Maternal mortality or maternal morality? A critique of proposals to introduce maternal upper age limits for Assisted Human Reproduction services in Ireland.

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Abstract

The process of in-vitro fertilization for post-menopausal women is an issue which generates fevered publicity, rancorous debate, and ethical dilemmas. Since the 1990s, assisted human reproduction (AHR) via IVF has become more affordable, widespread, and successful. While IVF is most commonly used to treat pre-menopausal women struggling with fertility issues, at an increased level, post-menopausal women are seeking treatment to implant fertilized embryos long after their own natural egg production has ceased. In recent months, the Irish Department of Health has taken steps to regulate the provision of AHR services in Ireland. This article aims to contribute to the legal and ethical discussion surrounding maternal age limits, considering current medical facts, ethical principles, and alternative models of AHR. If there is an age at which reproduction is deemed too risky, should formal legal restrictions be placed on access to infertility treatment based on age? Is that consistent with international cedes of human rights that recognize a right to reproduce? Should doctors support the autonomy and desire of older women to reproduce, or in fact should state-regulated infertility programmes seek to actively outlaw AHR for older patients?

Keywords: Assisted Human Reproduction, In-Vitro Fertilization, upper-age limits, infertility, regulation.

> *AHR treatment shall only be provided to a woman who is 47 years of age or under, irrespective of whether the woman is using her own gametes, an embryo created using her gametes, or gametes or embryos donated by a third party.*[1]
> - General Scheme of the Assisted Human Reproduction Bill 2017

Introduction

The process of in-vitro fertilization (henceforth IVF) for post-menopausal women is an issue which has generated significant levels of fevered publicity, rancorous debate, and ethical dilemmas which get to the very heart of the human condition. Since the 1990s, assisted human reproduction (AHR, also termed Assisted Reproductive Technology, or ART) via IVF has become more successful, affordable, and widespread. IVF involves the surgical removal of eggs from a woman's ovary and then the combination of these eggs with sperm outside of the body, followed by the re-implantation of the embryo in the woman's uterus, or its donation to another woman.[2] While IVF is most commonly used to treat pre-menopausal women struggling with fertility issues, at an increasing level post-menopausal women are seeking treatment to implant fertilized embryos long after their own natural egg production has ceased.[3] In recent months, the Department of Health has taken steps to regulate, for the first time, the provision of AHR services in Ireland. This essay will consider one such proposed regulation, namely a prohibition on the provision of ART to women over 47 year of age.

This article aims to contribute to the discussion surrounding whether such maternal age limits are justified, considering current medical facts, ethical principles, and alternative models. If there is an age at which

[1]Department of Health. *General Scheme of the Assisted Human Reproduction Bill* . Dublin (2017): An Roinn Sláinte, para. 6(4).

[2]American Society for Reproductive Medicine, "Frequently Asked Questions About Infertility - What is In Vitro Fertilization?" Accessed December 1, 2018.

[3]Gleicher, Norbert; Weghofer, Andrea; Barad, David. "Too old for IVF: are we discriminating against older women?" *Journal of Assisted Reproduction and Genetics* 24 (2007): 639.

reproduction is deemed too risky, should formal legal restrictions be placed on access to infertility treatment based on age? Is that consistent with international cedes of human rights that recognize a right to reproduce? Should doctors support the autonomy and desire of older women to reproduce – seen by some as a fundamental part of being human - or in fact should state-regulated infertility programmes seek to actively outlaw AHR for older patients?[4]

The article will proceed as follows: Part 1 will outline the background of AHR provision in Ireland with regards to IVF services. Part 2 will seek to clarify the contested set of medical facts concerning IVF for older women. Part 3 will assess the arguments in favour of upper age limits in the provision of IVF services, while Part 4 will consider the arguments against. Part 5 outlines an alternative model for IVF provision which cautions against age-based exclusions and instead promotes individualised care. Part 6 concludes.

Part 1: IVF in contemporary Ireland

i. Background

The technological advances of IVF have made it possible for women to circumvent their biological clock,[5] and give birth beyond what was formerly considered the 'natural' reproductive end-point: the menopause. Concurrently, national governments have struggled to keep pace with rapid developments in this sphere. The Department of Health's draft Bill on Assisted Human Reproduction seeks to formally regulate activities which have hitherto been conducted in the private sector without state supervision.[6]

Under the current system, women of all ages are at liberty to opt for IVF in the private sector, should it be deemed safe and suitable by their doctor. Ireland's current system (or lack thereof) typifies the position of most western liberal democracies, whereby governments promote pa-

[4]Caplan, Art L.; Patrizio, Pasquale. "Are You Ever Too Old to Have a Baby? The Ethical Challenges of Older Women Using Infertility Services." *Seminars in Reproductive Medicine* 28 (2010): 282.

[5]Daniel, Lincia. "Fertility treatment: How old is too old for pregnancy and parenthood?" *British Journal of Midwifery* 14 (2006): 341.

[6]Department of Health. "Government approves the drafting of the Assisted Human Reproduction Bill." *Press Releases - An Roinn Sláinte*. 3 October 2017. Accessed December 1, 2018. https://health.gov.ie/blog/press-release/government-approves-the-drafting-of-the-assisted-human-reproduction-bill/.

tient's freedom to reproduce without assistance or interference.[7] For years, a light-touch regulatory framework in this area was founded on a general deference to self-regulating medical practitioners acting in the best interests of patients, the privileging of individual choice, and a general queasiness with which reproductive and sexual issues are discussed.[8]

In the General Scheme of the Assisted Human Reproduction Bill 2017, Health Minister Simon Harris outlined plans to set an upper age limit of 47 years for women for the provision of AHR treatment.[9] No specific paternal upper age limit is stipulated.[10]

The General Scheme outlines how contravention of AHR's upper maternal age limit of 47 years will constitute 'an offence [...] liable on summary conviction to a class A fine, or imprisonment for a term not exceeding 1 year, or both.'[11] In light of this, the proposed Bill represents a comprehensive regulatory shake-up of the Irish IVF system.

ii. Understanding demand for IVF

A question central to the modern demand amongst older women for IVF is why women, at increasing rates, are seeking to delay motherhood. One simple answer is that new technology exists that enables the creation of children at ever-increasing maternal ages.[12] More women are choosing to delay childbearing to pursue careers and secure financial independence.[13] It is also worth noting that many older women pursuing IVF have been involved in multiple failed attempts at IVF using their own eggs, and may be seeking access to advanced oocyte donation treatment (IVF using donor eggs) as they near menopause. Others may be divorced and seeking to have children with new part-

[7]Banh, David; Havemann, Dara L.; Phelps, John Y. "Reproduction beyond menopause: how old is to old for assisted reproductive technology?" *Journal of Assisted Reproduction and Genetics* 27 (2010): 365.

[8]Reynolds, Melissa. "How Old is Too Old: The Need for Federal Regulation Imposing a Maximum Age Limit on Women Seeking Infertility Treatment." *Indiana Health Law Review* 7 (2010): 291.

[9]Department of Health (n 2).

[10]Ibid., para. 6(5).

[11]Ibid., para. 86(1).

[12]Caplan and Patrizio (n 5) 283.

[13]Klitzman, Robert L. "How old is too old? Challenges faced by clinicians concerning age cutoffs for patients undergoing in vitro fertilization' ." *Fertility and Sterility* (2016): 216.

ners.[14]

There exists a multiplicity of explanations for the modern phenomenon of late and postponed motherhood. The popular media narrative of older post-menopausal mothers pursuing IVF treatments for singularly selfish reasons, to supplement pre-existing families or fulfil a 'dying wish' of childbearing, is often inaccurate and sensationalist. The pursuance of IVF is more often a last resort than a long-planned choice.

iii. Comparison to other jurisdictions

As our nearest neighbours - geographically, legislatively, socio-culturally – analysing the Irish proposals relative to UK system seems attractive. However, the complexity, ubiquity, and idiosyncrasy of the British National Health Service, as a universal nationalised healthcare provider, distorts comparisons somewhat. The NHS imposes an age limits of 39 on all women seeking IVF treatment in the public system.[15] There are no legal age limits in the country's 85 private clinics,[16] where doctors make case-by-case determinations about the suitability of patients.[17] Yet given the UK health service is fully nationalised, IVF is one of many medical treatments that is subject to the constraints of resource allocation. A society which offers free medical services to all of its members may feel that it has a right or even a duty to decide which type of treatment will or will not be paid for.[18] As such the British public system of public health is regulated and constrained to a degree not directly comparable to our own.

Further afield, Australia bars IVF after the average age of natural meno-pause, usually interpreted at 52 years of age.[19] In 2010, Quebec became the first jurisdiction in North America to cover the costs of IVF for couples unable to conceive on their own,[20] initially covering up to three IVF cycles for women irrespective of age. However, as older women with very poor prognoses of success were found to

[14]Ibid.

[15]Caplan and Patrizio (n 5) 284.

[16]Daniel (n 6) 341.

[17]Klitzman (n 14) 217.

[18]Paulson, Richard J., and Mark V. Sauer. "Oocyte donation to women of advanced reproductive age: 'How old is too old?'." *Human Reproduction* 9 (1994): 571.

[19]Ibid.

[20]Ubelacker, Sheryl. 2015. "Quebec's high cost of funding IVF without an age limit, a cautionary tale." *Global News Canada*. 19 October 2015.

have received treatment, plans were advanced to alter the legislation to cap the age for public-funded IVF rounds at 42 years, while permitting older women to receive private treatment.[21] No doubt the Quebecois experience, alongside the others mentioned above, informed the Department of Health's reasoning when it was compiling the draft AHR Bill.

Part 2: Disputed 'facts' of IVF

While the overall success rates of IVF have been on the increase, there is little doubt that it still declines markedly with age.[22] The success rate of IVF in women under the age of 35 is 25%-28%, and for women over the age of forty, the success rate significantly decreases to 6%-8%.[23] The rate of miscarriage following IVF can be as high as fifty percent in women over the age of forty.[24] Additionally studies show the occurrence of a number of foetal complications such as low birth weight, alongside Downs Syndrome and other chromosomal abnormalities, increases significantly with maternal age.[25] Furthermore, numerous studies into maternal wellbeing find that statistically significant increases in maternal mortality and other risks to the mother accrue with age.[26] These can include heart attacks, strokes, haemorrhaging, pre- eclampsia, diabetes, and high blood pressure.[27]

However, recent medical developments in oocyte donation have resulted in IVF becoming a far more viable option for older and postmenopausal women. While the likelihood of IVF success using one's own eggs dramatically falls after the age of 40, the use of donor oocytes (immature eggs extracted from donor ovaries) greatly increases the likelihood of IVF success, regardless of the age of the recipient.[28] With oocyte donation, older mothers can circumvent the foetal risks associated with the use of their own eggs (such as chromosomally abnor-

[21] Ibid.
[22] Klitzman (n 14) 216.
[23] Reynolds (n 9) 283.
[24] Ibid., 285.
[25] Ibid., 287-8.
[26] Banh, Havemann and Phelps (n 7) 367; Salihu, Hamisu M., Aliyu, Muktar H.; Bosny, J. Pierre-Louis; Alexander, Greg R. "Levels of Excess Infant Deaths Attributable to Maternal Smoking During Pregnancy in the United States." *Maternal and Child Health Journal* 7 (2003): 219.
[27] Daniel (n 7) 341.
[28] Gleicher, Weghofer and Barad (n 4) 640.

mal foetuses).[29] Additionally, more recent studies of health outcomes of post-menopausal mothers have found that, with careful screening and selection, healthy post-menopausal mothers themselves are at no greater obstetric risk than that which exists in the general population.[30]

Thus, though there appears to be broad medical consensus regarding the sharp decline in IVF success for older mothers, advances in oocyte donation have resulted in increased success rates across all age-groups, and mitigated foetal risks. There appears to be differing opinions surrounding the obstetric risks faced by older mothers, with various studies generating conflicting results. This background of considerable medical disagreement problematizes the formulation of inflexible Irish legislative policy (as has been proposed), and suggests a more individualised regime taking into account a number of factors, beyond simply the age of the woman, may be appropriate.

Part 3: The case for age-limits

i. Success rate

> *Female age is one of the main factors affecting the outcome of AHR and a woman's ability to conceive a child inevitably reduces with age*.[31]

As is clear from the reasoning given in the General Scheme above, doubts surrounding IVF success rates underlie the government's proposed prohibition on AHR for older women.[32] Proponents of age limits cite low success rates to rationalise a preference for younger, pre-menopausal women.[33] This criterion is based on utilitarian theory, measuring 'utility' in the context of fertility treatment by the 'take-home-baby' rate.[34] Utilitarianism applied to interventions of which the consequences are uncertain requires that we choose that course of action

[29]Edwards, Robert Geoffrey. "Pregnancies are acceptable in post-menopausal women." *Human Reproduction* 8 (1993): 1543.

[30]Antinori, S.; Versaci, C.; Hossein Gholami, G.; Caffa, B.; Panci, C. "A child is a joy at any age." *Human Reproduction* 8 (1993): 1542.

[31]Department of Health (n 2) para. 6(4) Explanatory Note.

[32]See n 28.

[33]Pennings, Guido. "Postmenopausal Women and the Right of Access to Oocyte Donation." *Journal of Applied Philosophy* 18 (2001): 174.

[34]Ibid., citing Savulescu, Julian. "Consequentialism, reasons, value and justice." *Bioethics* 12 (1998): 212.

which maximises expected value,[35] which in the case of IVF would imply the preferencing of younger women.

However, the 'success rate' argument, when framed from a utilitarian/consequentialist standpoint, raises questions of other determinants which have a detrimental effect on pregnancy success following IVF. When the smoking, drinking and obesity levels of the recipient all negatively correlate with IVF success,[36] one wonders why age-based limitations are being proposed for women seeking IVF, but no other health-related stipulations are outlined. If a society chooses to categorically deny access to health care to a specified group of patients, it should strive to maintain consistency with respect to these regulations.[37] The reason may be a case of simple politics – withholding AHR treatment from obese women, or from women who smoke or drink excessively, would likely be incredibly unpopular. Yet the taboo nature of older motherhood, and indeed the revulsion levelled and post-menopausal mothers, may have enabled the Irish government to single out this population group for regulation.

ii. Rights of the unborn embryo and parenting capacity of older mothers

The General Scheme makes no explicit mention of parenting capacity of older mothers, or the welfare of the unborn child, in its brief justification of the imposition of a maternal upper age limit. However, it is widely accepted that fertility treatment needs a special ethical framework because of the consequences of the treatment, i.e., the birth of a child,[38] and the parenting capacities of older mothers relative to the interests of the child are commonly cited as morally relevant issues in the IVF debate.

Special consideration must be given to the potential child so it is likely that at least one parent will likely live to see the child reach adulthood. As Klitzman points out, mothers and fathers who are 50 year old at the time of a child's birth have a 10% and 15% likelihood, respectively, of dying before the child is 15 years; and mothers and fathers who are 60 years have a 20% and 30% chance, respectively, of doing

[35]Pennings (n 34) 174; Robertson, John A. "Patient selection for organ transplantation: age, incarceration, family support, and other social factors." *Transplantation Proceedings* 21 (1989): 3397.

[36]Pennings (n 34) 174.

[37]Paulson and Saur (n 19) 571.

[38]Ibid., 177.

so.[39] It has been found that children who experience the death of a parent, much less an only parent, are at a greater risk for depression, posttraumatic stress disorder, and future drug abuse.[40] This matter was amplified with the death of Maria Bousada, a 66-year-old single mother who died 3 years after conceiving with donor eggs from an in-vitro fertilization facility in California, leaving behind her 2-year-old orphaned twins.[41]

There exists differing opinions concerning the childrearing abilities of older parents, specifically whether they will retain the physical capacity to raise young children at an advanced age, or whether in fact those same children will be forced prematurely into caring for them.[42] Equally, Pennings points out that no-one has yet been able to indicate characteristics that reliably predict who will be a good parent,[43] and indeed cases of grandparents raising young children due to parental death or absence are extremely commonplace.

Few would dispute that the case of Maria Bousada, and other high-profile instances of women in their 70s successfully conceiving through IVF, are headline-grabbing exceptions, rather than the norm. Yet under the Irish government's proposals, women aged 50 would be prevented from accessing IVF – though these women would only be 68 upon their child's 18th birthday. Given that the latest WHO figures list the life expectancy of Irish females to be 83.4 years,[44] concerns surrounding mothers dying before their children's adulthood need only be raised for prospective mothers of 65 and above, not 47-year-olds.

iii. No inalienable right to conceive.

Caplan and Patrizio detail the international legal framework surrounding the right to a family life,[45] as enshrined in Article 16 of the UDHR, which recognises that 'men and women of full age, without limits due to race, nationality or religion, have the right to found a family'.[46] Article 12 of the ECHR makes essentially the same statement. On

[39]Klitzman (n 14) 222.
[40]Ibid., 366-7.
[41]Banh, Havemann and Phelps (n 8) 365.
[42]Klitzman (n 14) 222.
[43]Pennings (n 34) 178.
[44]Buckley, Dan. "Irish living 2.5 years more than in 2005." *The Irish Examiner*. 29 December 2017.
[45]Caplan and Patrizio (n 5) 285.
[46]United Nations Universal Declaration of Human Rights [1948] Art 16.

the national level, the provisions of Article 41 of the Constitution establish a number of family rights, including the right to marital privacy with respect to family planning.[47]

However, Caplan and Patrizio rightly point out that these documents do not and were not intended to create a right to reproduce. Rather, they were intended to respect the right of persons to be left al one and not coerced with respect to reproductive choices.[48] They draw a distinction between negative rights (in this case, the right to be left alone) and positive rights – namely the right to claim entitlement to a service. Nothing in these documents recognizes the duty of the state to supply citizens with access to reproductive technologies.[49]

Nonetheless, though one may grant that the Constitution and international human rights treaties do not impose upon states a duty to provide AHR services, each document privileges individual privacy, autonomy and freedom from coercion with respect to family planning decisions. Yet does the imposition of this somewhat arbitrary cut-off not act coercively on Irish women in their forties, encouraging them to seek multiple rounds of IVF treatment before the 'cut-off', after which they face significant fines and even prosecution for seeking to reproduce? Indeed, there seems nothing more coercive the threat of looming prosecution in the event of a decision to seek IVF at a certain age. Such a suggestion makes a mockery of the rights to privacy in family planning as outlined in the Constitution.

iv. Voluntariness

Often, childless older women's requests for IVF are met with criticisms of their failure to produce children at what society deems the 'appropriate' time.[50] While fault is widely rejected as morally irrelevant to the question of access to healthcare,[51] this is sometimes overlooked when refusing older and/or postmenopausal women as donor oocyte recipients. This is related to a popular opinion that those who are responsible for their own illnesses have less claim on healthcare resources than those who cannot be blamed for their medical needs.[52]

[47] *Bunreacht na hÉireann* Art. 41.1.1°
[48] Caplan and Patrizio (n 5) 285.
[49] Ibid.
[50] Anna Smajdor, 'The Ethics of IVF over 40' [2011] 69 *Mauritas* 37.
[51] Ibid., Pennings (n 34) 175.
[52] Pennings (n 34) 176.

There exists a widespread belief that the main reason women put off having children is the priority they give to their career. Although professional aspirations can underlie the postponement of pregnancy for a few years in their twenties and thirties, only 5 percent of women delay motherhood to their forties because of career considerations.[53] People in general do not control the primary factors contributing to postponement of motherhood, namely infertility, psychological impediments, and the lack of a suitably stable sexual relationship.[54] As Pennings argues, misjudgements of IVF motivations can easily lead to a 'victim-blaming' stance in which women are held accountable for their own infertility. Moreover, the pursuance of a career is only something a woman is to be blamed for when one accepts the idea that women have a moral obligation to bear children and to sacrifice their lives raising them,[55] an idea that few would stand over in modern Ireland.

Part 4: The case against age-limits

Having analysed, and rebutted, a number of arguments in favour of maternal age cut-offs, we now turn to consider the case against them.

i. Gender-based discrimination

Explicit in the General Scheme for the proposed AHR Bill is a gender-based distinction with regards to age limits for those seeking AHR treatments. While an upper cut-off of 47 is set for women, an equivalent is not established for men. In the area of IVF regulation, the imposition of upper age limits on women alone has fuelled accusations of double standards against regulatory bodies. Granted, no-one disputes the biological asymmetry between men and women of older ages seeking to reproduce, in terms of both the menopause and increased risks faced by children of older mothers.[56] However, with advances in AHR technology, differences between the sexes need no longer manifest in the cessation of older women's reproductive capacities, but rather the degree of artificial reproductive assistance required by older women, relative to their male counterparts.

[53]Ibid., citing Berryman, Julia C. "Perspectives on later motherhood." In *Motherhood*, by A. Phoenix, A. Woollett and E. Lloyd. London (2010): Sage Press.
[54]Pennings (n 34) 176.
[55]Ibid., 177.
[56]Caplan and Patrizio (n 5) 283.

Moreover, critics of age limits claim that they exemplify the collective taboo associated with older motherhood.[57] Klitzman labels the social rejection of phenomena that feel distasteful the 'yuck response'.[58] Less negative attention is drawn to men who conceive children at an older age compared to women of a similar age, as seen by media criticism and tabloid hysteria in the Patricia Rashbrook, Maria Bousada, and Daljinder Kaur cases, among others.[59] Guido Pennings hypothesizes that societal norms surrounding the 'natural reproductive life span' shape public acceptance of, or revulsion towards, mothers of different ages.[60] This concept is used to indicate that the menopause is a natural limit to the right to procreate, and provokes judgments of women who breach that limit. A person's life proceeds along successive steps (childhood, youth, midlife, old age) and each step is associated with different expectations, demands, powers and responsibilities. This framework also determines what one can reasonably wish for, how one should behave and which goals are deemed reasonable at a certain age. Deviance from and interference with the 'natural reproductive life span' is socially rejected.[61]

Pennings advocates for a conscious reshaping of social expectations surrounding the goals of women at various stages of their lives, reflecting increased female financial and professional autonomy, and lengthening life spans. Klitzman, too, argues for a thorough scrutiny of feelings of social disgust evinced by older motherhood.[62] However, rather than legislating for a flexible regime that integrates broader visions of modern motherhood, the proposed AHR Bill entrenches traditional social philosophy that young women constitute the only acceptable mothers.

ii. Autonomy

Autonomy refers to patients making decisions involving their own care through the educated use of information. Many medical providers believe that the decision about whether patients should become parents should be left solely to the patients themselves, not the provider,

[57] Paulson and Sauer (n 19) 571.
[58] Klitzman (n 14) 222.
[59] Banh, Havemann and Phelps (n 8) 366.
[60] Pennings (n 34) 172.
[61] Ibid.
[62] Klitzman (n 14) 222.

or indeed, the state.[63] A common defence of the older IVF patient lies in the primacy of their autonomy, and a belief in the inviolable liberty of the individual to practice something does no harm.[64] Indeed, Edwards go as far as to label any state which seeks to infringe on patients' reproductive autonomy as a 'nightmare world... a Kafka-like system of regulations and permits to reproduce.'[65] Though Edwards phraseology verges on the hyperbolic, his argument is compelling. Society's role is to enable women to make informed choices, not to condemn them on the basis of subjective social and moral judgements.[66]

Inherent to the question of autonomy is the issue of risk, as medical assessments of predicted risk can occasionally justify an infringement on patient autonomy. It is generally accepted that it is riskier to have a child at 40 than at 30, or at 50 than 40. A superficially appealing approach is to identify the medically lowest risk option as always the best. But there are values and goods in people's lives that supersede merely medical or clinical benefits. Reproduction is one of these.[67] Human wellbeing depends on more than good health, and given that the creation of a family is considered an important life project,[68] it is natural that women are willing to autonomously undertake risk in pursuit of children. Every day, individuals assume medical risks for minimal, or no, outright medical benefits (for example, in cosmetic surgery).[69] Risks rise incrementally, and given that we generally expect reproduction to be risk, it is not clear that gradual incremental differences provide sufficient grounds for overriding patient autonomy and refusing treatment outright to women over the age of 47.[70]

iii. The alternative: better for the child not to be born at all?

We have established above that older parents are obviously more likely to die sooner than younger parents. This fact is cited by those age limit advocates as a reason to prohibit IVF procedures amongst older women. Fundamentally, this argument is premised on the question-

[63] Ibid., 220.
[64] Edwards (n 36) 1543.
[65] Ibid.
[66] Smajdor (n 51) 37; Daniel (n 7) 341.
[67] Ibid.
[68] Pennings (n 4) 173.
[69] Gleicher, Weghofer and Barad (n 4) 642.
[70] Smajdor (n 51) 38.

able notion that children of elderly parents would rather not have been born, than to suffer the indignity of elderly parents or the trauma of losing a parent at a young age.[71] Though a child's satisfaction with the counterfactual state of 'not being born' will never be provable, it seems facetious to suggest that children would not rather an abridged relationship with a parent, as opposed to not existing at all.[72] While most commentators agree that physicians' assessments of imminent abuse and harm to a potential child conceived through IVF should offset a patients' desire to have a child (assessments of a patients' mental state and criminal record history, for instance, are not uncommon),[73] this evaluation should not extend to dubious long-term projections of the child's will to live (or wish never to have been born), contingent on the potential premature death of a parent.

Weighing the above cases in favour of, and against, the imposition of maternal age limits for AHR provision, a fixed age limit as proposed in the Department of Health's General Scheme seems ill-advised. Arguments citing IVF success rate are inconsistently applied, while assumptions concerning the parenting capacity of older mothers seem unfounded. While there does not exist a state duty to provide ART, international treaties and the Irish Constitution underscore the importance of freedom in family life and choices. The subject of voluntariness is also problematized by a number of ethicists. Moreover, several socio-ethical arguments make a persuasive case against age limits, including issues of gender discrimination and autonomy.

The points raised above have established the ethical importance of treating patients without allowing punitive regulatory measures based on regressive social judgements to enter the frame.[74] The final section of this paper will outline an alternative model of IVF provision, which takes into account a number of individual factors and aims for greater beneficence, equity and autonomy than the prohibitive system currently proposed.

Part 5: Towards an ethical regulatory model of IVF provision without maternal age limits

[71] Paulson and Sauer (n 19) 572.
[72] Daniel (n 7) 341.
[73] Klitzman (n 14) 222.
[74] Smajdor (n 51) 39.

One cannot contest the need for a system of prioritisation of IVF recipients under the proposed Irish legislation, in light of the resources and labour required by AHR provision, coupled with the limited supply of donor oocytes. While formal government regulations concerning age-based cut-offs have been criticised,[75] alternative systems of prioritization which incorporate age as one of many relevant factors can ensure regulated IVF provision in Ireland is as equitable, fair and beneficent as possible.

Banh, Havemann and Phelps recommend consideration of the following factors when providing IVF services to older/postmenopausal women:[76]

1. *The patient should undergo extensive medical screening.*
Given the medical complications associated with pregnancy, reproductive endocrinologists must be extremely selective in providing ART to women of advanced reproductive age. This may include the referral of the patient to an obstetric specialist for evaluation of high-risk pregnancy associated with advanced maternal age.[77]

2. *Both parents should undergo psychological evaluation.*
Physicians should carefully assess a patient's understandings and appreciation of these risks. The fact that patients may misunderstand or minimize the complex statistical issues involved underscores the need for increasing public and patient education concerning the low odds of success, and the possible risks and disadvantages of older women seeking to become mothers through ART.[78]

3. *A contingency plan should exist for guardianship in the event of death or illness of one or both parents.*
Reproductive endocrinologists should identify potential custodianship arrangements, whether it is a spouse, a godparent, or other guardian, as a contingency plan for parents of advanced reproductive age. Taking these additional steps to ensure the future welfare of the child is critical.[79]

Additionally, Guido Pennings proposes that medical urgency, and

[75]Klitzman (n 14) 223.
[76]Banh, Havemann and Phelps (n 8) 366-69.
[77]Caplan and Patrizio (n 5) 284-5.
[78]Klitzman (n 14) 223.
[79]Banh, Havemann and Phelps (n 8) 366-69.

waiting time, as factors that must be accounted for in the prioritization of access to IVF services.

4. *Assessment of medical urgency*
This factor intervenes when one can predict that the medical condition of the woman will deteriorate to such an extent that a pregnancy would no longer be acceptable or possible in the (near) future. Pennings cites the example of a woman who is scheduled to soon undergo a hysterectomy that would destroy her capacity to bear children. Urgency may also correlate with age, once a certain threshold is surpassed, such that women nearing menopause are deemed in more urgent need of care relative to younger women, all else being equal.[80]

5. *Elapsed waiting time*
Time on a waiting list cannot be the sole consideration for prioritization of care – if it were so, nothing would prevent young women joining the queue as soon as they became eligible by surpassing lower age bracket. However, the emotional burden of waiting for IVF treatment must be recognised in any proposed system. In Penning's proposed points-ranking system attaches points to waiting time (say 20 points per year), such that patients who were put on the waiting list for premature ovarian failure at the age of 29 will have a total sum that is largely sufficient to give them priority over women put on the list for age-related infertility at the age of 40.[81]

Pennings' points-based ordinal ranking system is an operable model which allows for accurate representation of gradual factors such as age and urgency, while also leaving room for objective assessments of mental and physical suitability for the procedure. In general, he claims, 'the introduction of an 'objective' system of automatically operating rules should help us to achieve a fairer and more equitable distribution of the reproductive material.'[82]

Conclusion

In January 2019, following the historic referendum to repeal the 8th Amendment, a service for termination of pregnancy was legalised nationwide, in what constitutes the greatest expansion of women's repro-

[80] Pennings (n 34) 178.
[81] Ibid., 179.
[82] Ibid., 180.

ductive freedom and autonomy in the history of the Irish state. However, this year the Government is also proposing legislation which seeks to curtail that same reproductive freedom on another front. Going one step further, the Government seeks to enshrine in law provisions to fine and prosecute individuals in contravention of this limit, echoing the punitive criminalisation of abortion and contraception that most Irish citizens wish to be consigned to history.

This article has argued against proposed legislation for maternal age limits in AHR provision on ethical, social, and medical grounds. It has highlighted a number of misconceptions and logical inconsistencies in common arguments favouring the institution of maternal cut-offs, while elaborating on compelling cases against them. Finally, it has outlined an objective system of ordinal, points-based ranking which could be adopted in place of blanket cut-offs, reflective of the 'individualised care' advocated by medical practitioners in this field.[83] In general in the field of medicine and ethics, broad categorical exclusions or rules that precludes consideration of individual histories should be guarded against.[84] Yet this is exactly what the Department of Health's General Scheme is proposing. Medical therapy should not be denied to individuals founded upon unproven age-based concerns. If the Government wishes to honour the considerable mandate of the May 2018 referendum beyond termination policy, its proposals to regulate women's reproductive freedoms in AHR care warrant a serious rethink.

[83] Paulson and Sauer (n 19) 572.
[84] Ibid.

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