

Are You Ever Too Old to Have a Baby? The Ethical Challenges of Older Women Using Infertility Services

Art L. Caplan, Ph.D.,¹ and Pasquale Patrizio, M.D., M.B.E.²

ABSTRACT

Older parenthood raises a variety of important factual and ethical questions. None of the questions have received sufficient attention despite the rapid expansion in the United States and other nations in the numbers of older parents. We do not know much about the safety, economic, and psychosocial impact of these emerging practices on children or parents. Nor have there been many analytical considerations of the ethical issues raised. We argue in this article that there are reasons for concern when older persons seek to utilize fertility treatments, including the safety of pregnancy for older women, risks posed to children delivered by older mothers, issues around what constitutes safe conditions for having a child relative to the age of parents, and the importance of guaranteeing that someone will serve in the parental role should an older parent or parents become disabled or die. To protect the best interest of children created by technology in new familial circumstances, internationally recognized and enforced standards for fertility clinics to follow ought to be enacted in making decisions about treating older parents seeking infertility services.

KEYWORDS: Older parents, age limits, right to reproduce, best interest of children, postmenopausal reproduction

Programs offering fertility services in the United States and other nations are increasingly faced with requests from women of advanced reproductive age seeking assistance in becoming pregnant. Oocyte donation, new drugs, the technique of single intracytoplasmic sperm injection, and in vitro fertilization (IVF) afford older women the opportunity to give birth well beyond the natural limit imposed by menopause, and more and more women are taking advantage of this opportunity.¹⁻⁴ With egg freezing transitioning rapidly into a therapeutic option, it can be anticipated that more and more

younger women will freeze their eggs for future use either in old age or even after their deaths.⁵

Older parenthood does and should raise a variety of important factual and ethical questions. None of the questions have received sufficient attention despite the expansion in the numbers of older parents. We do not know much about the safety, economic, and psychosocial impact of these emerging practices on children or parents. Nor have there been many analytical considerations of the ethical issues raised. Although it is imperative that more be done to monitor and evaluate

¹Director, Center for Bioethics, University of Pennsylvania, Philadelphia, Pennsylvania; ²Professor, Obstetrics and Gynecology, and Director, Yale University Fertility Center, Yale University, New Haven, Connecticut.

Address for correspondence and reprint requests: Pasquale Patrizio, M.D., M.B.E., Professor, Obstetrics and Gynecology, and Director, Yale University Fertility Center, Yale University, New Haven, CT 06511 (e-mail: pasquale.patrizio@yale.edu).

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older parenting, which uses infertility technology including postmortem birth, this article will focus on the key ethical questions raised.

One core ethical question is how to describe older parenting (and postmortem) fertility treatment. Are these instances of human experimentation and should doctors providing these services be held to the standard ethical requirements governing clinical research? If new technologies are being tried in novel ways where the risks and benefits are not well known, there may be a case for insisting that infertility interventions for patients who are very old only be done by doctors who have constructed research protocols and had them approved by appropriate peer review bodies.

Other questions abound. Should infertility programs discourage, tolerate, or encourage pregnancy in old age? Or, instead, should ethical programs try to discourage and constrain who it is that can bear a child in their later years? Should restrictions be in place on advertising and marketing in magazines, the Web, and other forums for fertility services that target older persons? And should governments, private insurance companies, and other third-party payers pay for fertility treatments for older patients?

GROWTH IN OLDER PARENTING

There is no question that the phenomenon of postmenopausal women seeking to become pregnant through egg donation has increased greatly in the past decade.⁶ In the United States between 1996 and 2006, the birth rate for women ages 40 to 44 increased by 50% and for those 37 to 39 years of age by 70%. Although a very small number of these births occurred spontaneously, most are attributable to egg donation and the utilization of IVF. In 2003, there were 263 births reported in women between the ages of 50 and 54.⁷⁻⁹

Among the oldest women to give birth using IVF in the past decade are:

1999: Harriet Stole of Southgate, North London, who gave birth to a son in April 1999, at the age of 66. She had agreed to be a surrogate mother for her infertile daughter-in-law, Lucy Handerson. Lucy and her husband, Harriet's son, Ross Stole, had Lucy's egg fertilized with Ross' sperm and then implanted into Harriet's womb. The child was born prematurely at 8 months, weighing 4 pounds, 5 ounces, but survived and has had no further known medical problems as he has grown up.

2003: Satyabhama Mahapatra of Nayagarh, Orissa, India gave birth to a son on April 9, 2003, at the age of 65. The baby, weighing 6 pounds, 8 ounces (2.95 kg), was born by caesarean section. Mahapatra became pregnant through the help of IVF, using an egg donated by her 26-year-old niece and sperm from her husband, Krishnachandra. This was their first child after 50 years of

marriage. Doctors had attempted to persuade her and her husband not to undergo IVF due to the risks involved. Mahapatra was hospitalized for the last trimester of her pregnancy.

2005: Adriana Iliescu gave birth to two daughters at a hospital in Bucharest, Romania on January 16, 2005, at the age of 66. After undergoing IVF using donated eggs, Iliescu became pregnant with triplets. One of the fetuses died in utero. The surviving two were delivered by caesarean section. One baby died shortly after birth.

2006: Maria del Carmen Bousada de Lara is the oldest woman known to have given birth. She had twin sons at Sant Pau Hospital in Barcelona, Spain on December 29, 2006, at the age of 66—1 week shy of her 67th birthday. The babies were delivered prematurely by caesarean section and weighed 3.5 pounds (1.6 kg) each. Bousada became pregnant after receiving IVF treatment using donor eggs at the Pacific Fertility Clinic in Los Angeles, California. She had no job, no husband, and had sold her home to pay for the infertility treatment. Doctors at the clinic claimed that Bousada lied about her age, saying that she was 55. Her family was unaware that she had gone to the United States to undergo fertility treatment until she returned pregnant to Spain. Bousada's older brother criticized her decision, expressing concern over whether she would be able to raise children at her age. In response to such concerns, Bousada stated, "My mother lived to be 101 and there's no reason I couldn't do the same." Maria died on July 11, 2009 from stomach cancer.¹⁰

2007: An Austrian woman gave birth to her third child in March 2007 at the age of 66. She had previously given birth to another child, a girl weighing 6 pounds (2.72 kg), in the middle of December 2002 at the age of 61. Her oldest child, a daughter, is 30. IVF was used in both pregnancies. The Italian IVF specialist S. Antinori oversaw the second. This is the only known case in the world of two pregnancies and births involving the same woman over the age of 60.

2008: Seventy-year-old Omkari Panwar gave birth to twins, a boy and a girl, in India via emergency cesarean section. The babies weighed 2 pounds each. Omkari became pregnant through IVF treatment, which she and her husband pursued to produce a male heir. Omkari has two adult daughters and five grandchildren. In response to hearing that she'd possibly broken the record for world's oldest mother, Omkari stated, "If I am the world's oldest mother it means nothing to me. I just want to see my new babies and care for them while I am still able."

2009: Elizabeth Adeney, aged 66, gave birth to a 5 pound 3 ounce son in Addenbrooke's Hospital, Cambridge, England. The child, who was conceived through IVF treatment in Ukraine from donor egg and sperm, was delivered by caesarean section on May 28th.

WHY HAVE CHILDREN AT LATER AGES?

Why do women of later reproductive age want to have children? Their motivations vary.¹¹

One reason is that new technology exists that permit the creation of children, and it is widely available in all parts of the world. For example, there are at least 20 infertility programs operating in nations in the Middle East. Some are operated in collaboration with British, German, Australian, or other non-Middle Eastern infertility programs. There are also programs operating in Pakistan, India, Bangladesh, Malaysia, and Egypt.⁸ And there are programs operating in many nations including Britain, India, Canada, Singapore, the Netherlands, Australia, France, Brazil, Argentina, Israel, Spain, the United States, and Germany.

In America, part of the explanation for woman giving birth later in life involves the fact that women in America are marrying later in life, often due to pursuit of their careers or due to economic necessity and, consequently, postponing motherhood. American women are also bombarded by media messages that suggest that technology can extend the age at which a woman can be fertile with little difficulty.

“Forty may be the new thirty,” but fertility drops drastically after the age of 35. Despite media suggestions that women can have a child at any age, some women do not realize the low odds of having their own biological child or what is involved in terms of cost and time using infertility services to have a child after age 35.⁹ The aging of the eggs is a well-known biological phenomenon, and it is rarely emphasized that even with IVF the chances of a successful pregnancy and a live birth are extremely low (less than 5%) for women 43 or older.^{12,13}

During IVF, it was recently reported that only 1% of the eggs collected in women between the age of 41 and 42 result in the production of a live-born baby.¹³

The risk of a miscarriage during the first trimester of a pregnancy for women older than 40 is also higher (double) than the risk at age 35 or younger, 50% versus 22%, respectively.

Some older women have been involved in prolonged infertility treatment for many years with no success and have been referred to egg donation at older ages. Others are divorced and remarried and want to have children with their new husbands.

In other cases, women who never married are deciding they wish to have a child even without a man acting as a father. And in some cases, the death of a child prompts a woman to attempt to have another child.¹¹

Less is known about the extent to which woman are seeking to use technology to have children at older ages in other nations. But the phenomenon is certainly present and growing. Many couples who suffer from infertility want to remove the shame of being childless or to honor the desire to continue the family lineage and, thus, seek infertility treatments. Some older couples will

use techniques such as sperm, egg, or embryo donation but keep that fact a secret.

WHY IS OLD AGE AN ETHICAL PROBLEM?

The decision of women to have children later in life using donor eggs and other forms of reproductive technologies raises important ethical questions. Central among these is whether there is an age at which a woman should be viewed as “too old” to have a child.¹⁰ Why should this be? There may be risks associated with pregnancy in an older woman that are simply too great for mother or potential child to face.

If there is an age at which reproduction is simply too risky, then should formal legal restrictions be placed on access to infertility treatment based on age? Is that consistent with national and international codes of human rights that recognize a right to reproduce? Should religious advisors and doctors not connected to fertility clinics support the desire of older women to reproduce, create that desire, tolerate it, or discourage it?

And why pick on women? Haven't men been having children in their old age since the reports offered in the Bible down to the present day?¹⁴

It is true that men have been able to father children in their later years albeit in recent times not at the ages attributed to the biblical sages. There is a report of one man having his twentieth child at age 90. Some see sexism when issues of older parenting are raised since most questions arise about older women.¹¹ However, there are huge differences medically and ethically between men and women having children at very old ages.

Men are not placed at any serious risk by the process of generating sperm. And although there is some evidence that older men are at risk of creating children with a higher incidence of genetic problems and diseases,¹⁵ the risk to children is far greater in women than it is in men.

When older men historically had children, they had younger wives who were still capable of giving birth. This meant that the child would in all likelihood have at least one biological parent available to play that key role. That historically has not been true of most older woman situations. Single older moms may not have the energy, resources, or health to act as competent parents to teenagers.

Also the biological facts are asymmetrical when men and women of older ages seek to reproduce. Older men do pass on genetic dangers at a higher rate to their offspring.¹⁶ But women having babies at older ages put themselves at serious risk and increase the risks faced by their babies, especially when multiple embryo transfers are involved.¹⁷ Pregnancy complications in older women (women over 40) are well known. They include pregnancy-induced hypertension, premature rupture of the membranes, preterm delivery, vaginal bleeding, and

gestational diabetes.⁸ Pregnancy exposes older women to physical risks wholly different from those that younger women face—risks to the cardiovascular system, along with a much greater chance of postpartum hemorrhage and cesarean section.⁸

Those who favor allowing older women to parent argue that studies on older mothers are misleading because they include spontaneous pregnancies, women who have not been prescreened prior to pregnancy, women who are socioeconomically disadvantaged, and women who were in poor health prior to pregnancy. They contend that women over age 40 entering oocyte donation programs are typically rigorously screened prior to acceptance into fertility programs. But there are no data showing this is so.¹⁸ And there are little data showing that older “fit” women fare better than other older women when they have children.⁴

PROGRAMS LEFT TO MUDDLE THROUGH IN MAKING DECISIONS ABOUT AGE

Without clear guidelines, concern about the ethical propriety of the technologically driven extension of the normal reproductive age is a matter of the marketplace. If you can pay, you can probably find a clinic or a doctor who will do what you want. And because the issue is parenting and childbirth, many are reluctant to comment or become involved in the ethical assessment of the practice, much less suggest the imposition of limits upon it.

As a result, thoughtful doctors and clinics not just seeking a payday from women to pursue their goal of having a child must struggle with the following questions: How should the risks of pregnancy in older women be weighed against the rights of women to control their own reproductive lives? How should a woman’s age and life expectancy factor into a clinic policy concerning access to services? How hard should a clinic try to establish what parenting arrangements have been made in the event of the death or severe disability of the would-be mother or father? What do we know about the capacity for postmenopausal women to parent infants and toddlers? What do we know about the development of children resulting from such services and how they fare as the children of comparatively aged parents?

The last question has not been answered because the long-term consequences of pregnancy in older women are unknown. There are no mandatory registries following older mothers or their children. Still, some nations, notably the United Kingdom, have decided to err on the side of caution and impose age limits on single mothers seeking infertility treatment.⁴ This has led to some women from the United Kingdom going overseas to seek care in countries that lack restrictions.

Concerns about the children of older mothers seem to fall into two categories: one is about the life expectancy of the mothers and the fear that children will be orphaned at an early age. The other is about the health of the older mothers and the fear that they will not have the energy and the stamina to care for children.

Those arguing in favor of allowing oocyte donation for postmenopausal women say that society is accepting of older men marrying younger women and having children, so to deny treatment to older women would be ageist and sexist. They also argue that grandparents often take on the parenting role and “bring economic stability, parental responsibility, and maturity to the family unit.”²

There are also those who argue that each clinic should figure out its own policy about age restrictions. But is this consistent with patient rights to reproduce and not to be discriminated against in using medical services? And given the lucrative nature of fertility treatments, how hard will clinics try to actually screen much less enforce any age restrictions? Much publicity follows from having the “oldest mom” in the world give birth and that translates to prestige, prominence, and profits.

RESTRICTIONS AND LIMITS ON ACCESS TO TREATMENT DUE TO AGE

Disciplinewide guidelines are inconsistent or entirely lacking, so American programs have no generally accepted standards to provide guidance in making decisions about these patients. For example, the American Society for Reproductive Medicine (ASRM) in Practice Guidelines recommends that all recipients of oocyte donation over the age of 45 undergo thorough medical evaluation including cardiovascular testing and a high-risk obstetric consultation before treatment. The guidelines do not include recommendations for age restrictions, however.¹⁹

A statement from the ASRM Ethics Committee asserts that oocyte donation to postmenopausal women “should be discouraged.” ASRM also holds that patients and programs should determine on a case-by-case basis whether a woman’s health, medical and genetic risks, and provision for child rearing justify proceeding with treatment.^{2,19}

Italy enacted a very restrictive policy governing eligibility for infertility services in 2004. Heterosexual couples—whether married or living together—in which both persons are of potentially fertile age have access to treatment.²⁰ Homosexual couples, minors, and singles (i.e., individuals who are not in a heterosexual relationship) are not. Postmenopausal women cannot undergo treatment. In fact, the Ministry of Health Guidelines require that embryos that have been produced at the request of women who are not “of potentially fertile age”

shall not be implanted but rather collected in a central repository.²⁰ An unmarried couple in what the law terms a “de facto” relationship qualifies for treatment. However, the law avoids defining in any detail what a de facto relationship is, specifying only that it occurs whenever a man and a woman live together.

Under the new Italian law, both parents-to-be must be alive at the time the treatment begins. However, if the man’s death occurs between the time of fertilization and implantation, the process is not interrupted and all fertilized embryos must be transferred.²⁰

The Human Fertilisation and Embryology Authority law enacted in 1990 in the United Kingdom, one of the few nations to address older parents, determined that recipients of donor oocytes should not be over age 45, based on the view that it is in the best interest of the child to be parented into young adulthood.¹⁷ Another clinician used the same argument—that children need an adult to raise them until they can live independently—but recommended that the treatment should be limited to women under the age of 60.²¹

IS THERE A BASIC RIGHT TO REPRODUCE IN INTERNATIONAL LAW AND ETHICS?

In 1948, the United Nations Universal Declaration of Human Rights declared in article 16 that “men and women of full age, without limits due to race, nationality or religion, have the right to found a family.”²² In 1950, the European Convention for the Protection of Human Rights and Fundamental Freedoms in article 12 made essentially the same statement (“Convention for the Protection of Human Rights and Fundamental Freedoms”).²³

These documents are important, but if one looks at them more closely, they do not and were not intended to create a right for each person to reproduce. Rather, they were intended to respect the right of persons to be left alone and not coerced with respect to reproductive choices.

There is a difference between negative rights—the right to be left alone—and positive rights—the right to claim entitlement to a service or a means to obtain something.²⁴ Nothing in these international covenants and treaties recognizes the duty of the state or government to supply single persons with mates much less access to reproductive technologies.

Although governments can and do adopt pronatalist stances encouraging people to marry and have children by means of money, housing, or other perks,²⁵ there is no fundamental positive right to reproduce. Moreover, some nations, such as China, have clearly felt that even the negative right to be left alone can be infringed if there is a grave danger posed to the state by uncontrolled population expansion. Although that position is certainly open to debate, there is no doubt that

nowhere is the positive right to reproduce recognized in international law, treaties, covenants, or legislation. So there is no legal obligation to provide older persons with the technology requisite for them to reproduce.

CONCLUSIONS

There are many reasons why older parents having children might be a commendable moral act. But there are also a host of reasons for concern based on the safety of pregnancy for older women, risks posed to children delivered by older mothers, issues around what constitutes safe conditions for having a child relative to the age of parents, and a lack of data on the impact of older parenting within and outside of marriage on children. It would seem prudent in terms of trying to advance the best interest of children to have some internationally recognized standards that fertility clinics must follow in making decisions about older parenting. And given the uncertainties of how well very old parents can parent and the known risks to mothers and children of pregnancy in old age, it would seem morally appropriate to demand thorough medical assessments of older candidates for IVF; extensive examination of the precautions in place to ensure a parent in the case of single, older women; and the setting of restrictions on both the age of women eligible to use infertility services as well as on the number of embryos that ought be transferred per cycle to older women.

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