

# Borrowed Wombs: On Uterus Transplants and the “Right to Experience Pregnancy”

I. Glenn Cohen<sup>†</sup>

## I. INTRODUCTION

Taylor Siler looks ready for anything. In one photo she is strikingly cradled by her husband Clint, whose size envelops her and makes her look small, but anything but fragile.<sup>1</sup> Wearing her hair a bit like Reese Witherspoon, her eyes are what really grab your attention. The slight darkness under them testify to a woman who has seen it all, and as a nurse and the mother of two young boys she probably has.<sup>2</sup> But she has also seen something that no woman in America had seen before her: giving another woman her uterus and seeing life flourish inside of it.<sup>3</sup>

One in five hundred women suffer from Uterine Factor Infertility—women who were born without a uterus, lost their uterus, or their uterus no longer functions.<sup>4</sup> Historically, this condition meant that some women had no chance to ever have a pregnancy.<sup>5</sup> But that reality changed in December 2017 when it was announced that the first birth from a uterus transplant in America occurred at Baylor University

---

<sup>†</sup> Deputy Dean and James A. Attwood and Leslie Williams Professor of Law, Harvard Law School. Faculty Director, Petrie-Flom Center for Health Law Policy, Biotechnology & Bioethics. I thank Vrushab Gowda and Jessica Cianci for excellent research assistance pertinent to this article. I thank Alex Chen, participants at the University of Miami’s Legal Theory Workshop, and participants in the *Forum*’s symposium for their comments.

<sup>1</sup> Sarah Sarder, *Baylor’s Uterus Transplant Trial Ushers in the Future of Fertility Amid Concerns Over Ethics, Cost*, DALLAS MORNING NEWS (Jan. 12, 2019), <https://www.dallasnews.com/news/2019/01/12/baylors-uterus-transplant-trial-ushers-in-the-future-of-fertility-amid-concerns-over-ethics-cost/> [<https://perma.cc/W5W9-CM4A>].

<sup>2</sup> *Id.*

<sup>3</sup> Alexandra Sifferlin, *Exclusive: First U.S. Baby Born After a Uterus Transplant*, TIME (Dec. 1, 2017), <https://time.com/5044565/exclusive-first-u-s-baby-born-after-a-uterus-transplant/> [<https://perma.cc/GSJ3-RAWZ>].

<sup>4</sup> Jacques Milliez, *FIGO Committee Report: Uterine Transplantation*, 106 INT’L J. GYNECOLOGY & OBSTETRICS 270, 270 (2008); Pernilla Dahm-Kahler et al., *Human Uterus Transplantation in Focus*, 117 BRIT. MED. BULL. 69 (2016).

<sup>5</sup> Jennifer Whitlock, *Can You Get Pregnant After a Hysterectomy?*, VERYWELL HEALTH (Oct. 7, 2021), <https://www.verywellhealth.com/is-pregnancy-possible-after-a-hysterectomy-3156844> [<https://perma.cc/MAJ9-XKRM>].

Medical Center in Dallas, Texas (there had been prior births in Sweden).<sup>6</sup>

Siler was thirty-six at the time she donated her uterus.<sup>7</sup> She had a deep desire to help other women experience parenthood and had considered becoming a gestational surrogate (carrying the child of another woman), but she was already the mother of two young boys and worried that this might be too disruptive.<sup>8</sup> When she saw an ad from Baylor recruiting possible donors, she couldn't believe we had come so far with the technology.<sup>9</sup> She knew she wanted to help: "I have family members who struggled to have babies, and it's not fair," said Siler, "I just think that if we can give more people that option, that's an awesome thing."<sup>10</sup> Siler did not know the woman who would carry her womb—but they exchanged letters the day of the surgery, and Siler was given another letter to let her know the recipient was pregnant: "I've just been crying and getting teary thinking about it. . . . I think about her every day and I probably will for the rest of my life."<sup>11</sup>

While in Siler's case the uterus came from a living stranger, in other reported cases the uterus has been donated by a family member (such as a mother or sister).<sup>12</sup> In still other cases, the uterus has come from a cadaver, as discussed below—literally life brought into being and nurtured from death.<sup>13</sup> As I discuss below, it may also be possible in the future to transplant uteruses on to the male pelvis, allowing trans women assigned male at birth or cisgender men to experience pregnancy, though the science is not yet solid.<sup>14</sup>

As strange as it sounds, would it better to get needed uteruses from the dead rather than the living? Should uterus donors be paid? For deceased donors, is a general authorization (as with kidney donors) good enough, or should there be a requirement that authorization be given

---

<sup>6</sup> Sarder, *supra* note 1.

<sup>7</sup> Sifferlin, *supra* note 3.

<sup>8</sup> Sarder, *supra* note 1.

<sup>9</sup> Sarder, *supra* note 1.

<sup>10</sup> Sifferlin, *supra* note 3.

<sup>11</sup> Sifferlin, *supra* note 3.

<sup>12</sup> Sarah Klein, *A Baby Was Born for the First Time from a Uterus Transplanted from a Dead Donor*, HEALTH (Dec. 5, 2018), <https://sports.yahoo.com/baby-born-first-time-uterus-174510866.html> [<https://perma.cc/K9QW-2SK5>]; *First Baby Born from a Uterus Transplant in the U.S. Delivered in Texas*, CBS NEWS (Dec. 4, 2017), <https://www.cbsnews.com/news/first-baby-born-from-a-uterus-transplant-in-the-u-s-delivered-in-texas/?ref=hpver.com> [<https://perma.cc/J64E-XUD8>].

<sup>13</sup> Klein, *supra* note 12.

<sup>14</sup> John A. Robertson, *Is There a Right to Gestate?*, 4 J. LAW & BIOSCIS. 630, 634–636 (2017); Amel Alghrani, *Uterus Transplantation: Does Procreative Liberty Encompass a Right to Gestate?*, 3 J. LAW & BIOSCIS. 636, 638–41 (2016); Robert Sparrow, *Is it "Every Man's Right to Have Babies if He Wants Them"?: Male Pregnancy and the Limits of Reproductive Liberty*, 18 KENNEDY INST. ETHICS J. 275 (2008).

to this specific organ to be donated? Do private or public payers have an obligation to pay for these transplants as they would kidney or liver transplants, or should we think about them more like infertility treatments or even plastic surgery (to use a purposefully provocative comparison)? How, if at all, does the answer differ if the ultimate transplant recipient is a man or trans?

This article does not purport to resolve all or even most of those questions. Its narrower focus is to compare uterus transplants to other ways to achieve parenthood, especially surrogacy and adoption, to evaluate what kinds of rights claims those who seek to use uterus transplants are making against the state and offer some tentative thoughts on how those claims should be treated. Among other things, I consider the way more recent reproductive technology innovations subtly shift the rights claims at issue—from rights to “mimick” what is possible through non-assisted reproduction to right to “extend” such reproduction. I then discuss two remaining family law issues with living uterus donors, one related to intra-familial donation and the other to uterus donor anonymity. Before addressing these questions, I discuss why uterus transplants are sought and how they work.

## II. WHY UTERUS TRANSPLANTS ARE SOUGHT BY WOMEN AND HOW THEY WORK

Uterus transplants are sought, like many reproductive technologies, both because of medical issues faced during pregnancy and a particular set of reproductive goals.<sup>15</sup> I will start by describing the medical issues relevant for uterus transplants and the two main ways in which uteruses for transplants have been provided—from living and deceased uterine donors.<sup>16</sup> I will turn to the reproductive goals in greater depth a bit later as a way to understand the rights claim made by those seeking such transplants and how we should judge it.

The medical issue giving rise to most women’s<sup>17</sup> desire to have a uterus transplant is uterine factor infertility.<sup>18</sup> This occurs in women who were born without a uterus, lost their uterus, or whose uterus no

---

<sup>15</sup> Ariel Lefkowitz et al., *The Montreal Criteria for the Ethical Feasibility of Uterine Transplantation*, 25 *TRANSPLANT INT’L* 439, 440 (2012).

<sup>16</sup> Throughout this article I will use the term “donor,” which tracks how the uterus transplants have occurred thus far. In principle, though, as with sperm and egg we could have payment, in which case “donor” may be a bit of a misnomer such that “provider” would be better. For present purposes, though, I will largely stick with the more common “donor.”

<sup>17</sup> For simplicity’s sake I will use “woman/women” to refer to cisgender women and “man/men” to refer to cisgender men. I will specify when I mean something other than that (i.e., trans men and trans women). This is purely for readability.

<sup>18</sup> Lefkowitz et al., *supra* note 15, at 440. I will return towards the end of this article to the potential future claims of trans women or cisgender men in the future for uterus transplants.

longer functions.<sup>19</sup> In the middle category, hysterectomies are performed in large numbers across the world and were an insurmountable obstacle to pregnancy until uterus transplants came on the scene.<sup>20</sup> There were 633,000 hysterectomies performed in the United States alone in 2000.<sup>21</sup> Of those 40% were performed on women under the age of forty-four years, the main population for which pregnancy (in some instances through IVF or other Assisted Reproductive Technologies) is a life goal.<sup>22</sup> The primary medical reasons for these hysterectomies included fibroids, cervical cancer, and emergency postpartum hysterectomy—which itself is associated with caesarian births, which have been on the increase.<sup>23</sup> After a hysterectomy, absent this new technology, it is simply impossible to achieve a successful pregnancy.<sup>24</sup>

#### A. The Science of Uterus Transplants with Living Uterus Providers

Let's start with a brief overview of how uterus transplants work when the uterus comes from a living donor. Transplanting a uterus is a major undertaking. A potential uterus donor will be extensively screened through a months-long process involving lab work, radiology tests, psychological evaluations, and extensive paperwork, all of which Siler had to complete.<sup>25</sup> Once the donor and recipient have been cleared, the underlying surgery and immunosuppression regimen is quite intense.<sup>26</sup> The woman receiving the uterus will go on immunosuppressive drugs to prevent her body rejecting the uterus and undergo an extensive surgery to transplant the donor uterus into her pelvis.<sup>27</sup> After a few months her menstrual cycle will resume and within twelve months of transplant the uterus will hopefully be fully healed and able to accept embryos for implantation.<sup>28</sup> Following a successful pregnancy or pregnancies, the recipient of the uterus will undergo a Caesarean section delivery and then a hysterectomy to remove the donor uterus.<sup>29</sup> Once it is removed, she can stop taking the immunosuppressive drugs, which is

---

<sup>19</sup> Milliez, *supra* note 4, at 270; Dahm-Kahler et al., *supra* note 4, at 69.

<sup>20</sup> Dahm-Kahler et al., *supra* note 4, at 70; Whitlock, *supra* note 5.

<sup>21</sup> Kate M. Brett & Jenny A. Higgins, *Hysterectomy Prevalence by Hispanic Ethnicity: Evidence from a National Survey*, 93 AM. J. PUB. HEALTH 307, 307 (2003).

<sup>22</sup> Dahm-Kahler et al., *supra* note 4, at 70; Brett & Higgins, *supra* note 21, at 307.

<sup>23</sup> Dahm-Kahler et al., *supra* note 4, at 70.

<sup>24</sup> Whitlock, *supra* note 5.

<sup>25</sup> CBS NEWS, *supra* note 12; Omer Ozkan, et al., *Preliminary Results of the First Human Uterus Transplantation from a Multiorgan Donor*, 99 FERTILITY & STERILITY 470, 471–72 (2013).

<sup>26</sup> CBS NEWS, *supra* note 12; Ozkan et al., *supra* note 25, at 472–73.

<sup>27</sup> Ozkan et al., *supra* note 25, at 472–73.

<sup>28</sup> John A. Robertson, *Other Women's Wombs: Uterus Transplants and Gestational Surrogacy*, 3 J.L. & BIOSCIS. 68, 74 (2016); Dahm-Kahler et al., *supra* note 4, at 75.

<sup>29</sup> Lefkowitz et al., *supra* note 15, at 442.

safer for her long-term health.<sup>30</sup> The uterus is then discarded, not transplanted back to the donor, which it means the donor will no longer be able to achieve pregnancy.<sup>31</sup>

With that overview as background, let us now discuss some of the medical risks involved in greater detail. Uterus transplantation involves prolonged operations for both donor and recipient. For the recipient it is far more than just a simple or even radical hysterectomy.<sup>32</sup> The procedure requires extensive dissection to avoid damaging the surrounding anatomical structures of the donor such as the ureters, the uterine and iliac arteries, and other major branches of the aorta.<sup>33</sup>

Once the uterus is removed from the donor, a transplant surgery is undertaken to graft it on to the pelvis of the recipient, but the nerves connected to the uterus are not reattached.<sup>34</sup> The result is that the recipient-mother will not feel the movement of the fetus nor the contractions during pregnancy, and monitoring will be required to assess the fetus' activity and determine the point of labor.<sup>35</sup> There have not yet been enough successful transplants to give a clear picture as to what extent (if any) this phenomenon results in maternal-fetal estrangement and what it does to the woman's experience of pregnancy or connection to her child once it is born.<sup>36</sup>

For the recipient woman, the surgery also carries several risks. The vascular surgery required to perfuse the grafted uterus may yield several postoperative complications, including microvascular thrombosis, kinked vessels, or infection, all of which have been documented in the first two transplants conducted, which occurred in Saudi Arabia and Turkey.<sup>37</sup> There are also associated risks of fetal distress and preeclampsia—risk factors for subsequent preterm birth—in the pregnancies that result.<sup>38</sup>

<sup>30</sup> Dahm-Kahler et al., *supra* note 4, at 70; Bethany Bruno & Kavita Shah Arora, *Uterus Transplantation: The Ethics of Using Deceased Versus Living Donors*, 18 AM. J. BIOETHICS 6, 7 (2018).

<sup>31</sup> Bruno & Arora, *supra* note 30, at 12.

<sup>32</sup> *Id.* at 9.

<sup>33</sup> Robertson, *supra* note 28, at 72; Mats Bränström, *Uterus Transplantation*, 99 FERTILITY & STERILITY 348, 348 (2013); Dahm-Kahler et al., *supra* note 4, at 74.

<sup>34</sup> Robertson, *supra* note 28, at 70.

<sup>35</sup> Lefkowitz et al., *supra* note 15, at 442.

<sup>36</sup> Robertson, *supra* note 28, at 74.

<sup>37</sup> Judith Daar & Sigal Klipstein, *Refocusing the Ethical Choices in Womb Transplantation*, 3 J. L. & BIOSCIS. 383, 384 (2016); Valarie K. Blake, *Ovaries, Testicles, and Uteruses, Oh My! Regulating Reproductive Tissue Transplants*, 19 WM. & MARY J. WOMEN & L. 353, 359–60 (2013); Dahm-Kahler et al., *supra* note 4, at 74.

<sup>38</sup> Daar & Klipstein, *supra* note 37, at 385; Pentti K. Heinonen et al., *Livebirth After Uterus Transplantation*, 385 LANCET 2352, 2352 (2015).

As with other tissue recipients, uterine transplant recipients must receive long-term immunosuppressive drugs to prevent immunological rejection.<sup>39</sup> Such rejection may be particularly hard to detect in the acute phase because the uterus cannot be readily visualized, unlike other vascularized composite allografts, due to the lack of innervation.<sup>40</sup> Moreover, the timing of rejection is critical. When there is solid-organ rejection, the usual response is removal of the graft.<sup>41</sup> That will be emotionally difficult for the recipient if it occurs *before* she can begin a pregnancy, but should it occur *during* pregnancy it would require the removal of the uterus together with the developing fetus it contains or else both the mother and the fetus are likely to die.<sup>42</sup> While the standard immunosuppressive drugs used in these transplants do not cause cancer, they do cross the blood-placenta barrier and have been associated with prematurity and low birth weight.<sup>43</sup> They also pose risks during the pregnancy including preeclampsia, hypertension, new-onset diabetes, increased incidence of infection, and in the chronic term, renal damage.<sup>44</sup>

Apart from all the transplant elements, to achieve pregnancy the recipient will typically rely on In Vitro Fertilization (IVF).<sup>45</sup> That in turn requires ovarian hyperstimulation, egg retrieval, fertilization, and possibly embryo storage if multiple embryos are fertilized, all of which carry some risks and costs.<sup>46</sup> A successfully fertilized embryo can be transferred one year after the uterus transplant.<sup>47</sup>

If a pregnancy is successful, the fetus must be delivered by a Caesarean section, because a vaginal birth is not possible without innervation.<sup>48</sup> Once the desired number of pregnancies has occurred, the uterus can be surgically removed allowing the cessation of the immunosuppressive drug.<sup>49</sup>

## B. Life from Death: Transplants from Deceased Uterus Providers

Uterus transplants may also come from deceased donors. In such cases, the medical risks for the recipient are largely the same but the

---

<sup>39</sup> Ozkan et al., *supra* note 25, at 472.

<sup>40</sup> Robertson, *supra* note 28, at 74. *Infra* note 61 (defining vascularized composite allograft).

<sup>41</sup> Daar & Klipstein, *supra* note 37, at 385–386.

<sup>42</sup> *Id.*

<sup>43</sup> *Id.* at 385.

<sup>44</sup> *Id.* at 384–385.

<sup>45</sup> Blake, *supra* note 37, at 359; Ozkan et al., *supra* note 25, at 474.

<sup>46</sup> Robertson, *supra* note 28, at 74.

<sup>47</sup> Robertson, *supra* note 28, at 74; Blake, *supra* note 37, at 359.

<sup>48</sup> Lefkowitz et al., *supra* note 15, at 442; Robertson, *supra* note 28, at 74.

<sup>49</sup> Bruno & Arora, *supra* note 30, at 7.

donor is beyond all risks and benefits, being dead. There are several advantages to using a dead donor. The consequence of “injury” (if that term is even appropriate given that the donor is dead) to the structures surrounding the uterus is no longer nearly as significant and this enables faster and more efficient harvesting of the uterus.<sup>50</sup> These benefits of deceased donation must be weighed against the benefits afforded by live donor transplantation, which include more finely focused surgical planning and the ability to obtain an extensive history from the patient, together with a shorter ischemic time (and thus a lower risk of post-transplant immune rejection), although there are still some open empirical questions on the latter.<sup>51</sup>

In theory, the supply of possible deceased uterus donors is much greater and their recruitment potentially easier in the sense that a significant portion of the current female deceased donor pool might be potential uterus donors.<sup>52</sup> I say “in theory” because there has been some dispute in the literature about how uterus (as well as other reproductive tissue) donations should be treated for the purposes of general versus specific authorization while alive, in comparison to kidney donations, for example.<sup>53</sup>

With this background we are now ready to discuss how the law has thus far dealt with uterus transplants.

### C. The Law Applicable to Uterus Transplants

Uterus transplants are governed by the same background principles of medical malpractice and health law that govern every other form of transplant. Most importantly, the laws pertinent to organ donation appear to treat uterus transplants the same as they would more common forms of organ transplant, like kidney transplants.

First, let us discuss deceased donors. Since 1968, the National Conference of Commissioners on Uniform State Laws has promulgated the Uniform Anatomical Gift Act (UAGA) to promote uniformity among states and simplify the process of obtaining organs from deceased persons.<sup>54</sup> To just briefly summarize a fairly detailed scheme, the most recent version of the UAGA:

---

<sup>50</sup> Dahm-Kahler et al., *supra* note 4, at 75.

<sup>51</sup> Bränström, *supra* note 33, at 348; Dahm-Kahler et al., *supra* note 4, at 75.

<sup>52</sup> Michelle J. Bayefsky & Benjamin E. Berkman, *The Ethics of Allocating Uterine Transplants*, 25 CAMBRIDGE Q. HEALTHCARE ETHICS 350, 352–353 (2016).

<sup>53</sup> Bruno & Arora, *supra* note 30, at 8–11; Blake, *supra* note 37, at 370.

<sup>54</sup> NATIONAL ACADEMIES OF SCIENCES, ENGINEERING, AND MEDICINE, OPPORTUNITIES FOR ORGAN DONOR INTERVENTION RESEARCH: SAVING LIVES BY IMPROVING THE QUALITY AND QUANTITY OF ORGANS FOR TRANSPLANTATION 73–75 (James F. Childress et al., eds., 2017). Every state has adopted a version of this act, either the original version or revised versions promulgated in 1987 or 2006, with (as of June 2017) forty-six states, the District of Columbia, and the U.S.

provides that individuals aged 18 years or older may choose or refuse to make an anatomical gift. The law also permits anyone applying for a driver's license to offer authorization, allows for symbolic or oral communication of donative intent, disallows the possibility of authorization for the removal of body parts for transplantation by a medical examiner's office without the decedent's or the surrogate's authorization, and lets individuals other than the decedent make an anatomical gift unless the decedent expressly refused donation during his or her lifetime. The gift may be of the entire body or parts of the body, and the donor determines whether the gift will be used for education, teaching, research, or transplantation. The UAGA establishes the donation as property that can be transmitted to others by authorization of the decedent before death, by will, by next of kin or surrogate after death, or, in their absence, by the state.<sup>55</sup>

Among other provisions, the act also establishes who can donate on behalf of the decedent, assuming the decedent has not made a recognized refusal, and a priority order of family members in making the decision.<sup>56</sup> Although the UAGA does not specifically discuss reproductive organs like a uterus, its definition of an organ is broad enough that by failing to explicitly exclude a uterus it can be read to treat it just like the deceased donation of any other organ.<sup>57</sup>

When it comes to *living* uterus donors, it is not the UAGA but the National Organ Transplant Act of 1984 (NOTA) that is the most relevant law.<sup>58</sup> NOTA, among other things, makes it “unlawful for any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce,” with a codified narrow exception for paired kidney exchanges.<sup>59</sup> It lists several examples of what it defines as a “human organ” but also explicitly indicates that the prohibition includes “any other human organ (or any subpart thereof, including that derived from a fetus) specified by the Secretary of Health and Human Services by regulation.”<sup>60</sup> By regulation, the Secretary has added

---

Virgin Islands having adopted the most recent version. Bruno & Arora, *supra* note 30, at 8–11; Blake, *supra* note 37, at 370.

<sup>55</sup> Childress, *supra* note 54, at 75.

<sup>56</sup> *Id.* at 73.

<sup>57</sup> Blake, *supra* note 37, at 373.

<sup>58</sup> 42 U.S.C. § 273.

<sup>59</sup> *Id.* § 274e(a).

<sup>60</sup> *Id.* § 274e(c).



“vascularized composite allograft” (VCA) to the list of organs, and that definition seems to include uterus transplants.<sup>61</sup>

With this background, we are ready to tackle the legal and ethical issues raised by uterus transplants.

### III. UTERUS TRANSPLANTS AND REPRODUCTIVE RIGHTS CLAIMS

In this Part, I want to situate the claims of those who seek to use uterus transplants in the various kinds of reproductive rights claims an individual might make. In particular, I argue that in regimes where surrogacy is possible, uterus transplants introduce a new kind of reproductive rights claims—the *right to experience pregnancy*, separate from claims regarding genetic parenthood.<sup>62</sup> To get there, though, I work my way through some more general thinking about different kinds of reproductive rights claims.

#### A. Mimics, Extenders and the New Wave of Reproductive Technologies

We are currently facing a new revolutionary wave of reproductive technologies. I characterize the first wave as encompassing everything from Artificial Insemination to In Vitro Fertilization (IVF), Surrogacy, and Preimplantation Genetic Diagnosis (PGD). I think of this new wave as composed of technologies that are either currently being used (uterus

---

<sup>61</sup> The regulation reads, in relevant part:

Vascularized composite allograft means a body part:

- (1) That is vascularized and requires blood flow by surgical connection of blood vessels to function after transplantation;
- (2) Containing multiple tissue types;
- (3) Recovered from a human donor as an anatomical/structural unit;
- (4) Transplanted into a human recipient as an anatomical/structural unit;
- (5) Minimally manipulated (i.e., processing that does not alter the original relevant characteristics of the organ relating to the organ’s utility for reconstruction, repair, or replacement);
- (6) For homologous use (the replacement or supplementation of a recipient’s organ with an organ that performs the same basic function or functions in the recipient as in the donor);
- (7) Not combined with another article such as a device;
- (8) Susceptible to ischemia and, therefore, only stored temporarily and not cryopreserved; and
- (9) Susceptible to allograft rejection, generally requiring immunosuppression that may increase infectious disease risk to the recipient.

42 C.F.R. § 121.2. *See also* KAITLIN SWANNER & KRISSEY LAURIE, BRIEFING TO THE OPTN BOARD OF DIRECTORS ON: ESTABLISH MEMBERSHIP REQUIREMENTS FOR UTERUS TRANSPLANT PROGRAMS (treating uterus transplants as VCAs and thus falling within the ambit of NOTA).

<sup>62</sup> In this respect I differ from my late colleague John Robertson, who in a posthumously published response paper argued that “procreative liberty should include a right to gestate when gestation is essential to or part of a person’s way to have genetic offspring for rearing,” but was skeptical that the right could attach when it was not. Robertson, *supra* note 14, at 631. By focusing on the right to experience pregnancy as such, my view would make more room for rights claims to uterus transplantation.

transplants, egg freezing,<sup>63</sup> and mitochondrial replacement techniques<sup>64</sup>), not yet used in humans but showing some promise in animals and embryological work (In Vitro Gametogenesis<sup>65</sup>), or in the case of human heritable gene editing, having had one widely condemned human usage to date.<sup>66</sup>

As disruptive as the first wave was to legal and social constructs of parenthood and family, it pales in comparison to the potential impact of this second wave. The first wave focused on restoring or enabling the kind of reproductive options available to fertile, heterosexual, couples, a focus on what I call “mimicking.” It largely expanded access to that which could be achieved by traditional reproduction. The social, legal, and ethical dilemmas it raised were thus inherently procrustean—an attempt to fit these new technologies into traditional conceptions of family and parenting, which required bending but not breaking of old paradigms.

By contrast, the new wave of reproductive technologies is more focused on “extending” reproduction beyond what is possible through sexual reproduction, rather than “mimicking” what has come before. In so doing, it has already raised some profound questions such as: Is it permissible to require male-only sex selection as a prerequisite for using a technology to prevent mitochondrial alteration transfer?<sup>67</sup> Is it morally permissible to create thousands of embryos from adult cells in search of the “best” one and discard the rest (a kind of embryo farming)?<sup>68</sup> But the question I want to focus on here is a more general normative one: Are “extension” uses of reproductive technologies normatively and/or legally different from “mimicking” uses, or is this a distinction without a difference?

To see why this distinction has interesting legal and ethical implications, let me show how it complicates some prior distinctions theorists

---

<sup>63</sup> *E.g.*, JUDITH DAAR ET AL., REPRODUCTIVE TECHNOLOGIES AND THE LAW 632–635 (3d ed. 2022); John A. Robertson, *Egg Freezing and Egg Banking: Empowerment and Alienation in Assisted Reproduction*, 1 J.L. & BIOSCIS. 113 (2014).

<sup>64</sup> *E.g.*, DAAR ET AL., *supra* note 63, at 941–989; I. Glenn Cohen et al., *The Regulation of Mitochondrial Replacement Techniques Around the World*, 21 ANN. REV. GENOMICS & HUM. GENETICS 565 (2020).

<sup>65</sup> *E.g.*, DAAR ET AL., *supra* note 63, at 1049–1100; HENRY T. GREELY, THE END OF SEX AND THE FUTURE OF HUMAN REPRODUCTION (2016).

<sup>66</sup> *E.g.*, DAAR ET AL., *supra* note 63, at 990–1044; NAT’L ACADS. OF SCIS., ENG’G, AND MED., HUMAN GENOME EDITING: SCIENCE, ETHICS, AND GOVERNANCE (2017).

<sup>67</sup> I. Glenn Cohen & Eli Y. Adashi, *Mitochondrial Replacement Therapy: The IOM Report and Its Aftermath*, 17 NATURE REVS. GENETICS 189, 190 (2016). There have also been other technologies since the first wave that have threatened this disruption—cloning of humans, though it never became a reality, comes to mind. However, what is striking about the new wave is how each of its technologies pushes much further away from mimicking.

<sup>68</sup> I. Glenn Cohen et al., *Disruptive Reproductive Technologies*, 9 SCI. TRANSLATIONAL MED. 2959 (2017); *see generally* GREELY, *supra* note 65.

have drawn in the area. Let's start with the categorization of users of reproductive technologies that I associate with Lisa Ikemoto among others: distinctions between fertile, medically infertile, and "dysfertile" individuals.<sup>69</sup> Ikemoto defines the dysfertile as "those rendered childless by their failure to fit the definition of infertile, because they are unmarried and/or lesbian or gay."<sup>70</sup> I would expand the category slightly to include all individuals who have no medical limitation to their fertility but instead face an obstacle towards their reproduction. Some might prefer "socially infertile" to refer to this broader population, but I will continue to use "dysfertile."

Applying my distinction between mimics and extenders, we can now see that there are claims by the dysfertile for a right to mimic versus a right to extend. Indeed, perhaps less intuitively, the *same person* could be making one kind of claim as to one reproductive technology and a different claim as to a different reproductive technology. Take the example of a single man. If he wants to fertilize an egg provided by a woman (an egg provider or "donor") and implant it in a gestational surrogate, he is asserting a mimic claim. He seeks to achieve that which he could have achieved but for his dysfertility (in this case, the fact that he has no female reproductive partner).<sup>71</sup> If the same single man sought to also fertilize an egg provided by a woman (an egg provider or "donor") but then use a uterus transplant to carry the fetus to term himself, he would be making an extension claim. He would achieve reproductively what his dysfertility impedes him from doing, but to satisfy that goal he would also achieve something that noninfertile and nondysfertile men *cannot* achieve: pregnancy.

Should the two claims be on equal footing? Normatively? Legally? To prefigure a point I will discuss below, in countries that permit surrogacy, does the availability of the mimicry option diminish the man's claim to the extension option? That is, could a society say, "We will satisfy your claim only to the point of mimicry. When mimicry is not possible, and extension is the only option, then we will treat your claim as weighty. But when you have chosen to extend *rather* than mimic, we have no obligation to satisfy that claim"?

In my prior work I have tried to unbundle the right to or not to procreate as consisting of:

---

<sup>69</sup> Lisa C. Ikemoto, *The In/Fertile, the Too Fertile, and the Dysfertile*, 47 HASTINGS L.J. 1007, 1033 (1996).

<sup>70</sup> *Id.*

<sup>71</sup> His desire to mimic could be achieved through so-called "traditional" surrogacy where the surrogate both carries the child and her own egg is fertilized via artificial insemination with his sperm, and in some ways, this might even be more clearly mimicking, but for the sake of parallelism with the extender example that comes next, I focus on IVF and surrogacy.

A right not to be a gestational parent	A right to be a gestational parent
A right not to be a genetic parent	A right to be a genetic parent
A right not to be a legal parent	A right to be a legal parent <sup>72</sup>

But importantly for our present purposes *each* of these rights could be understood, to use Isaiah Berlin's famous (though perhaps sometimes reductive) framing, as either a negative or positive liberty rights claim.<sup>73</sup> The negative liberty version is a noninterference right—the State should not prevent me from using this option by, for example, making it illegal. The positive liberty version is instead that the State has an obligation to enable me to use this option by, perhaps, paying for it by including it in a publicly funded health care bundle (especially in universal health care systems) or by requiring private insurers to cover it.

This positive-negative liberty distinction can also be combined with the mimic-extender distinction. That is, a political theory analysis might reveal that the line matters for one side but not the other of that first distinction; we might conclude that our hypothetical single man has a *negative* liberty noninterference right to mimic *or* extend (to use egg provision with IVF and surrogacy *or* to use egg provision and IVF with a uterus transplant), but has a *positive* rights claim for state support *only* to mimic and not to extend. That is, a state should not *prohibit* uterus transplants for single men, but it is not obligated to *pay* for them.<sup>74</sup>

What is the attraction of the mimic-extension line? For better or worse, I think it mirrors much of the attraction of drawing a distinction between treatment and enhancement more generally in bioethics; those defending such a line claim the state has an obligation to permit (and perhaps fund) medical interventions that seek to restore individuals into the range of species-typical normal functioning (treatment), whereas there is no obligation to permit (and certainly no obligation to fund) that which allows individuals to exceed that range (enhancement).<sup>75</sup> This is connected, for a Rawlsian like Norman Daniels (one of the most prominent defenders of this line), to a conception of health and why the state has a role in promoting it, namely, as a way of furthering

---

<sup>72</sup> I. Glenn Cohen, *The Constitution and the Rights Not to Procreate*, 60 STAN. L. REV. 1135, 1140 (2008).

<sup>73</sup> *Id.* at 1140–41.

<sup>74</sup> Of course, in the U.S. at least, governments and even insurers do not pay for much of the reproductive technology needs of citizens, and often draw lines between LGBTQI and heterosexual couples in what they cover. See DAAR ET AL., *supra* note 63, at 299–325.

<sup>75</sup> One of the most prominent defenses of this line comes from Norman Daniels. See, e.g., NORMAN DANIELS, *JUST HEALTH: MEETING HEALTH NEEDS FAIRLY* 149 (2008).

the larger goal of ensuring that all have access to the “normal opportunity range” that is “the array of life plans reasonable persons are likely to develop for themselves.”<sup>76</sup> Extenders are seeking things that are clearly species *atypical*, and the case of men using uterus transplants is a good illustration of that. Of course, the fact that this line is familiar and frequently invoked is not to say it is sound.<sup>77</sup> I will return to the application of these distinctions to uterus transplants below, including by showing that, especially as applied to trans women, it may not be as easy to apply a guide as one would think.

There is also something attractive about the mimic-extender line in terms of *constitutional* claims for those who harbor more traditionalist conceptions of what the United States Federal Constitution protects.<sup>78</sup> In particular, for those for whom in the words of *Washington v. Glucksberg*,<sup>79</sup> the key to substantive due process protection is that a “personal activit[y]” be “so deeply rooted in our history and traditions, or so fundamental to our concept of constitutionally ordered liberty,”<sup>80</sup> the distinction between mimics and extenders may be relevant.<sup>81</sup> All that said, the constitutional status of rights to use reproductive technologies in the United States in general is currently so underdetermined—we have very little case law on the constitutionality of restrictions to even first-wave reproductive technologies like IVF or surrogacy—<sup>82</sup>that it is very hard to know whether courts are likely to view the mimic-extension line as the relevant one for constitutional analysis.

I wrote the preceding paragraph before the U.S. Supreme Court’s decision in *Dobbs v. Jackson Women’s Health Organization*.<sup>83</sup> As I have noted elsewhere, that decision further undermines a claim that there is

<sup>76</sup> *Id.* at 43–46.

<sup>77</sup> For some skeptical takes, including my own, *see, e.g.*, I. Glenn Cohen, *Beyond Best Interests*, 96 MINN. L. REV. 1187, 1225–29 (2012); Frances M. Kamm, *Is There a Problem with Enhancement?*, 5 AM. J. BIOETHICS 5, 6–9 (2005). I will return to the application of these distinctions to uterus transplants below, including by showing that especially as applied to trans women it may not be as easy to apply a guide as one would think.

<sup>78</sup> *E.g.*, Cass R. Sunstein, *Due Process Traditionalism*, 106 MICH. L. REV. 1543 (2008).

<sup>79</sup> 521 U.S. 702 (1997).

<sup>80</sup> *Id.* at 727.

<sup>81</sup> For many years there were similar points raised about the constitutional status of a right to engage in human cloning (a form of reproductive technology that never was really pursued). *See* JOHN A. ROBERTSON, CHILDREN OF CHOICE: FREEDOM AND THE NEW REPRODUCTIVE TECHNOLOGIES 162–64 (1994); Cass Sunstein, *Is There a Constitutional Right to Clone?*, 57 HASTINGS L.J. 987 (2002); Sonia M. Suter, *The “Repugnance” Lens of Gonzales v. Carhart and Other Theories of Reproductive Rights: Evaluating Advanced Reproductive Technologies*, 76 GEO. WASH. L. REV. 1514, 1538–39 (2008).

<sup>82</sup> For a recent survey, *see* I. Glenn Cohen, *The Right(s) to Procreate and Assisted Reproductive Technologies in the United States*, in THE OXFORD HANDBOOK OF COMPARATIVE HEALTH LAW 1009 (David Orentlicher and Tamara K. Hervey eds., 2020).

<sup>83</sup> 142 S. Ct. 2228 (2022).

a constitutional right to use IVF, let alone much newer reproductive technologies, at least insofar as they involve embryo destruction.<sup>84</sup> Beyond the general skepticism of some of the court's prior substantive due process approach, the more direct reason is the language from Justice Alito's majority opinion that "[w]hat sharply distinguishes the abortion right from the rights recognized in the cases on which *Roe* and *Casey* rely is something that both those decisions acknowledged: Abortion destroys what those decisions call 'potential life' and what the law at issue in this case regards as the life of an 'unborn human being'" and emphasizing that "[n]one of the other decisions cited by *Roe* and *Casey* involved the critical moral question posed by abortion."<sup>85</sup> The same might be said as to reproductive technologies that involve embryo destruction suggesting they are now even more firmly in a space where the Constitution does not restrict state action. Because uterus transplantation does not typically in and of itself involve embryo destruction (IVF alongside it might), I think the main effect of *Dobbs* will be to further cement the historical *Gluckberg*-ian approach to substantive due process analysis; such an approach is likely to be hostile to constitutional claims to use uterus transplantation or other new reproductive technologies.

1. The right to experience pregnancy?

I now want to move from the general way of sorting rights claims through the mimic-extender line to the more specific rights claims at issue in uterus transplants.

When describing the reason why people (so far, primarily those assigned female at birth) seek uterus transplants, I believe it is important to describe it as an interest in experiencing "pregnancy," not "parenthood" or even "genetic reproduction." Why should we insist on this specificity?

As with all reproductive technologies, adoption remains a possibility for some individuals or couple such that the need being met is not "parenthood" *simpliciter*. I say "some individuals" because across the world, there are many legal restrictions for single persons or same-sex

---

<sup>84</sup> I. Glenn Cohen, Judith Daar & Eli Y. Adashi, *What Overturning Roe v Wade May Mean for Assisted Reproductive Technologies in the U.S.*, 328 J. Am. Med. Ass'n 15 (2022); I. Glenn Cohen, *Reproductive Technologies and Embryo Destruction After Dobbs* (Geoffrey R. Stone & Lee C. Bolinger eds) (forthcoming) (manuscript on file).

<sup>85</sup> *Dobbs*, 142 S. Ct., at 2258.

couples.<sup>86</sup> Potential parents may also face age-based restrictions or intercountry restrictions at the agency or regulatory level.<sup>87</sup> Of course, there is also the question of the availability of children for adoption.<sup>88</sup>

Adoption, where available, results in *legal* but not *genetic* parenthood. Other reproductive technologies do enable access to the latter. A woman or a couple in which the woman has fertile eggs can undergo IVF to harvest those eggs, fertilize the eggs with a male reproductive partner's or provider/donor's sperm and then, where legal and available, use a gestational surrogate (who carries the fetus but does not contribute an egg and thus is not a genetic mother to the child). In so doing, the intended mother can achieve genetic parenthood as well as legal parenthood.<sup>89</sup>

But she still will *not* have *experienced pregnancy*. Where IVF and surrogacy are available, the best way to understand the potential rights claim made by someone who wants to have a uterus transplant is as a claim to a "right to experience pregnancy." Once again, such a right could exist as either a positive liberty claim (I have a claim to state support to experience pregnancy) or as a negative liberty claim (the state may not interfere in my right to experience pregnancy). I argue that the right way to consider the claims made by those who want to undergo uterine transplants in cases where IVF and surrogacy are available as an alternative is *as a right to experience pregnancy*.<sup>90</sup>

---

<sup>86</sup> See, e.g., Cynthia Godsoe, *Adopting the Gay Family*, 90 TUL. L. REV. 311, 330–40 (2015) (discussing history of restrictions on adoption and fostering by gay individuals in the United States); Rachel H. Farr & Abbie E. Goldberg, *Sexual Orientation, Gender Identity, and Adoption Law*, 56 FAM. CT. REV. 374, 377–79 (2018) (discussing challenges faced by LGBTQ couples in adopting even when formal adoption prohibitions are not present or rescinded).

<sup>87</sup> Jessica Leinaweaver, *Geographies of Generation: Age Restrictions in International Adoption*, 16 SOC. & CULTURAL GEOGRAPHY 508, 511–13 (2015); Danwood M. Chirwa, *Children's Rights, Domestic Alternative Care Frameworks and Judicial Responses to Restrictions on Inter-Country Adoption: A Case Study of Malawi and Uganda*, 16 AFR. HUM. RIGHTS L.J. 117, 124–32 (2016).

<sup>88</sup> Olga Khazan, *The New Question Haunting Adoption*, ATLANTIC (Oct. 19, 2021), <https://www.theatlantic.com/politics/archive/2021/10/adopt-baby-cost-process-hard/620258/> [<https://perma.cc/PEU6-BS6U>]; JO JONES & PAUL PLACEK, *ADOPTION: BY THE NUMBERS 2* (Chuck Johnson & Megan Lestino eds., 2017).

<sup>89</sup> At least in states like California that have created clear legal rules that the intended parent and not the gestational surrogate will be the legal parent of a child if there is an agreement. See *Johnson v. Calvert*, 851 P.2d 776, 784 (Cal. 1993).

<sup>90</sup> My framing differs from that of the late great John Robertson who argued "in answering the question of whether reproductive/procreative liberty includes a right to gestate, one must first answer the question of what counts as 'reproduction.' I have argued that reproduction is having or rearing offspring with of one's own genes." Robertson, *supra* note 14, at 633. He then claims that rejecting this view "morphs into a claim of a right to adoption—a right to rear a child—without a genetic connection at all," which he views as outside the procreative rights bundle, even if valuable. *Id.* I think he missteps by not giving due recognition to the *experience* of pregnancy and that this might not only be a rights claim, but one that is *part of* the procreative rights bundle.

My framing may also help us understand a component of the claim of harm in switched embryo cases like *Perry-Rogers v. Fasano*, 715 N.Y.S.2d 19 (App. Div. 2000), where an embryo is unintentionally placed in the womb of a woman who is not its intended parent. Even if the child is

But what about when surrogacy is *not* available as an alternative? Many countries have sought to restrict commercial or even noncommercial surrogacy out of concern for the exploitation or undue inducement of surrogates, the commodification of women's reproductive labor, or other reasons.<sup>91</sup> In jurisdictions that prohibit commercial surrogacy, there may be a stronger claim to uterus transplants than in jurisdictions where surrogacy is available because individuals would lose out on their claimed rights to genetic and legal parenthood, in addition to their right to experiencing pregnancy.<sup>92</sup> In these jurisdictions, the interest in experiencing pregnancy seems to "tag along" as more of a secondary interest to a primary rights claim about achieving parenthood.

Exploring the uterus transplant claims in these two settings allows us to confront one very interesting, albeit strange, use case: that of uterus transplantation to *enable* surrogacy. Suppose a woman wants to serve as a commercial or noncommercial gestational surrogate—she would carry the fetus through pregnancy but without any genetic parenthood nor any interest in legal parenthood, but to do so she needs a uterus transplant due to a prior hysterectomy or other cause of uter-

---

ultimately carried to term by that woman and returned to the intended parents who are its genetic parents and become its legal parents, we can understand that the woman who intended to gestate her own embryo claims a deprivation of her right to experience pregnancy. Notice the duality of the possible framing: one could either view this as a loss for that woman or think that compensation is due to the woman who carried the fetus (as a kind of surrogacy by accident), or both. Like a few of the quirkier examples in the main text that follow, one might also wonder whether the rights claim to experience pregnancy is modulated by it being your genetic child (or a child you intend to rear).

<sup>91</sup> See, e.g., I. GLENN COHEN, PATIENTS WITH PASSPORTS: MEDICAL TOURISM, LAW, AND ETHICS ch. 9 (2015) (discussing countries that restrict reproductive technology access and the reasons they offer for doing so).

<sup>92</sup> This does not exhaust the possible ways of framing the rights claims, of course. When I presented this paper as part of a symposium at the University of Chicago, Emily Waldman helpfully asked me whether even when surrogacy *is* available some women might prefer a uterus transplant to avoid the need to involve third parties in their reproduction, whether due to legal, financial, or other concerns. In some ways, such a rights claim would interestingly mirror a potential future use of In Vitro Gametogenesis that Sonia Suter has called "solo IVG," using the technology to create sperm and egg from the same person. Sonia M. Suter, *In Vitro Gametogenesis: Just Another Way to Have A Baby?*, 3 J.L. & BIOSCIS. 87, 88 (2016). Solo IVG seeks to exclude the stranger's participation from genetic parenthood while uterus transplant tries to exclude the stranger's participation from gestational parenthood. This "exclusion" framing raises the question of whether the law is primarily interested in end-states (are you the genetic and legal parent?) or the process by which it was achieved when there are collaborative and non-collaborative options. On the other hand, one might press on the claim that uterus transplants (as opposed to solo IVG) really exclude the "stranger's" involvement. The "stranger" is involved as uterus donor, just not as active gestator (as they would be as a gestational surrogate). The two certainly "feel" different, but this raises interesting questions of whether normatively the "labor" or "participation" involved in being a uterus donor is categorically different from that involved in being a gestational surrogate? To me, this raises interesting, classic questions about the way in which the "labor" of surrogacy is categorically different from, say, providing an egg, reminiscent of the questions raised in Elizabeth Anderson, *Is Women's Labor a Commodity*, 19 PHIL. & PUB. AFFS. 71 (1990).



ine infertility. We might say that such a woman claims a “right to experience pregnancy,” *without* achieving genetic parenthood and without any intention of being a legal parent. Otherwise put, her interest is in “pregnancy standing alone.” Intuitively, it seems as though such a woman would have the weakest rights claim of the cases I have discussed thus far because it is only her interest in pregnancy that she seeks to satisfy. But upon reflection, one can see this use case as a kind of “remainder” or “delta” between the prior two cases; she is seeking, standing alone, the one thing that the woman who could have used a surrogate but wants a uterus transplant is seeking. This raises the question of whether, normatively speaking, the whole is more than the sum of its parts? That is, should the interest in experiencing pregnancy be given more weight when in service of intended legal parenthood than when not?

To further examine our intuitions, one could imagine a perhaps even stranger case of a woman who wished to have a uterus transplant to produce a child she intended to put up for adoption. Here she claims a right to experience pregnancy of a child for whom she will be the gestational mother but very explicitly *does not* intend to be the legal mother. One could also imagine a slight variant that would have her seeking to receive a uterus transplant in order to serve as a *full* not gestational surrogate, i.e., she undergoes IVF using her own eggs, but with the intention of giving the child to the commissioning parents. Within the realm of existing family structures, such cases might seem less odd. For example, a gay male couple who seeks to use one man’s sperm and eggs from the other man’s sister (to try to replicate their own genetics in the baby) and then have the pregnancy carried to term in the sister’s uterus, either by the sister or by someone to whom the sister’s uterus is transplanted.

If that run of variations has your head spinning, that is a good thing. It helps us see that what seemed like a simple question—what claims women seeking uterus transplants are making—turns out to be a fairly complicated and nuanced matter. It also helps us see how uterus transplants raise a new kind of claim—a right to experience pregnancy—that is not present in the more “traditional” reproductive technologies like surrogacy or IVF, which focus on the right to be a genetic parent, either conjoined (in the case of IVF using one’s own eggs) or split (in the case of gestational surrogacy) from the experience of pregnancy.

Less obviously, this exploration lets us see that the rights asserted in the uterus transplant case are separated from a different controversial but (in many places) legally protected set of rights—abortion rights. In abortion, the rights claim is commonly framed as one to *terminate a pregnancy*. There are, however, cases where the abortion right is framed as a right to *continue a pregnancy* over another’s objection. The

most common, but by no means frequent, example is in surrogacy contracts that purport to require abortion by the gestational surrogate if certain eventualities occur, such as if the fetus is diagnosed with a serious genetic abnormality.<sup>93</sup> The claim of women seeking to use a uterus transplant bears a family resemblance to that latter right, except it is to *enable*, not *continue*, a pregnancy. The right against an unwanted abortion is more directly tied to bodily integrity as it is currently conceived, than the claim of the woman seeking a uterus transplant. It would be an invasion of a woman's body to force her to have an abortion, but a uterus transplant requires a woman have something *added* to her body. Perhaps the better analogue, then, is a right against involuntary sterilization,<sup>94</sup> though sterilization *removes* something that belongs to the person as opposed to a claim to have something *added*.

## 2. Valuing the rights claim?

All this conceptual work has got us to a place where we can understand the rights claim being put forward by women seeking to receive uterus transplants and begin to think about how the rights claim should be valued.

It is useful to separate out the negative liberty (noninterference) and positive liberty (financial support) claims.

### *a. Negative liberty claim for a right to experience pregnancy*

In jurisdictions that prohibit surrogacy (or typically, to be more precise prohibit *commercial* surrogacy), I think a women's negative liberty, noninterference claim against state prohibition of uterus transplants is strong. Indeed, I think this claim is *stronger* than their rights claim to using surrogacy in such jurisdictions, especially where uteruses are derived from deceased donation.

With surrogacy, the medical risks of pregnancy and emotional/psychological risks of affective forecasting (and someone like Elizabeth Anderson would add the moral indignity of alienating oneself from one's body and its reproductive labor) are all on the surrogate.<sup>95</sup> While in com-

---

<sup>93</sup> See Cohen, *supra* note 72, at 1191–95 (discussing the small amount of case law and commentary on the enforceability of agreements to refrain from having an abortion or to have one under some circumstances). Of course, as a matter of doctrinal constitutional law the Supreme Court has recently rejected a federal constitutional right to abortion. *Dobbs v. Jackson Women's Health Organization*, 142 S. Ct. 2228 (2022). But here I am discussing the normative claims made by those who would recognize abortion rights and how those normative claims do and do not carry over to the rights claims that could be made as to uterus transplants.

<sup>94</sup> *Skinner v. Oklahoma*, 316 U.S. 535 (1942) is the touchstone. More modern cases include *In re Hayes*, 608 P.2d 635 (Wash. 1980) and *Vaughn v. Ruoff*, 253 F.3d 1124 (8th Cir. 2001).

<sup>95</sup> See Anderson, *supra* note 92.

mercial surrogacy the surrogate certainly gets something out of the exchange (warm-glow altruism and money), those are balanced against these risks to the surrogate. By contrast, in uterus transplantation from a deceased donor, all the risks and benefits are concentrated on the woman who receives the transplant—she both faces the medical risks of any transplant but gains the benefit of legal, gestational, and in many instances genetic parenthood that would not be available in regimes where surrogacy is prohibited.<sup>96</sup> The deceased donor is, to put it bluntly, dead, such that there are no medical risks to her. To put the point another way: the reasons states may have to prohibit commercial gestational surrogacy—such as concerns about exploitation or coercion or undue inducement of surrogates, the corruption of the valuation of women’s reproductive labor, et cetera—are not present (or at least much weaker) with deceased uterus transplants such that such a state is on stronger ground in deciding that such reasons trump the intended mother’s rights claims in surrogacy than in uterus transplants.<sup>97</sup>

The rights claim of the transplant recipient has a weaker pull in the case of a living uterus donor for two reasons. First, the distribution of risk is now split between the donor and recipient rather than being only on the recipient.<sup>98</sup> This arguably is still somewhat better than the surrogacy case because there are substantial medical risks on both sides, as opposed to surrogacy where more of the medical risk is on the surrogate. On the other hand, the medical risk to the uterus donor may be more significant than the risk to a gestational surrogate (see the discussion above).<sup>99</sup>

Suppose one were to believe that the risks to the uterus donor and recipient were comparable to that of other forms of organ donation, like

---

<sup>96</sup> This is true in the usual case of a woman seeking to receive a uterus transplant and legal parenthood of the child that will result but not in the quirkier thought experiments I offered above regarding a transplant in order to serve as a surrogate or put a child up for adoption.

<sup>97</sup> For more on what these kinds of arguments prohibiting commercial surrogacy look like, see, e.g., COHEN, *supra* note 91, ch.9. To be precise, one could make some of these arguments relating to exploitation or undue inducement or corruption as to deceased organ donors as well, but these arguments are much more commonly marshaled as to live organ donors. See, e.g., I. Glenn Cohen, *Regulating the Organ Market: Normative Foundations for Market Regulation*, 77 L. & CONTEMP. PROBS. 71, 73–80 (2014).

<sup>98</sup> See Robertson, *supra* note 28, at 76 (discussing the views of some physicians that the risks of uterus transplant to both sides are great). For some jurisdictions, the welfare of the fetus might also be a relevant consideration although here there is the complication of how to weigh that welfare against the counterfactual that the fetus will not come into existence without the transplant being permitted. See generally I. Glenn Cohen, *Regulating Reproduction: The Problem with Best Interests*, 96 MINN. L. REV. 423 (2011).

<sup>99</sup> I say “more” not “all” because in gestational surrogacy arrangements the intended mother may be the source of the egg, in which case she internalizes the medical risks of egg harvesting. I say “medical” risks because in surrogacy the intended parent does face risks and costs—the cost of paying the surrogate and the risk of a breakdown of the planned surrogacy if, in the worst-case scenario, there is a legal fight over parentage.

kidney donation, where the law does permit it to go forward after psychological and medical evaluation (among other safeguards). Does it follow that uterus transplants must therefore also be permitted? One might respond that the risks with kidney donation are assumed for the sake of saving or at least extending a life, and the balance might be different when instead the interest we are fulfilling is one of enabling genetic reproduction. I think it would be plausible to view the latter as a lesser interest, or to put it more formally: in the name of justified paternalism the state may be justified in restricting risk taking by a third-party to enable genetic parenthood that would not justify restriction when the risk is taken to save a life.

*In jurisdictions that permit commercial surrogacy*, the state may justifiably ask, “Why do you need uterus transplantation when surrogacy is available?” One answer is, “I cannot afford a surrogate,” but that is based more on a positive liberty claim and one might respond that if a person cannot afford commercial surrogacy, chances are they cannot afford uterus transplants either.<sup>100</sup> If the answer is instead, “Because surrogacy does not satisfy my right to experience pregnancy,” then the question is whether the state should prohibit the practice of uterus transplantation when *that* is the interest it satisfies. When there is a woman who has made clear that she is willing for her uterus to be used in this way after death (see below), and it satisfies an interest that the recipient deems important, I think the state does not have strong reasons to prohibit it. However, the state’s reasons *are* stronger compared to cases where surrogacy is prohibited and this is the only pathway for achieving not only the experience of pregnancy, but also genetic and legal parenthood bundled together.

When we are discussing living donors, by contrast, I think the question is much closer. Experiencing pregnancy is certainly an interest, but is it an interest the state should conclude outweighs protecting uterus donors from the risks? There are many experiences particular individuals will find particularly meaningful but nonetheless carry risks society forbids them from taking—base jumping and the ingestion of psilocybin are two that come to mind where many states restrict the activity. But what distinguishes those (the former especially) is that the experience of pregnancy might be thought of as much more central to a life

---

<sup>100</sup> One important difference between uterus transplants and surrogacy is that, because a significant portion of the transplant costs are the costs of surgery and immunosuppressive drugs, it is easier to imagine uterus transplantation costs being covered like other transplants by public or private insurance, as opposed to surrogacy where much (but not all) of the cost is the payment directly to the surrogate. But if *this* is the reason an individual puts forward as to why they need a uterus transplant and not surrogacy, it seems to me it is *this* oddity a state should be focused on. It would be passing strange to address inadequate funding for surrogacy by having the state or insurers instead pay for uterus transplants.

plan of childrearing and/or the experience of one's gender, and thus more closely tied to personhood. On the other side, with uterus transplants, unlike those two examples, the risk is not only to the one who gains the experience but to the one who helps provide what is needed to have the experience (the uterus), such that this is not merely harm to self but also harm to (consenting) others, the state has more room to justifiably intervene. In this respect one rule of thumb might be that the rules a jurisdiction sets out for living organ donation for kidneys, for example, might be thought of as a floor but not a ceiling for what it adopts as to uterus transplants.

As with most weighing exercises, these are judgment calls and your mileage may vary. But I have tried to show why those seeking uterus transplants have noninterference (negative liberty) claims that are stronger if surrogacy is prohibited in the jurisdiction and if they are using a deceased donor, and weaker if it is a live donor and surrogacy is already available in the jurisdiction as an alternative.

*b. Positive liberty claim for a right to experience pregnancy*

A state may support uterus transplants either directly (by covering it through public health insurance funding) or indirectly (by requiring private insurers to cover it as it does with some mandates pertinent to IVF).<sup>101</sup>

A state's position on surrogacy funding seems insufficient to determine if it should pay for uterus transplants.<sup>102</sup> It is possible for states to "draw the line" to include surrogacy and exclude uterus transplants or vice versa based purely on cost differentials. It could also make decisions based on different numbers of users involved.

Even if (unrealistically) the cost was exactly the same for surrogacy and uterus transplants, a state could conclude that corrupting the valuation of women's bodies or their reproductive labor through surrogacy was offensive to it in a way that uterus transplant achieved by donation

---

<sup>101</sup> See, e.g., I. Glenn Cohen & Daniel L. Chen, *Trading-Off Reproductive Technology and Adoption: Does Subsidizing IVF Decrease Adoption Rates and Should It Matter?*, 95 MINN. L. REV. 485, 537–39 (2010) (collecting state insurance mandates relevant to IVF). Earlier this year, Colorado became the first U.S. state to adopt such a prospective registry. I. Glenn Cohen, Eli Y. Adashi, Seema Mohapatra, *The End of Anonymous Sperm Donation in Colorado: A Step Forward to a New Fertility Future in the US?*, JAMA (Oct 24, 2022), available at <https://jamanetwork.com/journals/jama/fullarticle/2797964>.

<sup>102</sup> I am unaware of any jurisdiction where the state pays compensation to the surrogate directly. In some jurisdictions, though, elements of surrogacy such as egg retrieval, fertilization, and implantation may be covered by public insurance or required to be covered by private insurance. *Key Findings: Infertility Insurance Mandates and Use of Assisted Reproductive Technology*, CTRS. FOR DISEASE CONTROL & PREVENTION (Apr. 1, 2016), <https://www.cdc.gov/art/key-findings/insurance.html> [<https://perma.cc/UCR6-XMA4>].

(as opposed to sale) was not. This would be consistent with current Medicare coverage of kidney transplants, but not surrogacy.<sup>103</sup> A state may also weigh the emotional risk of surrogacy gone wrong differently than the medical risk to the uterus donor or recipient.

What about the distinction between live and deceased uterus transplants? The costs are typically lower for the latter, but as discussed above, the success rate may be lower as well. Perhaps a state might say the points made above about the distribution of risk (and the fact that deceased donors are beyond risk) are relevant, and this gives the state a reason to reduce the number of live uterus donations, especially because some of the costs associated with live donations may flow back to the state if the donor suffers adverse medical or psychological effects.<sup>104</sup>

What then should we look to in thinking about whether or when a state should pay (directly or indirectly through private insurance mandates) for uterus transplants? Here, I think it *does* matter whether we are talking about a rights claim to experience pregnancy, standing alone, or a rights claim to a uterus transplant as the only way to achieve genetic and legal parentage (i.e., in instances where gestational surrogacy is forbidden or unavailable).

I will not give a complete answer, but instead sketch two very different approaches to answering the question. These will bring us back to some of the distinctions we drew above, for political theory purposes, between mimics and extenders.<sup>105</sup>

First, let's consider welfare consequentialist theories about what the state should pay for. Such theories are interested in how much a particular intervention does or does not do to advance the individual's welfare and the cost of paying for it. In their purist form, such theories may discard "health" as an intermediate concept to some extent; that is, it does not matter whether a uterus transplant (or a cosmetic surgery, for example) advances "health" or a nonhealth interest of the individual. What matters is how much it advances that welfare interest

---

<sup>103</sup> *Organ Transplants*, MEDICARE.GOV, <https://www.medicare.gov/coverage/organ-transplants> [<https://perma.cc/5APJ-GQGP>] (last visited Jan 17, 2022).

<sup>104</sup> It also does not seem that whether a jurisdiction permits or prohibits surrogacy should be determinative as to the policy it should select as to paying for uterus transplants. Under some theories opposing surrogacy—in particular those concerned with the corruption of women's reproductive labor and the alienation of oneself from one's pregnancy—a state could both conclude that surrogacy should be forbidden and that uterus transplants should be paid for.

<sup>105</sup> These two approaches are far from exhaustive of all possible approaches to this problem. For example, it would be interesting to think about how the capabilities approach associated with Martha Nussbaum would treat the matter. For Nussbaum, it is the state's role to enable human flourishing by raising people above the threshold level on a number of "capabilities," and her "bodily health" capability has, as part of it, reproductive health. MARTHA C. NUSSBAUM, *FRONTIERS OF JUSTICE* 76–78 (2006). Would that include a uterus transplant? Is pregnancy itself, as opposed to having children, what the relevant capability protects?

and at what cost. The interest in experiencing pregnancy becomes comparable to other kinds of experiences and the fact that the claimant needs it because of the background injustice that led to their infertility or dysfertility is not particularly important.

On such views, if we ask, “Yes, but is it a health care intervention?,” we ask that question not because it matters as a first-order matter, but because we have ministerially divided the world of what the government pays for into buckets, and we are asking whether this should come out of the health care bucket.<sup>106</sup> One interesting, surprisingly liberal, feature of this approach is that it does not categorically draw a distinction between the interest in uterus transplants by those assigned female at birth experiencing uterine infertility on the one hand and trans women or those assigned male at birth on the other. Their interest in experiencing pregnancy is, in principle, comparable. Indeed, one could imagine a world where the welfare benefit of a uterus transplant is *greater* for a trans woman because the experience of pregnancy may be more significant to them as part of living their true self.<sup>107</sup>

More familiar to bioethicists would be the Rawlsian approach discussed earlier and associated with Norman Daniels. Whether the state should pay for a uterus transplant would turn on the question of whether uterus transplants support species-typical normal functioning. It is species-typical for females to have functioning uteruses that permit them to gestate a fetus. On this view, a just state would include uterus transplants for cisgender women amongst the things it pays for as part of its health care budget. By contrast, for those assigned male at birth, trans or otherwise, a functioning uterus would be species-atypical. Thus, a just state would have no obligation to provide it (it is an enhancement not a treatment).

Now one might push back by noting that the species-typical/atypical normal functioning line is itself justified by its connection to a state’s obligation to ensure that all have access to the “normal opportunity

---

<sup>106</sup> There are more tempered consequentialist approaches that attempt to apply some of the same techniques *within* the sphere of health goods. Perhaps the most familiar are attempts to allocate public resources according to quality adjusted life year (QALY) or disability adjusted life year (DALY) systems. See, e.g., Paul T. Menzel, *Bias Adjustment and the Nature of Health-State Utility*, 7 J.L. & BIOSCIS. 1 (2020); Sarah J. Whitehead & Shehzad Ali, *Health Outcomes in Economic Evaluation: The QALY and Utilities*, 96 BRIT. MED. BULL. 5, 5 (2010). As far as I know there have been no attempts to value the loss of the *experience* of pregnancy using these methods. One interesting question is whether to consider the alternative, if available, in quantifying the value of a uterus transplant using such methods. That is, should a uterus transplant be more highly valued using these methods when surrogacy is *unavailable*, and the benefit of the transplant is both the experience of pregnancy and genetic parenthood?

<sup>107</sup> See Alghrani, *supra* note 14, at 639 (“Trans women could regard pregnancy as the final step in re-aligning their life in accordance with the gender they psychologically identify with, as opposed to their biological sex. UTx may remedy this, enabling trans women to experience gestational motherhood.”).

range” that is “the array of life plans reasonable persons are likely to develop for themselves.”<sup>108</sup> I think there is an argument that for some trans women this normal opportunity range might include a uterus transplant just as much as it might include gender confirmation surgery.<sup>109</sup> For such a person it is a reasonable life plan to is to live life as the gender that they conclude is their gender. Just as some trans women might view having a functioning vagina as necessary to experience sex *as a woman would*, so some might view having a functioning uterus as needed to experience pregnancy *as a woman would*. One might object, “but you can achieve genetic and legal parenthood via artificial insemination with surrogacy, you do not need a uterus transplant, many women have children without pregnancy.” But, if we have concluded that experiencing pregnancy is needed for accessing the normal opportunity range for such persons assigned female at birth, and the claim of the trans woman is that their normal opportunity range is to achieve a life that is as close as possible as those assigned female at birth, then to achieve *that* life plan the uterus transplant is needed.

Admittedly there is something that feels a bit “bootstrappy” about this reasoning. However, so long as we think that for some individuals assigned male at birth, a life that is as close as possible to those assigned female at birth is a reasonable life plan, which seems quite solid a claim to me, then their right to experience pregnancy is just as much of a health care claim as it is for cisgender women with uterine infertility. In the final analysis, the question is: for those who adopt the Daniels/Rawlsian approach, is the species-typical line a mere proxy for the more general conception of an equal opportunity range (in which case trans women populations have a strong claim to uterus transplants)? Or is it doing some separate normative sorting work? If the latter, trans women may be shut out from support by a concept of what is species-typical for their sex assigned at birth, not their gender identity.

This leaves us with cisgender men. Here, the species-typical approach excludes them. But I do not think they will do much better under the “normal opportunity range” approach. For the normal opportunity range, the idea of an array of reasonable life plans, to be meaningful it must have some exclusionary force. The approach is different from the consequentialist one; to enable us to meet the normal opportunity range the state does not owe us everything that makes our lives better, only those things demarcated by this line. Many men of my height (slightly

---

<sup>108</sup> DANIELS, *supra* note 75, at 43–46.

<sup>109</sup> I say “some” to recognize the vast heterogeneity in the trans experience and that not all trans individuals assigned male at birth are interested in trying to live life as close as possible to those assigned female at birth. In this section, I am focusing specifically on those trans individuals that are interested in that life plan. To avoid making the language more cumbersome, I won’t repeat this qualification again and again in the text.



above five feet and nine inches) would like to play NBA basketball. Amongst the many reasons why I will never play in the NBA is my height. That does not mean I have a claim against the state to pay for a limb lengthening surgery. It does not turn my height into a disability.<sup>110</sup> A *reasonable array* of life plans does not mean everyone gets *every* life plan, nor does a particular person have a claim just because a particular life plan is particularly important to them. And if a man finds the idea of experiencing pregnancy to be particularly important to him, that does not transform his want into a health care claim against the state for a uterus transplant.

My conclusion is that the cisgender women and trans individuals assigned male at birth do have *bona fide* health claims for a positive liberty right to experience pregnancy while cisgender men do not. What makes me uneasy about this conclusion? That I have ended up with a very gendered conception of the appropriate array of life plans. Because most cisgender women who reproduce experience pregnancy and view that as an important part of being a woman, women and trans women have a rights claim to experience pregnancy, but this claim is not held by cisgender men. “Destroy the binary” my inner voice yells back at me as I survey this page. Why treat the current setup of our sexes as normatively important? Why not push for a queer future where cisgender men’s pregnancy is not the stuff of mediocre 1990s comedy?<sup>111</sup> And I respond, somewhat sheepishly, “Well, I will meet you part of the way.” When it comes to the negative liberty rights claim, I think distinctions between the cisgender man and the cisgender woman and trans woman are less relevant. But when it comes to positive liberty claims, I see the matter differently.

The ambivalence I (and perhaps, you, dear reader) feel about this is likely a reflection of the role that “reasonable array” of life plans is doing in the analysis. It is normative all the way down. It has a necessary role as a disciplining tool—without it, we would have positive liberty obligations to foster *any* life plan and the special importance of ideas of health or disability would fade away. That would be bad. At the same time, as with all “reasonable X” tests in the law it has a certain static and traditionalist quality to it that is limited by the kind of social

---

<sup>110</sup> This is not to say that short height can never be a disability (or more precisely, can never lead one to make a claim on the state similar to what those with what we more commonly refer to as disabilities can make on the state). The question is again the reasonable array of life plans and the normal opportunity range. For some heights it is plausible that the reasonable array will not be available. The FDA was faced with a concrete version of these questions in its consideration of to whom to approve access to human growth hormone for short stature. See Dov Fox, *Safety, Efficacy, and Authenticity: The Gap Between Ethics and Law in FDA Decisionmaking*, 2005 MICH. ST. L. REV. 1135, 1144–46 (2005)

<sup>111</sup> JUNIOR (Universal Pictures 1994).

order in which we live; it stands as an obstacle to the most bold and reconstructive revisions to a social order. One must pick one's poison.

#### IV. SOME REMAINING FAMILY LAW QUESTIONS ABOUT LIVING UTERUS DONORS

As discussed above, there are medical reasons to potentially prefer living uterus donors like Taylor Siler, who we met at the start of this article, over deceased ones. There are two family law issues that arise when using living donors that I want to briefly explore.

##### A. The Legal Parenthood of the Uterus Donor

Our families give a lot to us, but few mothers have given what two women in Sweden provided their daughters in 2012 in a world's first: a mother-daughter uterus transplant. In operations performed over a weekend at the Sahlgrenska Hospital at the University of Gothenburg in Sweden, two women received uteruses transplanted from their mothers.<sup>112</sup> One woman was born without a uterus and the other woman's uterus was removed as part of treatment for cervical cancer years before. Both recipient women, then in their thirties, had eggs harvested and fertilized through In Vitro Fertilization (IVF).<sup>113</sup> A similar case occurred in India in 2017, with a forty-three-year-old mother having her uterus transplanted to her twenty-one-year-old daughter, who had been born without a uterus, at Pune's Galaxy Care Hospital.<sup>114</sup>

How do we describe the various relations of the women in these stories? The older woman who is donating her uterus is a genetic mother to the recipient and a "uterine mother" to the recipient, but she is also a "uterine mother" to her granddaughter as well as being a genetic grandmother to the child. To highlight the unfamiliarity of this arrangement, the same uterus produced a woman and produced that woman's own daughter. If we were so inclined, we might describe them as "uterine sisters" while also being genetic mother and daughter.

We could, in theory, tread even more deeply into the unfamiliar. Suppose the woman receiving the uterine transplant has agreed to serve as a gestational surrogate for her gay brother and his husband who will be using the brother's sperm and a donor egg to produce a baby girl. Now, the woman donating the uterus is again both a genetic

---

<sup>112</sup> Ashley Hayes, *First Mother-Daughter Womb Transplants Performed in Sweden*, CNN (Sept. 20, 2012), <https://www.cnn.com/2012/09/19/health/uterine-transplant/index.html> [<https://perma.cc/FNV5-SGWL>].

<sup>113</sup> *Id.*

<sup>114</sup> Medhavi Arora, *Mom Donates Womb to Daughter in India's First Uterus Transplant*, CNN (May 19, 2017), <https://www.cnn.com/2017/05/19/health/india-uterus-womb-transplant/index.html> [<https://perma.cc/BCQ8-9U4M>].

mother to the recipient and a “uterine mother” to the recipient of the transplant, and she is again also a “uterine mother” to her granddaughter as well as being a genetic grandmother to the child. The recipient is a genetic aunt, a gestational mother, and a “uterine sister” to the baby. The man who gives his sperm is a genetic father to the baby, a “uterine brother,” and a sibling to the baby’s gestational mother, which may also make him gestational uncle to his genetic child.

*Did you get all that?*

Beyond being unfamiliar, does any of this matter *legally* speaking? There is well-established case and statutory law pertaining to the “old” reproductive technologies regarding the rights claims or sperm donors, gestational and full (i.e. surrogates who also provide the egg) surrogates, and intended parents.<sup>115</sup> Many of these cases are complicated and heartbreaking, but we have reached a point of relative stability, if not uniformity, in approach. Does the introduction of a uterus donor upset that stability? Could a uterus donor assert parental rights to the children who are born from their uterus (posttransplant)? If such children needed child support could the state require it from the uterus donor? Before you dismiss that possibility as outlandish, there was an analogous attempt by Kansas to seek child support payments from a man who was recruited as a sperm donor on Craigslist.<sup>116</sup>

I think there are very good reasons to treat uterus donors differently from gamete donors or surrogates in terms of the potential for parental duties or rights. The uterus donor’s role is too attenuated in reproduction. A kidney donor also enables a female kidney recipient to survive and thus enables her to achieve a pregnancy post donation, and yet no one would think that the donor ought to have parental rights or duties. Of course, the connection between the uterus and pregnancy is much more direct than that between the kidney and pregnancy, but both organs are a but-for cause of the person being able to become pregnant. It is easy to distinguish the role of gametes, which directly shape the way a child comes into existence, from either the kidney or uterus. The case of surrogacy is a bit harder and pushes us to understand what exactly the claim of the surrogate mother to parental rights or duties might be. If the story is one of *contribution*, then one faces the difficult question of whether the contribution of nine months of gestation by a

---

<sup>115</sup> See generally DAAR ET AL., *supra* note 63, at 466–536 (collecting and discussing major cases).

<sup>116</sup> State v. W.M., No. 2012DM2686, 2016 WL 8293872, at \*1 (Kan. Dist. Ct. Nov. 22, 2016). The trial judge ultimately found it was not in the best interests of the child for the sperm donor to be treated as the legal father notwithstanding that he would have been a source of support, but the best interests analysis was case specific, and the court did not reject the possibility that it might find support obligations in another case. DAAR ET AL., *supra* note 63, at 466–536.

surrogate is greater than the contribution of the surgical and other undertakings necessary to be a uterus donor.

To me, that's a little like asking if a rock is heavier than a wood plank is long. It is more like comparing Apples and Tuesdays than even Apples and Oranges. But that is a good reason to doubt that the surrogacy contribution is so clearly greater than the uterine donation. In one case, the uterus stays put, in another it is detached, but in both cases the person helping is making a major contribution via their uterus.

Instead, to me the better way to think about what might give the surrogate mother a claim is *bonding*. It is the *experience* of carrying a particular child in one's womb, in a biologically and psychologically intense way, that might give you a stronger claim to parental rights or duty. Of course, this very line of argument has met with significant controversy in cases deciding whether to enforce surrogacy agreements rather than let a surrogate mother choose only *after* the birth whether to give up parental rights.<sup>117</sup> For present purposes I do not need to take sides on this question. I merely want to show that for those who believe gestational bonding serves as a reason to allow the retention of parental rights by the surrogate, that the same argument does *not* apply to uterus transplants.

There is, though, another more fundamental question regarding familial (as opposed to "stranger") uterus donation: should it be allowed at all? It is sometimes said that family is a place where life begins and love never ends. That is very sweet, but it is also true that families are a bed of hard-to-detect currents of pressure, guilt, resentment, and trauma.

To be sure, there are potential dangers in market transactions, familiar from the so-called "commodification" debate, but it would be a mistake to think that familial donation does not have its own risks.<sup>118</sup> The market is arm's length, it has at least some transparency of terms, and most importantly, the interaction between the parties ends at the moment of transplantation. The pressures that cause a family member to give a uterus to another are buried deep and hard to police. How many women would deny their daughter or sister a uterus if asked? How many truly want to give? What happens to the relationships of those who do refuse? These are reasons why we may be concerned about the level of voluntariness.

A different worry is the way in which these altered familial relationships will continue long into the child's life. A woman who gives her

---

<sup>117</sup> These debates are endemic to the court cases and commentary on the question, *see generally* DAAR ET AL., *supra* note 63, at 466–536. For one good-pointed exchange, compare the majority and dissent in *Johnson v. Calvert*, 851 P.2d 776 (Cal. 1993).

<sup>118</sup> *See, e.g.*, Cohen, *supra* note 97.

sister a uterus will always be the resulting child's genetic aunt, but it seems possible that she and the child might also think of her as *something more*. That something more could be positive (a kind of second mother to whom the child can find emotional support) or negative (a family member who thinks her opinions deserve more weight because of her role in conception). But it may produce a distinct new familial ecosystem in a way that "stranger" donation does not.

Should the law prevent familial donations for this reason? In the context of donating other organs, we have not taken that step, instead preferring psychological screening as a bulwark. But again, perhaps the life-saving nature of these transplants differentiates them from uterus transplants. Familial donation of egg or sperm, or even serving as a gestational surrogate for a family member, might be thought of as a better analogy. We currently have no prohibitions on doing so, and indeed sibling gamete donation is pursued by some in order to allow genetic materials from "both sides of the family" when a sibling's sperm or egg is combined with one's romantic partner's. But while egg donation does carry burdens and risks of, among other things, ovarian hyperstimulation syndrome, it is much less invasive, and the risks are much lower for the donor than in uterus transplants.<sup>119</sup>

Perhaps the best we can say is that intrafamilial uterus donations should be subjected to a particularly searching form of psychological assessment that should be sensitive to more subtle forms of pressure and discomfort. How far to go in this might also depend on the availability of alternative donors—in a world where "stranger" donation is widely available, perhaps we should do more to discourage intrafamilial donation than in a world where this is one of very few options.

## B. Uterus Donor Anonymity

One final family law question pertains to whether children conceived by uterus donation should have access to information about their uterus donors. In the case of familial donors, such anonymity is less likely to be sought, but what about in the case of donation by stranger?

Once again, there are a few competing analogies. The first is sperm and egg donation. While some countries permit donor anonymity, others require that donors place identifying information in a registry available to donor-conceived children when they turn a certain age so they

---

<sup>119</sup> *E.g.*, Practice Committee of the American Society for Reproductive Medicine and Practice Committee of the Society for Assisted Reproductive Technology, *Repetitive Oocyte Donation: A Committee Opinion*, 113 FERTILITY & STERILITY 1150, 1150–51 (2020).

could recontact the donor.<sup>120</sup> The identifying information is made available to donor-conceived children who request it at age eighteen, and the nonidentifying information is provided at age sixteen.<sup>121</sup>

By contrast, when it comes to kidney or other solid organ donation, the strong default is to keep the identity of the donor and recipient anonymous. As the Organ Procurement and Transplantation Network (OPTN), the United States' key institution managing the process, explains:

Non-directed living donor organs are donated with the understanding that, in most cases, the organ recovery center controls the recipient selection process. The recipient should not receive information about the donor. Both donors and recipients understand that the donation process must be anonymous.

If a living non-directed donor and the recipient are in the same center, care should be taken to limit the chance of disclosure of the candidate's identity. Centers should identify plans to maintain anonymity around vulnerable times of surgery and appointments. Even when these plans are in place, maintaining anonymity is challenging and cannot be guaranteed.

If a non-directed donor or the recipient wish to break anonymity, hospitals should consider all applicable rules or regulations and available guidance on exchanging information between non-directed donors and recipients.<sup>122</sup>

Should we think of uteruses more like solid organs (strong assumption of anonymity) or sperm and egg (in many countries, requiring the sharing of identifying information at a certain age if the resulting child requests it)? Once again, this will require us to think more deeply about how we conceptualize the various rights claimed by the parties.

Gamete donor-conceived children have often claimed a "right to know one's genetic origins," either framed in terms of harm to donor offspring if they do not get access to this information or of a wrong committed, and perhaps even a human rights violation, if their knowledge of genetic connectedness is impeded.<sup>123</sup> Most such claims have emphasized *genetic* origin or *genetic* connection which is relevant. There has

---

<sup>120</sup> E.g., I. Glenn Cohen et al., *Sperm Donor Anonymity and Compensation: An Experiment with American Sperm Donors*, 3 J.L. & BIOSCIS. 468, 471 (2016).

<sup>121</sup> *Id.*

<sup>122</sup> *Living Non-Directed Organ Donation*, ORGAN PROCUREMENT & TRANSPLANTATION NETWORK (Dec. 2015), <https://optn.transplant.hrsa.gov/resources/ethics/living-non-directed-organ-donation/> [<https://perma.cc/75HX-565Y>].

<sup>123</sup> For attempts to struggle with how exactly to frame the claim and some pushback on its

not, for example, been a similarly strong call for nonanonymity among surrogates, who in turn would have a stronger bond with the offspring than uterine donors. It would be tempting to point to the medical information inherent in genetic heredity as distinguishing the two cases, but the claims of donor-conceived children have gone beyond receiving medical information provided to actually getting to know the identity of their genetic parent.

I think the better rule, even in countries that require gamete donor anonymity, is not to extend it to uterus donors and instead treat uterus donors more like kidney and other solid organ donation with a strong expectation of anonymity. This may also be desirable for the separate reason that protecting uterus donors from obligations of contact by offspring might help with recruitment.<sup>124</sup>

## V. CONCLUSION

This article has focused on clarifying what is at stake in debates over uterus donation (primarily a normative rights claim to experience pregnancy) and giving an account of how a just state would think about such a rights claim under negative and positive liberty approaches. I have also argued that uterus donors should not be considered legal parents of the children produced and that, even where existing law requires gamete donor nonanonymity, the uterus donor should not be reidentifiable.

Part of what makes uterus transplants so interesting is that we can analyze them within two very different comparative sets. The first is other ways of reproducing with assistance, in particular surrogacy. The second is as compared to other organ transplants—not just kidney transplants but other transplants we associate more closely with who a person is, namely vascularized composite allografts like face and hand transplants. Resolving what the law of uterus transplants ought to be requires us to continuously ask, “In this respect, is it more like surrogacy or more like organ transplantation?” in a way that is unusual and intriguing among other reproductive technologies.

---

underlying premises, see I. Glenn Cohen, *Sperm and Egg Donor Anonymity: Legal and Ethical Issues*, in THE OXFORD HANDBOOK OF REPRODUCTIVE ETHICS 499 (Leslie Francis ed., 2016); see e.g., Vardit Ravitsky, “Knowing Where You Come From”: *The Rights of Donor-Conceived Individuals and the Meaning of Genetic Relatedness*, 11 MINN. J.L. SCI. & TECH. 665 (2010); Note, Elizabeth S. Chestney, *The Right to Know One’s Genetic Origin: Can, Should, or Must a State that Extends This Right to Adoptees Extend an Analogous Right to Children Conceived with Donor Gametes?*, 80 TEX. L. REV. 365, 365 (2001).

<sup>124</sup> Of course, there may be uterus donors who find the possibility of connecting with the offspring their uterus enables a plus and thus a reason to participate. The question would then become whether such expectations of contact in the future are permissible or instead a “red flag” for that particular donor?