FREEZING EGGS FOR LIFESTYLE REASONS

Only around 50% of women who postpone childbearing until their thirties conceive in the six years following. Infertility causes significant harm to those who suffer it, and we argue for promoting access to treatments, such as cryopreservation of eggs, to enable women to pursue their reproductive goals as they choose. Preserving ovarian tissue is another means to achieve this, however as the authors rightly point out, it raises ethical concerns about consent and risk. Unassisted, fertility declines with age, as older women often have few or no viable eggs for fertilisation. There is also a critical relationship between the age of the egg and successful conception—“It is the age of the egg, not the age of the womb, which determines the miscarriage rate.”1 However “very satisfactory pregnancy rates can be achieved using oocytes donated by younger women”.2

Where frozen eggs are used, some studies suggest a live birth rate of 4% per egg using new vitrification methods.3 While this rate is lower than the current rate of success of IVF using fresh eggs, other studies have demonstrated that cryopreservation of oocytes does not affect IVF success rates.4 Freezing eggs can disrupt their genetic material and hence compromise developmental competence. Eggs preserved using vitrification, however, reportedly have a 91.2% survival rate, as opposed to 73.2% using the older, slow-cooling method. Further, immature eggs matured in vitro after being frozen using slow freezing protocols have also resulted in births5 and frozen ovarian tissue has recently been successfully grafted in humans.6 Healthy births from oocytes generated this way were reported in 2004 and 2005.7

A retrospective study of research on pregnancies using cryopreserved eggs reported 272 pregnancies up to July 2006. Health status information was available for 197 newborns, with only one reported congenital abnormality (well within normal range). Follow ups of child

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health from birth up to three years was available for 31% and all were developing normally. Genetic defects due to slow freezing are a major risk associated with egg freezing. New vitrification techniques have little or no effect on meiotic spindles and chromosome alignment, removing this risk. For those who wish to reproduce later in life, would increase their chances of being able to conceive. Yet the British Fertility Society (BFS) does not encourage egg freezing for social reasons. The American Society for Reproductive Medicine has called for fertility clinics to stop offering egg freezing to healthy women. As a result, women have recently been confronted by a slew of headlines: “Women urged not to use frozen eggs as insurance”, “Career women ‘must not have eggs frozen to delay family’”, and “Docs pour cold water on egg-freezing promises”. We argue that there are good moral arguments in favour of egg freezing for social reasons. Zoloft et al’s paper is a timely contribution to the debate on the freezing of eggs and ovarian tissue, and many of the issues it explores are relevant to egg freezing for non-medical reasons. We present two main arguments in favour of allowing and promoting access to egg freezing for social reasons: benefits to women and equality. We then consider the range of objections to egg freezing for social reasons, and conclude that these do not outweigh the arguments in favour. Women are having children later today, partly because they are more likely to pursue higher education and a career. Cost of living increases have also increased the need for women to contribute to family earnings. The time of child-bearing has an identifiable impact on educational and employment outcomes for women, constraining their capacity to make the most beneficial choices about their careers. Some women may consider their chances of receiving the education they desire, or pursuing the career of their choice is improved if they can postpone childbearing. Egg freezing may increase their chances of conceiving later in life if they choose to do so postpone. Some also feel pressure to find a partner and have children by their mid-thirties. The absence of a partner can be a key variable affecting the chance of starting a family at older ages, while

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13 We recognise that there is a significant body of feminist literature in this area, and that indeed as Laura Purdy has commented, the consequences of the new reproductive technologies “cry out for feminist analysis” (L. M. Purdy. 1996. Reproducing Persons: Issues in Feminist Bioethics. Ithaca and London: Cornell University Press: 75). In particular, the concept of “relational autonomy” as argued for by feminist writers such as Susan Sherwin is one we believe does need consideration in this area given the embedded and constrained nature of women’s choices in relation to reproduction (see, e.g., S. Sherwin, et al. 1998. The Politics of Women’s Health: Exploring Agency and Autonomy. Philadelphia; Temple University Press; A. Donchin. Reworking Autonomy: Toward a Feminist Perspective. Camb Q Healthc Ethics 1995; 4: 44–55; S. Dodds. 1999. Choice and Control in Feminist Bioethics. In Relational Autonomy: Feminist Perspectives on Autonomy, Agency and Social Self. C. MacKenzie & N. Stoljar, eds. Oxford and New York: Oxford University Press: 213–235). It is, however, beyond the scope of this paper to do these approaches full justice, although they will drawn on where possible.
the odds of a woman having a child are three times higher for those with partners than for those without.\textsuperscript{14} The option to freeze one’s eggs can address these factors that might otherwise lead some women into unhappy marriages, single parenthood or unwanted childlessness.

Measures that help women to choose when to conceive may also allow them to choose the best time to have children. Currently, they must juggle establishing a career and having a family. It may be better for the child and parents that the family is the result of mature and well considered choice, and is financially secure so that the parents are able to spend time with their children.

As Zoloft et al discuss in their paper, freezing eggs and ovarian tissue is an option for girls and women with cancer or autoimmune disease about to undergo treatment.\textsuperscript{15} As they state, “a diagnosis of cancer now confronts [women] with two threats. The first is one’s own mortality, and the second is the possible end of their reproductive life”. The chance to freeze eggs or ovarian tissue may present an “unprecedented choice” for such women and girls, opening up the possibility of retaining their ability to reproduce.

We argue that there are many other situations in which women might wish for a similar form of ‘insurance’—to allow them to have another child later if their circumstances change: they change partners, their financial circumstances improve, their child dies, or they simply change their attitudes. This unprecedented choice should be offered to these women as well, if they are fully informed and prepared to bear the loss if the ‘insurance policy’ fails. At the time when the Joseph Project began, it was highly uncertain whether cryopreservation techniques would be successful. The data we cite above suggests that this position has changed, and that women who freeze their eggs have a significant chance of using them successfully in the future. Given this, they should be allowed to make this choice.

For Zoloft et al, the choices of girls present a particular problem—“the need to simultaneously hold and abandon the sense of innocence of children with the violation of surgery and the thought of the child’s future sexual preferences”. In the context of our argument for women’s choices, this concern does not apply. However, we would argue that Zoloft et al over-state the problem for girls. Having children is demonstrably something most people choose to do in their lives. It is therefore not problematic to assume that most girls will at least wish to have this choice open to them in later life. We do not need to sexualise them to make this assumption, as we can derive it from the demonstrated choices from most adults. The main concern is that removing an ovary may reduce reproductive capacity if it turns out the treatment does not affect reproductive capacity in the end. The child will be left with less capacity as she will have only one ovary. This should be the focus of decision making—whether this risk is too great to take on. This can only be determine the context of the particular illness.

Objections raised to egg freezing for non-medical reasons rest largely on welfare concerns for the woman and her child. One view is that it is not in a woman’s interests because it is better for her to have children earlier in life when she is fitter and more able to deal with pregnancy and parenting. But pregnancy is much safer today, even in older women,\textsuperscript{16} and empirical evidence suggests that older women often have more positive experiences of pregnancy than


their younger counterparts, because they are more prepared and more committed to the “parenting experience”.17

Women are also criticised for bearing children when older, while men do not face such censure. Men already enjoy the choice of when they have children. Women should have the opportunity to enjoy the same choices, if we can provide them. Allowing egg freezing will increase equality in this context.

In terms of the child’s welfare, it is sometimes argued that an older mother is more likely to die while the child is still quite young, and as Arthur Caplan has argued, producing orphans is not “good public policy”.18 However, while an older mother may have less years of life to spend with her child, allowing postponement of childbearing through egg freezing is unlikely to produce many ‘orphans’. It is in fact more likely than not that a woman who becomes pregnant late in life will be alive to care for her child for many years. In the UK, average life expectancy for women is over 80 years, so even a woman who postpones childbearing until she is 50 can still reasonably expect to live until her child reaches adulthood.19

Another objection is that widespread availability of egg freezing may give women a false sense of security about their chances of reproducing, discouraging them from finding ways to have children at the age when their reproductive capacity is at its peak.20 For example, Mark Fritz, chair of the ASRM expert committee that issued a warning this year against social egg freezing argues that women may have a false impression that storing their eggs ensures their chances of conceiving later in life.21

This argument does not apply to the cases considered by Zoloft, and rightly so. Women facing treatment that may destroy their ability to reproduce have little choice already. They do not rely on egg freezing, they probably have no other choice if they wish to retain reproductive ability. But in the case of healthy women, the reliance concern is valid. We argue, however, that it is merely an argument against poor information provision, rather than egg freezing. Simply because women may take precautions against an unwanted outcome does not mean they will rely on these precautions unduly. In fact, it demonstrates that they are risk averse, and hence may be more likely to be aware of the problems they may face in trying to conceive later.

As techniques to freeze eggs and ovarian tissue continue to improve, we need to consider deeply the ethics of allowing women to make the choice these techniques give them. We have limited information about how widely used, and how successful, the techniques will be. Zoloft et al’s study will yield findings highly relevant to the consideration of this issue, as is to be welcomed.

19 Recent demographic information supports this view, particularly for women in high status jobs. Life expectancy for such women—the group most likely to postpone childrearing by freezing their eggs—is now 85, higher than that for women generally. J. Sheerman. Wealthy, Healthy and Aged 85: The Women Living Even Longer. The Times 25 October 2007. While we recognise that there may be good reasons not to conceive children at some stages of life, some determined by age, our argument does not require us to set a threshold age beyond which egg freezing should not be permitted. We are not arguing for a right to egg freezing, but rather against a general prohibition on it, and that women should have access to it. We do not suggest that such access would always be unlimited. We also argue that, given the points made in the text, we can say a biological age of 50 for conceiving would not be objectionable, and if egg freezing is needed to conceive at this point, this is ethical acceptable based on our arguments.