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A Conversation with Karey Harwood

Author of *The Infertility Treadmill*

Feminist Ethics, Personal Choice, and the Use of Reproductive Technologies

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Q: What is assisted reproductive technology [ART]?

A: The Centers for Disease Control and Prevention defines ART as follows: “All treatments or procedures that involve surgically removing eggs from a woman’s ovaries and combining the eggs with sperm to help a woman become pregnant. The types of ART are in vitro fertilization, gamete intrafallopian transfer, and zygote intrafallopian transfer.”

The basic idea of ART is that it requires a woman’s eggs to be harvested from her ovaries and then combined with sperm—this combination takes place either *in vitro*, which means outside the body (literally “in glass”), or back in the fallopian tubes (as in GIFT). Since fertilization typically takes place in the fallopian tubes, it is thought that there may be some advantage in placing the egg and sperm directly back in the fallopian tubes. However, the vast majority of ART procedures are IVF—where fertilization takes place in the lab, the embryo or embryos are allowed to develop briefly, and then one or more embryos are placed back in the woman’s uterus, where hopefully implantation will occur and a normal pregnancy will ensue. ART does not technically refer to “lower tech” forms of assisted reproduction, such as artificial insemination, which has been around for much longer.

Q: In your book, you mention “the career pill.” How is it linked to ART?

A: The career pill may or may not ever be a reality. The idea of the career pill is that it would function to preserve a woman’s fertility until she was ready to have children, allowing her to finish her education or pursue a career. The career pill is only at the research stages, but the idea is that a woman’s ovaries would be shut down, preventing unwanted pregnancy when she was younger, and then re-started in later years when pregnancy was desired. The name “career pill” I guess implies that it would be appealing to professional women who might want to delay childbearing. The link with ART is delayed childbearing—the career pill explicitly responds to delayed childbearing; ART in *some but not all* cases is a response to delayed childbearing. Many women use ART for many different reasons, but it is true that there is a strong demand for ART among women who are over 40. This age group is also, notably, most likely to need donor eggs.

What is becoming a reality faster is egg freezing, which is being marketed as a way to defer childbearing. Women can “bank” their eggs for future use. (One company that is on the

[more]

The University of North Carolina Press

2-2-2 A Conversation with Karey Harwood

forefront of offering the service of egg freezing is Extend Fertility.)

Q: Who is most likely to use ART?

A: The studies that have been done suggest that married women with higher levels of income and education, as well as private health insurance, are most likely to use ART. Infertility is a problem that spans all races and socio-economic classes. Sexually transmitted disease plays a large role in causing infertility, but so does aging. The quality of a woman's eggs begins to decline in her thirties, and declines more dramatically by 40.

The fact that users of ART tend to be older, married, college-educated, high income and white is at least partially explained by the expense of ART. There are many out of pocket costs associated with ART because it is usually not covered by health insurance plans. Although now 15 states require that health insurance cover infertility treatments.

Q: How widespread is the problem of infertility in the United States? Are these numbers increasing?

A: I have seen figures that suggest 6-10% of the population experiences infertility at any given time. Infertility is usually defined as the inability to conceive after a year of unprotected intercourse. I don't think the overall percentage of the population who experiences infertility is increasing in any significant way. However, the Baby Boom cohort, many of whom delayed childbearing, may be responsible for an increase in the absolute number of women who are experiencing infertility.

Q: How much can someone considering ART expect to spend on the process? Who bears these costs?

A: The cost of IVF really varies, depending on whether you have health insurance coverage, depending on how many rounds of IVF you undergo, and depending on whether you add in additional services, such as a donor egg or surrogate. The other complicating factor is the rise of shared risk programs—where a client might pay more up front for a package of IVF trials (say 3) but be guaranteed an 80% or even 100% refund if she does not become pregnant. So if she becomes pregnant on the first try, she will have overpaid, but if no pregnancy occurs, she gets most of that money back. For example, I've seen a price list (in a Chicago clinic) that offered up to three "fresh" IVF cycles, with medications and ultrasound included, for \$25,000. An 80% refund is guaranteed if there is no pregnancy.

For a single shot at IVF, out of pocket, a woman should probably expect to pay a minimum of \$10,000, and probably much more depending on her geographic location.

Although there are 15 states that require health insurance plans to include fertility treatments, for the most part, individual consumers bear the cost of ART out of pocket. Many people use their life savings or forego other major purchases or borrow from family members in order to finance ART.

[more]

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3-3-3 A Conversation with Karey Harwood

Q: Your research focuses on a particular group of women in Atlanta in a group called RESOLVE. Why did you choose them?

A: I think I originally became aware of RESOLVE's existence because their old headquarters in Somerville, Massachusetts—in the heart of Inman Square—was just a few blocks from where I lived during the mid-1990s. I could walk to Inman Square from my house, and there on the corner of the Beacon and Cambridge Streets was the main office of RESOLVE. I wandered in there once out of curiosity to look at their brochures. This would have been before I even went to graduate school. Later, when I became interested in researching reproductive technologies, my prior acquaintance with RESOLVE must have influenced my choice. In addition, it was quickly apparent that RESOLVE had a strong chapter in Atlanta and a strong presence nationally. Both women and men are members of RESOLVE and it is the largest organization of its kind that offers support to people experiencing infertility. I considered researching the group Hannah's Prayer, which has a specifically religious orientation, but decided that RESOLVE might offer a more broadly representative cross-section of the people who were seeking infertility services, including ART.

Q: Is there a central controversy or problem surrounding the use of ART?

A: In my mind, the central controversy surrounding the use of ART is its overconsumption by some and its unaffordability by many others. I don't think the central controversy is about whether the use of ART is inherently immoral. I think the practice of using medical assistance to overcome infertility, to allow for the birth of an ardently desired child (who otherwise would not have existed), has strong philosophical support. There is more lingering controversy around the specific practice of using third party donors, but the "basic" procedure of IVF is now so widely practiced around the globe that it has the status of a generally accepted medical procedure—even if only a minority of women experiencing infertility actually have access to ART and choose to use it.

The real problem is that ART appears to be highly addictive for those who have the means to try it. This overconsumption is problematic for many reasons, not the least of which is its impact on women's health. For everyone else who happens not to have health insurance coverage for infertility treatments and who cannot afford to pay for ART out of pocket, their lack of access is the main problem—part of larger problem of social justice and how health care benefits are distributed in this country.

Q: What kind of forum do you think these issues should ultimately be resolved in?

A: I think these issues are in fact being debated in the public sphere. I think public awareness of the infertility industry has increased dramatically (due in part to the huge crop of books on the subject that has been published in recent years but also to the widespread coverage in the mainstream media), and that people are more willing to raise critical questions about the infertility industry. I happen to think that increased regulation of the infertility industry would not be such a bad thing. For example, I don't think it places an onerous restriction on individual

[more]

The University of North Carolina Press

4-4-4 A Conversation with Karey Harwood

freedom for there to be a limit on the number of embryos that can be transferred back to a woman's uterus during a single cycle of IVF in order to avoid a multiple gestation pregnancy. I also think patients need better information about their likelihood of success: How much do the chances of success decrease with each successive failed IVF cycle? How much do the chances of success decrease with age? Better statistics could help educate patients to make better decisions, but ultimately a little medical or state paternalism might be justifiable. For their own good, patients should be restricted from trying an unlimited number of IVF cycles. Where should this restriction come from? I'm not sure: either from the physicians themselves, following recommendations from their medical societies (e.g., ASRM, AMA), or from insurance companies who limit their coverage to x number of cycles. When people have the freedom to purchase a seemingly unlimited amount of cosmetic surgery in the United States, it's hard to imagine a law that would limit outright the number of times someone could try IVF. (The practice of medicine regulated by the states, and much of the "regulatory" or ethical directives doctors follow come from medical societies such as the American Society for Reproductive Medicine—so it's a system of self-policing.)

Q: Do you think that women are unwise to rely on ART to start a family later in life?

A: Yes, I do. I think it is an unwise gamble to approach ART as a family planning tool. It is a medical treatment for infertility, and it works best in younger women who have fertility problems that don't affect the quality of their eggs. For example, IVF can circumvent blocked fallopian tubes, getting a healthy egg out of the body, where it can be fertilized *in vitro* with sperm, and then placed back in a functioning uterus. ART is significantly less effective for women over 40, yet unfortunately this is the cohort that leads the surge in the demand for ART.

I am lately particularly concerned about the marketing of egg freezing to fertile, otherwise healthy women. I think egg freezing remains highly experimental and that this use of medical technology in otherwise healthy individuals has much less moral justification than IVF to treat existing infertility. I think when any type of assisted reproduction is sold to women *explicitly* as a means to defer reproductive aging, women are vulnerable to being sold a "bill of goods"—in other words, I am concerned that they may be exploited for the profit of the companies offering these services.

Q: When, if ever, do you think that the use of ART is appropriate?

A: I think ART is appropriate as a treatment for infertility, and I think it is prudent to use it when its chances for success are greatest. (We have a good deal of data, thanks to the CDC's efforts to collect success rates every year—for every age, for donor vs. non-donor eggs, for every type of IVF, etc. So a prospective user of ART can get a pretty good picture of the possible outcomes.) Just because I may think it is unwise for a woman over 40 to attempt IVF with her own eggs does not mean that I think it is unethical. As long as she has been fully informed of her substantially diminished chances of pregnancy, I think we have to support her freedom to make that choice. However, that does not mean that her physician should stand by neutrally, making no

[\[more\]](#)

The University of North Carolina Press

5-5-5 A Conversation with Karey Harwood

effort to persuade her of the folly of that endeavor. Physicians are not mere service providers—and they are not mere entrepreneurs. They have a moral obligation to look out for the best interests of their patients. Women who have low chances of becoming pregnant through ART should be compassionately counseled and given full, accurate information.

Q: How are issues of race and class affected by ART?

A: As I alluded to earlier, race and class do play a role in who has access to ART. But I think the use of ART, in turn, can further exacerbate class-based and race-based disparities. If ART almost becomes a way of life for a certain demographic of relatively wealthy and white people, many of whom have delayed childbearing, it risks further distancing the group of people of who use ART from the vast majority who don't. It becomes a case of piling on advantages alongside a compounding of disadvantages.

Other scholars I've read and talk about in my book, like Dorothy Roberts, point out that the use of ART by white, wealthy woman does nothing to change some of the social inequalities that brought about the infertility problem in the first place. So, it becomes a “technological fix” for a social problem—and it's a “fix” that only a few can benefit from, leaving everyone else to fend for themselves.

Q: What do you think is the future of ART?

A: Well, I'm not entirely sure. I think the expansion of Internet-based agencies that recruit egg and sperm donors, combined with some general apprehension about the commodification of children, may spark greater regulation of the infertility industry. The United States is, after all, somewhat unusual among developed countries that have access to ART in terms of having relatively little regulation. Other countries (e.g., UK) limit the number of embryos that can be transferred in an IVF cycle, prohibit egg and sperm donors from being paid, and regulate the practice of surrogacy. So, on the one hand, I think we are due for some modest move toward greater regulation. (It is somewhat strange, for example, given that the sale of organs is prohibited in the U.S., that we permit the sale of eggs, sperm, and even embryos.)

However, on the other hand, I think the use of ART will most likely level off, continuing to attract a steady interest but by no means usurping the customary way of having children. Indeed, my hope would be that more women would consider being trailblazers—by which I mean continuing to pursue all the educational and career aspirations they desire while also trying to have children when it is biologically easier. I have consistently argued (in my book and elsewhere) that social changes that promote more sexual equality and “family-friendly” policies are greatly needed. How different it would be, for example, if the U.S. had a high quality universal preschool system—something on the order of what exists in France. Sometimes we as Americans take for granted that things have to be the way they are: women simply have to defer childbearing if they want to pursue a career. I like to think the conversation about ART, and its critics, will spark people to imagine how things could be different.

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6-6-6 A Conversation with Karey Harwood

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