Essays

Parenthood standards underlying medically assisted reproduction regulation in France in the wake of 2021 Bioethics law

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ABSTRACT: This inquiry aims to disclose and describe parenthood standards underlying – and perpetuated by – legal regulation of medically assisted reproduction in France. To what extent did MAR French law detach the right to medical support to fulfil a desire for a child from traditional, biogenetically grounded, couple-centred, and gendered conceptions of parenthood? Do some parental projects remain explicitly or implicitly excluded by the rules regarding access to MAR and MAR procedures? This article provides a few answers through an analytical and socio-legal approach to MAR regulation in France in its recent developments.

KEYWORDS: Medically Assisted Reproduction; bioethics; parenthood; gender; ART

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1. Introduction

Medically assisted reproduction (MAR)[1] is a distinctive field of medicine, since it operates not only to restore bodies to their normal, even vital functions, but also to fulfil a desire, the desire for a child. Because it sometimes entails intensive operations on the bodies and raises multiple issues regarding parenthood, MAR activities were gradually endowed with

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[1] The term *Medically assisted reproduction* (MAR) seems preferable here to *assisted reproduction technologies* (ART), given the definitions offered by the 2009 International Committee for Monitoring Assisted Reproductive Technology (ICMART) and the World Health Organization (WHO) revised glossary. According to this terminology ART refers to "all treatments or procedures that include the in vitro handling of both human oocytes and sperm or of embryos for the purpose of establishing a pregnancy. This includes, but is not limited to, in vitro fertilization and embryo transfer, gamete intrafallopian transfer, zygote intrafallopian transfer, tubal embryo transfer, gamete and embryo cryopreservation, oocyte and embryo donation, and gestational surrogacy", but it does not include assisted insemination using sperm from either a woman's partner or a sperm donor. ICMART's definition of MAR is broader and closer to the existing practices in France: "reproduction brought about through ovulation induction, controlled ovarian stimulation, ovulation triggering, ART procedures, and intrauterine, intracervical, and intravaginal insemination with semen of husband/partner or donor".

elaborate normative frameworks. Therefore, 1994 French Bioethics Law laid down rules for existing biomedical practices. It was followed by three revisions in 2004, 2011 and 2021 to adapt it to scientific progress and meet increasing demands for justice and equality in access to reproductive technologies. MAR French authorizes a wide range of techniques and welcomes multiple parental configurations. The latest revision of Bioethics law extended the practice of insemination with third-party donor and opened MAR to female couples and single, that is to say, unmarried women. MAR is also thought in France as a matter of national solidarity, since Health Insurance now covers for six inseminations, and for four attempts of in vitro fertilization (IVF) to obtain pregnancy. Is this to say that French MAR law does not produce, and perhaps most acutely, "good parenthood" standards, themselves based on normative conceptions of kinship and family?

While law authorizes, prohibits, and governs practices, it undoubtedly shapes ideal types that orient or are imposed on individual choices and collective behaviours. In this respect, MAR law is normalizing, in that it defines legal and illegal practices and outlines legitimate, socially acceptable parental projects.[2] This work aims to disclose and describe parenthood models underlying – and perpetuated by – French MAR law and to highlight changes and persistence of parenthood traditional standards along its evolution up to its most recent developments. To do so, it tackles the two following questions: which desires for a child does MAR law satisfy, in other words which parental projects does society allow the resources of medicine and national solidarity to be devoted to? (1) Secondly, through which technical means does it appear in the eyes of law legitimate, or illegitimate, to seek to fulfil those desires? (2).

Before going any further, a few clarifications are in order. This research does not target civil law rules governing the establishment and recognition of kinship in the specific case of births made possible by MAR. Those are undoubtfully highly problematic and duly addressed by numerous legal scholars.[3] But this study reflects on MAR law, not as if it were independent from civil law – that would be absurd – but by assuming its specificity, considering to the fact that MAR involves medical administration of procreation. Consequently, it focuses on what happens when individuals *embark* into MAR to become parents. For that very reason it does not focus either on the norms regarding educational behaviours, familial solidarity, or child-parent relationships in general. The term *parenthood* must be understood in the following pages as the conjunction of three dimensions which legal normativity could engage with: i) the nature of the bond between the parent and the future child, which can be biological – genetic or physiological – or grounded on an emotional bond; ii) the family structure, which can be (in broad outline) couple-based or single-parent, straight or same-sex; iii) the distribution of the roles in the procreative process, understood as the material, physical, and emotional investment which contributes to define individuals as parents or future parents. With those precisions in mind, this paper tries to assess the grounding of MAR French law on a typical parenthood model, whose foundation is a biogenetic bond, whose configuration is couple-based, and whose mode of distribution of procreative tasks is heteronormative. It argues that even where procreation seems to be detached from

[2] L. MARGUET, *La construction genrée de la parenté par le droit de la procréation en France et en Allemagne*, in *Enfances, Familles, Générations*, 38, 2021, 1.

[3] For a sum of legal analysis of this issue see M.-X. CATTO, K. MARTIN-CHENUT (eds.), *Procréation assistée et filiation. AMP et GPA au prisme du droit, des sciences sociales et de la philosophie,* Paris, 2019.

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sexuality and even couple life, a biological-grounded, heteronormative, and gendered conception of parenthood remains, which excludes some individuals and shapes the way individuals undergoing MAR procedures are treated. The method combines analysis of positive law and socio-legal approach consisting in examining the way recipients of regulation understand and implement it on the job. A such, close attention is paid to potential discrepancies between positive rules, and actual conditions under which they are implemented by the actors, especially health care professionals, given their own culture and norms, and considering the severe constraints faced today by French healthcare institutions.

2. Access to MAR and non-straight and non-couple-based parenthood

2.1. From MAR for infertile straight couples to the "PMA pour toutes"

The legal framework drawn by 1994 French Bioethics Law intended MAR to provide care to straight couples doomed with pathological infertility or serious transmissible disease. In its first version, article L. 151-2 of French Public Health Code stipulated that: "Medically assisted procreation is intended to meet a couple's parental request. Its purpose is to remedy infertility whose pathological nature has been medically diagnosed. It can also be used to prevent the transmission of a particularly serious disease to the child".[4] MAR was thus conceived as a technique to counter-act a flaw in human nature, since fulfilling medically a desire for a child was justified only for couples who could at least try to procreate carnally. In this paradigm, MAR was envisaged basically as conventional medicine, even though infertility often remained unexplained, and was certainly never treated and healed as such. This pseudo-therapy led to the establishment of a "pseudo-biological filiation",[5] which consisted in pretending that the child could have been the fruit of a carnal conception and in hiding the specificity of this mode of procreation, even when it involved recourse to a third-party donor. This legal framework, based on mimicry with the laws of nature *de facto* excluded non-traditional family patterns[6] and confined family structures eligible for MAR to those with a father and mother dividing up naturalized gendered parental roles.

Developments in civil law, especially the opening of marriage and adoption to same-sex couples in 2013 fuelled demands for equal access to MAR regardless of family type. Increasing transnational competition for access to MAR[7] also contributed to growing economic injustice in access to parenthood, distress for some families, and threat to children's rights. Therefore, French Parliament adopted a new act in 2021, the main contribution of which was to open MAR to female couples and to single unmarried women. This revision was a watershed regarding legitimate parenthood in the eyes of the law in two ways. Firstly, it de-pathologized infertility, by asserting the primacy of a "parental project" over

[4] My translation. Original text: "L'assistance médicale à la procréation est destinée à répondre à la demande parentale d'un couple. Elle a pour objet de remédier à l'infertilité dont le caractère pathologique a été médicalement diagnostiqué. Elle peut aussi avoir pour objet d'éviter la transmission à l'enfant d'une maladie d'une particulière gravité", Code de la santé publique, art. L. 151-2 (version en vigueur du 30 juillet 1994 au 22 juin 2000). In 2000, it became art. L. 2141-2, but the wording remained the same until 2021.

[5] I. THÉRY, *Mariage et filiation pour tous. Une métamorphose inachevée*, Paris, 2016, 99-100.

[6] D. MEHL, *Les lois de l'enfantement. Procréation et politique en France (1982-2011)*, Paris, 2011, 120-131.

[7] E. DE LA ROCHEBROCHARD, V. ROZEE, *L'aide à la procréation en dehors du cadre légal et médical français: quels enjeux aujourd'hui ?* in *Populations et sociétés*, 593, 2021.

the physical impossibility of procreation, so far as to admit same-sex and non-couple-based parental projects.[8] Secondly, it stated equality between parental projects thanks to a non-discrimination clause worded as follows: "This access may not be subject to any difference in treatment, particularly with regard to the marital status or sexual orientation of applicants".[9] Nonetheless legal scholars were quick to point out the revision's flaws, especially its stigma on the filiation of children born to lesbian couples, who are required to undergo early joint recognition,[10] the effect of which is to make the achievement of insemination visible, precisely where there is no doubt about it.[11] But what about *access* to MAR as such? Does law explicitly or implicitly, hold conditions or obstacles to have medical assistance in the realization of certain parental projects?

2.2. Enduring restrictions on access to MAR based on age and "couple stability"

The first set of explicit exclusion criteria of specific parental projects is made up of rules regarding the age of access to MAR. September 28, 2021 Conseil d'État decree sets the following limits: i) may have their gametes removed or collected with a view to MAR women up to their 43rd birthday, and men up to their 60th birthday; ii) gamete self-preservation with a view to subsequent MAR is open to women aged between 29 and 37, and men aged between 29 and 45; iii) artificial insemination, use of gametes or germ tissue collected, retrieved or preserved for the purposes of MAR, and embryo transfer may be carried out up to the woman's 45th birthday, and up to the 60th birthday of the member of the couple who is not intended to carry the child.[12] These *règlements* set lower and upper limits for access to certain technologies, but do not create a right to benefit from any of them, since medical decision will

[8] Art. L. 2141-2-1 was reworded as follows: "Medically assisted procreation is intended to respond to a parental project. Any couple consisting of a man and a woman or two women, or any unmarried woman, has access to medically assisted procreation (...)". My translation. Original text: "L'assistance médicale à la procréation est destinée à répondre à un projet parental. Tout couple formé d'un homme et d'une femme ou de deux femmes ou toute femme non mariée ont accès à l'assistance médicale à la procréation […]".

[9] My translation. Original text: "Cet accès ne peut faire l'objet d'aucune différence de traitement, notamment au regard du statut matrimonial ou de l'orientation sexuelle des demandeurs", Code de la santé publique, art. L. 2141-2-2.

[10] "Couples or unmarried women who, in order to procreate, have recourse to medical assistance requiring the intervention of a third-party donor must give their consent in advance to a notary, who will inform them of the consequences of their act with regard to filiation and of the conditions under which the child may, if he or she so wishes, have access at the age of majority to the non-identifying data and identity of the third-party donor". My translation. Original text: "Les couples ou la femme non mariée qui, pour procréer, recourent à une assistance médicale nécessitant l'intervention d'un tiers donneur doivent donner préalablement leur consentement à un notaire, qui les informe des conséquences de leur acte au regard de la filiation ainsi que des conditions dans lesquelles l'enfant pourra, s'il le souhaite, accéder à sa majorité aux données non identifiantes et à l'identité de ce tiers donneur", Code civil, art. 342-10-1.

[11] L. BRUNET, *L'ouverture de l'AMP à toutes: enjeux et scories du débat sur l'établissement de la filiation homoparentale*, in *Journal du Droit de la Santé et de l'Assurance-Maladie*, 25, 2020, 11-18; M. MESNIL, *La loi de bioéthique, une grande loi famille ?* in *Journal du Droit de la Santé et de l'Assurance-Maladie*, 9, 2021, 83-91; L. MARGUET, *Chapitre 14. Le nouveau droit de l'assistance médicale à la procréation. Entre démédicalisation et stigmatisation: les tâtonnements du principe d'égalité*, in *Journal international de bioéthique et d'éthique des sciences*, 2, 2023, 187-200.

[12] *Décret n° 2021-1243 du 28 septembre 2021 fixant les conditions d'organisation et de prise en charge des parcours d'assistance médicale à la procréation*, art. R. 2141-36, 37, 38.

always take precedence over the possibilities opened by the law, as I shall come back to. Those age limits mostly signal the law's control over the generational coherence of parental projects.

Public Health Code also sets out a series of negative criteria related to the situation of couples. It prohibits insemination or embryo transfer in the event of death of one of the couple's members or filing of an application for divorce or legal separation by mutual consent, the cessation of cohabitation, or the written revocation of consent by either member of the couple.[13] The first provision points out the law's attention to prohibiting post-mortem filiation,[14] which is not unrelated to the question at stake here, since the desire to have a child with a deceased spouse could be considered as a potentially valid parental project, especially since French law now allows a woman to receive sperm donation on her own.[15] However, it raises too many legal issues such as the possibility of disposing of materials derived from a person's body after death, the legitimacy of pursuing a design formed by the person during his or her lifetime, or the interest of the unborn child in a family marked by mourning, of a richness and complexity that unfortunately could not be addressed in the present analytical framework.[16] The other

[13] "The man and woman forming the couple must be alive, of childbearing age and consent to the embryo transfer or insemination beforehand. The death of one of the members of the couple, the filing of an application for divorce or legal separation or the cessation of cohabitation, as well as the written revocation of consent by the man or woman to the doctor responsible for implementing medically assisted procreation, are obstacles to the insemination or transfer of embryos". My translation. Original text: "L'homme et la femme formant le couple doivent être vivants, en âge de procréer et consentir préalablement au transfert des embryons ou à l'insémination. Font obstacle à l'insémination ou au transfert des embryons le décès d'un des membres du couple, l'introduction d'une demande en divorce ou en séparation de corps ou la cessation de la communauté de vie, ainsi que la révocation par écrit du consentement par l'homme ou la femme auprès du médecin chargé de mettre en œuvre l'assistance médicale à la procreation", Code de la santé publique, art. L. 2141-2-2.

[14] L. BRUNET, *Quelles limites temporelles au désir de devenir père par assistance médicale à la procréation? Les incertitudes du droit français*, in *Dialogues*, 219, 2018, 37-50.

[15] ECtHR recently highlighted the inconsistency of French legal framework and case law regarding the ban on *post mortem* insemination and its corollary, the refusal by medical authorities to restitute genetic material of a deceased man to his former spouse or partner in order for her to proceed to an insemination in a country which allows it. In the *Baret and Caballero v. France* case, the Court vindicated French authorities' refusal to restitute gametes and embryos destinated to post mortem procreation, considering "the domestic authorities had struck a fair balance between the competing interests at stake and the respondent State had not overstepped its margin of appreciation", but added that "nevertheless, the Court acknowledged that the legislature's decision to extend the right to MAR to female couples and single women since 2021 reopened the debate as to the relevance of the justification for maintaining the prohibition complained of by the applicants. The Court reiterated that, while the States enjoyed a wide discretion in the bioethical sphere, the legislative framework put in place by them had to be coherent" (ECtHR, *Baret and Caballero v. France*, 22296/20 and 37138/20). Such an *obiter dictum* could challenge the ban on postmortem insemination in France and draws obvious conclusions regarding differentiated parenthood situations in French law. See J.-L. MARGUENAUD, *L'interdiction de la procréation* post-mortem *entre sursaut et sursis*, in *Revue trimestrielle de droit civil*, 4, 2023, 841; M. SAULIER, *L'interdiction vacillante de l'AMP* post mortem*?*, in *Actualité juridique Famille*, 12, 2023, 585; M. MESNIL, *La CEDH sonne le glas de l'interdiction de la procréation* post mortem, in *Dalloz actualités*, 29 septembre 2023, https://bit.ly/3VHAGRr, last visited on 2024 June 12th.

[16] Suffice it to highlight a startling twist in the relationship between reproduction and death in French civil and health law. Today's techniques for freezing gametes enable their quality to be preserved for very long spans of time, and there is no regulation governing the maximum storage period for donated gametes. Thus, it is possible to carry out an insemination with gametes from a deceased donor, and, if successful, to give birth to children genetically derived from a deceased individual. As gamete donation implies complete renouncement of any future link with the child or children conceived thanks to it, legal parentage resulting from a *post-mortem*

provisions reflect a concern for the situation of couples undergoing MAR procedures. *Prima facie*, this control is slight. Indeed, the "stability condition" for access to MAR guaranteed by marriage or proof of at least two years' cohabitation[17] was abolished by 2011 revision. Today, any couple, whether married, in a civil union or not, has access to MAR. MAR must only cease as soon as the couple is in the process of legal separation, whether by divorce, legal separation or cessation of cohabitation. The spirit of this provision is not to exclude specific family or couple configurations, but rather to ensure that parental projects are rooted in a peaceful couple life and will provide a favourable environment for the development of the future child. In other words, law controls *instability*, with minimal tools, rather than it imposes a positive conception of couple life. However, this tolerance is perhaps only apparent. In fact, the *Agence de la biomédecine* website reminds that the "reality of the couple" is an "obligation" for access to MAR as a couple.[18] However, nothing else in the texts qualifies what makes a couple "real": assessment is left to the doctors, paving the way for variability in the intensity of control and in the criteria for admissibility of parental projects. This delegation of assessment of the quality of the couple's life makes it difficult to predict the effectiveness of opening of MAR to other family configurations and makes it plausible that parental projects will be selected according to heteronormative norms on which MAR centres were historically built since 1994.

2.3. Double-edged enhancement of doctors' discretion and decision-making power

Apart from, and maybe above those remaining criteria, law gives doctors a wide – and widening – margin of discretion when it comes to deciding whether people can access to MAR. This decision-making power is enshrined in the mandatory interviews prior to entry into MAR procedure: "Any couple made up of a man and a woman or two women, or any unmarried woman, have access to medically assisted procreation *after individual interviews with members of the multidisciplinary clinico-biological medical team* carried out in accordance with the procedures set out in article L. 2141-10".[19] This requirement supersedes the previous mandatory medical diagnosis of pathological infertility. In this respect, it results from the access to MAR now being based on mere the existence of a parental project. However, article L. 2141-10 expounds and emphasizes the purpose of these interviews: not only are

conception remains impossible (Code civil, art. 342-9). However, 2021 Law lifted donor anonymity: adults born through gamete donation can now request the donor's identity or some non-identifying data, even in case of the latter's death (Code de la santé publique, art. L. 2143-2). Therefore, they could find out they are descended from a deceased person, or even from two, in the (very) hypothetical case of double gamete donation. While filiation with a deceased person remains taboo, one could see here a spectral form of legal posthumous parenthood.

[17] This condition was enshrined in law as soon as 1994 Law. Former article 152-2 specified: "The man and woman forming the couple must be alive, of childbearing age, married or able to provide proof of at least two years' cohabitation, and consenting prior to embryo transfer or insemination". My translation. Original text: "L'homme et la femme formant le couple doivent être vivants, en âge de procréer, mariés ou en mesure d'apporter la preuve d'une vie commune d'au moins deux ans et consentants préalablement au transfert des embryons ou à l'insémination".

[18] Agence de la Biomédcine website, https://www.procreation-medicale.fr/vos-questions/est-il-necessaire-de-prouver-la-vie-commune-et-sa-duree/, last visited on 2024 January 1st.

[19] My translation. Original text: "Tout couple formé d'un homme et d'une femme ou de deux femmes ou toute femme non mariée ont accès à l'assistance médicale à la procréation après les entretiens particuliers des demandeurs avec les membres de l'équipe médicale clinicobiologique pluridisciplinaire effectués selon les modalités prévues à l'article L. 2141-10", Code de la santé publique, art. L. 2141-2.

they the starting point of the procedure, but also a means for professionals to assess the parental projects themselves. Indeed, the article specifies that team doctors must first and foremost "verify the motivation of both members of the couple or of the unmarried woman".[20] Moreover, doctors can postpone or suspend entry into MAR procedure, when they estimate it is contrary to the "future child interest", without any explicit definition or criteria of the latter.[21]

The social competence of professionals is consequently extended by the opening of MAR to single women and female couples. One could read this development as a follow-up of the phenomenon of "medicalization" described by the sociologist Dominique Memmi as that by which "the judge tends to leave his place to the doctor, and the State delegates its supervisory power to liberal professions often associated with public service".[22] The weight given to the interviews may reinforce what Memmi called "government by speech",[23] i.e. the control of individual conducts by medical profession through the implicit injunction of health service users to produce plausible reasons for receiving care. And while law defines these reasons in terms that leave the protagonists considerable room for interpretation, individuals who do not present the appropriate biographical or parental identity expected by professionals, may be refused, or delayed, medical care. The paradox is as follows: while the law "de-pathologized" infertility, it keeps entrusting doctors alone the task of verifying the motivation of female couples or single women whose infertility is not medical to become parents. Arrangements seem to have been made to mitigate this increasing responsibility given to doctors in the assessment of parental projects: decree no. 2021-1243 issued by the Conseil d'État on September 28, 2021 and the ministerial order of October 5, 2023 added "social service" to the list of professionals who may be consulted during the prior investigation.[24] However, such consultation is not compulsory, and the decision to postpone or refuse MAR rests with the doctor, so that the possibility of legal recourse against a doctor's refusal to allow a couple or a woman to undergo MAR is virtually non-existent.

[20] My translation. Original text: "Les médecins de l'équipe mentionnée au premier alinéa du présent article doivent: 1° Vérifier la motivation des deux membres du couple ou de la femme non mariée", Code de la santé publique, art. 2141-10-2.

[21] "Medically assisted procreation cannot be implemented by the doctor who has also participated in the interviews provided for in the first paragraph [...] when this doctor, after consultation within the multidisciplinary clinicobiological team, considers that an additional period of reflection is necessary for the unmarried woman or the applicant couple, in the interest of the unborn child". My translation, original text: "Elle ne peut être mise en œuvre par le médecin ayant par ailleurs participé aux entretiens prévus au premier alinéa […] lorsque ce médecin, après concertation au sein de l'équipe clinicobiologique pluridisciplinaire, estime qu'un délai de réflexion supplémentaire est nécessaire à la femme non mariée ou au couple demandeur, dans l'intérêt de l'enfant à naître", Code de la santé publique, art. L. 2141-10, al. 15.

[22] My translation. Original quote: "Le juge tend à laisser sa place au médecin et l'État délègue son pouvoir de surveillance à des professions libérales souvent associées au service public", D. Memmi, *Faire vivre et laisser mourir. Le gouvernement contemporain de la naissance et de la mort*, Paris, 2003, 26.

[23] My translation. Original quote: "Gouvernement par la parole", D. Memmi, *ibid*., 11.

[24] *Décret n° 2021-1243 du 28 septembre 2021 fixant les conditions d'organisation et de prise en charge des parcours d'assistance médicale à la procréation*, art. R. 2142-18; *Arrêté du 5 octobre 2023 modifiant l'arrêté du 11 avril 2008 relatif aux règles de bonnes pratiques cliniques et biologiques d'assistance médicale à la procréation et abrogeant l'arrêté du 30 juin 2017 modifiant l'arrêté du 11 avril 2008*, IV-2.1, "Parcours des personnes réalisant une AMP avec don de gamètes ou d'embryons".

What are the impacts of this growing power to assess parental projects regarding entry into MAR given to professionals? Does it alter some couple or individuals' chances of becoming parent? At present, going beyond surmise on these matters is highly dubious. A few field studies have been carried out by sociologists and some are in progress.[25] Their observations tend to underline the difficulties encountered by medical profession in making decisions concerning MAR for single women, and the discomfort they face regarding the obligation to assess these parental projects according to non-medical criteria. The balance between legal norms of equality and non-discrimination, professional ethical standards and the pursuit of the future child interest could be achieved in multiple ways. One could assume that professionals will stress more rigorously on medical obstacles such as age or ovarian reserve to account for decisions which can decently not reflect social arbitrariness. They may even use these criteria as "proxis" to justify refusals or delays, in situations where the social conditions for parenthood do not seem to them to have been met. In addition, the sector's extremely tense context could accentuate competition between demands and pave the way for non-effectiveness of rights.[26] The inevitable sorting of parental projects may benefit projects corresponding to the traditional frameworks MAR centres have historically been built on. It is also worth noting the development of committees aimed at collectively reflecting on the responses to be given to thorny requests and grounding them on general principles of justice, or even norms of international law,[27] which helps counterbalance higher risk of medical power reinforcement on people's procreative future. In any case, it seems that opening MAR to all women has the paradoxical effect of reinforcing medical professions' normative activity regarding parenthood and compels them to integrate into their reasoning some considerations reaching far beyond parenthood's physiological or psychological possibility conditions.

3. MAR procedures regulation between biology and gender

Law's normalizing effect on socially accepted parental projects are not only at play at the entry into MAR, but also in the regulation of MAR procedures. It diffracts in several modes: that of authorizing or proscribing certain medical techniques, and that of explicitly or implicitly ranking and prioritizing these techniques in order of relevance. Indeed, MAR techniques are not neutral: they also prescribe *who* may or may not be a parent, and *how*. Anthropology enlightens the diversity of ways in which human

[25] I rely here on observations made by V. VILLARD (Université Paris Cité, Cermes3-INSERM) during field research in MAR centers in Rhône-Alpes region in 2022. Her work remained unpublished due to respect of the will of observed actors and sensitivity of the topic. Another field research in MAR centers in Paris region is currently conducted by S. MATTHIEU (École pratique des hautes études).

[26] "The time between making an appointment and the first attempt at MAP with sperm donation had risen to 14.4 months nationally by the end of December 2022 (compared with 12 months a year earlier), and 23 months for oocyte donation. Nearly 6,200 people are waiting for MAP with sperm donation, 40% of whom are single women. Although the number of candidates for sperm donation has risen from 600 to 764 between 2021 and 2022, and the number of candidates for oocyte donation from 900 to 990 over the same period, this is not enough to meet the societal demand that is now enshrined in law". My translation of V. LEFEBVRE DES NOETTES, *PMA, FIV… La « fabrique de l'humain» face aux enjeux biologiques, sociétaux et éthiques*, in *The Conversation*, 29/11/2023, https://theconversation.com/pma-fiv-la-fabrique-de-lhumain-face-aux-enjeux-biologiques-societaux-et-ethiques-218548, last visited 11/04/2024.

[27] M. IACUB, P. JOUANNET (ED.), *Juger la vie: les choix médicaux en matière de procréation*, Paris, 2001, 7 (intro).

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societies understand and interpret procreation. The roles of father and mother can be alternatively that of genitor, conceiver, or nurturer of the child.[28] This diversity leads to different visions of the link each has with the child resulting from procreation, and of their duties, rights and expected behaviours. Contemporary development of MAR techniques led to unprecedented separation of those roles in procreation. Gamete retrieval and storage makes it possible to isolate cells needed for procreation, to manage fertilization's temporality, but also, and above all, to make radical distinction between those individuals who will have a genetic link with the child, and those who will be the child's social parents. IVF, embryo storage and transfer techniques also make it possible to carry out fertilizations that would otherwise be difficult or improbable, as well as potentially separating the embryo's genetic origins from its place of gestation. The combination of gamete retrieval, IVF, and embryo transfer techniques can lead to configurations where a child has social parents, whose genetic material it neither shares, nor who carried it during pregnancy. What possibilities does French law open in this dizzying field of possibilities? What do the choices made by French legislator reveal about its underlying conception of parenthood?

3.1. The erosion of legal primacy of intra-couple reproductive technologies

At first, French MAR law noticeably fostered the maintenance of the genetic link. 1994 Bioethics law favoured from the outset autologous procedure, meaning intra-couple procedures, when gametes come from the parents. It authorized exceptionally a couple "for whom medically assisted procreation without recourse to a third-party donor is unsuccessful" to receive an embryo.[29] Embryo reception depended then on a judicial decision. Techniques with a third-party donor could only be used "as a last resort" when medically assisted procreation within the couple had failed.[30] Law explicitly promoted autologous methods over resorting to donation, and thus favoured recourse to IVF when *in utero* fertilization on medical grounds was impossible, which is the case most of the time. However, insemination with third-party and *a fortiori* IVF, are more demanding and considerably riskier for the woman carrying the child. She must have hormonal ovarian stimulation, undergo oocyte puncture, with or without general anaesthetic, before embryo transfer. Procedure involves extensive monitoring, daily injections and medication for several cycles, several ultrasound scans, and its side effects are notoriously frequent and heavy (weight gain, dermatological problems, moodiness, fatigue, etc.). This state of the law thus ratified unequal distribution of procreative burdens to the detriment of women, their

[28] M. GODELIER, *Métamorphoses de la parenté*, Paris, 2004, 242-243.

[29] My translation. Original text: "A titre exceptionnel, un couple répondant aux conditions prévues à l'article L. 152-2 et pour lequel une assistance médicale à la procréation sans recours à un tiers donneur ne peut aboutir peut accueillir un embryon", Code de la santé publique, art. L. 152-5. Embryo reception allows a couple or a single unmarried woman to anonymously receive one or more embryos originally conceived and frozen in anticipation of later use during an MAR carried out by another couple or another single woman, who no longer have a parental plan, and who agree to give their surplus embryos to people who need them in a new procedure.

[30] My translation. Original text: "L'assistance médicale à la procréation avec tiers donneur ne peut être pratiquée que comme ultime indication lorsque la procréation médicalement assistée à l'intérieur du couple ne peut aboutir", Loi n° 94-654 du 29 juillet 1994 (…), art. L. 152-6

extreme dedication to the implementation of the MAR course, and the intensive mobilization of their "reproductive workforce"[31].

2004 revision partially broke away with this explicit prioritization of intra-couple methods, and thus of a biogenetic basis for parenthood. New article L. 2141-7 abolished the subsidiary nature of artificial insemination and gave three reasons for recourse to third-party donor insemination: 1) when there was a risk of transmitting a particularly serious disease to the child or to a member of the couple, 2) when techniques of medically assisted procreation within the couple were unsuccessful, 3) when the couple, duly informed, renounced an intra-couple method.[32] Economics of this new legislation remained ambiguous, however, and undoubtedly reflected the fact that couples will first be advised to try intra-couple methods. Moreover, law maintained the ban on double donation, as embryos conceived by IVF must be created with the gametes of at least one member of the couple.[33] Law not only suggested it was preferable for there to be a genetic link between the parents and the child, but it also made mandatory this link with one of the two. As such, it set in stone the biological conception of parenthood. MAR law, even though it recognized the legitimacy of emotional parenthood, could not as far as detaching it from a genetic component. One could be surprised, however, that as early as 1994, embryo reception was authorized, and even preferred to insemination with donor, even though it implies a total absence of genetic link. However, this anomaly should no doubt be seen as a solution found by the legislator to the problem posed by the legal status of IVF-conceived embryo as "potential person"[34]: given the ethical value given to embryos, and the technical investment involved in their manufacture, the law has found this solution so as not to "squander" them, once the parental project that motivated their conception has been realized or stopped. It should be noted that today embryo reception remains possible on a subsidiary basis, and subject to a specific judicial procedure.

Following the removal of the precondition of pathological infertility for access to MAR, the latest revision in 2021 repealed article 2141-7. French MAR law no longer seems now to bear any trace of prioritizing a genetic basis for parenthood. On the contrary, it puts all techniques on the same level, and tends to conceal medical and social implications of the different techniques especially in terms of the distribution of the procreative burden. The 2021 revision also opened the possibility of double gamete donation, and thus accepted forms of parenthood that could be solely physiological and emotionally

[31] I.-L. HERTZOG, *Le travail re-productif des femmes: le cas de l'assistance médicale à la procréation (AMP) en France*, in *Tracés*, 32, 2017, 111-132.

[32] My translation. Original text: "L'assistance médicale à la procréation avec tiers donneur peut être mise en œuvre lorsqu'il existe un risque de transmission d'une maladie d'une particulière gravité à l'enfant ou à un membre du couple, lorsque les techniques d'assistance médicale à la procréation au sein du couple ne peuvent aboutir ou lorsque le couple, dûment informé dans les conditions prévues à l'article L. 2141-10, renonce à une assistance médicale à la procréation au sein du couple", Code de la santé publique, art. L. 2141-7 (abrogé).

[33] "Un embryon […] ne peut être conçu avec des gamètes ne provenant pas d'un au moins des membres du couple", Code de la santé publique, art. 2141-3 (version en vigueur du 09 juillet 2011 au 04 août 2021).

[34] In its very first opinion, published in 1984, the French *Comité consultatif national d'éthique* stated: "The embryo or fetus must be recognized as a potential human person who is, or has been, alive, and whose respect is incumbent on everyone". My translation. Original text: "L'embryon ou le fœtus doit être reconnu comme une personne humaine potentielle qui est, ou a été vivante et dont le respect s'impose à tous"*, Avis sur les prélèvements de tissus d'embryons et de foetus humains morts, à des fins thérapeutiques, diagnostiques et scientifiques,* 22/05/1984, online: https://www.ccne-ethique.fr/sites/default/files/2021-02/avis001.pdf.

grounded for a couple, or purely physiologically grounded, for a single woman. Donation has also been encouraged by the lifting of the condition of having already procreated to be able to donate. However, while Public Health Code no longer seems to bear any trace of an absolute attachment to the genetic parental link, ministerial decree of 2023 does bear some slight traces of it: MAR with a third-party donor, embryo reception or adoption are presented in it as "alternatives" that doctors must present to the patients as part of their right to information, implying that the main modality is intra-couple.[35] However, it would be unfair to draw from these provisions that the law itself maintains a necessarily genetic conception of parentage. It persists in practice (in 2021, 95% of MAR attempts were intra-couple) for other reasons: gamete stocks available for donation are too low to meet demand, and waiting times are notoriously long. Mostly, patients themselves wish to use their own gametes as much as possible, and to come as close as possible to procreation by "natural" means, sometimes at the cost of an extremely heavy medicalization of the woman's body.

Parenthood exclusive of the physiological bond with the future child, ie. pregnancy by one of the future parents, remains impossible through MAR legal services in France.[36] Surrogacy, whatever its modalities remains prohibited, and current state of debate does not suggest any medium-term evolution on this point.[37] MAR necessarily rhymes with gestation by the future legal mother of the child, whether it comes from the fertilization of gametes from one, both, or neither of its parents. However, other configurations, which do not involve gestation by a third party, are also implicitly prohibited by French MAR law. These are procreation projects that do not meet heteronormative distribution of parental roles, or rather a cisgendered distribution of parental roles. These implicit prohibitions in MAR law also reveal its underlying conception of parenthood that distributes parental roles according to traditional gender criteria.

3.2. Non-cisgender procreation: a touchstone for the gender-differentiated parenthood models underlying MAR law

Recent work in sociology of health documented the strong gender differentiation in conceptions of parenthood, understood as the right way to become a parent, in discourses and practices in MAR centres. In her 2013 survey,[38] the sociologist Séverine Mathieu describes the way doctors present the

[35] *Arrêté du 5 octobre 2023 modifiant l'arrêté du 11 avril 2008 relatif aux règles de bonnes pratiques cliniques et biologiques d'assistance médicale à la procréation et abrogeant l'arrêté du 30 juin 2017 modifiant l'arrêté du 11 avril 2008*, "Titre II. Dispositions communes à la prise en charge des personnes en AMP".

[36] In 1989, the French *Cour de Cassation* invalidated surrogacy agreements in application of Civil code, article 1128 according to which "only things which are in commerce can be the object conventions", and non-compliance of these conventions with the principle of public order of the unavailability of the state of persons. It was then prohibited by 1994 Law which introduced in the Civil code a new article 16-7 according to which "any agreement relating to procreation or gestation on behalf of others is void". French Penal Code, article 227-12 also provides for criminal sanctions, on the grounds that surrogacy is provocation of child abandonment.

[37] For a synthesis of cases against legalization of surrogacy in French context see S. EPELBOIN, *Un utérus en prêt: pour qui, pourquoi et comment?,* in C. PONCELET, C. SIFER, S. EPELBOIN (ED.), *Physiologie, pathologie et thérapie de la reproduction chez l'humain*, Paris, 2011, 677-689. For a more recent, legal, and pro-legalization of surrogacy cases see D. BORRILLO, T. PERROUD (ED.), *Penser la GPA*, Paris, 2021.

[38] S. MATHIEU, *L'enfant des possibles. Assistance médicale à la procréation, éthique, religion et filiation*, Paris, 2013.

stakes of using a third-party donor in cases where procreation with the couple's own gametes was impossible. Professionals explain to couples requesting sperm donations, and in particular to men, that "parenthood is not only biological, it's a human adventure", that "the father is the one who raises the child". But in the consultations where the possibility of egg donation is discussed, doctors are less insistent on the social aspect of parenthood and overemphasize the pregnancy period. Being a gestator trumps being a parent. As Séverine Mathieu concludes: "For mothers, biologization of kinship, for fathers, its socialization".[39] What about the law itself? Does it uphold such differentiated conceptions of parenthood? And how? It does through two obstructions: the prohibition of ROPA method, and the exclusion of non-cisgender parental configurations from MAR procedures.

3.2.1. Prohibition of ROPA or reluctance to shared biological maternity

Reception of oocytes from partner (ROPA), also known as "partner-assisted reproduction" or "reciprocal IVF" is a method of procreation used by couples who both possess female reproductive organs. In this procedure, one of the partners provides an egg, which is fertilized by IVF with gametes from a third-party donor, and the embryo is then transferred to the second woman's uterus. This method has been tested in Spain since 2007, and is now allowed in several European countries, such as Cyprus, Ukraine, Belgium and the United Kingdom. It does not present any technical issues, as it is a combination of techniques already authorized under French law. It enables a lesbian couple to conceive a child who will have a biological link with both mothers, genetic for one and physiological, ie. made by pregnancy, for the other. Mostly, it offers a chance to share procreative burden. ROPA arose during the debates on the latest revision of the Bioethics laws, but its ban was ultimately maintained. A group of Socialist *députés* indeed proposed an amendment worded as follows: "Any person or couple undergoing medically assisted reproduction must be able to use their gametes"[40]. The explicit aim of this amendment was to allow ROPA method, without imposing it on female couples. Two reasons were then provided for its rejecting.[41] Firstly, ROPA would add unnecessary burden to the treatment of female couples. Instead of a simple insemination with a third-party donor, patients would have to undergo ovarian puncture, IVF, and embryo transfer. This would be contrary to the medical deontology principle of economy of means, i.e. minimizing interventions on bodies. Secondly, ROPA has been dismissed as a directed donation incompatible with the relatively strict legal framework for gamete donation, and with the French conception of gamete donation.[42]

[39] My translation. Original quote: "Aux mères la biologisation de la parenté, aux pères sa socialisation", S. MATHIEU, *ibid*., 108.

[40] My translation. Original text: "Toute personne ou couple pris en charge dans le cadre d'une assistance médicale à la procréation doit pouvoir recourir à ses propres gametes", Assemblée nationale, 3/07/2020, https://www.assemblee-nationale.fr/dyn/15/amendements/3181/AN/492.pdf.

[41] "Bioéthique: l'Assemblée rejette la Ropa et la PMA post mortem", *LCP*, 2020 July 20th, last visited on 2024 June 14th, https://lcp.fr/actualites/bioethique-l-assemblee-rejette-la-ropa-et-la-pma-post-mortem-31684. G. Giovannini also identified in media statements at the time of this bill a "slippery slope argument", according to which ROPA would be a prelude to a form of legal surrogacy, in G. GIOVANNINI, *The French Law on Bioethics and its Limitations : Challenges for the Future from a Comparative Perspective*, in *International Journal of Law, Policy and The Family*, 2022, 1-22, https://doi.org/10.1093/lawfam/ebac011.

[42] The debate seemed noteworthily to elude the question of inegalitarian consequences regarding reproductive rights of the ban in France of ROPA while a lot of European countries allow it, resulting in the building of a market

Both arguments are questionable. The first one does not stand up to the demand for equal access to MAR for people of all sexualities, in cases where the woman who is going to carry the child cannot provide an oocyte. In this case, the woman carrying the child would be forced to resort to a double donation or embryo reception, with the waiting times implied. It would also make no difference to the number of technical procedures required for MAR, since a donor would have to suffer it for the couple. The second argument is more interesting for the question at hand: if the woman who provides the egg is really going to become the child's mother, is this really a donation or simply a gamete transfer? What is the difference between receiving a partner's oocyte and intrauterine insemination in a straight couple, which is carried out because of an obstacle to sexual intercourse, quality of the cervix, sperm mobility or else? Isn't it just as much a case of directed donation? Why is it so difficult for MAR law to envisage such a procedure?

This resistance to legalizing ROPA reveals differentiated conceptions of parenthood between men and women underlying MAR law, which implies differentiated treatments of female and male gametes, more precisely a restriction of the technical possibilities for manipulating and transferring female gametes. Male gametes seem indeed automatically detached from the man's body and become genetic material that will fertilize an egg. Consequently, the representation of paternity is originally built on the assumed genetic link, and on the emotional link as a substitute of the latter. But in both cases, the conception of paternity is based on a separation between the man and his gametes, and on the social grounding of paternity. On the other hand, in the case of women, the conception of maternity is on the one hand based on the genetic link, i.e. the use of oocytes, but this genetic link is seen as secondary, or at any rate less necessary than that which results from gestation. A more classical way to express this idea is the *mater semper certa est* principle on which maternal filiation in French civil law is built. Above all, these two roles are conceived as complementary, and therefore watertight: only the genetic mother can carry the child, and only the one who carries the child can be the genetic mother. The father has the choice (free or not) between genetically or emotionally grounded parenthood. Consequently, in a female couple, the woman who carries the child is the child's "actual" mother, and her partner can only endorse the symbolic role of father. In other words, her parenthood can only be social, yet never biological. Even though she could have a genetic link with the child, she is forbidden to do so. It should be noted, however, that under current law, a lesbian couple can resort to double-donation or embryo reception. Thus, the only case in which a woman can carry an oocyte she has not produced herself is when this oocyte is an anonymized donation, producing an affective filiation based on the male model, and compensated by the pregnancy which allows again a "pseudo-biological filiation".[43]

excluding *de facto* some parental projects on socio-economic grounds. See F.R. ACOCELLA, *Love is love: Why intentional Parenting should be the Standard for Two-Mother Families Created through Egg-Sharing*, in *Cardozo Public Law, Policy and Ethics Journal*, 487, 14, 2016. Choice was made here to focus on the expressed cases made in the French debate against ROPA from a domestic point of view, however, the analysis could be completed with such a transnational perspective.

[43] Cf. note 5.

3.2.2. MAR regulation coping with transgender parental projects

MAR law parenthood standards also show through legal possibilities of using MAR given to transgender people.[44] Transgender people can request MAR, but the possibilities open to them are limited, uncertain or complicated by the bicategorization of the sexes in civil status. French law indeed allows people to have both a male civil *status* gender and a functional female reproductive system, or to have a female civil status and a functional male reproductive system. Since 2016, transgender people are no longer required to be sterilized[45] to obtain a change in their civil status sex, so that (trans) men can have a uterus and ovaries, and (trans) women can still produce sperm if they have not undergone surgery. Furthermore, fertility preservation has been in 2021 permitted for any person, on medical grounds (due to potentially sterilizing treatment) or without medical grounds.[46] People undergoing transition can therefore preserve their gametes before their transition is finalized and their gender change registered.

However, transgender people are almost systematically blocked or hindered in their family projects if they need help of MAR to realize them.[47] A trans man who has kept his uterus in a couple with a cisgender man, has no access to it at all, because even if their reproductive organs correspond to a straight couple, they are from the point of view of civil status two men. If he is single, the same problem arises. Though he could be pregnant, he cannot receive sperm donation, since it is reserved to women. The only solution open to them is to apply for adoption, or, if this is still possible, to postpone the change of gender on their civil status, in order impersonate a single unmarried woman or a straight couple for the time needed to benefit from MAR. The situation for trans women in a couple is more favourable, but unsettled. Nothing explicitly prohibits the use of a transgender woman's (male) gametes: it is possible for a couple made up of a transgender woman and a cisgender woman to access

[44] Literature about the establishment of legal parenthood for trans persons, and the challenges it poses to legal conceptions of gender identity is quite abundant both in French and other national contexts. See for the specific question of the motherhood of trans men in German and English contexts A. MARGARIA, *Trans Men Giving Birth and Reflections on Fatherhood: What to Expect*, in *International Journal of Law, Policy, and The Family*, 2020, 24, 225-246. The present argument focuses on MAR procedures and leaves aside civil law rules regarding the establishment of parenthood, with or without recourse to MAR.

[45] November 2016 reform amended the Civil Code, article 61-6, adding to it a paragraph 3: "The fact of not having undergone medical treatment, surgery or sterilization cannot be a reason for refusing to grant the request to change the gender mention in civil status". My translation. Original text: "Le fait de ne pas avoir subi des traitements médicaux, une opération chirurgicale ou une stérilisation ne peut motiver le refus de faire droit à la demande de changement de la mention du sexe à l'état civil".

[46] "Any person whose medical care is likely to impair fertility or whose fertility is at risk of being prematurely impaired may benefit from the collection or retrieval and preservation of his or her gametes or germ tissue with a view to the subsequent performance, for his or her benefit, of medically assisted procreation, with a view to preserving or restoring his or her fertility or with a view to restoring hormonal function". My translation. Original text: "Toute personne dont la prise en charge médicale est susceptible d'altérer la fertilité ou dont la fertilité risque d'être prématurément altérée peut bénéficier du recueil ou du prélèvement et de la conservation de ses gamètes ou de ses tissus germinaux en vue de la réalisation ultérieure, à son bénéfice, d'une assistance médicale à la procréation, en vue de la préservation ou de la restauration de sa fertilité ou en vue du rétablissement d'une fonction hormonale", Code de la santé publique, art. 2141-11.

[47] L. CARAYON, *Personnes trans et loi de bioéthique: histoire d'un silence*, in *Actualité juridique famille*, 10, 2021, 543

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MAR, if the gametes used are those of the transgender woman or from a sperm donation from a third-party donor. However, the use of such inseminations is still limited, and CECOS (C*entres d'étude et de conservation des ovocytes et des spermatozoïdes*) remain reluctant to accept them, as well as they can fear gamete conservation process in the first place, which depends on the good will of the centres.[48] The most problematic cases are undoubtedly those of transgender men who have kept their uterus and in a couple with a cisgender woman. In such cases, the use of a third-party donor for the male gametes is necessary. The woman then is allowed to get an insemination with third donor, and carry the child, as in the case of cisgender straight couples with an unfertile man. However, other choices are open: her partner could carry the child, after having received an insemination, or after an IVF with an egg from her partner and a donation, or event an IVF made with one of his eggs (retrieved or preserved) and a spermatozoid donation. However, in the texts, especially in the 2023 decree which supervises MAR processes, only a *woman* can become pregnant, and it is always the woman in the couple who is intended to carry the child.[49] The only option open to this type of couple is therefore third-party donor insemination, and if insemination is not possible or fails, adoption, though pregnancy again could be performed by the man. These cases show that in the current state of MAR law, despite the absence of any true technical obstacle,[50] it is still necessary for: 1) the role of gestation to be performed by a woman; 2) the gametes to correspond to the legal gender of the person providing them. MAR regulation thus acknowledges quite consistently the separation between sexuality and procreation, but not yet the potential discrepancy between procreation and gender. Its binarity and mimicry of the "laws of nature" that support a heteronormative model of parenthood locks people into their gender roles and reduces their possibilities to make a family.

4. Conclusion

Which parenthood standards underly French law regarding MAR? To what extent 2021 Bioethics Law' opening of MAR to lesbian couples and single unmarried women entailed a "rupture anthropologique majeure"[51] in what law and society consider as a legitimate family? Legal access to MAR, while being decorrelated from pathological infertility and welcoming non-traditional parental projects, does not yet guarantee equality of treatment and equal consideration of those, since responsibility of the assessment of the legitimacy of parental projects was transferred to MAR professionals in a context of competition between growing numbers of patients. MAR regulation also bears traces of a biologically based on the one hand, and gendered conception of parenthood on the other hand, burdening

[48] S. GOUILHERS, D. GARDEY, R. ALBOSPEYRE-THIBEAU, *De la stérilisation imposée à la préservation de la fertilité des personnes trans: les médecins au travail*, in *Travail, genre et sociétés*, 50, 2023, 61-78.

[49] "A clinico-biological investigation is carried out prior to the medically assisted procreation. It aims to: [...] at least a clinical evaluation of the *woman* who will carry the child". My translation and underlining. Original text: "Une investigation clinico-biologique est réalisée préalablement à l'APM. Elle vise à: […] l'évaluation clinique au minimum de la *femme* qui portera l'enfant», Arrêté du 5 octobre 2023, Titre II-3.

[50] L. HERAULT, *La gestion médicale de la parenté trans en France*, in *Enfances Familles Générations*, 23, 2015, online.

[51] "PMA pour toutes : les 'réserves' de l'Académie de médecine sur 'une rupture anthropologique majeure'", *Le Monde*, 22 septembre 2019, https://www.lemonde.fr/societe/article/2019/09/22/pma-pour-toutes-les-femmes-l-academie-de-medecine-exprime-des-reserves_6012591_3224.html, last visited 2024 June 14th.

individuals, and especially women embarking into MAR, and producing legal uncertainty if not exclusionary effects of non-cisgender individuals or couples wishing to conceive thanks to MAR.

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