Breaking the ice: Young feminist scholars of reproductive politics reflect on egg freezing[1]

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Abstract

While proponents of social (i.e., nonmedical) egg freezing argue that it is liberating for women, opponents contest that the technology provides an individualist solution to a social problem. This article comprises personal and academic reflections on the debate on social egg freezing from four young women studying reproductive technologies. We challenge the promotion of social egg freezing as an empowering option for women and question cultural assumptions about childbearing, the disclosure of risk, failures to consider sexual diversity and socioeconomic status, and the expansion of the market in reproductive tissues.

1. Introduction

In October 2012, the American Society for Reproductive Medicine (ASRM) amended its policy on egg freezing, announcing that it "should no longer be considered experimental" (Practice Committees 2013, 42). The announcement included a note stating that while egg freezing was no longer an [End Page 236] experimental procedure, "there are not yet sufficient data to recommend [egg freezing] for the sole purpose of circumventing reproductive aging in healthy women" (2013, 42).[2] Despite the ASRM's tentative tone, many lauded the potential of a technology that would enable young women to delay childbearing without worry. In "Women, Consider Freezing Your Eggs," feminist anthropologist Marcia C. Inhorn advised female graduate students to find "a supportive partner who has a nontraditional, flexible career path" and to "consider freezing your eggs as you approach your mid-30s, so you can choose when to become a mother" (2013).

As feminist scholars of reproductive politics and young women graduate students, we were particularly intrigued by Inhorn's article because we are the very audience to which her advice is targeted. While reading her contribution, we considered the demands of an academic career and our own reproductive futures. In the context of our lives, as scholars and young women, we were troubled by her message,

[1] All authors contributed equally to the writing and editing of this manuscript.

[2] In January 2014, the American College of Obstetricians and Gynecologists issued an opinion on egg freezing, supporting the position of the ASRM and repeating the ASRM's statement that, though the procedure was no longer experimental, egg freezing should not be used "for the sole purpose of circumventing reproductive aging in healthy women" (Committee on Gynecologic Practice 2014, 2; Practice Committees 2013, 42).

not only for what she was saying but also for what she left out. As such, this paper is a response specifically to Inhorn's article and, more broadly, to proponents of social (nonmedical) egg freezing.[3] Building on themes that emerged from a series of in-person and online conversations that took place between May and November 2013, this commentary brings together narrative and analytic reflections that explore some of the issues of the social egg freezing debate from both our personal and our academic positions.

We come from a variety of disciplinary backgrounds (sociology, political science, public health) and have different career and reproductive goals (e.g., some of us want to have biologically related children, while others are uncertain). We do not claim to present a single, homogenous voice, nor do we claim to provide an exhaustive critique (e.g., we do not take up many important questions related to egg freezing, such as the implications for trans people[4]); rather, in this commentary, we present several points of critique that emerged in our discussions and reflections. As much of what has been written about egg freezing has come from women advocating its liberating potential (and, in the case of Inhorn, a woman considering egg freezing retrospectively as someone who has already had biological children and has a successful academic career), we offer our perspectives as young women graduate students who are currently finishing our doctoral degrees and planning for our future careers and families, whatever forms they may take. The question of social egg freezing is not an abstract or theoretical one for us; it is a real-life question that we face as we orient toward the future. [End Page 237]

In this commentary, we challenge the promotion of social egg freezing by combining our personal experiences (in italics) with our collective academic knowledge and reflections. We begin by considering the problematic claim that egg freezing allows women to "have it all." We follow this with a discussion of how the risks of egg retrieval are rarely identified and an examination of the heteronormative and classist assumptions underlying much of the existing work on reproductive technologies, including egg freezing. Lastly, we consider social egg freezing within the context of for-profit tissue economies that capitalize on women's reproductive capacities.

2. "Having it all"

> *My desire to conduct my research on reproductive technologies stems in part from the hope that, through social and structural changes, I can help women who want both a career and family to do so, before their so-called biological clock sets in. As my twenties speed by and I become increasingly immersed in my career* goals*, it scares me, as a woman who may want both, that I might have to choose. Or that if I do not have to choose, I am part of the exception.*

A great deal of the literature advancing egg freezing asserts that the technology and the reproductive freedom that it enables is a feminist "game changer" (Inhorn 2013) that will enable women to "have it

[3] Jodie Shupac (2012) provides a clear definition of social egg freezing, writing that it occurs when "a woman elects to freeze her eggs and defer childbearing for non-medical reasons—such as finding a partner or establishing a career." This could be contrasted with historical uses of egg freezing for medical reasons, such as egg freezing for adolescents and young women undergoing chemotherapy whose reproductive capacity might be damaged by their treatment.

[4] We write this paper as cisgender (nontrans) women, meaning that we all identify with the gender identity we were assigned at birth. We acknowledge that most of what has been written about egg freezing assumes that all women are cisgender, overlooking the experiences and perspectives of trans people—namely, trans men. Adding gender minority people's voices to this debate is needed (see note 6).

all" by circumventing biological limitations (Harwood 2009; Richards 2013; Urist 2013). The main message is that freezing our eggs will eliminate having to choose between pursuing career aspirations and having biologically related children. We are warned by well-meaning academics in our lives that career success for young women scholars demands dedication to our career(s)—a dedication that often conflicts with childbearing, at least until we are on the tenure track. Academics in our lives, like Inhorn (2013), often speak from their own experiences of having had to balance the demands of an academic career and birthing biological children. While women (and men) academics advocate for change in departmental cultures and policies to recognize the demands of an academic career and a family (Mason et al. 2013; Mason 2013; Wolfinger 2013), these changes are slow to come and, as we argue ahead, not necessarily supported by encouraging young women scholars to freeze their eggs. We suggest that the rhetoric of "game changer" and "having it all" oversimplifies the real-world challenges of working in an increasingly competitive academic [End Page 238] environment. While social egg freezing does not give us confidence that we can "have it all," this rhetoric makes it seem to others that this is now surely possible for us.

Some critics do challenge the idea that social egg freezing provides women with reproductive freedom or fertility insurance, and assert that egg freezing is, in fact, an expensive and physiologically risky procedure that offers an individualist solution to social reasons for delayed childbearing. Rather than individual social egg freezing, feminists like Morgan and Taylor (2013) have argued that more women would be empowered by systematic efforts to establish "paid parental and sick leave, affordable child care, comprehensive health insurance, immigrant health care, and adequate wages." When egg freezing is framed as an individual problem, there is little perceived need and less support for structural changes.

A second concern we have regarding the idea of "having it all" through proactive social egg freezing is the way in which the existence of the technology and how it is marketed emphasize the responsibility of women to bear children, or at least to ensure that we have the option to do so. We are concerned that the existence of the technology generates a moral imperative to engage in social egg freezing ("just in case") in order to be able to fulfill that responsibility. That is, if we are women who have the option to freeze our eggs, then we should do so, and any negative consequences arising from our failure to control the future through our decision not to freeze our eggs are our responsibility and fault alone.

Not only are we, as young academics, encouraged to "have it all" by conceiving children once our careers are established, we are encouraged to address our potential infertility by undergoing medical procedures to suspend the ticking of the omnipresent biological clock, a metaphor that effectively translates complex social events and processes into numbers and chronological timelines. It also contributes to a sense of urgency ("time never stops!") and obscures the complex social and cultural understandings of bodies, fertility/reproduction, families/kin, and career success and makes them into a singular, homogenous, and homogenizing biomedical understanding of women's in/fertility. This biomedical emphasis encourages us to be proactive about age-related infertility (i.e., freeze our eggs) in the ephemeral period before infertility arises. Rather than increase funding for child care or create positive messages about diverse family forms, the focus remains on extending women's fertile years by way of risky biomedical interventions. [End Page 239]

3. The risks of egg freezing

> *As a young woman doing research on assisted reproduction while more and more people in my life are starting families, I am often called upon to serve as a source of personal knowledge about infertility treatments, including egg freezing. I struggle with telling my friends about the medical risks of using reproductive technologies when they are engaged in the pursuit of having biologically related children no matter the physiological or financial costs. It is even harder to share what I know when their doctor has already told them that the side effects of treatment are minimal, and the drugs that they are taking are safe.*

The media coverage of the ASRM's decision to lift the experimental label on egg freezing that promoted the practice largely failed to mention or, if it did, downplayed the physiological risks of the relevant procedures. Egg freezing requires young, otherwise healthy women to take an extended course of hormones to stimulate egg production and to undergo surgery to retrieve those eggs, which are then frozen. The risks of egg retrieval include headaches, bloating, and abdominal pain, and, in more extreme cases where severe ovarian hyperstimulation occurs, there may be severe pain, vomiting, fluid buildup, and, in rare cases, death (Motluk 2011). Beyond these risks, little is known about the health effects of egg retrieval, in part because there is limited oversight of the in/fertility industry in the United States (and Canada), and, to date, there has been no longitudinal research on the health effects of the procedure (Morgan and Taylor 2013). In addition, egg freezing is intended to allow women to become pregnant with their own eggs, which likely means, if they put their frozen eggs to use, that they may be faced with the risks associated with undergoing pregnancy at an advanced reproductive age, including "increased risk of miscarriage, ectopic pregnancy, preeclampsia, hypertension, gestational diabetes, placental complications, intrauterine growth restriction, and caesarian section" (Society of Obstetricians and Gynaecologists of Canada 2013). Without the disclosure of these risks, we argue, the promotion of social egg freezing obscures the personal, social, economic, and physiological costs of the technology.

4. Class privilege and heteronormativity

> *When I started dating my first female partner and finally convinced my grandmother that I actually had a girlfriend—"I'm not joking, Baba"—she [End Page 240] said something like this to me: "so that means you won't be having kids. …"*
>
> *For me, there are many questions to consider, beyond the fundamental one on the minds of many young feminist scholars: do I want (to have) kids? If the answer is yes (and I am not always sure it is), when is the best time to have/make them? If I am in a same-sex relationship when/if I decide to have children, the idea of "making" children will be particularly pertinent to me as a sexual minority woman. To what extent is timing even in my/our control? How will I/we have/make them? Will I or will my partner carry the child? If I (need to) rely on reproductive technologies, how many children can I even afford to have/make?*

As discussed earlier, the promotion of egg freezing as a solution or "game changer" to delayed childbearing is premised on the notion that, given the financial means to freeze one's eggs, women can and should be able to have the lives they want. Estimated at a cost of between 7,000 USD to 10,000 USD per cycle in the United States (Urist 2013), and at approximately 5,000 CAD to 10,000 CAD in Canada (Shupac 2012), egg freezing does not necessarily change the game for women who do not have a lot of

money (and this includes many racialized women, single women, and sexual minority[5] women). Unlike celebrities and other advocates of egg freezing (see Richards 2013), few of us have thousands of dollars in savings and/or parents willing to help us freeze our eggs (Gootman 2012).

For women in same-sex couples, pregnancy rarely happens by accident; it has to be planned, and, indeed, many sexual minority women spend years not only making the decision to have a child but also considering who will carry the child and whether to use a known or unknown (sperm) donor (Almack 2006; Chabot and Ames 2004; Goldberg 2006). Many women must also consider how they will afford to have a child, particularly if reproductive technologies are needed.

Furthermore, for those of us who are sexual minority women (and all sexual and gender minority[6] people, for that matter), we are up against an in/fertility system that was not set up with us in mind. The path to accessing reproductive technologies seems to have been developed for white, heterosexual, cisgender (nontrans), married (presumably monogamous) couples with substantial financial resources who are experiencing fertility problems (green et al. 2012; Ross et al. 2014). Sexual minority women are just missing a piece, so to speak; [End Page 241] not all of us are experiencing infertility as it is traditionally, biomedically defined (we are "socially infertile"; see Luce 2004). Likewise, many sexual and gender minority people encounter barriers to accessing reproductive technologies because of a lack of funds, discrimination, and providers who do not understand our unique family creation needs, to name just a few (Ross et al. 2006, 2014).

Largely due to the cost and underlying assumptions about heterosexuality that are embedded in the way that reproductive technologies are accessed, we want to emphasize that the choice to freeze one's eggs is not available or accessible to all women. Indeed, despite her promotion of egg freezing, even Richards (2013) acknowledges this reality: "The cost is prohibitively high for most women and is rarely covered by insurance or paid for by employers." We argue that it is imperative to include the voices of sexual minority women, single women, and low-income women in the egg freezing debate.

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[5] Sexual minority individuals, for the purposes of this paper, are those whose sexual identity, orientation, and/or behavior differ from the majority (heterosexual) population. The 2011 Canadian census revealed that 16.5 percent of lesbian couples and 3.4 percent of gay male couples have children age twenty-four and under living in their homes (Statistics Canada 2012). These are likely underestimates, as census data do not capture individuals who chose not to disclose their same-sex partners, those who were single or living with a different sex partner (e.g., many trans and bisexual people), or those whose children were not living in their home (Patterson and Riskind 2010, 328). [End Page 244] In the United States, many bisexual people report a biological connection to a child: 44.8 percent of bisexual women and 15.8 percent of bisexual men (U.S. Department of Health and Human Services National Center for Health Statistics 2002).

[6] Gender minority individuals, for the purposes of this paper, are those whose gender identity and/or expression does not traditionally align with their birth sex, contrary to the majority (cisgender) population. Examples include genderqueer, transgender, or transsexual. A recent study of 433 trans people in Ontario, Canada, found that 27 percent of trans people are parents (Bauer et al. 2010, 2).

5. Selling ourselves (short)

> *What does it mean to pay to extend my childbearing capacity? Is it worth paying more than I can afford to ensure that if I want my "own" children, I can have them? Is it worth it if I get tenure in the meantime?*

In addition to the reality that egg freezing may not be accessible to all women, debates and discussions concerning the process must be considered in the context of the growing for-profit, largely unregulated industry providing this service. Removing the experimental designation has opened the door to for-profit companies aimed at marketing to all women of childbearing capacity. In this context, nearly every young woman is a potential client/patient, ready to insure her fertility if she can afford it.

Social egg freezing must also be considered within a broader framework of feminist reproductive politics concerned with the commodification of women's bodies and tissues in reproductive technologies and scientific research. For example, women's eggs are critical for several areas of stem cell research, such as the somatic cell nuclear transfer technique. Feminists suggest that the need for female reproductive tissues in scientific research reduces women to objects from which biological materials, such as eggs, are extracted (Dickenson 2007). Women's bodies are seen not only as biological clocks but also as biological mines. However, not all women's bodies are equally mined. Racialized [End Page 242] women and those with less financial capital, including women in the Global South, are more likely to be "mined" for their reproductive tissues and their reproductive capacities (e.g., surrogacy) (Scheper-Hughes 2001; Waldby and Cooper 2010). We suggest that the need for women's eggs in scientific research may provide a transnational market for surplus eggs frozen for personal use, thus raising important social questions for women who freeze their eggs. Will money be exchanged for the future research use of these eggs? If so, how will value be measured? Will women have a choice as to the research in which their eggs are used? We suggest that questions and concerns about the commodification of women's reproductive tissues and the potential for-profit uses of women's frozen eggs be foregrounded in debates and discussions regarding social egg freezing.

6. Conclusion

I identify as one of the many nameless, faceless graduate students to whom Inhorn's advice to consider freezing eggs was directed. Inhorn's personal account reflects the constant rhythmic ticking of our bodies as a "biological clock." Even though I question the overdetermination of our social lives by this biological metaphor, I find myself lulled into taking account of some of my own numbers. How many more years will I be fertile, according to current biomedical knowledge? How many more years before my eggs will be "too old" or "rotten"? How many more years until I complete my degree? Number of fertile years minus years to degree completion plus the cost of freezing eggs equal what? Engaging in this numerical exercise came as a surprise to me since I have never assumed that I would have my own biological children. Even still, I was compelled to imagine myself pulled between the "opposing" goals of having my own biological children or a successful career.

The assumption that some women can "have it all" by first establishing a career and then raising biologically related children (conceived from frozen eggs) oversimplifies these challenges by suggesting that egg freezing offers women an effective, possibly "easy" solution to complex social and cultural questions. It advances a bioessentialist understanding of the family, and does not recognize the underlying inequitable socioeconomic structures that limit our reproductive choices from the first.

Considered together with the limited disclosure (or data) about the long- and short-term risks of egg freezing, the [End Page 243] presumption of heterosexuality in how reproductive technologies are theorized and applied, and the commodification of women's reproductive tissues in both egg freezing and research, we argue that there are strong reasons to challenge advice to "consider freezing your eggs" (Inhorn 2013). As young feminist scholars engaged in reproductive politics, both personally and professionally, we contend that the option of social egg freezing not only is shortsighted but also fails to challenge the very conditions that produce its need. We reject the claim that egg freezing empowers all women by offering a nonproblematic reproductive choice.

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