Philsoc Student Essay Prize, Michaelmas term, 2020 – 2nd Equal Prize

Do you think that we should use the eggs of aborted foetuses to help infertile couples to have babies? Why and what would you say to those who disagree?

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The dynamic field of bioethics considers the cutting edge of technological and medical advancement. However, circumstances race ahead of previous philosophical theories. When considering the proposition in the essay title it is important to remember that this is already medically possible.

At the 2003 Madrid conference of the European Society of Human Reproduction and Embryology, researchers from Kfar Saba presented a study showing that it is a relatively easy procedure to extract eggs from aborted foetuses to use them for assisted reproduction procedures. This could alleviate the worldwide shortage of donor eggs for IVF (In-Vitro Fertilisation) and ART (assisted reproductive technology).

Operating at a purely theoretical level, this could 'convert' an unwanted child into a wanted child, and unwanted fertility could ameliorate unwanted infertility. Surely this can only be a beneficent act? Unfortunately, the practicalities of this proposal and the emotional implications for the individuals involved mean that this is not the case.

Let us consider the rights of the individuals involved (for simplicity of argument let us assume that a heterosexual couple have conceived the foetus that will be aborted and a heterosexual couple would be parents of the baby that is created using the aborted foetus' donor eggs).

MF = mother of the foetus, FF = father of the foetus, F = foetus, MB = mother of the baby, FB = father of the baby, B = baby.

MB and FB hold much of the agency in this scenario, they are clear in their intentions, given every opportunity for informed consent with time for consideration and reflection, and are likely to be funding the procedure. Brake describes this putative right to procreate as being located within a nexus of interests.[1]

MF is at a disadvantage due to her urgent need for a safe abortion. Assuming that she is a competent adult, she can consent to the abortion; but could consent to the donation of the foetal eggs be considered informed? If she felt under duress to consent to the donation at a time when she is inherently vulnerable or felt that access to the abortion was conditional on agreement for donation, then this would not be regarded as informed consent. It is important here to note that the medical field of Gynaecology covers both abortion and IVF practitioners, so absolutely clarity would be needed as to which doctor is acting in the best interests of which patient.

MF is also affected by the constraints of the donation. Female foetuses only develop their ovarian tissue after 16 weeks gestation. However, best practice for abortion care is for the abortion to take place as soon as possible after the decision has been made to minimise harm to both the psychological and physical health of the mother. In 2019 in England and Wales, 82% of abortions were performed at under 10 weeks gestation. [2]

MF may also be affected by the constraints of place, and therefore method, of abortion. Presumably only surgical (suction) abortion in a registered healthcare setting would be appropriate to allow the

[1] Brake and Millum, "Parenthood and Procreation"

[2] Department of Health and Social Care, Abortion Statistics, England and Wales: 2019

aborted foetus to be quickly transferred to the laboratory, so therefore medical (hormonal pills) abortion could not be offered. Medical abortion is considered to be lower risk for the future reproductive health of the woman, and taking the second medical pill at home means that the experience can be less traumatic. In 2019 in England and Wales medical abortions accounted for 73% of total abortions.[3]

The negative effect on MF of these practical constraints could be circumvented if only women presenting for abortion after 16 weeks gestation were approached for foetal egg donation, but at this later stage of pregnancy the issues of urgency, distress and duress would be of even higher consideration. Later abortions are more likely to be driven by foetal abnormality rather than for social reasons. However, several of the foetuses used in the original Kfar Saba research were aborted due to abnormalities but the researchers claimed that the extracted lab-grown follicles showed no signs of abnormality.

FF would not legally be required to consent to the abortion, he may not be aware of the pregnancy or party to the decision to abort. However, given that F's eggs are comprised of half FF's genetic material he would need to consent to the donation. This adds a further layer of complexity to practical constraints, as it would draw FF into discussions about the abortion itself, which would not be required if it were abortion without donation.

Combining previous precedents, F is conferred no rights in this scenario. Firstly, MF's right to abort transcends F's right to life under current law within a 24-week timeframe. Secondly, parents have the right to consent to neonatal organ donation[4] after two months of age. If MF and FF agree, F is not understood to have individual rights that require consideration.

The rights of B as a person who does not yet exist is described by Brake as a non-identity problem[5]. Some of the issues faced by B are relevant to all gamete donated offspring and some are specific to this scenario.

In has been an assumption (or a convenient assumption) by infertile couples and ART providers that any baby born as a result of gamete donation would rather have life than to never have been born at all. However, as more donor conceived offspring come of age and make their views known, the data does not necessarily support this assumption.

As a caveat, this is an emerging field of research, and some of the reports may not be to a high quality, peer reviewed standard. Participants may be self-selecting, as some of the research has been commissioned for campaigning purposes, either for recognition of donor conceived children as a political pressure group or from a family values perspective. Further research in this field is needed as previously the experiences of the infertile couple has dominated the agenda and associated funding for research priorities.

Marquardt states that 'about half of people [conceived via sperm donors] have concerns or serious objections to donor conception itself, even if parents tell their children the truth. Nearly half are disturbed that money was involved in their conception.'[6]

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[3] Department of Health and Social Care, Abortion Statistics, England and Wales: 2019

[4] AoMRC (2105) paragraphs 34 - 38

[5] Brake and Millum, "Parenthood and Procreation"

[6] Marquardt, Glen and Clark (2010)

The factors most strongly correlated with a negative experience of being donor conceived are donor anonymity (or inability to trace the donor) and family secrecy, telling the child about their origins late in life or not at all.

Velleman[7] states that procreation using anonymous gamete providers is wrong because it frustrates children's interest in knowing their genetic forbears.

It is unclear in the proposed scenario whether MF and FF would provide their identity, as there has been no precedence for putative grandparents to give consent for gamete donation. Donor anonymity itself has been exploded by DNA testing sites which can identify donors through their relatives. This risks MF and FF being contacted and brought back into contact years after moving on from the abortion, which may be harmful.

The positive message that B would be likely to receive from MB and FB that they were a very much wanted baby, intentionally created to be part of a loving family, may be negated by their knowledge of MF and FF's original rejection of F. This rejection may even be more harmful to B's sense of self than the financial incentive to donate that other donor offspring are aware of as part of their personal history. The only alternative to this knowledge of rejection is family secrecy, which is itself shown to be very harmful.

In addition to the rights of the individuals involved in this scenario, there is a wider ethical point on wealth disparity that affects the distributive justice of the proposal and also has a bearing on specific cases.

As most IVF procedures are self-funded, we can assume that the income profile of the average IVF couple is relatively affluent and privileged, whereas poverty can be a contributing factor in the decision to abort. If there is a financial disparity between the donor and recipient, this transcends the issue of money as an inducement to donate. Even assuming that MF and FF were not offered monetary compensation for the donation, had they the same financial resources that MB and FB have at their disposal, then the decision to abort might have been different. The foetus might have been wanted if the economic resources were in place to raise it.

In conclusion, the moral costs of one course of action must be weighed against the moral costs of another course of action. There is insufficient evidence that the benefits to MB and FB would outweigh the potential for harm to the other individuals involved in the scenario. Using a fiduciary model, in which the rights of children (including those who do not yet exist) are paramount over those of their parents, we should not use the eggs of aborted foetuses to help infertile couples to have babies.

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