

Postmenopausal Reproduction: In Whose Interests?

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For some years now, aging baby boomers have insisted that “60 is the new 50.” For those approaching this major milestone who are physically fit and cognitively healthy, no doubt this statement rings true. So it is that persons who are 60-something and who maintain an active lifestyle dismiss as irrelevant any and all references to chronological age as a marker for what they can or should do. To date, discussion on this point has focused largely on the workplace and mandatory retirement. But with the recent birth of twin boys to Ranjit and Jagir Hayer—proud parents at the age of 60—public attention has shifted to parenting, and more specifically to postmenopausal reproduction.

According to media reports, this Calgary couple travelled to India for fertility treatments that Canadian doctors refused to provide. After in vitro fertilization (IVF) using oocytes from a much younger woman, a triplet pregnancy was established. The pregnancy was subsequently electively reduced to a twin pregnancy.

This case attracted significant national media attention, with many commentators insisting that there is a natural limit on women’s reproductive capacity, and that this limit should be respected.^{1,2} On this view, pregnancy at 60 is unnatural and, for this reason, ethically unacceptable.

A second set of objections to the use of medical interventions to induce postmenopausal pregnancy emphasizes the burdens of parenting beyond the venerable age of 60. Critics have argued that caring for young children can be both emotionally stressful and physically demanding. Reasoning along similar lines, clinicians have suggested that a 60-year-old woman should not be treated with IVF and oocyte donation, because her advanced maternal age could make it particularly difficult for her to raise children.²

A third cluster of arguments against postmenopausal reproduction focuses on potential harms to the women who

become pregnant and to the children who are born. The potential physical harms to women include hypertension, cardiovascular complications, gestational diabetes, multiple gestation, preterm labour and delivery by Caesarean section, and preeclampsia.³ The potential harms to offspring are generally identified as psychosocial harms associated with having parents old enough to be mistaken for one’s own grandparents.

In response to these objections to postmenopausal IVF, one could point out that very little about medicine (and more specifically fertility treatment) has to do with accepting what is “natural.” Further, there is no conclusive evidence showing that older women and their partners lack the physical and psychological stamina for raising children. In many societies (including our own), it is not unusual for children to be raised by grandparents who take on parenting roles, and in many instances parenting responsibilities are shared among family members. Moreover, mature parents may also help to bring economic stability to the family. From another perspective, one could argue further that it is important not to discriminate on the basis of gender. Older men can, and do, father children—typically this raises little public attention and even less public ire.

Our goal with this article is not to resolve the debate we have outlined, but rather to respond to the clarion call for careful reflection on appropriate guidelines for the use of assisted human reproductive technologies. According to media reports, the Calgary couple went to India to access fertility treatments that were denied them in Canada. Assuming this is accurate, it behooves us to ask the following question: was this refusal of treatment unwarranted discrimination or sound medical practice?

Importantly, there are no Canadian professional guidelines that stipulate an upper limit on the age at which women may access technologies to assist reproduction. Information on point, however, can be gleaned from the Joint SOGC-CFAS *Guidelines for the Number of Embryos to Transfer*

*Following In Vitro Fertilization.*⁴ The guidelines advise Canadian physicians to transfer only one or two embryos to women under 35 (with the higher number reserved for cases with an unfavourable prognosis), two or three embryos to women 35 to 39, and three or four embryos to women aged 40 or older. Notably, these guidelines do not recommend withholding IVF treatment from women aged 40 or older (who might be in their 50s and 60s), and who are still actively pursuing a reproductive project—albeit with the use of donor oocytes.

The guidelines do recognize, however, that criteria other than age may influence decision-making about the nature of services that might be provided:

Decisions on the number of embryos to transfer should be based upon prognosis determined by variables including the woman's age, prior outcomes, and the number and quality of the embryos available for transfer, and should be made to minimize the risk of multifetal gestation while maintaining a high probability of healthy live birth.⁴

Significantly, this recommendation is consistent with a decision to withhold IVF from a 60-year-old woman, but it is also consistent with a decision to transfer four or more embryos because of a reduced chance of successful implantation. This is a particularly salient fact in the case of Ranjit Hayer, given that her medical history indicated her chance of successfully gestating a single fetus was poor, even after adjusting for her age.

Now, if we look to the United States for guidance, we find that the Ethics Committee of the American Society for Reproductive Medicine affirms the belief that “it would be wrong to deny women the use of donated oocytes solely because of their age.”⁵ From the profession's perspective, therefore, there should be no limit on the age at which prospective parents may access assisted human reproduction involving the use of donated oocytes. This perspective is consistent with the Society for Assisted Reproductive Technology and the American Society for Reproductive Medicine's *Guidelines on Number of Embryos Transferred*, which makes recommendations based on age and prognosis.⁶ This policy recommends the transfer of no more than one or two embryos (cleavage-stage or blastocyst) for women under 35, no more than two blastocysts to three cleavage-stage embryos for women 35 to 37 years old, no more than three blastocysts or four cleavage-stage embryos for women aged 38 to 40, and that women over 40 have no more than three blastocysts or five cleavage-stage embryos transferred. With these recommendations, no discrimination in treatment is indicated for women over 40—there is no upper limit on

the age at which it is acceptable to transfer five embryos to a woman over 40 years of age.

Notably, both Canadian and American guidelines include an open-ended category of “women over 40”—why? Is the underlying assumption that no upper limit needs to be specified because this will be determined on an individual basis with the onset of menopause? If so, is this a reasonable assumption given the availability of oocyte donation? Considered from another perspective, if 50 is the typical age for the onset of menopause⁷ and fertility specialists are willing to accept women patients up to 50 or so years, then why not accept 60-year-old patients in a world where 60 is the new 50?

But what if the decision by Canadian doctors to not provide fertility treatment for the Calgary couple was not based on ageism, but rather on concerns about the woman's health and well-being, as well as the health and well-being of her potential offspring? Surely, health and well-being are legitimate considerations in determining what medical services to provide. But can such criteria function meaningfully in a social context where reproductive medicine is a consumer option and reproductive travel an available alternative? With IVF and oocyte donation as treatment options in the marketplace, there is the very real risk that ability to pay becomes the only relevant access criterion. This is deeply troubling because this fact, more surely than anything else, likely will lead to a steady increase in fertility treatments gone awry.⁸

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