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