.

statistically normal function includes having a uterus that ‘works’: one that can perform the usual functions of a uterus, including the capacity to carry a baby to term.¹⁶

However, below I argue that appealing to normal functioning does not let us avoid addressing the question of what value the experience of pregnancy has, along with how to weigh that value, when considering what a state should fund or what doctors should provide.¹⁷ First, uterus transplants are not forever, nor even intended to last for the average period in which women would have a working uterus. The risks of the transplant are such that the intention is to remove the uterus after the successful gestation of a child, or a couple of children. Thus, what is done in transplanting a uterus is to enable the experience of pregnancy. It does not provide women of childbearing age with a functioning uterus for the time that she falls within such a reference class. Hence, still, it makes sense to ask about the value of gestation rather than only about securing normal functioning when assessing uterus transplants.

Some might object that the central component of normal functioning of a uterus is to succeed at bearing a child, or a few. Hence, by enabling that central function, uterus transplants promote normal functioning. Yet some women do not bear children even though they would

¹⁶ Just as the concern is not only that a person has a kidney, but that they possess a kidney that can perform the usual functions of a kidney, which includes the capacity to filter out toxins. On normal functioning, see C. Boorse. Health as a Theoretical Concept. *Philosophy of Science* 1977; 44(4): 542–573. While there are problems with this account, it is the relevant one to address here when defending the importance of addressing the value of gestation. On a value-laden approach to defining health, one would already be committed to considering gestation as valuable, if its lack is to be seen as unhealthy.

¹⁷ For an argument with parallels to that below on uterus transplants as meeting medical needs below, see Carolyn McLeod’s case against justifying funding IVF by an appeal to medical necessity on the grounds that we cannot avoid assessing how important the capacity restored by a treatment is and once we do so, there are reasons to think a government ought not promote this particular capacity — over and above other ways to become a parent. See, her, The Medical Nonnecessity of In Vitro Fertilisation. *The International Journal of Feminist Approaches to Bioethics* 2017; 10 (1).

easily be able to do so. It is inaccurate to describe such women as lacking normal functioning: their uteruses may be in perfect condition. Thus, 'normal functioning' is better cashed out in terms of a capacity to succeed at getting pregnant and carry that pregnancy to term, under the right conditions, and for that time period of a life where women are usually fertile.

Nonetheless, an opponent might insist that what is *valuable* about the normal functioning of a uterus is the ability to gestate a child and thus, the transplant does provide what counts, even if it does not secure normal functioning per se. However, then one is committed to discussing the value of gestation, rather than relying on appeals to normal functioning alone absent such value judgements. This concession suffices for the following argument to apply — an argument that casts doubt on whether the value of gestation justifies uterus transplants.

A second objection to medical need based approaches to defending uterus transplants is more serious. On plausible interpretations of promoting normal functioning, and any alternative conception of meeting medical need, performing a uterus transplant fails to count as doing so. Consider the more common organ transplants, such as kidneys, livers, hearts, or lungs. These transplants are largely carried out when a person will otherwise die, as in end stage heart disease, or where the alternative treatment leads to a shorter life span with severe side effects, as in the case of kidney transplants. In such cases, transplants are the best available option to meet medical need or preserve life and so some level of functioning, despite risks like infection and rejection.

Uterus transplants are different.¹⁸ They are not performed for the sake of prolonging or preserving life. Further, they drastically increase a person's need for medical treatment, including future surgery, immunosuppressant drugs, treatment for infections or rejection episodes. So, too, uterus transplants reduce overall functioning. In particular, they involve suppressing the immune system. Thus, in exchange for providing a woman with a chance at reproductive success, we

¹⁸ Catsanos et al. also note that uterus transplants move away from considerations of beneficence to quality of life improvement *op. cit.* note 3, pp. 66-67.

diminish her immune system and leave her at higher risk of death, including a lasting increased risk of certain cancers. That does not constitute a net gain in normal functioning, nor an overall diminishment of medical need otherwise defined.

Some might object that such side effects are irrelevant when assessing if medical need is met. Perhaps we meet medical need whenever we meet a *particular* need, even if in doing so we create additional medical needs that outstrip the original ones. Thus, one meets the medical need (fixing an inability to bear children) even if, in so doing, one thereby suppresses the immune system. However, in general, to claim that medical need is met by treatments that do more harm than good is unappealing, especially where that is explained away on the grounds that the greater harm is done to a different part of the body than that which intend we treat. How could a medical need be met where the net overall consequence of some treatment is a diminishment of functioning or health? At the least, in order to succeed, such an objection would rely on finding some alternative understanding of medical need and one that neither relates it to normal functioning nor any conception of an organism's overall health: both of these measures would be too holistic for uterus transplants to count as meeting medical need, given the overall impact on the body of such a transplant. But what could such an alternative be?

Still objecting, others might observe that transplants are sometimes performed for reasons other than saving or prolonging a life. As such, they might continue, I demand too much of a justification of uterus transplants based on medical need. Perhaps an argument from the analogy to these other non-life saving transplants could suffice to justify uterus transplants. If these other transplants are justified — despite bringing risks of rejection, infection, and immune system suppression and where they do not promote functioning or meet medical need in the most obvious of senses — uterus transplants may be justifiable too. Putting aside more minor instances like skin grafts, on the grounds that these do not decrease functioning in the same way, the relevant examples would include cornea or face transplants.

However, these other transplants are carried out in cases where the alternative is a limited and difficult life. For instance, loss of sight can severely impact a person's ability to move around

the world easily, along with limiting access to work. Further, cornea transplants are seldom rejected, and so they come with less risk of diminishing functioning. Where face transplants are carried out, prior to the surgery the person may be unable to eat or speak easily or without assistance, and feel unable to go out in public owing to others' reactions to their appearance.

One might try to argue that being unable to gestate a child also creates an equivalently limited or difficult life, seeking to use this parallel to other transplants to justify uterus transplants, without getting into the question of the value of gestation. However, the way in which the absence of the capacity to gestate is limiting for a life is strikingly different to these other forms of transplant. Women are not expected to (and cannot) gestate continually. Many women choose never to gestate. Further, for a prospective candidate for a uterus transplant, large areas of life are unaffected by her lack: it is as easy for her to move around public spaces, work, eat, and so on, as for women who do have the capacity to gestate. Thus, as Catsanos et al. comment, the lack of a functioning uterus is neither 'visible or socially inhibiting in the way that prosthetic upper limbs or facial deformities typically are'.¹⁹

Nonetheless, a woman who cannot bear children and yet wishes to may experience this inability as a deep and serious loss. Her life does not go as she desires, or a project she wished to

¹⁹ *Op. cit.* note 3, p. 67. Here, some might object that in imagined or actual societies where gender inequality is still more deeply ingrained, women may indeed feel their whole lives are inhibited by an inability to bear children. Perhaps there could be societies where this inability is one that others would easily know, a widespread way in which they could be judged or a visible source of social exclusion. It is beyond the scope of this article to deal with such instances, but I would remark that it would be concerning for the response to be surgery to help all women conform to that especially oppressive social ideal, rather than tackling this notion of what makes a woman of value. With thanks to two referees for noting the possibility that gestation could have such pervasive significance.

devote herself to has been denied to her.²⁰ For others, it might be less a question of what life projects they have committed to or are passionate about and more a matter of finding out that some opportunity they always assumed would be there turns out to be closed to them. However, discussing the value of gestation then becomes unavoidable. We cannot stick to some value-free notion of normal functioning or simply appeal to medical need. Instead, uterus transplants would be a way to enable a particular life project, or provide one type of opportunity. For most, having a child is not a life's only project or valuable opportunity. We may also desire to pursue certain careers; seek to maintain valuable relationships with partners, friends, or family; try to make a positive impact on our communities; as well as pursuing a range of other hobbies or activities. Further, the project in question is narrower still; namely, to *gestate* a child. There are other ways of having a child, after all, including surrogacy and adoption. Thus, we have to ask, what is the value of experiencing gestation and how does this opportunity compare to these many other valued projects and activities of a life? To what extent should it be provided or funded where other valued experiences and opportunities are not, and at what cost?²¹

There is one last way some might think we could avoid having to get to grips with the value of gestating for the purposes of understanding the correct attitude of the state and medical profession towards uterus transplants; namely, rely on people's own subjective preferences. Then, if a woman says that frustrating her desire to gestate children is severely life limiting, we need enquire no further, even if the ways it limits a life are less obviously pervasive or accessible from an external observer's viewpoint than for the other cases where one would perform transplants. I return to this idea that we ought to simply respect people's wishes in

²⁰ Here, I use the term 'project' in a general sense, to describe any moderately long-lasting or persistent commitment of a person's life, as the examples to follow show. See also McTernan *op. cit.* note 15. For a more constrained account of projects and their value see Rulli *op. cit.* note 4. With thanks to a referee for prompting this clarification.

²¹ Parallel questions are asked in McTernan, *op. cit.* note 15 about fertility treatment in general. See also, against funding IVF over and above other ways to parent, McLeod *op. cit.* note 17.

section 4. For now, note that this is still a turn to the value of gestation. It is simply one that leaves it entirely up to the individual to determine that value.

3. What is the value of gestation?

What, then, is the value of gestating? This is the relevant issue, rather than the more often considered issue of the value of having children, since we have to hand the cheaper, less risky options of surrogacy and adoption.²² To address this issue, a good starting point is asking what a life without the experience of gestation is like. In particular, we would want to know what such a life lacks.

We ought to be wary of claiming that lives without gestation lack too much. Some choose not to bear children and others end up not doing so. Many still experience their lives as rewarding and flourishing. Indeed, some take their lives to be all the more rewarding for that lack.²³ So, too, gestation is an experience that, in nearly all cases, men do not have.²⁴ In addition, while there may be value in experiencing pregnancy secondhand as Gheaus suggests, as when one's partner is pregnant, such an experience would be one of sharing in the kinds of value (and disvalue) sketched below and its shortcomings.²⁵ At any rate, my focus is on the experience of those who gestate themselves, as the best grounds for invasive medical treatment performed on that individual. At this stage, the point I intend to make is only that we ought not say that gestation is essential for a good or flourishing life *for all*. From what I have said thus far,

²² E.g. H. Brighouse & A. Swift. 2014. *Family Values: The Ethics of Parent-Child Relationships*. Princeton University Press.

²³ For a concise and helpful summary of studies on differing attitudes to infertility, see McLeod *Op. cit.* note 17, pp. 83-4.

²⁴ For one experience, see T. McDonald. 2016. *Where's the Mother: Stories from a Transgender Dad*. Trans Canada Press.

²⁵ *Op. cit.* note 4.

gestation may yet be essential for a good life, let alone for a flourishing one, for those women who deeply desire it.

Gestation, then, is amongst the experiences that some can have, some through choice, others not. For some, the experience of pregnancy itself is valued; for others that experience is not one that they treasure. Describing its value, Gheaus, drawing on feminist literature, suggests that the experience of pregnancy can begin the bond between parent and child. As she describes it, ‘during pregnancy many—perhaps most—expectant parents form a poignantly embodied, but also emotional, intimate relationship with their fetus’.²⁶ Another route is to see the experience of pregnancy as preparing the parents for the arrival of the baby by providing experiences like broken sleep and being less able to get around.²⁷ However, the experience of adoptive parents places limits on how strong these claims could plausibly get: we ought not deny that adoptive parents can form bonds to their children, nor that they can successfully prepare for their children’s arrival. In addition, not everyone experiences this kind of bonding during their pregnancies. Others might appeal to the feeling of being a creator to explain the value of pregnancy: there is something powerful about the experience of growing a new life. Again, however, that won’t be a feeling that all who are pregnant share.²⁸

There is one further reason to hesitate before thinking any of the above claims could ground the value of gestation in a way that might justify uterus transplants. Namely, imaginative connection offers an alternative way to attain these goods. Consider the non-gestating partner who says that he or she forms an embodied bond with the future child or has a sensation of being a creator. I take it we usually accept such claims — and note that Gheaus chooses the term

²⁶ Ibid, p.446.

²⁷ L. Levesque-Lopman. Decision and Experience: A Phenomenological Analysis of Pregnancy and Childbirth. *Human Studies* 1983; 6: 247–277.

²⁸ For different challenge based on the oddness of valuing the act of creation itself, see Rulli *op. cit.* note

‘expectant parents’ rather than ‘gestating parent’. These feelings are not in fact embodied for the non-gestating partner but, rather, a product of imaginative identification. Likewise, one could, if one wanted, create similar imagined bonds with children where no expectant parent gestated the child in question, such as in surrogacy agreements. So, too, adoption could involve a period of imaginative identification prior to becoming a parent to a particular child. Certainly, nothing stops the expectant but not-gestating parent (including those who adopt or use surrogates as well as those who have pregnant partners) from gaining experiences of broken sleep or being less able to move around — perhaps, say, through strapping on a fake infant, setting an alarm to go off in the middle of the night repeatedly, or constantly carrying around a large amount of stuff to cater to the needs of a future child — were they to think these an essential part of preparing for parenthood.

On the other side of the scale are the risks and costs of pregnancy.²⁹ There are social costs, including for some women losing their jobs or even the right to control over their bodies, which occurs when a woman is forced to undergo medical treatment for the sake of her unborn child.³⁰ Other social costs are more subtle and more common, from being excluded from future work projects to experiencing social judgement for any deviation from perceived ideals of behaviour for pregnant women, like eating raw fish or having a glass of wine. Then there are the physical costs of pregnancy, ranging from months of nausea, constipation, headaches, swollen

²⁹ See also Gheaus’s description of the burdens of pregnancy, *op. cit.* note 4, esp. pp. 447-8.

³⁰ A recent report in the UK found that 11% ‘reported that they were either dismissed; made compulsorily redundant, where others in their workplace were not; or treated so poorly they felt they had to leave their job’ in: IFF Research Ltd, Equality and Human Rights Commission, HM Government, UK. Pregnancy and Maternity-Related Disadvantage: Summary of Key Findings. 2016. Available at <https://www.equalityhumanrights.com/en/managing-pregnancy-and-maternity-workplace/pregnancy-and-maternity-discrimination-research-findings>. For discussions of the latter and social costs more generally, see S. Bordo. 2004. *Unbearable Weight: Feminism, Western Culture, and the Body*. University of California Press, ch. 7, ‘Are Mothers Persons?’.

feet, constant nasal congestion, limited energy and ability to move around in pregnancy's late stages, to the traumas of birth including vaginal and/or anal tears. There are also the more serious health risks, including pre- or postnatal depression, pre-eclampsia, gestational diabetes, blood clots, embolisms, postpartum psychosis, organ prolapse, and long-lasting or life-long faecal and/or urinary incontinence.³¹

The above is brief but suffices to make two claims. First, gestation is part of many women's lives and some women find it valuable and some do not. Further, amongst those who do not find it valuable or part of what made their lives go well are some who expected it to be so, but found it is not, whether because of things going wrong, the usual physical costs of a pregnancy, or merely because it did not turn out to be as fulfilling as they had hoped. The above also motivates a second claim when addressing the ethics of uterus transplants. In this particular case, it is very easy to be mistaken about what will make our lives go well. We can think that gestating a child is essential to flourishing for us, for a good life, or for promoting our wellbeing, and it can turn out that it is not, or even has the opposite effect. Note, again, that this is a claim about pregnancy, not parenthood. Even supposing that parenthood promotes flourishing or wellbeing, it does not follow that gestation does.

Some may want to go further than this claim that we can be mistaken about whether gestation would be valued as an experience. An alternative approach sees pregnancy as a 'transformative experience' in L.A Paul's terminology, an experience that transforms us, changing our perspective on the world.³² If so, we can only know what it is like once we do it and, as such,

³¹ For some common problems see <http://www.nhs.uk/conditions/pregnancy-and-baby/pages/common-pregnancy-problems.aspx>. On the physical burdens of pregnancy, see also Rulli *op. cit.* note 4, at p. 695.

³² L. A. Paul. 2014. *Transformative Experience*. Oxford University Press. It might be observed that we could want to have a transformative experience, finding transformation itself valuable, with thanks to a referee for this objection. If so, pregnancy is a poor choice, given the uncertain impact it has, compared to other possibilities.

on Paul's model we cannot make rational decisions about whether to pursue it. Note that the more special and unique one takes the experience of gestation to be, the more force this doubt about whether we can rationally choose has. Yet, the idea that gestation is transformative does not ring true for all, especially if the experience of *bearing* children is separated from the experience of *having* children. Nonetheless, for some, it may be transformative. However, if so, we should be still more sceptical about our ability to assess the value of this experience, even for ourselves.

There is one last reason to doubt the sufficiency of an appeal to the value of gestation to justify uterus transplants in particular. Ruby Catsanos, Wendy Rogers and Mianna Lotz observe that the experience of pregnancy that a transplanted uterus provides is not akin to the typical experience of pregnancy. They observe that the sensation of a transplanted uterus may not be like a non-transplanted one: nerves are not reattached and hence movements may not be felt. Yet, in so far as a woman does form an intimate, embodied bond with a fetus, that is likely grounded on feeling its movements since those sensations are what frequently remind her that there is another being inside her, growing and reacting to sounds, including her voice. Further, Catsanos et al. point to the feelings of alienation some have towards transplanted organs, especially if there is any experience of organ rejection. That too might interfere with the value of the experience of gestation — of feeling it to be one's 'own' pregnancy.³³ In addition, there are a variety of ways in which the experience of the woman who has a uterus transplant is medicalised far more than a typical pregnancy: the conception is through implanting a fertilised ovum, the birth is through caesarean section, and an extensive series of tests are carried out on the women, along with the drug regime. In the Swedish trial, these regular tests included: 'ultrasound evaluation of the endometrium and the uterus, Doppler ultrasound to evaluate the

³³ Catsanos et al. *op. cit.* note 3, esp. pp. 68-69.

blood flow in the uterine arteries, and visual inspection of the cervix as well as cervical cultures and cervical biopsies.³⁴

To the above it might be objected that any of our desires or projects, once fulfilled, might turn out to fail to make our lives go better. As such, experiencing pregnancy is no different to any other experience we have in terms of the possibility that we may mistake its value. However, there is a case for thinking that we are more likely to get it wrong regarding the benefits of uterus transplants than for many other life experiences. That is for the reasons already sketched above: uterus transplants provide a chance at a very different variant of the experience to that most women have, in the degree of medicalisation and sensation of a transplanted uterus. Further, gestation is amongst those experiences that people do not always find valuable, particularly given its social and physical costs.

Further, even were we as likely to be mistaken about the value of a uterus transplant as any other choice we make about our lives, uterus transplants are invasive and risky procedures. That fact raises the stakes of our getting it right over whether the experience will be valuable or will make our lives go well. We need some good grounds to hold that the benefits of experiencing gestation outweigh the risks of the transplant surgery. Yet these benefits — of potentially finding the experience of pregnancy valuable — are uncertain. A justification of uterus transplants based on the value of gestation thus rests on weak foundations.

As an aside, this section allows me to say something about one last type of transplant overlooked above: namely, penis transplants. These transplants too are at an experimental stage, and these too are not for the sake of prolonging or preserving life. Again, much of a life can continue as before in the absence of the transplant, although less so than in the uterus transplant case given the extensiveness of the possible effects on one's intimate life, ranging from the added difficulties in dating to the inability to perform what for many are central sexual activities.

³⁴ For a list of some of the tests done, see L. Johannesson & S. Järholm. Uterus Transplantation: Current Progress and Future Prospects. *International Journal of Women's Health* 2016; 8: 43–51, at p. 47.

In light of the above, there is one important difference between the two cases. Men who are currently candidates for a penis transplant know what it was like to have a functioning penis and have experience of its functions. Those desiring a uterus transplants who have not borne children before do not know this. Not all experience pregnancy as a positive and a particular woman cannot know in advance whether she will.³⁵

4. The case against enabling

What follows from the discussion above? For a start, given that we should consider uterus transplants as something that some deeply desire, rather than as meeting a medical need, the case for state funding of uterus transplants is weakened. It becomes harder to slot this kind of treatment into a state funded healthcare system, insofar as the goal of these systems is to meet medical needs. Some might think that this criticism of funding uterus transplants, on the grounds that they fit poorly within the usual rationale for state funded healthcare, in fact applies to all fertility treatment. Indeed, elsewhere, I argue that raising a child is itself only one amongst various other projects that people might regard as important and valuable for their lives but not one that ought to be funded over and above these others. We fund fertility treatment in a way that we often do not fund other projects that people would wish to embark on. Yet we do not, I argue, have a right to assistance in having a child. Having a child is not a basic need, nor essential to flourishing, given the number of people who live without children and whose lives go well regardless.³⁶

Uterus transplants are in a still worse position as compared to other fertility treatments. First, in section 2 of this article I provided reasons to think that uterus transplants are

³⁵ Here I leave aside those who have gestated children before who then later want a uterus transplants — insofar as we disregard the ways in which the transplant experience is fundamentally different, these cases might be more akin to penis transplant cases where people know what they are missing. Thus far, however, the treatment has been provided for women who have not experienced pregnancy.

³⁶ McTernan, *op. cit.* note 15.

particularly hard to justify by appeal to meeting medical need: those transplants seem only to increase medical need. Second, the good that they enable is that of gestating a child, rather than having children. Even if it is possible to argue that there is something unique or special about having children, such that the state should fund attempts to do so, it is much harder to make a parallel case for the experience of gestating a child, given the last section's observations of the serious risks of pregnancy and its variable value to those who experience it.

However, there is a further issue to address beyond the question of state funding; namely, whether it is ethical even to offer uterus transplants. Some may argue that we should justify performing these transplants by appeal to personal preference alone. Surely, we ought to be delighted that medical advances have made possible an experience that some deeply desire. Even if some will not in the end find the experience valuable, and despite the fact that it comes with significant health risks, still neither the medical profession nor the rest of us should be in the business of choosing what options should be open to others. Providing that the patient consents, that finding a donor is done in some non-exploitative way and that there are few additional risks for any resulting child, some will be inclined to say no ethical issues with uterus transplants remain. Indeed, one might think, it would be wrong — paternalistic, inappropriate, or illiberal — to decide for others what is good for them, and banning uterus transplants would be an instance of this wrong. Thus, if doctors can perform this treatment, then why not let them do so — even if we should not provide it as a component of state-funded healthcare?

However, the above provides too simple a map of the ethical terrain. When faced with an individual who wishes to do something risky, that she may not end up finding valuable, we can refrain from enabling her beyond simply not funding the treatment. We may find refusal inappropriate or paternalistic, but it does not follow that we must assist or that we cannot

otherwise obstruct. There are two sets of agents who can refrain from enabling.³⁷ First, doctors could refrain from offering the treatment, or at least from suggesting it as amongst the usual treatments. Some might object that this last suggestion violates a doctor's duty to disclose relevant information when providing care. However, it is always necessary to make choices about which treatments are suggested as amongst the standard options. No doctor lists all and every single option. So, too, we have to make choices about how to order information. How information is ordered shapes how we choose owing to our cognitive biases and the way in which we process information, as Richard Thaler and Cass Sunstein have shown.³⁸ Alternatively, if one rejects the idea that doctors ought to refrain from enabling, then a state could. States can regulate the treatment, insisting on delays, counselling sessions or other extra hoops to jump through.

Such obstructions and refusals to enable would not be unique to uterus transplants. Admittedly, the examples we currently have are controversial.³⁹ Consider how abortions in the UK require two doctors to sign off on the procedure, and agree that the woman likely faces more psychological or physical harm from continuing the pregnancy than from the abortion. Alternatively, take the session(s) with a counsellor demanded by some doctors or hospitals prior to proceeding with preventative mastectomies, for women who request a caesarean section without medical indications, and for female sterilisation where the woman is young and has not

³⁷ There is a third set of agents who might also refrain from enabling: those funding or carrying out experiments to make uterus transplants an available option. Questions around what research ought to be carried out, and what funders ought to fund, lie beyond the scope of this article.

³⁸ With thanks to Carolyn McLeod for this objection from a duty to disclose. On shaping choices, see R. Thaler & C. Sunstein. 2008. *Nudge*. Yale University Press.

³⁹ With thanks to Carolyn McLeod and an anonymous referee for noting this problem with existing examples. I suspect that the reason for the controversy is the apparent views they reflect about women, around their 'natural' role or ability to make decisions. That doesn't rule out the possibility that we could do better when we re-consider what treatments really should be obstructed — or enabled.

had children where the last is agreed to at all.⁴⁰ Take, for instance, the comment on the information page for female sterilisation on the NHS: ‘Surgeons are more willing to perform sterilisation when women are over 30 years old and have had children’ — suggesting a lack of willingness in other cases.⁴¹

I do not here intend to suggest that these other instances of refusing to enable are permissible, nor to provide a complete account of the various forms that refusing to enable could take. Instead, the suggestion is that there are ethical issues we can address outside of whether we should fund a treatment or ban it: we should also consider whether some treatment ought to be enabled or obstructed. It is beyond this article’s scope to lay out precisely the forms that this refraining from enabling should take in the case of uterus transplants. Further, whether it is in the end defensible to obstruct the provision of uterus transplants will depend on precisely what form that refusal to enable ought to take. As such, this article cannot provide a complete answer as to whether and how such transplants should be obstructed. Instead, I offer two concluding thoughts in support of refraining from enabling uterus transplants.

First, uterus transplants will not always — and likely will not often — pass the bar of the dictum, ‘first, do no harm’. The potential benefits may not outweigh the potential harms, given both the health risks and the fact it is uncertain whether the experience will be, in fact, valued. Thus, uterus transplants may fail to meet the principle of beneficence - or even of non-

⁴⁰ On caesareans, see NICE. 2011. Caesarean section, clinical guideline [CG132]. Available at <https://www.nice.org.uk/guidance/cg132/chapter/1-Guidance#planned-cs>. On sterilisation, see, H. Blockwell. 2016. I Fought a Four-Year Battle with the NHS to be Sterilised at 30 - and Won. *The Telegraph*, 24 March. Available at <http://www.telegraph.co.uk/women/life/i-fought-a-four-year-battle-with-the-nhs-to-be-sterilised-at-30/>

⁴¹ At <http://www.nhs.uk/conditions/contraception-guide/pages/female-sterilisation.aspx#Who>.

maleficence.⁴² The value of gestation and so the benefit of a uterus transplant is too uncertain to justify the costs of a transplant surgery.

Suppose, however, that there are some women for whom the lack of the experience of gestation is indeed found life limiting, or blocks her ability to flourish to the extent that we might suppose that the risks of a uterus transplant are outweighed by the importance of providing the opportunity to gestate. In these cases, treatment might be consistent with abiding by the principles of beneficence and non-maleficence. However, we also then have reason to ask why a woman feels that a good life is not possible without the experience of gestation.⁴³ None of us form our beliefs and preferences in a vacuum. Indeed, they are formed in a world in which gender inequality is endemic. One of the central features around which this inequality forms itself and a place where gender stereotypes are, perhaps, the most unreconstructed, is pregnancy and motherhood.⁴⁴

My claim is not that we should disregard people's preferences whenever these may be the result of gender stereotypes. Rather, I suggest that an awareness of this background to our preferences changes the ethical character of the situation in which we find ourselves. Where background conditions that directly form preferences are unjust, as in the context of endemic

⁴² For a description of the four principles including non-maleficence and beneficence, see T. L. Beauchamp. The 'Four Principles' Approach to Health Care Ethics. *Principles of Health Care Ethics* 2007: 3-10. Catsanos et al. make a similarly negative appraisal of uterus transplants' chances of justification by considerations of beneficence, *op. cit.* note 3.

⁴³ Robertson objects that 'A preference for transplant over available surrogacy is not necessarily an internalized reflection or essentialist view of a woman's role', *op. cit.* note 10, at p. 76. That is, of course, true. The claim here is it is likely to be, where gestation matters to such an extent that the benefits would outweigh the harms.

⁴⁴ For one account of how to consider choice in the context of sexism, see Chambers, C. 2008. *Sex, Culture and Justice: The Limits of Choice*. Penn State University Press. For a discussion of motherhood and gender inequality, see Bordo, *op. cit.* note 30.

sexism, fulfilling those preferences is not obviously morally better than leaving them unfulfilled. As a result, uterus transplants might be, in one sense, more ethically akin to breast enlargement than one might have thought. That is, some women may find these procedures necessary for their lives to go well or flourish, given the unjust society in which they live, the pressures from their gender socialisation, their wider culture, and their particular intimate relationships. But it is unclear that we should celebrate this. Further, by enabling gestation, we may be only increasing the pressure on other women to follow.⁴⁵

Thus, we ought not to embrace uterus transplants. The value of gestation is too uncertain. Indeed, even where the benefit of fulfilling the desire to gestate a child does outweigh the risks of the transplant, still that gives us no reason to embrace uterus transplants. Instead, it draws attention to the kinds of pressure women are under to perform their expected gender roles, including bearing children. Uterus transplants will not diminish that pressure. In a world where such transplants become regarded as an available and reasonable treatment option, the pressure on women to perform this expected role can only be increased — this time, demanding women assume health risks far exceeding even the normal risks of pregnancy.

⁴⁵ See Lotz for a detailed description of how the ‘genetic and gestational bias’ would be reinforced by public funding of uterus transplants, leading people away from other routes to having children than using assisted reproductive technologies, *op. cit.* note 7. Here, I make a parallel claim for the sexist norms around women and pregnancy.