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Clinical practice

The ethics of egg donation in the over fifties

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Abstract

It has been conclusively demonstrated that postmenopausal women can gestate and give birth to children. However, to do so, they require donated oocytes, which are in short supply. In this paper, I explore a number of arguments for limiting access to donated oocytes to women of normal reproductive age. I consider the idea that older women have already had their chance to reproduce, and have chosen to forego it. I also consider the question of whether younger women have a more compelling clinical need, and ask whether the risks involved in postmenopausal motherhood are excessive. I argue that many of the concerns about postmenopausal motherhood are based on unjustified assumptions. Postmenopausal women are treated very differently to men of similar ages in the context of reproduction. I question whether this constitutes unjust discrimination or whether it reflects intrinsic differences between women's and men's reproductive capacities, and parental roles. In either case, women are often at a disadvantage and are subject to heavy social pressure in their reproductive choices. I conclude that there are no compelling reasons for a systematic ban on the use of donated oocytes in postmenopausal women. However, the procurement of oocytes for use in *any* woman raises some series ethical issues, and as new technologies and research avenues proliferate, pressure on this resource is likely to increase.

Keywords: Menopause, oocyte donation, ethics, reproductive technology, fertility

Introduction

Liz Buttle, then aged 60, hit the headlines in 1997 when she gave birth to a baby following *in vitro* fertilization (IVF) treatment, becoming the UK's oldest mother.[1] The birth of Ms Buttle's child demonstrated to the public what had already been noted by fertility specialists, namely that reproduction is now possible 'in virtually any woman with a uterus'.[2] This expansion of reproductive possibilities has not universally been regarded as a welcome new facet of choice for postmenopausal women, however. The prospect of women using donated eggs to reproduce after the menopause may raise a number of concerns. It might be thought wrong for women to transgress the natural boundary of the menopause in this way.[3,4] Some people regard gamete donation as being inherently wrong.[5] In this paper, I neither explore the ethics of gamete donation *per se*, nor do I question whether postmenopausal motherhood is unethical specifically because it is unnatural. Rather, I ask whether – given that oocytes are a scarce resource – there are any ethical grounds for denying treatment to postmenopausal women or for deprioritizing their claims.

Many other medical resources, such as drugs or diagnostic equipment, are scarce because they are time-consuming or costly to create or manufacture. However, human organs and eggs are scarce not specifically because they are expensive to obtain, but due to the physical risks and ethical complications involved. Because of their scarcity, the problem of how to discriminate between claimants arises. This raises a variety of ethical questions. Have postmenopausal women already had their chance? Should gametes be provided only to those who have a genuine medical need? Are there grounds for refusing donated eggs to women over 50 on the grounds of harm to the mothers and children? Or would this be discriminatory?

A fair innings?

Postmenopausal women who seek treatment with donated eggs are competing, as it were, with younger women whose claims might initially seem far stronger. These may be women who have lost their fertility as a result of cancer treatment, who have undergone premature menopause or who fear to use their own eggs because they are carriers of a genetic disease. No woman chooses to suffer these problems: they are the result of unfortunate circumstances, and thus perhaps intuitively deserving of medical intervention. In contrast, it is commonly assumed that a woman who reaches the age of normal menopause without having children has had ample opportunity to become a mother but has chosen to

postpone or forego it.[3] If this were so, it might be argued that such women have a lesser claim to treatment since they have brought their childlessness on themselves.

In 2005, a group of fertility experts writing in the *British Medical Journal* speculated that women who are currently of reproductive age are now deliberately delaying pregnancy on the assumption that reproductive technology will help them out in later years.[6] This kind of assumption often feeds into an undercurrent of feeling that seems to inform attitudes towards older and postmenopausal motherhood. That is, women have a duty to reproduce at the 'appropriate' time and that they can be condemned for failing to do so. In particular, it tends to be assumed that career ambitions and a desire for social and economic status are at the root of women's failure to make appropriate reproductive choices.[6]

There are a number of questions to be asked here. Do women who fail to reproduce at the 'right' age display immoral characteristics? Is it really true that women are consciously delaying motherhood? Many of the underlying concerns about women's motivations and characteristics in making reproductive choices have been brought to the fore in the context of egg freezing. Again, there are two potential categories of claimant: those women who suffer from the kind of medical conditions outlined earlier and those who might seek to freeze their eggs as a kind of insurance policy. Dr Gillian Lockwood suggests that '...egg freezing may come to be seen as the ultimate kind of family planning'.[7] However, the use of egg freezing as 'insurance' in this way was swiftly denounced by many fertility clinics and by the American Society for Reproductive Medicine.[8]

Selfishness

The idea that women may use technology to facilitate their career aspirations and plan for later motherhood seems to be unpalatable to many people. But why is this? Perhaps, partly because the idea of furthering one's career rather than having children just does not seem *motherly*. Ann Oakley has observed that there is a tendency to 'pose an artificial conflict of interest between women and their fetuses, to remark on an apparent absence of that effortless altruism which is itself a hallmark of femininity'.[9] This claim seems to be borne out by descriptions of older mothers as cold, selfish and calculating, willing to impose unnecessary risks on their offspring in an endeavour to fit motherhood with their careers.[10] RL Shaw and DC Giles also point out the frequent reiteration of 'selfishness' and 'wanting to have it all' in media discussions of older motherhood.[11] Indeed, many commentators who address this topic suggest, whether explicitly or implicitly, that women must accept some degree of blame for the trend towards later motherhood, and the consequent demand for fertility treatment for older or postmenopausal women.[12]

The question of whether women really are showing selfish characteristics cannot be answered without considering the process by which these decisions are made. Part of the rhetoric of selfishness relies on the idea that women *could* do otherwise if they pleased, but choose not to do so, placing their own interests above those of their children. The language used to describe the decisions and choices faced by women often seems to emphasize this idea of choice and of deliberate postponement. A typical phrase reads: '[m]any people are choosing to put off having children until relatively late in life'.[13] The use of terms such as 'put off', 'delay' and 'postpone' reinforces the idea that there is a specific choice being made here.[11]

Deciding to postpone motherhood

Women who do not reproduce at the right time can thus be compared unfavourably with those who do. On the one hand, there is the paradigm of conscientious reproductive planning: the woman who decides to have a child at the optimal reproductive age. On the other, there is the woman who puts her career first and makes a conscious decision to postpone motherhood – the postmenopausal patient of 20 years hence. If women were *not* perceived as making a conscious choice not to have a child earlier, it would be far less plausible to portray them as calculating or selfish. Likewise, the idea that they have had a 'fair innings' would not seem so compelling.

What is the nature of the decisions people make regarding pregnancy? Large numbers of women get pregnant accidentally, even in countries where contraceptive use is widespread.[14] In these cases, no specific decision has been made. However, the decision to have a child *can* be a discrete event occurring at a particular time and place. It may be followed by noticeable changes of habit and action. (Indeed, it is often assumed that reproductive decisions *should* be of this type, and accidental pregnancies are typically regarded as a public health problem.)[15] Likewise, *not* having a child may be either the result of a conscious choice or the result of an 'accidental' combination of circumstances.

Although some women do make a deliberate choice to delay or forego motherhood, there are many women for whom the failure to reproduce is not necessarily attributable to any conscious decision. Not deciding to conceive a child is not necessarily a discrete choice. *Not deciding to have a child* is not logically, morally or experientially the same as *deciding not to have a child*. For this reason, it may be wrong to assume that postmenopausal women who seek treatment must have made a deliberate choice not to have a child earlier. This being the case, it is relevant to ask whether postmenopausal women who are regarded as having had a fair innings have made a positive choice to postpone motherhood, or whether their childless status has transpired for other reasons.

Factors beyond women's control

Guido Pennings roundly dismisses the idea that women actively seek to delay pregnancy for the sake of their careers. He argues that it is not generally plausible to construe failure to reproduce in one's twenties or thirties as a choice, since it is almost invariably associated with factors that are beyond the woman's direct control.[16] The freedom to choose to have children is contingent on a number of variables, including relationship status and economic and social stability. One might argue that women who long for children *could* have them even if circumstances were not ideal. Certainly, some women do this. But whether those who do not can be regarded as making a free choice is doubtful given the pressures to which they are exposed. Women who are deemed to have reproduced too young, or in poor economic circumstances, who lack partners or are out of work are subject to extreme social criticism.[17]

However, even if Pennings is correct that most women do not defer pregnancy for the sake of their careers, and if I am correct that women seldom make a discrete decision to delay motherhood, there may nevertheless be some women who *do* make these choices, and for these reasons. Supposing we could identify such women, would it be acceptable to withhold treatment from them?

One of the most obvious answers to make here is that medical resources are not usually withheld on this kind of punitive basis in the UK. A woman who develops type II diabetes may do so as a result of choices made earlier in life. But we would not normally see this as a reason to deny treatment. Perhaps, if a person's choices may make treatment ineffective (as in the case of liver transplants to alcoholics) there might be justification for denying treatment, especially where resources are very limited. However, it has been established that postmenopausal women *can* successfully gestate and give birth to children conceived with donated eggs. On this view, postmenopausal women have as much to gain from treatment as younger women.

Clinical need

Perhaps there is nevertheless a difference between younger and postmenopausal women in terms of their clinical eligibility for treatment. This might not be an issue if oocytes were not so scarce, but since they are, it is necessary to develop some way of prioritizing claimants. Being postmenopausal is not the same as being infertile; it is a normal part of female ageing. On this view, whatever postmenopausal women's capacity to benefit from treatment, it would not necessarily be justified in terms of clinical need. A younger woman, on the other hand, who has lost her fertility through cancer treatment may have a far more compelling case. A paper published by the Ethics Committee of the American Society for Reproductive Medicine emphasizes this point. The authors argue that the provision of eggs to patients of normal reproductive age suffering from 'pathological conditions' poses no 'unique ethical problems'. Provision of eggs to postmenopausal women, however, *is* problematic, since they do not suffer a pathological condition.[4]

But what is clinical need in the context of reproductive technology? In her essay 'Technologies of Procreation', the feminist writer Ann Oakley asks what reproductive technologies are *for*. In answer to her own question, she quotes the debate on the protection of the unborn children bill, describing fertility clinicians as 'medical scientists working in response to a great humane need'.[18] Reproductive technologies are, apparently, the means by which this great need is met. Accordingly, it has been assumed by many commentators that egg donation can be incorporated into the health-care systems that encompass IVF as a means of meeting this need.

Yet, the relationship between reproductive technologies and clinical need is not always clear-cut. Writing about donor insemination, Simone Bateman asks '[w]hat reasoning led physicians to assume that they were providing treatment for infertility, when the technical act they were proposing may be understood as an alternative mode of conception to heterosexual intercourse?'[19] Bateman's point – which applies equally to egg donation – is that donated gametes do not restore any faculty; they do not prolong life or cure a disease. This being the case, it is not clear that young infertile women have a greater clinical need for donated eggs than postmenopausal women. Indeed, it is not clear that *anyone* could be said to have a medical need for this kind of treatment. Richard Ashcroft asserts that 'it is not at all clear how to specify the criteria for being a "proper" medical or health care intervention'.[20] Arguably, this is particularly so in the context of reproductive technologies.

It is not within the scope of this paper to explore fully this vexed issue. However, it is important to note that reproductive therapies are a particular area of uncertainty, and that for this reason, establishing clinical need is more than ordinarily fraught. This being the case, it becomes still more important to establish what, if any, are the reasons for restricting access to donated eggs to those of premenopausal age.

The issue of age in general in the context of fertility treatment has been somewhat controversial. For example, the National Institute for Health and Clinical Excellence (NICE) stipulates that IVF should be provided to women aged only up to 39 years. John Harris has argued that this is discriminatory.[21] However, he has been taken to task over this by Michael Rawlins and Andrew Dillon (respectively, the chairman and chief executive of NICE), who argue that the age limit is perfectly acceptable within NICE's framework.[22] Ethical and social concerns do not fall within NICE's remit, which is the assessment of clinical need and efficacy alone.[23] Thus, according to Rawlins and Dillon, there is nothing ageist in NICE's position.

It is true that IVF is less successful in older women. However, it has been suggested that this can be circumvented if donated ova are used. That is to say, it is largely the egg's age rather than the woman's that determines the efficacy of treatment. Writing in Human Reproduction, Paulson and Sauer comment that from a purely physiological perspective, there is no obvious age-related cut-off point for treatment with donated eggs. Because of this, they argue that any limit must inevitably reflect ethical or social criteria rather than medical ones.[2] It is, therefore, extremely difficult to find a conclusive *clinical* argument in favour of restricting access to donated gametes to one group or another.

Risks to women and children

Fertility treatments do not fit easily into a paradigmatic model of clinical need and for this reason, clinical and physiological facts may not help in establishing which patients should have priority. However, as Paulson and Sauer suggest, perhaps there are compelling ethical reasons for preferring one group over another. One of the most obvious considerations here is the question of child welfare. It has been suggested that children born to older mothers may be at risk of physical damage, or psychosocial problems. The Ethics Committee of the American Society for Reproductive Medicine argues that the welfare of mothers and children is the 'central ethical issue' raised by the donation of eggs to postmenopausal women.[4] According to this paper, there are at least some occasions where clinicians' responsibilities for women's health would oblige them to exercise a paternalistic refusal of treatment.

However, it should be remembered that all pregnancies involve health risks for women.[24,25] In fact, despite the risks associated with the contraceptive pill, it is safer to be on the pill than to get pregnant. If one does become pregnant, it is statistically safer to have an early abortion

than to continue with the pregnancy.[26] Undoubtedly, the risks of pregnancy and childbirth increase with age, but perhaps – within reasonable parameters – women themselves should be permitted to weigh the risks and make their decisions on this basis.

But mothers' choices also affect offspring. Babies born to older women are at greater risk of being underweight and suffering from genetic disorders.[27] However, postmenopausal women who use donated gametes can circumvent many of the genetic risks associated with later pregnancies. And although the risks involved in later reproduction are greater than those involved in reproduction at the 'optimal' age, studies show that women of advanced age are likely to survive and take home a healthy child.[28,29]

Yet, even if the woman brings home a healthy child, she cannot guarantee her own health and lifespan. For many people, the risk of early orphanhood is a significant consideration.[3] Takahide Mori cites the right of children to be brought up by their parents, according to United Nations declaration on the rights of the child.[30] But, as Mori himself notes, lifespans in the developed world have been increasing to the extent that a woman of 60 can expect to live beyond the age of 80. It is also worth considering that *younger* women who seek to use donated eggs may do so precisely because their health and/or fertility has been impaired by cancer or genetic diseases, such as Huntington's disease. Therefore, postmenopausal women cannot systematically be assumed to have a lower life-expectancy than younger claimants for donated eggs.[2]

Discrimination

Any criteria designed to restrict access to donated eggs on ethical grounds may be vulnerable to criticisms of discrimination. In fact any restrictions at all might be termed discriminatory, since those who can reproduce unaided do not have to fulfil eligibility criteria and are not subjected to ethical scrutiny before being allowed to proceed.[31] It has been suggested that age-based restrictions on access to fertility treatments could be challenged under the Human Rights Act.[32] But women may also feel that they are the victims of discrimination because of the differences between the way they are treated and the way that *men* are treated. For example, there have been well-publicized occasions when children have been conceived *after* the father's death.[33] Should we quibble about mothers' lifespans when children have been born to fathers who are already dead?

The case of Liz Buttle highlighted a paradoxical social attitude towards parenthood. When pop star Rod Stewart announced he was going to become a father for the seventh time, also at the age of 60, the media focused on his joy at having a new son.[34] However, attitudes towards Liz Buttle were vastly different, focusing on anxieties for the child. George Monbiot has suggested that some of the condemnation arose from an underlying assumption that once women are no longer attractive to men, they should no longer be regarded as fit to be mothers.[35]

Men and women are treated very differently in reproductive terms. Is this a natural corollary of their physiological differences, or evidence of discrimination? It is interesting to consider a hypothetical example. Suppose a 60-year-old woman seeks treatment with donated oocytes. She plans to have them fertilized with the sperm of her much younger husband. She is refused treatment based on the idea that at her age she could not satisfy the child's needs.

Now imagine a 60-year-old man seeking treatment with donated sperm. His much younger wife is planning to use her own eggs. Would the man be refused treatment by the same clinics that refuse the woman of the same age? Both patients are the same age, and both plan to be the social parent of a child conceived with donated gametes. Yet, it seems highly likely that the two patients would be treated very differently. Indeed, the 'father' in the latter case might scarcely be regarded as a patient at all. Is it simply that mothers are more important to their children than fathers? Or is the difference simply based on discriminatory prejudices?

Perhaps, it is not as terrible to lack or lose a father as it is to lack or lose a mother. But if this were true, should women's reproductive choices be constrained relative to men's simply because women are inherently more important to their offspring? This would place women at a double disadvantage. Not only are they denied the choices open to men but also their options are constrained by the very 'needs' of the children they wish to have. Can it be right to argue that because the woman is so vital to the child, the child is not to be born at all?

Conclusion

Postmenopausal women may have made no decision to forego motherhood during their fertile years. Moreover, their reproductive choices are hedged about with social censure, and their parental role is subject to far more scrutiny than that of men. Yet, there remains the problem of prioritizing claimants for donated oocytes. Do any of the considerations addressed here provide a basis for systematic decision-making in this context? I do not think they do. In some cases, a postmenopausal woman's life-expectancy may be the same as or greater than that of a younger woman. Likewise, the risks to postmenopausal women and their children will not invariably exceed those faced by younger women and their offspring. Therefore, it does not make sense to rely on age as the deciding factor.

Finally, it is important to note that there remains a fundamental ethical concern: I have argued that it is not necessarily more unethical for postmenopausal women to use donated oocytes than for younger women to do so. But is the use of donated oocytes ethically acceptable at all? Egg harvesting is a risky procedure. In some countries, women can be paid for donating eggs, which raises ethical questions about commodifying gametes, and the possibility of coercion. But if donors are *not* paid, they undergo the risks and reap none of the benefits. There is a burgeoning market for eggs from which fertility clinicians and their patients stand to make significant gains. Perhaps to ignore this, and encourage 'altruistic' donation is just as exploitative as offering payment.

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