

# Use of fetal oocytes in assisted reproduction

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Some researchers have suggested that fetuses eventually might be used as a source for oocytes in oocyte donation programs (1, 2). One variant is to remove oocytes from the ovaries of aborted fetuses, mature them in vitro, and use them as donor oocytes for couples who need eggs as part of their IVF effort. A second variant is to remove ovaries from aborted fetuses and transplant them in women who lack ovarian function so the transplanted tissue eventually will contribute to the woman's normal reproductive cycle. Although at present the use of fetal oocytes for conception is hypothetical and speculative, its endorsement by some researchers and its critique by government-sponsored commissions make timely a discussion of its ethical dimensions (3, 4, 5).

The argument for using fetal oocytes, if this use were feasible, is first to help meet demand for oocyte donation and second to avoid risks and complications for adult donors. Oocytes presently are obtained from women who donate extra oocytes from their own IVF attempts; patients who agree to donate incidental to hysterectomy or other abdominal surgery; and friends, relatives, or women unknown to the recipient who donate oocytes following hormonal hyperstimulation and oocyte retrieval. Many clinicians maintain these methods have not been sufficient to meet demand; moreover, each has limitations. For example, hormonally stimulating anonymous donors presents physical risks, is potentially exploitative, and adds to the costs of assisted reproduction. Maturing oocytes in vitro from fetal ovaries could create an abundant source of oocytes and it could reduce the costs of oocyte donation.

Although fetal oocyte use would help meet a need in oocyte donation, its prospect raises a number of sensitive ethical concerns. First, fetal oocyte use would pose practical problems in gaining informed consent from donors and recipients. The donor, a woman who has just terminated her pregnancy, is placed in the position of deciding to continue her and her partner's genetic line through the potential birth of grandchildren at the same time she elects not to continue this line through the birth of a child. This complicated request would be especially problematic if made immediately following an abortion, when the woman may feel emotionally vulnerable. Therefore, presenting the option before abortion might lead to a more considered and informed choice. As in consent for research on aborted fetuses, the woman's decision to terminate her pregnancy needs to be made before her consent to donate fetal oocytes.

With fetal oocyte donation, there also is the need to obtain the male partner's consent. Although physicians need not obtain the male partner's consent before terminating a pregnancy or using fetal material for research, the situation changes if the abortion is followed by fetal oocyte donation. Here, the oocytes will be used to propagate the genetic line of both the male and female progenitors, which gives the male partner a defensible claim over the disposition of oocytes from a fetus. The timing of his consent would need to coincide with that of the female partner, and both consents would need to be given freely. Serious ethical reservations would arise if the male partner were not available because fetal oocytes should not be donated without his consent.

Obtaining informed consent from recipient couples also would be problematic in the first

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cases because those couples who receive oocytes from an aborted fetus would face uncharted emotional terrain in conceiving a child whose genetic mother was never born. The possibility exists that the couple would feel compelled to accept this option with its unknown emotional implications if they believed that fetal oocytes were their only hope of having a child. Informed consent thus would require a full airing of the alternatives and an understanding that little is known about the long-term emotional ramifications of this technique for donors and recipients. To gather information on these ramifications, physicians would be encouraged to collect data about and report on the psychological consequences of fetal oocyte use for donors and recipients.

A second area of concern is the psychological and physical well-being of the child. The psychological consequences of learning one was conceived from a deliberately aborted fetus are potentially unsettling, and careful attention would need to be paid as to whether the child should be told, and, if so, how. This information can be presented in a positive way that raises no greater problems than disclosure of other conceptions involving gamete donation. Still, the knowledge that one's genetic mother was aborted could have a disturbing impact on some persons. The psychological consequences of learning that one could never trace one's genetic mother are also unknown. On the one hand, the absence of a genetic mother could be less troublesome for a child than knowing a genetic oocyte donor exists; the child conceived with a fetal oocyte would not be in a position to search for the genetic mother. On the other hand, the child might feel emotionally unsettled if he or she could never find the genetic mother because she was never born. At most, the child could learn about his or her genetic grandparents: the woman who terminated her pregnancy and her male partner. Although the child might not be informed of the circumstances of his or her birth, the wisdom of introducing a technique about which participants might feel the need for secrecy is in itself problematic.

The impact of fetal oocyte use on a child's health remains unknown. On the one hand, fetal oocytes may have health advantages in that they have not been exposed to a lifetime of environmental toxins. On the other hand, the safety of using oocytes that have not matured over time needs to be demonstrated. In addition, propensity to ill health cannot be detected if the fetus is never born, and a child born with a fetus as genetic mother will not have access to a maternal medical history if illness develops. Whereas the psycholog-

ical and physical health concerns do not necessarily show that a child born in such a way would be so harmed as to make the child's existence wrong, these issues nevertheless raise questions that clinicians would need to address before proceeding with fetal oocyte use.

A third area of ethical concern relates to the use of fetuses as a source for reproduction. Persons who regard abortion as illicit are likely to view any use of fetal tissue as immoral complicity with abortion. Some individuals who think that abortion is ethically acceptable, at least in some circumstances, might not be troubled by fetal oocyte use. Others, however, might believe the fetal oocyte use raises symbolic concerns about depersonalization in assisted conception. Using the fetus's ovary to generate life when the fetus itself is not given the opportunity for life may be the height of irony.

It is possible that fetal oocyte use will never be technically feasible or that alternatives will be developed, such as the *in vitro* maturation of oocytes from adults or refinements that will lessen the burden on adult donors. In any case, the Ethics Committee sees fetal oocyte donation as a technique that poses emotional risks for children, presents complicated challenges for informed consent, and fosters an unwelcome, impersonal ethos in assisted reproduction. Given the concerns raised here and the absence of a current compelling need for fetal oocytes, the Ethics Committee believes that the use of fetal oocytes for oocyte donation should not be pursued.

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## References

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