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This issue's Feature Article and accompanying commentaries focus on the issue of uterine transplantation (UTx). Stephen Wilkinson and Nicola Jane Williams consider, in the Feature Article, whether there is any good reason why publicly funded healthcare systems such as the UK's National Health Service (NHS) should not fund UTx in the event that it becomes sufficiently safe and efficacious. They argue that public funding for UTx should not be denied on the ground that creating more people would contribute to climate change problems, nor on the ground that infertility might be better viewed as a social problem rather than a disease. They then question whether systems like the NHS might decline to fund UTx on the ground that there exist sufficiently good, cheaper alternatives to the problem of absolute uterine factor infertility (AUI), such as adoption and surrogacy. Both of these alternative options offer the possibility of 'social parenthood' (rearing children), which the authors note is the most powerful reason for the state to fund fertility treatment. However, neither of these alternatives is quite satisfactory. Prospective parents typically do not merely want social parenthood, they also want genetic and gestational parenthood (parenting a child to whom one is genetically related, and whom one parent has gestated). Adoption offers neither genetic nor gestational parenthood, and surrogacy offers at most only genetic parenthood. Wilkinson and Williams argue that while genetic and gestational parenthood are not the strongest reasons for the state to fund fertility treatment, neither are they so insignificant that they can plausibly be regarded as mere 'frills' or 'optional extras'. The authors concede that surrogacy might become a sufficiently good alternative to safe and efficacious UTx if the law surrounding it were reformed; until then, the case for refusing state funding for UTx is weak.

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THE HARM OF INFERTILITY AND CULTURAL ATTITUDES

Wilkinson and Williams's article is accompanied by commentaries by Amel Aghrani, Jacques Balayla, and Mianna Lotz. Aghrani and Balayla are broadly in agreement with Wilkinson and Williams. Lotz focuses her argument on the role played by social and cultural attitudes in the harmfulness of infertility. As she notes, Wilkinson and Williams concede that in many societies including the UK, people—especially women—who do not become parents are discriminated against, and this likely exacerbates the extent to which infertility is viewed as a harm. In particular, our socio-cultural attitudes encourage the view that it is important to become genetic and gestational parents. Were such attitudes not widespread in society, not having children at all, or parenting children to whom one is not genetically or gestationally related, might be more widely accepted as worthwhile alternatives to the traditional model of parenthood. Wilkinson and Williams argue that, until our society's attitudes change, the preference for genetic and gestational parenthood warrants viewing safe and efficacious UTx as sufficiently superior to adoption and surrogacy as to prioritise it for public funding over those alternatives. Lotz, in response, argues that Wilkinson and Williams underestimate both the likelihood of being able to change society's emphasis on genetic and gestational parenthood, and the extent to which prioritising fertility treatments that ensure genetic and gestational parenthood risks reinforcing that emphasis. According to Lotz, the possibility of implementing societal efforts to undermine this emphasis, along with the possibility of reforming surrogacy and adoption law, weaken the case for publicly funding UTx.

In their response to the commentaries, Wilkinson and Williams welcome Lotz's suggestion of societal efforts to reduce the emphasis on genetic and gestational parenthood, but they argue that such efforts could complement, rather than substitute, publicly funding UTx. Indeed, offering publicly funded UTx alongside educational efforts is preferable since it takes seriously and responds to the real distress of infertile couples.

HETEROSEXUALITY, HOMOSEXUALITY, TRANSGENDER, AND (IN)FERTILITY

The discussion in the Feature Article and the commentaries applies to the traditional model of starting a family in the context of a heterosexual relationship. However, these arguments are not quite satisfactory when we consider issues associated with starting families in the homosexual and transgender communities. Before considering why, let me introduce a few terms that have entered the public discourse, yet which are perhaps not so ubiquitous that they can be used without confusion. The term 'cisgender' refers to people who identify with the gender they were assigned at birth. 'Transgender' refers to people who do not identify with their gender assigned at birth. Some transgender people are trans men or trans women; that is, the gender with which they identify is different to the one assigned at birth. Some, but not all, trans men and trans women seek medical help to transition physically to the sex associated with the gender with which they identify. 'Transgender' also includes people who do not identify with any one gender; these include non-binary individuals who do not identify with any one gender, and gender fluid people who identify as both male and female at different times.

Gestational parenthood: A good for whom?

Wilkinson and Williams view gestation and genetic relatedness to one's child as an important aspect of parenthood. However, whilst men, in the absence of fertility problems, can attain genetic parenthood, they cannot experience gestational parenthood. Cisgender men do not typically bemoan the fact that they are unable to gestate children. Given that so many genetic parents are not gestational parents yet do not to view their experience of parenthood as impoverished as a result, the claim that gestation is sufficiently important to justify publicly funding efforts to enable prospective parents to achieve it requires further support. It is, of course, natural to interpret the claim about the importance of gestational parenthood not as a claim

about what is important for *all* parents, but as a claim about what is important for mothers. Yet, formulated as such, this claim is far more plausible when taken to apply only to cisgender women than when taken to apply also to trans women. This is because the claim draws upon widespread intuitions about parenthood, and there are no reliable widespread intuitions about what aspects of parenthood are valuable for trans women. If we want to know what trans women value about the experience of parenthood, then we need to ask them.

These considerations have consequences for decisions about publicly funded fertility treatments. Suppose that, in the future, it becomes possible for trans women to gestate. In this case, should trans women be considered for publicly funded UTx, if this turns out to be possible, safe, and efficacious? If this does become possible but is also significantly more expensive and medically riskier for trans women than for cisgender women, to what extent should these factors be taken into account in deciding its general availability? These questions place pressure on Wilkinson and Williams's claim that, despite the fact that the socio-cultural emphasis on gestational parenthood is undesirable, it should nevertheless be taken seriously in deciding which infertility treatments should be publicly funded. This is because it is not merely the case that—as Wilkinson and Williams acknowledge—this emphasis is damaging for cisgender women; these attitudes also feed into a wider set of difficulties faced by trans women, and by transgender people in general. That these attitudes are more dangerous than Wilkinson and Williams acknowledge might tip the balance in favour of *not* using public funding to enable infertile women to achieve gestational parenthood through UTx.

Familiar ways of achieving genetic and gestational parenthood

There already exist relatively cheap, straightforward measures to enable people to attain genetic and gestational parenthood, yet these are not always publicly funded. Lesbian couples who wish to start families using donor sperm may either decide which partner is to be genetically and gestationally related to the resulting child, or they may choose for one partner to gestate a child conceived using eggs donated by the other partner, thus enabling one parent to be a gestational parent while the other is a genetic parent. Despite the fact that many lesbian couples favour the latter route to parenthood, the

medical procedures necessary to enable one partner to conceive using the other partner's donated eggs are not funded by the NHS; consequently, there exists no public funding to enable both lesbian parents to attain one or other of genetic and gestational parenthood. Similarly, gay men who wish to become genetic parents receive no public funding to assist them with finding and using a surrogate. If achieving genetic and gestational parenthood is—as Wilkinson and Williams argue—a goal at which publicly funded fertility treatments should aim, then interventions like these warrant public funding. Further, since publicly funding surrogacy would require reform of surrogacy law, and since Wilkinson and Williams remark that reform of surrogacy law may render surrogacy a sufficiently good alternative to UTx and thereby weaken the case for publicly funding the latter, more extensive public funding of familiar ways to achieve genetic and gestational parenthood could undermine the case for publicly funding UTx.

What is infertility?

Wilkinson and Williams argue that infertility is more appropriately viewed as a medical condition than as a social problem, and this forms part of their justification for the claim that there is no good reason to deny public funding for UTx. However, this medicalised conception of infertility prioritises the fertility concerns of cisgender heterosexual couples. Most same-sex couples who wish to start families do not suffer from infertility in the sense that would be diagnosed by a doctor, but they do face significant obstacles to becoming parents as a result of the fact that their way of life does not include being able to conceive a child with their partner through sexual intercourse. Transgender people face a range of fertility issues, including ones similar to those faced by same-sex couples but also—if they have transitioned—including infertility as a result of medical treatment.

By focusing on infertility as a disease, Wilkinson and Williams ignore the difficulties faced by same-sex and transgender couples who wish to become parents. Given that many such couples wish to start families, targeting publicly funded fertility treatments at those who suffer from a disease state of infertility creates a bias in favour of cisgender, heterosexual would-be parents and against transgender people and those in same-sex relationships. That it is unfair to prioritise the needs of heterosexual couples who wish to become parents over those of same-sex

couples is already recognised in aspects of the law relating to fertility treatment and its alternatives: adoption agencies may not discriminate against same-sex couples who wish to adopt, for example. As such, when allocating publicly funded fertility treatments, it is less important to target those people who are suffering from a disease, and more important to target those people who are likely to need this sort of assistance in order to start families.

GENETICS, CLINICAL ETHICS, AND HUMAN ENHANCEMENT

Elsewhere in this issue, our Current Controversy papers explore ethical issues relating to developments in genetic technologies. Michele Loi argues for increased freedom in the 'direct to consumer' genetic testing market. He bases this claim on a right to self-ownership, which he argues has not been sufficiently recognised to date. Jonathan Pugh considers the possibility of reducing mosquito-borne diseases by using genetic modification to eradicate some species of mosquito. He arrives at a cautious conclusion that urges us to investigate the likely effect of such an intervention on the ecosystem, and in the course of doing so he reflects on and rejects some common objections to it.

Also this month, we feature a collection of papers on issues in clinical ethics, drawn from across three continents. Frederic Romain and Andrew Courtwright explore how Afro-Caribbean patients' distrust in the American healthcare system impacts their decision-making about life-sustaining treatment. Rosalind J. McDougall and Lauren Notini look at what sort of cases are referred by paediatricians to clinical ethics case consultation services in Australia. Morten Magelssen, Sophia Kaushal, and Kalala Ariel Nyembwe survey a variety of Norwegian physicians in order to learn how they conceptualise their decisions not to treat patients. Karin Yolanda Jongsma, Mirjam A. G. Sprangers, and Suzanne van de Vathorst reflect on how dementia patients' advance directives are best implemented when these patients' wishes and preferences change over time.

Our Editor's Choice paper in this issue is by John Danaher. He questions the familiar opposition between conservative morality and biomedical human enhancement, and argues that there are several reasons why conservatives should welcome the development of biomedical enhancements.¹

¹I am grateful to Rebecca Bennett for providing very useful feedback.