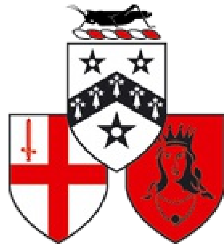

GRESHAM COLLEGE

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Fertility and Feminism
Transcript

Date: Monday, 16 February 2009 - 12:00AM

Multiple embryos

- Should the older woman be allowed to take risks?
- Dangers of multiple births – premature, cerebral palsy, stress, expense
- ARGC judgment

FERTILITY AND FEMINISM

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It is almost too simple to point out that most of the users of reproductive medicine are women, and the providers men. Early on in my chairmanship of the HFEA, I heard a respected doctor comment that he had made 1000 women pregnant! Women appear on the scene as grateful patients, nurses, counsellors, members of Ethics Committees and quite often as scientists. There is a great deal of money to be made out of successful IVF, but not by the women. They have one invaluable commodity, however, and that is their eggs, especially in demand now for stem cell research. Altruism, however, prevents sale of those eggs at a good price, in England in any case. There is no arguing with the principle that one should not sell a body part, nor should one be tempted to make a decision that one could regret all one's life, for the money involved. A pity, however, that this disadvantages the people who really need to recoup, namely, the women.

There are some interesting feminist questions which I will just pose, but cannot answer this evening whether for lack of time or theory. Are there different perceptions by each gender of infertility and fertility treatment; is there equal treatment or special treatment for women in fertility issues? Is there male bias in fertility law and ethics, and male perceptions in the administration of treatment? Is the woman's right to choose in questions of fertility in competition with the husband's, the wider family and as yet unborn children? I prefer to focus on simpler criteria of feminism, autonomy and equality of parenthood.

In this context the hallmark of autonomy and the integrity of the self is the right to make decisions about one's own body and regulate one's own fertility. Is woman's autonomy allowed to flourish under the law and practice of reproductive technology? I think it is, as long as it protected by the 1990 and 2008 Acts, by the general medical law and by the Human Rights legislation. I wonder whether woman's autonomy is undermined by popular perceptions of her as a mother, always wanting to be a mother and nothing else. This is often meant kindly, but is reinforced by the press ('my miracle baby' is the headline to watch), to the fascination of the warmhearted public. Women tend to take responsibility for infertility in a couple, regardless of the source, which is as likely to be the man as the woman. Infertility is increasingly portrayed as a disease for which there is a cure, if the woman tries hard enough and spends enough. This portrayal resembles the description of the exhortation to 'fight' cancer, as if it is the victim's fault for succumbing (John Diamond, *Because Cowards get Cancer Too* (1999)). Is it being assumed that all women are incomplete if they have no children, whether voluntarily or involuntarily? There is a risk that new techniques, which have scarcely been tested as safe or viable, are rushed into use by clinicians in order to be ahead of the field and advertise themselves as such. One sees the phenomenon of people remortgaging their homes and disposing of their life savings in order to undertake repeated attempts at fertility treatment, sometimes, one suspects, without even a conclusive diagnosis. There is a case for saying that the single most ethical principle in this field would be to ensure that the NHS undertook some fertility treatment all over the country, and not just patchily as at present. Is it acceptable for a private doctor to encourage a woman to undertake ten or more treatment cycles, and has he had regard to her feelings about this and the effect on the child, were it ever to be born? Is as much counselling devoted to failure as to the embarkation on fertility treatment? Should doctors be pressing techniques to the very edge of acceptability in order to achieve success (known as a 'take home baby')?

Even very successful and compassionate clinicians may create the impression that women's bodies are objects to be monitored and regulated, not aspects of one's self. It is as if they are saying that if those bodies are treated with the right drugs and by the right people, they will produce what they are supposed to produce. I wonder whether clinicians themselves have difficulty in coming to terms with failure to achieve a pregnancy, and their position in the situation, especially when it is so infused with compassion for the infertile.

Rising infertility has been attributed to women marrying much later, having pursued careers and contraception until they are 40. To reduce infertility significantly may mean pointing out that women should find partners and commence childbearing at an earlier age, adjusting careers proportionately. It might also involve a widespread campaign against the behaviour that gives rise to sexually transmitted diseases that destroy fertility. These restrictive messages are not necessarily welcomed by women.

There are also aspects of reproductive medicine that bolster the position of women. Only women can give the gift of parenthood to men (so far). Men have little choice in the matter, no matter how willing they are to offer commitment and good

parenting. If parenthood can begin in the laboratory or with genetic material provided by third parties, a woman's role in parenting becomes more like a man's, merely the provision of the gamete. It will be even more so if birth in an incubator without a womb ever becomes possible. There is then no reason for women to have the dominant role in reproductive choices, as they do now, and men will have to have an equal voice. The moderating influence in this scenario of potential conflict is statutory regulation. It requires that doctors and scientists inform patients and subjects, and then abide by the choices that these people have made. Feminists should certainly be opposing the unregulated application of new and possibly risky techniques to women, and the unregulated sale of eggs, as in the USA. They should stand up for the ethical principle of autonomy, which I discussed in my second lecture.

The message I wish to give and to reflect on in our examination of reproductive science is that every woman, like every man, is worthwhile as her own person, without having to be a mother. No childless woman should ever be made to feel that she can only be perfected and given a role in life by being subjected to every reproductive technique that can be provided at limitless expense. There has to come a time when a caring doctor should consider, with the infertile woman, what her future is if the treatment does not succeed. No doctor should hold her up as a trophy when that treatment succeeds against all the odds, nor depict inability or unwillingness to treat her as a failure. Children are a blessing and I have no wish to deny the enormous meaning and joy given to life by them. Nor would I wish to be though of as unfeeling towards those who suffer from infertility. Nevertheless, I wonder whether society takes sufficient account of the possibility that women's lives might be considered just as worthwhile and purposive without children as with children. I am concerned that reproductive medicine should not be pushed so far that men or women are made to feel incomplete unless they can reproduce. There are ethical, personal and practical limits to treatment, and this is represented by the fact that in this country we regulate the practice under the HFE Acts. We must beware the dangers and disappointments of the unlimited pursuit of success in infertility treatment. We must ask whether the passionate desire to become a parent justifies the taking of risks to health on a scale that would not be acceptable if the issue were food safety or environmental preservation. Even basic IVF is not without peril, for drugs may give rise to ovarian hyperstimulation syndrome, which is potentially fatal.

Older mothers

The earliest woman's issue that presented itself was the question of treating older women, that is women past the age of menopause when nature would not permit a natural pregnancy. British law has never stipulated an upper age limit, not for lack of will but simply because there could be no sensible age: to specify the menopause would be to bar from treatment younger women who had undergone early menopause, when that might be perfectly proper. Age questions were left to be caught up in the consideration of the welfare of the baby that clinicians were required to undertake before commencing treatment. Nature is hard on the older woman. The older man continues to be fertile until almost the very end, and this is especially noticeable when he remarries a younger woman; whereas the divorced woman may find difficulty in starting a family with a second partner in midlife. Women have fought hard to have career opportunities and family friendly non-discriminatory work environments; to have to put all these advantages to one side in order to ensure fertility at a young age is hard.

So two methods have evolved whereby woman can adapt and prolong their childbearing to suit their personal and professional lives, rather than risking the latter for the former. The first is the treatment of older women with donated gametes, and the second is the freezing of their own eggs by young women for future use. It is hard to argue against this sort of achievement of parity with men by the use of science, yet the feelings of disgust that are evident in the case of older women have yet to subside.

Liz Buttle, aged 60, was Britain's oldest mother when she gave birth in 1997 to a baby following IVF treatment. She had allegedly lied about her age, giving it as 49, and the papers initially treated this as a natural birth, whereas it utilised donated eggs. (Note that without ID cards, a clinic may never be sure how old, or even who a patient is.) Concerns were expressed for the child, who would be going to secondary school with a woman who looked like her grandmother if not greatgrandmother, and who might die in the earliest years of the child's life. Strong though those arguments are, they are not made in relation to older fathers, such as Rod Stewart, Jonathan Dimbleby or John Humphrys. Any of us may die at an early stage in our child's life, even with the best planning; any of us may lack the necessary energy or modernity required for childraising, but nobody is denied that chance, so it is illogical to hold this against the older mother. Ms Buttle was followed by Mrs. Patricia Rushbrook, a mother at 63, when she married a man who had never had children, although she already had some. These births certainly give publicity to the technical success of the clinics involved.

There did seem to be an element of irrationality in the very personal attacks on the two older women mentioned here.

We do not know why nature stops women having children in midlife, but does not stop men. The theory has been advanced that it is nature's way of making sure that women are free to act as grandmothers and help their daughters, rather than carrying on giving birth themselves. If this is so, then the social need no longer exists: one wonders whether nature will eventually adapt by abolishing the menopause by evolution after some millennia!

Frozen eggs

Freezing eggs offers great potential to change the lives of women. For many decades it has been possible safely and successfully to freeze sperm, both human and animal. Indeed, scientists allege that sperm may be frozen for many decades without harm to it or to the resulting offspring. It is for ethical and practical reasons that storage is limited to ten years by law. This facility means that a man facing chemotherapy and radiotherapy treatment for cancer may store his sperm before treatment and preserve it for the future insemination of his partner. The same possibility was not open to women until recently.

Early in 2000 the HFEA permitted the use of frozen eggs in fertility treatment. This meant that the woman who risked becoming infertile through cancer treatment could use the eggs she had frozen before it started. At first the HFEA allowed the storage of eggs, but not their use. This was not as illogical as it seemed, because research showed that most of the eggs did not survive the freezing, there were genuine concerns about the safety of babies born from frozen eggs and the success rate was only about 1%. Once the thawing had been shown to be safe, albeit still not at all successful, it was permitted. If a woman suffering cancer has a partner at the time of treatment, the option with most chance of success is to have embryos created and frozen for later use. However, where the patient is young or has no partner, the option of freezing embryos, as distinct from eggs, is not available. Another option open to women in this position is to remove and freeze sections of the ovary and either graft it back later or mature the eggs *in vitro*. This is also a new and experimental technique with tiny rates of success.

The feminist significance of this is that it was decided not to exclude women from freezing eggs for social reasons, as distinct from reasons connected with illness or early menopause. In this connection, science is serving women's life patterns. Worldwide, women are delaying childbirth in order to pursue careers and education, for financial and divorce reasons. In the UK the number of births to women over forty has doubled in a decade, (12,000 in 1996, 24,000 in 2006, 25,350 in 2007) and there are more births to mothers aged 30-34 than 25-29. The average age of mothers giving birth is 29.3. In 2006 there were 71 births to women over 50. This trend carries its penalties: the steep rise in miscarriage and Down's syndrome births to older mothers. But fertility at age 35 is half what it was at 25, and at 40 half of what it was at 35. So the reproductive lifespan is very restrictive in comparison with women's life plans.

The HFEA felt obliged to extend the possibility of freezing eggs to all women for all reasons, not least for fear of a legal challenge under the Sex Discrimination Act or the Human Rights Act. Since single women and lesbians of any age may seek treatment by IVF quite legally, there seemed no point in preventing women from freezing their eggs with a view to future treatment, regardless of history. Nevertheless, the success rate of the use of frozen eggs is so low, the procedure so expensive, that it would be a foolish woman who relied on this rather than thinking about conceiving naturally, even with a career ahead of her. Most studies give a success rate of only 2%, although there are a few with more optimistic outcomes. The water content of eggs has meant that ice crystals form during freezing, which may damage the egg when it is thawed. But a new process of rapid freezing is being developed, called vitrification, giving a 6% success rate.

Falling out over frozen embryos

Freezing embryos, as opposed to eggs, means two parties are involved. Unlike a natural pregnancy, where a man has no say in termination or treatment, every IVF treatment in the UK requires written consent from each partner to every stage - the removal of gametes, the storage, the thawing or perishing and the use in attempting pregnancy. Freezing for long periods means that there may be a significant change in the partners' intentions between the first trip to the clinic and the time when one decides that he or she is ready to become a parent.

The recent sad case of Natallie Evans received much attention. At a young age she was diagnosed with cancer, and the treatment involved removal of her ovaries. She was living with her partner, Howard Johnston, and with his assurance that they

would remain together, she had eggs removed and fertilised with his sperm; they were frozen in October 2001. After her treatment, but before she could use them, in May 2002 the relationship broke down. Her former partner established a home with another woman and said that he did not want to be a parent with Natallie, or to be involved in what would be single parenthood (for her), since he himself had come from a broken home. He relied on his rights, which were perfectly clear under the HFE Act 1990, to withdraw his written consent to storage and use of the frozen embryos.

Part of the dilemma lay in the speed with which events took place. Because there was urgency to start the cancer treatment, the decision to undergo IVF was taken very rapidly indeed with, it seems, no time to reflect or voice doubts with appropriate counselling for the couple, individually or together. Nor was it considered that it would be possible for Howard Johnston to allow Natallie Evans to use his sperm to become a mother, but that he would not be the legal parent and have no maintenance responsibility. The law does not appear to provide for this: arguably such a solution, while acceptable to the adults, would not be a good one for the welfare of any child to be born under those circumstances, even though the majority of babies in this country are now born out of wedlock (many are to people living together and there the men are participating, at least temporarily, in childcare.) On the other hand, it was the case that the couple had started to seek fertility treatment before Ms Evans' diagnosis with cancer, and that they had had sufficient time to become aware of all the implications.

Ms Evans would have kept her autonomy if she had had her eggs frozen without insemination, but at the date of her treatment frozen egg technology was in its infancy and had not yet produced a baby in this country. Alternatively she might have opted for anonymous donor sperm, but that would have seemed like an act of rejection to her partner, who was supporting her at that stage.

The High Court and the Court of Appeal rejected Ms Evans' request that Howard Johnston be made to keep his word, ruling that a man has as much right as a woman to say no, to give and withdraw his consent, an argument that is hard to disagree with. Had the genders been reversed, there would be little sympathy with the argument that Ms Evans should be forced to bear a child for Mr Johnston, even if she did not wish to. She pursued her case to the European Court of Human Rights in 2006, and in 2007 to its superior court, the Grand Chamber, relying on the human rights of life, private and family life and no discrimination, but lost those appeals as well, on similar grounds. It was her last chance to have her own children, but not his, although she could have had them by donor gametes. Public opinion was fairly evenly divided between those who agreed that a man should not have parenthood forced upon him in a situation where the process is formal and gradual, as under the HE Act, and that he should not be made to be a single parent or pay maintenance; and those who were more sympathetic to Ms Evans, whose hardship, they felt, was greater than that which might be suffered by Mr Johnston. Is there an inconsistency, in that a *pregnant* woman has complete control over decisions about abortion and childbirth, without regard to the father? The way to reconcile this is to argue that while the embryo is outside the body, there is complete equality between men and women; but once the pregnancy is established, physiology means that the woman's word alone determines the fate of her body.

The new law in the 2008 Act, however, has come up with a partial solution - in Sch 3 para 7, it is provided that if one of the two partners withdraws consent to the use of a frozen embryo, the clinic must notify the other partner, and instead of destroying it immediately it may be stored for 12 months for a 'cooling off' or discussion period.

The problem is not just a British one. It was faced some time ago in the US where Junior Davis and Mary Sue Davis sought fertility treatment in the 1980s and had embryos frozen. In 1989 they divorced, but the status of the embryos was unclear because the US has no law, as we do, about written consent and storage: it is left to each clinic to decide what to do, and this couple had made no agreement with the clinic or each other. Mary Sue, who, like Natallie Evans, would not have any other opportunity to have her own child, wanted to be allowed to use the embryos and claimed property ownership in them. Junior was also adamantly opposed to single parenthood for any child of his. The US courts interpreted the right of privacy and autonomy in the Constitution to pronounce that it was up to the couple to decide on the fate of their embryos. There was, they said, a right to procreate and a right not to. By this time, Mary Sue was prepared to donate them to another couple, and it was held that her interests would suffer less harm than his if his veto was determinative. Avoidance of procreation was favoured where the other party could still achieve parenthood by other means. Had Mary Sue wanted to use the embryos herself, the outcome might have been different, but it was an alarm signal to clinics to ensure that comprehensive written agreements were in place at every treatment.

A well known case which has gone the other way is the Israeli case of*Nahmani* (PD 50(4) 661). The Israeli Supreme Court ruled that in similar circumstances the right of a woman to be a parent outweighed the husband's right not to be a parent. Ruthie Nahmani wanted to use a surrogate for the frozen embryos created by her and her ex-husband Daniel as she was incapable of pregnancy herself due to illness. So like Mary Sue Davis she would not herself bear the child, (and as far as I know no child was

ever born) but her rights prevailed. The judgment says a great deal about the pronatalist policy of Israel, and the position of women: here is one situation where the stereotyping of women may work to their advantage.

Multiple births

Another situation where women are assumed to be ready to do anything to have a baby is not so clear cut. There are dangers in multiple births, that is twins or triplets, even though to an infertile woman the prospect of having several babies at once must seem like the perfect solution. The risks of multiple births, which come about in IVF because more than one embryo has implanted in the womb, are hypertension in pregnancy, greater risk of surgical intervention, increased maternal mortality rate, depression and illness. The risks to the babies are low birthweight, increased risk of infant mortality, premature birth, cerebral palsy and other illnesses. The cost to the state is high; three times as much cost for the NHS per twin as per single baby, ten times as much per triplet. Moreover, since so much of IVF medical practice is private, in effect the clinician takes his fee for making the woman pregnant, but the NHS picks up the extra costs if she is carrying more than one baby. One in four IVF pregnancies is a multiple, whereas the figure naturally is one in 80. 40% of IVF babies are twins, and one can almost assume IVF when seeing twins these days. Where a triplet or higher order pregnancy has been confirmed, it has been known for doctors, especially in the US, to offer 'foetal reduction', that is, termination of some of the foetuses in order that the others may have a greater chance of being safely born. This may be ethically and practically more distressing than the limitation of embryos to be implanted in any one treatment cycle. There was extensive publicity recently about the octuplets born in the US to Nadya Suleman, a pregnancy achieved by one Dr Kamrava. Maybe this was a personal success for the mother and for the doctor, whose success rate was very low. He is a registered medical practitioner but not registered as a specialist fertility doctor, and unlike in this country, he can escape inspection and ethical control if working in the US. If ever there was an argument for regulation British-style, it is this case.

All the British professional organisations are backing the one baby at a time strategy with its limitation on the number of embryos to be used - which of course has to be balanced against the desire of the woman and her doctor to maximise her chances of being pregnant. After extensive consultation the HFEA's Code (7th edition) was amended in 2007 to say that no more than two embryos may be used in the treatment cycle of a woman under 40 and no more than 3 if she is over 40. There is also a policy to use only one embryo in the youngest healthiest women.

A case heard in the Court of Appeal in 2002 (*The Assisted Reproduction and Gynaecology Centre* Case) shows how difficult it is to do this. Mr Taranissi, the Medical Director of the ARGC, a London clinic, had a patient Mrs. H. He and his patient challenged a ruling by the HFEA given at their request. At the material time the limit on embryos was three. Mr. Taranissi wished to treat Mrs. H by using five embryos and argued that it was appropriate to make an exception to the rule in Mrs. H's case, based on her particular treatment needs. Mrs. H was 47 and had married when she was 41. She and her husband were unable to conceive a child. Between 1996 and 2000 Mrs H underwent 8 IVF treatment cycles at the clinic, in each of which 3 of her embryos were replaced in the uterus. Mrs H however did not become pregnant. Mr Taranissi wrote to the HFEA inviting it to consider a relaxation on the ban on the insertion of more than 3 embryos in the case of older patients. He claimed that the risk of any such woman having a multiple birth was non-existent, but that the use of more than 3 embryos might give her a reasonable chance of conceiving. The HFEA carefully considered such statistics as there were relating to pregnancies and multiple births amongst women of that age, both in this country and abroad. (The HFEA data show a nil percent success rate for women of 46 and over, and 4% at age 43). The HFEA found that the birth rate was very low indeed, but that where pregnancy did occur there was some risk of a multiple birth, all the more threatening at an older age. It therefore advised Mr. Taranissi to follow the Code of Practice and was not willing to allow a relaxation as an exceptional case.

The appellants sought judicial review. The HFEA case was that it wished to minimise the health risks arising from multiple births, as outlined above, and had weighed this against the maximisation of the chances of Mrs. H's pregnancy. It had considered her human rights and the reasons for interfering with them in the interests of society at large. The judges held that this was an area of rapidly developing science in which judicial review had a limited role to play. Disagreements between doctors and scientific bodies in this pioneering field were inevitable. The UK had opted for a system of licensing and regulation and had empowered the HFEA to do this. Like any public authority, it is open to challenge by way of judicial review if it exceeds or abuses the powers and responsibilities given to it by Parliament: but where, as was manifest in this case, it considered requests for advice thoroughly, and produced opinions which were plainly rational, the court would not intervene. The fact that Mr Taranissi disagreed with the advice was neither here nor there, said the court.

Here we have an instance of the courts preferring the general rules of public health above the strong desire of a woman to take risks that might enable her to become pregnant. Whether it is a 'feminist' decision is a good question - is it better for women to be shielded from risky medical practices by the courts, when they themselves would accept the risk? Or is better to allow them in consultation with their doctors to do anything that is legal? My own answer to this is evident from my theme that the woman is a whole and worthwhile person in herself who should not be placed under too much pressure by modern reproductive medicine advances.

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