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Who should have access to assisted gestative technologies?

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Elizabeth Chloe Romanis has written another interesting and important paper on reproductive ethics entitled Assisted Gestative Technologies.[1] In this short commentary, I continue the discussion on the question of who should have access to assisted gestative technologies. This commentary should not be understood as a critical reply but as a friendly extension of one of the paper's themes. I am not trying to solve the question of who should have access to these technologies but I put forth some groundwork for future work.

Romanis calls assisted gestative technologies (AGTs) new technologies that allow people who want to undertake gestation involving technological intervention – or to have another person or a device perform the reproductive and gestational labour on their behalf. People using AGTs might or might not use their own genetic material for reproduction. Romanis argues that these assisted gestative technologies – such as uterus transplantation or artificial wombs – collectively raise ethical, legal and social issues that are distinct for example from assisted conception.

One important question related to AGTs is who should have access to such technologies. This is crucial especially since AGTs may – or may not – be publicly funded. Romanis recognizes that in publicly funded health care, where there is competition for resources, AGTs for less urgent clinical reasons (or social reasons) are unlikely to be prioritized over other forms of healthcare. This is a very reasonable claim, partly because when distributing scarce resources in healthcare, it is often thought that we should prioritize saving the lives of existing people rather than creating more lives by bringing new people into existence. Since assisted gestative technologies create new lives rather than save existing lives perhaps AGTs should not be publicly funded in the first place – even though having and raising children is important for many?

If that is the case, then a claim can be made that AGTs will only be available to well-off people who can afford them. This could have huge ramifications for justice because, as Romanis rightly notes, it could increase disparities that already exist in pregnancy outcomes. Richer people would simply have a choice about how much of the physical and psychological

burden of reproductive labour to bear while people in disadvantageous situations would not have the same choice.

An important issue here is whether we think the increase of such disparities is always and necessarily unjust. Romanis seems to think so, but it is not obvious that she is right. If we use an analogy, it might not always be unjust if the rich got richer while the poor remain poor. At least some are inclined to think that disparities in wealth are not unjust as long as the disadvantaged people have enough wealth to have a decent living. Similarly, if the 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.[i]

When it comes to societal justice, one advantage of AGTs is that with such technologies women could possibly have children at older age. This change should not be undermined. Postmenopausal women are treated very differently to men of similar ages in the context of reproduction[2] so if women could have children at later stages of their lives as well, this would be a desirable development because it would increase the equality between the two sexes. From this perspective, it makes sense to say that older women especially should have access to AGTs.

Another important feature of AGTs is that they could enable transgender women to have children. For instance, by combining uterus transplantation with artificial gametes it could become possible for transwomen to have children genetically related to them – and to gestate them. If transwomen can have access to AGTs it could be seen as an improvement, justice-wise, and their access to AGTs could solve some practical problems regarding trans people's opportunities for reproduction.[3]

A further possibility of AGTs is that they could potentially be used to create better lives than without them. If gestation in an artificial womb outside the female body would benefit the health and wellbeing of the fetus and the future child, it could arguably be good to have AGTs available, because as some have argued, we should create better rather than worse lives.[4-5] Gestation outside the female body, for instance, might enable fetuses that could become victims of maternal alcohol or drug abuse during pregnancy to have a safe and healthy place for fetal development. AGT, and especially ectogestation could therefore be offered to those women who have trouble abstaining from alcohol or recreational drug use during pregnancy because of an addiction.

People keep wanting to have children. AGTs are thus a welcome development. However, a society that wants to endorse people's desire to have children should offer ethically justified and non-discriminatory answers to the question of who should have access to these technologies.

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[i] I am not saying that there currently are not severe health disparities in pregnancy outcomes.

[1] Romanis E. Assisted gestative technologies. *J Med Ethics* 2022;xx:xxx-xxx. doi:10.1136/medethics-2021-107769.

[2] Smajdor A. The ethics of egg donation in the over fifties. *Menopause Int* 2008;14(4):173-177.

[3] Räsänen J, Smajdor A. The complex case of Ellie Anderson. *J Med Ethics* 2022;48(4):217-221.

[4] Savulescu J. Procreative beneficence: why we should select the best children. *Bioethics* 2001;15(5-6):413-426.

[5] Häyry M. If you must make babies, then at least make the best babies you can? *Hum Fertil* 2004;7(2):105-112