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mother who never existed, and she asked what the effect on the child would be when he or she realised that basic truth.³

Conception and adoption—a fair analogy?

A parallel is often drawn between assisted conception and adoption, with the underlying implication being that couples seeking fertility treatment should somehow prove their fitness as potential parents. We consider this to be a false analogy.

In the case of adoption the child already exists. Hence, the question being asked is: among all the couples who would like to adopt a child, which would make the most suitable parents for this child? The criteria for adoption will inevitably be determined by supply and demand. To put it bluntly, if there are only 10 babies for adoption and 5000 couples wishing to adopt, then the authorities can afford to be very particular about their criteria for accepting couples as adoptive parents.

The situation for a couple seeking help with conception is totally different. If we focus on the interests of the potential child the question that needs to be asked is: are the interests of this potential child better served if he or she is born to these parents or if he or she never exists at all? The possibility of “this” potential child being born to any other (possibly better) parents does not arise. This, crucially, is where the analogy with adoption breaks down.

Of course it is difficult to say when it would be better not to exist; the intrinsic worth of an individual's life cannot readily be quantified, least of all when that life has not yet started. We suggest, however, that the level of parenting would have to be very low for it to be preferable not to exist at all rather than exist as a child of those parents. Society's reluctance to step in and take a child into care except under the most dire circumstances of appalling parenting confirms this.

With regard to the 59 year old woman who gave birth to twins, a frequently reported objection is that the children's mother is likely to die when they are still quite young. No doubt, other things being equal, it is preferable to have a mother who survives well into one's own adulthood. But to put this forward as a sufficient reason for denying fertility treatment is tantamount to claiming that it is better never to have existed than for one's mother to have died when one is still quite young.

This is not the stance we should normally adopt in other contexts. Many serious medical conditions experienced by young women are also associated with difficulties in conceiving or bearing children. Yet these women's desire for children and need for fertility treatment is often regarded most sympathetically precisely because of their diminished life expectancy.

Interests of society masquerading as interests of the potential child

It might be argued that if we cannot help every couple who wants help—because of limited resources—then we should choose between “competing” couples, on the basis of seeking to maximise the number of happy children made per pound spent. If it is true that the children of younger parents usually enjoy a higher level of wellbeing than those of older parents, then we are likely to purchase more wellbeing by helping younger rather than older prospective parents.

In whose interests, however, are we acting? Selecting couples for in vitro fertilisation resembles other procedures that entail problems of allocating resources. For example, a hospital might delay admission of a patient who requires non-urgent surgery in

order to admit a patient requiring an urgent operation. No one would maintain that it was in the best interests of the first patient for his or her surgery to be delayed, but the justification for acting against those interests is that others in the society benefit thereby and that, all things considered, the decision is fair.

There are two main dangers in failing to distinguish between the interests of the particular potential child and those of the potential children who might come into existence if resources were used to help other couples instead. The first danger is that we might, wrongly, refuse to help a couple even when not helping them would not in fact benefit other couples—for example, when the treatment is funded by private resources that would not be available to other couples. The second danger is that society might fail to provide sufficient funds for assisted reproduction. It would clearly be wrong in general to fund assisted conception for an individual couple if it would be better for that couple's potential child not to exist. But it is a very different matter for society to provide insufficient funds for treatments that would confer a genuine benefit. Society may decide as a matter of policy that it will not fund medicine, gynaecology, or fertility treatment beyond a certain level, but that decision requires justification.

Conclusion

We conclude therefore that except in most unusual circumstances it is not right to withhold fertility treatment on the grounds of the interests of the potential child. Society may feel entitled to refuse fertility treatment because of cost or because it does not regard infertility as a priority health concern, but it should not feel comfortable justifying such failure of provision in terms of the interests of the potential child.

1 Mihill C. UK fertility doctors rule out test tube babies for older women because of fears for children's welfare. *Guardian* 1993 Jul 20.

2 *Guardian* 1993 Jul 20.

3 Laurance J. New fertility treatment facing ban: *Times* 1994 Jan 3.

(Accepted 18 January 1995)

Can older women cope with motherhood?

Jennifer Jackson

The reasons put about for refusing in vitro fertilisation to postmenopausal women may seem feeble—as if people first of all feel uncomfortable about such treatment then cast around for reasons to justify their misgivings.

Some consider that these older women are less likely to benefit than younger women in the competition for treatment. But I do not want to go into the vexed issue of “fair shares.” Resources aside, underlying people's misgivings is the thought that even though technology can fit such women for pregnancy, it does not fit them for parenthood—they are too old to be adequate parents to young children.

Is it wrong for a woman to seek to become a mother if she knows, or should know, that she will not be able to cope well with motherhood? It is wrong if her becoming a mother is unjust—as it infringes the resultant child's rights. But the child is not wronged since it cannot be born to better parents.

Yet even if such women are not acting unjustly they may still be acting wrongly. There are other vices

besides injustice, such as taking on a commitment as binding and permanent as motherhood when there are good reasons for anticipating that one will fail to cope. If the women who seek in vitro fertilisation are acting irresponsibly it is wrong for health professionals to assist them.

Women who become pregnant without medical help are not vetted by their doctors to see whether they are fit for motherhood before being allowed to proceed with their pregnancies. But it is one thing to draw the line at forcibly preventing people from acting fecklessly, another to help or enable them to do so. If my general practitioner, having earnestly remonstrated with me about my drinking, meets me in the pub the next day, I do not expect him to snatch my glass from my lips, but neither do I expect him to offer to buy me a refill. If someone is bent on acting irresponsibly others may be powerless to intervene. They are certainly under no obligation to give help.

Health professionals are not supposed to provide services indiscriminately, even to their paying patients. They are supposed to be providing their services in a cause—to protect and promote good health and wellbeing: that is their vocation. Hence, if gynaecologists know that older women are likely to be inadequate mothers it is wrong for them to offer their facilities for in vitro fertilisation to these women.

Of course it may not be reasonable to suppose that older women cannot cope with motherhood. We are, after all, perfectly happy about older men becoming fathers. A century ago when life expectancy for women in Britain was 47 years (as against the current 78 years) nobody objected to women embarking on motherhood in their late twenties. Nowadays, a woman who embarks on motherhood in her fifties has a better chance of seeing her children grow up.

All the same there may be reasons against changing a practice that do not surface if we examine a question only in relation to individual cases. The “case focused” approach dominates medical ethics. The ethical significance of practices deserves more investigation.

In vitro fertilisation is rarely successful in older women

Susan Bewley

The two most extreme views of infertility are that (a) it is an unfortunate circumstance but not a medical disorder worthy of treatment and (b) it is a distressing physical malfunction leaving people unable to fulfil a fundamental human potential. Disease or not, infertility is associated with distress and is currently widely investigated and treated. The disagreement thus seems to be not whether doctors have an obligation to infertile women but the extent of that obligation.

Debates on infertility, as on abortion, are clouded by different ethical value systems and deep prejudices about “deserving women” and “potential children.” Age is not an issue unless doctors have a prior obligation to help. If they do then very good reasons, apart from prejudice, have to exist to deny treatment to a particular woman. What criteria may legitimately be used to decide whether a particular woman is denied treatment (in this case, in vitro fertilisation)? Only three real arguments relate to risk-harm benefit, the interests of the potential child, and rationing of resources.

For doctors who believe in “first of all do no harm”

the most powerful argument relates to the risk-benefit ratio of treating a particular individual. The chance of successful in vitro fertilisation (which itself carries risks) in women aged over 45-50 is remote. A woman may die in pregnancy or childbirth, and there is a risk of creating harm (an orphan). If doctors applied the same criteria and refused infertility treatment to some women with medical disorders such as breast cancer and cardiac disease then they would be consistent. An overall, arbitrary age limit would not be possible as the facts for each patient would be different. Some ethicists claim that the issue of being an orphan is of “no harm” (because you cannot harm something that does not exist) rather than “not enough harm” usually to deny infertility treatment. If the success rates of in vitro fertilisation improve, and it is shown that a higher age is not a high personal risk and that old parents are not very damaging then risk-benefit objections to treating older women must be dropped.

For those who believe in maximising the interests of mother, child, and society (and this view of medical ethics that is based on interests is not universally accepted) a problem exists about weighing future children in the calculations. Do potential children count for something, and if so, what and how much? If potential children do count and it were conclusively shown that certain classes or racial groups had an adverse association with parenting skills then would these become legitimate reasons for denying infertility treatment? Most people would be uncomfortable with this view, and we therefore should not invoke such arguments in the debate. If we consider that the interests of the potential child in fact count for nothing, as the child does not yet exist then logically there would be no cases in which treatment could be refused, however old the potential parents.

Whatever the underlying ethical value system, the last argument relates to effective rationing. There is limited money for infertility treatment, and women over a certain age (for whom treatment becomes less effective) are just not going to get it. This at least would be an honest approach to rationing. Older women would be discriminated against, which is unjust, but there is a countervailing reason. There can be no objection, however, to these women spending their money in the private sector, whatever their age. The ability of richer women to have children when poorer ones cannot seems to reduce children to commodities, which may have adverse knock on social consequences.

Most ethical debates turn on the medical facts. Improvements in success rates will make it increasingly difficult to sustain objections to offering older women in vitro fertilisation. At present, it is merely the inefficacy of treatment that allows otherwise weak objections to maternal age to hold together.

The role of ethics committees

Ian Craft

When in vitro fertilisation was being developed some 20 years ago I was convinced that future assisted conception units would need ethics committees to consider the more emotive types of fertility treatment that gamete permutation would allow. Now I am by no means so sure.

The first such ethics committee was set up by the Royal College of Obstetricians and Gynaecologists in 1982. Since then I have always worked alongside an ethics committee, although the Human Fertilisation and Embryology Act 1990 does not require fertility