Postmenopausal Women and the Right of Access to Oocyte Donation

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ABSTRACT  This paper raises the question of distributive justice in the allocation of donor oocytes. The shortage of oocytes has resulted in waiting lists of several years. The largest group of candidate recipients are postmenopausal women. Questions have been raised about their right to these scarce resources. The criteria that might be morally relevant in the allocation decision are divided according to the stage at which they are applied: either for the admission to the waiting list or for the ranking of those already on the waiting list. Five factors are analysed: success rate, fault, parental competence, medical urgency and waiting time. It is concluded that none of the relevant criteria justifies discrimination against postmenopausal women.

Introduction

Oocyte donation has grown rapidly since it was first offered in 1984. The treatment gives women without ovarian function the possibility of bearing children genetically related to their partners. The categories of patients which are considered eligible for oocyte donation are increasing continuously. Originally, oocyte donation was developed for women whose ovaries failed prematurely. Later, other groups were added, such as women with a genetic defect transmissible to their offspring and patients whose ovaries had to be removed. The largest group, however, was much more controversial, namely women whose infertility is due to age and normal menopause.

This article will only briefly address the question of the acceptability of infertility treatment for postmenopausal women as such. The main focus is on whether these women can apply for donor oocytes, knowing that there is a severe shortage of donors. As a consequence of the discrepancy between supply and demand, the waiting lists are lengthening. All conditions are present to bring the question of distributive justice to the fore. If every woman has an equal claim on the same scarce resource, how should it be distributed among the candidate recipients? There is very little debate among the people involved on the question of the selection of recipients. To date, there are no published reports on the way fertility centres determine who will receive the oocytes that become available at a certain moment. The specific practices, policies and criteria used in the centres that provide oocyte donation are virtually unknown.

One of the few admission criteria accepted by most centres is age [1]. The upper age limit varies however from one centre to the next. Age is a very ambiguous criterion since it contains both medical and non-medical aspects. For organ donation, medical practitioners as well as ethicists agree that admission to the waiting list should be based solely on medical criteria. However, there is a tendency to rationalise non-medical criteria in medical terms [2]. Medical criteria carry the connotation of objectivity and
scientific validity and are used to strengthen the impression of impartiality on the part of the selectors. Special attention should be dedicated to this point when considering age.

The main task is to decide which allocation criteria are ethically relevant. We will analyse the possible relevant characteristics in light of the request for oocytes by post-menopausal women. The analysis of the criteria should allow us to devise a system of rules for the allocation of oocytes. This system should enable us to make a rational choice between potential recipients. Does a woman of 25 with premature ovarian failure have priority over a 45 year old woman with age-related infertility? The ethical theory can be considered successful when those candidates who have to wait cannot reasonably complain that their interests were not given sufficient weight.

The “natural reproductive life span”

Several reports have stated that donated oocytes should not be used to extend the “natural reproductive life span” [3]. The wish of a postmenopausal woman for a child is rejected because having children at that biological stage is ‘unnatural’. If this concept is used to indicate that menopause is a natural limit to the right to procreate and that biological processes should be immune from human intervention, it is not very illuminating. The term is “so selectively invoked . . . that it serves as little more than another way of saying that we don’t like something” [4]. Callahan explicitly disavowed this sense when he introduced his notion of the “natural life span” to regulate medical care. The “natural life span” is a social construction based on “a consistent pattern of judgment in our culture of what it means to live out a life” [5]. 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 reasonable or pathologic at a certain age. For instance, heterosexual married people are expected to want children during their twenties and thirties. After that period, they should enter a phase in which other goals and wishes are appropriate. This structure is revealed in the term ‘grandmother’ which the popular press frequently uses to indicate a postmenopausal mother. The label not only refers to her age but also to the inter-generational role she should adopt at her age. This deviance from and interference with the natural life course is rejected. Although the notion of a “natural life span” has a certain intuitive appeal, it is highly unlikely that we will reach a consensus on its definition. In a pluralistic society, different conceptions of this crucial concept will exist and will inevitably result in different attitudes towards controversial instances of the parental project.

A major problem is that the concept of the “natural life span” which we construct now and which structures our evaluation of actions presupposes a fixed life span. The principle that the acceptability of goals, activities and projects depends on the average life expectancy forces us to re-evaluate certain projects when the average life expectancy changes. While the conception of a child by a woman of fifty who has a life expectancy of seventy could be condemned as an example of irresponsible parenthood because the woman may not be able to raise the child to adulthood, this argument is no longer valid when she can expect to live in health into her nineties [6]. A postmenopausal woman can expect to be able to discharge her parental obligation to her child. Late
parenthood is no longer irrational or irresponsible. It is conceivable that future generations will build a professional career before embarking on parenthood. An extended average life span allows the opportunity of multiple careers and changes the evaluation of the actions and wishes at certain ages [7]. Moreover, it is difficult to condemn people for trying to accomplish life’s possibilities when the occasion presents itself and when it can be pursued without harm to others. Since the creation of a family is generally considered as an important life project, postmenopausal women who can achieve this goal with the help of medical technology should at least be allowed to try.

**Determining the relevant criteria**

Three selective steps or stages in the selection of recipients can be distinguished: referral for the treatment, admission to the waiting list and selection from the waiting list. Very little is known about the first stage. The crucial player at this point is the physician whose evaluation of the patient as a potential recipient will be decisive. Personal values, religious convictions and prejudices about social class and parental competence may all influence the decision to refer a patient for oocyte donation. For obvious reasons, it is impossible to estimate how many people do not get past the first gate.

The criteria on which I focus concern the second and third stage of the selection process. The same characteristics can be used both to regulate admission to the waiting list and to rank individual candidate recipients on the list. There seems to be a distinct preference for the latter procedure. The editors of the *Lancet* argued that one of the factors to be considered in the distribution of oocytes was “the use of scarce and expensive health resources that might deprive infertile younger women of similar benefit” [8]. They further claim that “justice demands that young infertile women should take precedence over those who are postmenopausal”. In the same vein, Baird [9] stated that “prioritization based on appropriate use of scarce resources suggests that donor-egg IVF should not be available to postmenopausal women until the needs of women in the normally fertile age group have been addressed.” Women with a low chance of success, women who already have a child and those who are to be blamed for their need for oocytes are given penalty points or fewer credit points than their competitors. The main advantage of referring them to the back of the list is the ‘mitigating’ effect of this procedure compared to its alternative. The older women are not categorically denied access, but they are given lower priority. The sincerity of such a procedure is determined by two factors: the scarcity of the oocytes and the points accorded to certain features. If the shortage is permanent and serious, any set-back on the list amounts in practice to the exclusion from treatment. It is also easy to fix the amount of penalty points in such a way that having the feature implies denial of access. The system of lower priority nevertheless also implies that postmenopausal women would be eligible for treatment when there is an increased availability of donor oocytes.

The second position which applies at the admission phase is expressed by the Royal Commission on New Reproductive Technologies, from Canada. This commission recommended that postmenopausal women “should not be candidates to receive eggs or zygotes” [10]. Their position goes a step further and denies these women admission to the waiting list. The argument that has to be advanced for this proposal differs from the previous one. Whereas the ranking procedure can deny equal access to
postmenopausal women based on a comparison with the other candidates (the others have a greater right), the latter position does not refer to the younger competitors but denies treatment as such. The shortage of donor oocytes does not really determine the exclusion. The older women are not entitled to donor material — on this account — even if there were a sufficient number of donors.

Criteria for admission on the waiting list

Success rate

Success rate is probably the most widely used method of prioritising patients [11]. This criterion is based on utilitarian theory. Utility in the context of fertility treatment is measured by the ‘take-home-baby’ rate. This is a gross reduction of the notion of utility in infertility treatment but it is nevertheless considered both by patients and by fertility centres as the ultimate criterion for the quality of the treatment. The publication of success rates by centres in the United States and the Patient’s Guide in the United Kingdom and the Netherlands demonstrates this point. If we accept this criterion, the waiting list should be composed in such a way that the expected number of pregnancies from a given number of oocytes is maximised. The oocytes should be given to the woman with the highest chance of pregnancy. Utilitarianism applied to interventions of which the consequences are uncertain requires that we choose that course of action which maximises expected value. According to some authors, it would be wasteful and senseless to do otherwise. An allocation system that does not take account of the medical efficacy would only “promote an abstract and sterile notion of equality” [12].

It has been argued that for efficiency reasons, donor oocytes should preferably be donated to younger women who have a greater chance of becoming pregnant [13]. Baird also based her position on the utilitarian principle that since “younger women have a greater chance of bearing a child, they are more likely to benefit from treatment” [14]. This presupposes that older women have a lower success rate than younger women when donor oocytes are used. The debate on this question is still going on with great fierceness. According to some studies, the better results of women younger than 40 years of age are due to the effect of uterine age which makes the uterus less receptive to implantation [15]. Other studies, however, claim that there is no adverse effect of recipient’s age on pregnancy outcome after oocyte donation and that success rate is determined by the quality of the oocytes [16]. Whatever the final conclusion of this debate, if we accept the success rate as an important factor in the ranking of candidate recipients, other determinants that have a detrimental effect on the pregnancy rate, like smoking, drinking and obesity should also be included. Also more individual factors, like a history of miscarriages and thus a higher likelihood of losing the pregnancy, should be considered when we have to decide whether to allow women access to scarce oocytes [17].

The present problem is a conflict between the principle of justice and the principle of utility. If the oocytes should be donated to those who have the highest success rate (thus maximising utility), then some women will never have the opportunity to be treated. If, as Harris [18] argues, each individual is entitled to an equal opportunity to
benefit from the health care system, then each woman has the right to receive oocytes even with a very slim chance of becoming pregnant. All women are alike in their need of oocytes notwithstanding their different prognoses. A trade-off between on the one hand the medical efficacy and utility and on the other hand the equality of opportunity can be found in a threshold principle. This principle fixes a minimum level of success that has to be reached for someone to be admitted to the waiting list. Above that line, no interpersonal comparisons of chances of success are made. The maximisation-rule implied by utilitarianism is dropped, as incompatible with the principle of equality of opportunity. If Mary has a 90% chance of success and Sarah 5%, then this does not constitute a reason to give priority to Mary. Sarah’s 5% chance still constitutes a fair chance that she can reasonably take. The threshold principle implies that success rate is not a relevant factor for choosing between individuals on the waiting list. It only determines whether someone will be eligible for placement on the waiting list. The use of a minimal threshold simultaneously constitutes an answer to the counter-intuitive idea that even women with a chance of 1/1,000,000 to get pregnant should receive oocytes. Oocytes are a rare and valuable resource that should not be wasted. The selection of recipients according to chances of success can be interpreted as an obligation following from the gift. This obligation has been termed “the obligation of grateful use” [19]. Since the donor considers her oocytes as precious and charged with a special symbolic meaning, it would be wrong to use this gift in a treatment that has almost no chance of success. Should a particular patient or group of patients be offered IVF with donor oocytes when the chances of success are estimated to be three percent? Below the threshold, treatment can be labelled as medically futile. Allocating donor oocytes to those patients would infringe the ‘good management’ rule.

An obvious problem is that it will be very difficult to reach a consensus about how small a chance of success carries with it a loss of equality of status [20]. Admittedly, line-drawing is always a problem but it is still possible to compare broad classes of prognoses [21]. There are borderline cases where society will have to decide whether or not to admit certain patients to the waiting list. The chance of success as an objective measure does not impose a conclusion by itself. The conclusion (whether or not to offer donor oocytes) depends on several value judgments like the justifiability of making society pay for a treatment which almost certainly will be unsuccessful, the degree of paternalism of the physician or the degree to which he/she leaves the ultimate decision to the patient, the extent of the shortage of oocytes, the importance accorded to the child wish in the life of a person etc.

**Fault**

The matter of fault touches the very complex ethical question of responsibility. We assume in the present discussion that responsibility for an act or outcome is determined by the degree of voluntariness and intentionality and by the possibility and extent of control. We will consider some points in detail about the late pregnancies.

Fault is widely rejected as morally irrelevant by currently accepted principles of justice for scarce medical resources [22]. Nevertheless, an important reason for refusing older and/or postmenopausal women as donor oocyte recipients is that they brought it upon themselves. This is based on an interpretation of the principle of justice which says 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 [23]. The older women should not have postponed pregnancy until it was too late. The formulation is revealing since ‘to postpone’ means to put off what one should or could have done at an earlier time. The reasoning is analogous to that for donor kidney or donor liver candidates whose lifestyle contributed significantly to their end-stage organ failure [24]. The older women would get lower priority than women with premature ovarian failure and women with a genetic reason for donor oocytes because the latter are in no way causally or morally responsible for their need.

There exists a persistent belief that the main reason women put off having children is the priority they give to their career. Although this motive underlies 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 [25]. The late pregnancies can be explained by a number of events in the life of the woman. The three most important reasons that account for the delay are infertility, unresolved identity issues that make the person feel not psychologically ready to nurture a child and the lack of a sexual relationship that is sufficiently stable to start parenthood [26]. Generally, women do not consider their living conditions as optimal for childrearing. Moreover, an increasing number of the requests for oocytes are made by older women who want to have a child with a second partner.

When we examine the history of the postponement or the reason for the existence of a child wish at advanced age, it seems that women have little control over the events that cause it. People in general do not control the social and psychological changes that could prevent the postponement, i.e., falling in love, meeting the right partner, reaching stability. In that sense they are not responsible for the delay and thus retain an equal claim to oocytes. In most cases, delayed childbearing is not a voluntary choice. There is of course a voluntary element included. A woman can have a child with the first man she likes at the age of 25 regardless of whether he is prepared to assume parental responsibility. Since this is an option, postponement is a free choice. It is doubtful however that these ‘solutions’ would meet with approval. Notice moreover that the reasons mentioned above also turn up in the abortion context. If these factors justify aborting a pregnancy, they should surely be accepted as compelling moral reasons for postponing a pregnancy.

But even if most women cannot be blamed for not having made a child earlier in their life, this still does not show how we should deal with those women who did postpone pregnancy because of career considerations. There is one plausible interpretation of this choice which has been expressed succinctly by Glannon: “If a person acts on autonomously formed preferences and choices, and if he is capable of knowing what the probable consequences of his behaviour will be, then he weakens his entitlement to receive treatment for a diseased condition he has brought upon himself. The weakening of the entitlement is . . . something that he brings upon himself as the consequence of his own preferences, choices, and actions over time” [27]. This view is, however, only defensible to the extent that the social, economical and political conditions are present to make autonomously formed choices possible. Precisely on this point some doubts can be raised. “It is easier to blame the individual woman than to understand the political and economic context in which she must act, but it does not make for good social policy. If we want to decrease infertility in part by having women concentrate childbearing in their twenties and early thirties, we have to make it possible for
The influences and restrictions imposed by social and cultural forces and structures strongly qualify the personal responsibility of the woman. The misjudgment of the political and economic context 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. The rejection of career women and their disqualification for access to scarce resources is at least partially based on this conception of the ‘natural role’ of women. A final argument against the use of fault in medicine is the principle of formal justice: people who are equal in relevant respects should be treated equally and those who are unequal in relevant respects should be treated unequally. This principle demands the treatment of postmenopausal women since these patients are relevantly similar to other classes of patients who also receive assistance in reproduction [29]. Fault is a very selectively used criterion in the context of health care. It is almost solely referred to when we are talking of what society considers as vices, e.g., smoking, drinking, promiscuous behaviour. However, judgments of this kind could not be made consistently in medicine [30]. If this scheme of responsibility were used, almost no one would receive appropriate treatment since almost all health problems are to some extent caused by acts of the patients. People wounded in car accidents are not selected for treatment according to whether or not they were driving under the influence, speeding or not wearing seat belts. We are not able to determine degrees of voluntariness to a sufficient degree to pass judgment fairly.

Parental competence and well-being of the child

The content of the notions of fairness and equity is determined by the concrete context in which the decisions are made. Fertility treatment needs a special framework because of the consequences of the treatment, i.e., the birth of a child. Within this framework, the worthiness of the patients for parenthood can be introduced as morally relevant. The recipients would be placed on a scale according to the degree to which they are considered fit for parenthood. The most difficult issue confronted when trying to introduce such ranking is the fact that no one has been able to indicate characteristics that reliably predict who will be a good parent [31]. The attempt to select on the basis of parental competence can be seen as an attempt to maximise utility in terms of the well-being of the child. The oocytes should be given to those women who will raise the happiest child. Although the difficulty of performing such an estimation will be evident, this argument has been used to exclude older women.

The position towards postmenopausal parenthood is determined by several different beliefs and background theories. People try to fit all these elements into a structure in which frontal contradictions, incoherence and dissonance are avoided. A person who is convinced that older people are no longer competent to parent will tend to overestimate the medical risks of pregnancy for the older women, and vice versa. The same applies to claims about the necessary physical and mental capacities needed to meet one’s parental obligations [32]. The proponents of an age limit will stress the difficulties of parenthood while the opponents will present ‘a child as a joy at any age’ [33]. The interaction between objective scientific data and large background theories on the family, the normative reproductive period and the role of women makes this a discussion in which
it is impossible to prove someone wrong; the winner is the one who manages to persuade the others.

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. A woman might be scheduled to undergo a surgical intervention (like a hysterectomy) that will destroy her capacity to bear children. Much more frequent is the increase of pregnancy complications due to age. Most practitioners will refuse to proceed if the pregnancy will seriously jeopardise the health of the woman. Like success rate, medical urgency and health risks are medical criteria which need to be evaluated and interpreted by means of an ethical framework. How high is too high? Again, the degree of paternalism demonstrated by the physician will be decisive in the final conclusion. Nevertheless, especially in view of the obligation of the physician not to cause harm, there is a level of risk for the life or health of the women which justifies a refusal of the request [34]. The physician should ascertain the woman’s ability to safely tolerate pregnancy, labour, and delivery [35]. Health risk is thus also structured as a threshold principle. The nearer the woman comes to the critical threshold, the more urgent her request for treatment. On the basis of justice considerations, the limited supply should be allocated to those with the most urgent need. While a younger woman can wait a little longer, the older one should be awarded priority. This type of selective allocation is called ‘peacetime triage’ [36]. An important negative consequence of this policy is that younger patients remain longer on the list. Even if we accept that there is no significant decrease of success with older age, the mean age of the women will be higher at the moment of treatment. Consequently, they will all have a higher risk of medical complications and, if the fears of some authors prove to be true, they will experience more difficulties in the upbringing of their children. The main advantages of such a system are that everyone has the opportunity to try for a child and that relatively few women will reach the upper age limit without having been offered treatment.

Waiting time

Most people understand the importance of justice in the allocation procedure when they consider the conflicts between waiting time and utilitarian elements like urgency and efficacy. The ‘first come, first served’ rule has an intuitive appeal because we represent the waiting list as a queue. The queuing principle is generally considered as a neutral non-evaluative principle because it requires no background information on the recipients. The only relevant consideration is when a person gets in line [37].

The time factor carries a lot of weight because of the psychological effects of being put on a list. Waiting is frequently accompanied by disagreeable feelings and experiences like frustration, stress, powerlessness and uncertainty about finding a suitable donor in time. In this sense, waiting time expresses the psychological burden. The queuing principle is a means to spread the disadvantages and costs of the scarcity and simultaneously to distribute the possibility of trying. Still, a number of elements diminish the value of waiting time as a criterion. Firstly, in the experience of patients, the waiting
period may have started at the moment of the diagnosis of infertility. People who wish for a child when they are 25 and who, after passing through the preliminary tests and all kinds of alternative treatments, are eventually put on the waiting list for donor oocytes at the age of 35, have had their wishes and plans frustrated for 10 years. The psychological strain may be much higher for these people than for a postmenopausal woman who wants to have a child in a new relationship and who is immediately diagnosed as in need of oocytes. Secondly, length of time on the waiting list is an easily manipulated criterion [38]. Once it becomes known that time on the waiting list is a decisive factor, some physicians will list their patients well in advance of the final diagnosis.

The example above shows that waiting time and age do not go hand in hand. Time is precisely what older women do not have. This factor cannot be estimated independently from the upper age limit. Waiting time should be balanced with urgency. It is obvious that time on the list cannot be the sole consideration for an equitable distribution. When I am waiting for the doctor and someone is brought in who is clearly in a critical condition (and I am not), I will accept that the doctor treats him first. We generally accept that urgency and seriousness give a person the right to move up on the list. This judgment should be expressed in the point system which is designed to regulate the decision-making process.

Balancing the criteria

Once we have decided which criteria are relevant in the allocation process, we still have to weigh the different factors. The assignment of relative weights to the various factors expresses our moral judgments concerning the allocation. We can ‘test’ the algorithms by imagining a large number of hypothetical micro-allocation situations. The weights could then be adapted to obtain allocation decisions that correspond with our moral intuitions and/or that would not strike us as morally unacceptable. As an example, we need to find an algorithm which balances medical urgency and the burden of waiting. If we attach many points to waiting time (say 20 points per year), 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. Alternatively, we could attribute a large number of points to medical urgency starting with an exponential increase of credit points at the age of 45 (supposing 50 is the upper age limit). We could add 20 points at the age of 46, 40 points at the age of 47 and so on. In such a distribution, almost all women would have the possibility of receiving treatment before the age of 50. More complex systems can be proposed to value each factor on its moral value. For instance, it would be possible to give additional points when a patient has to wait more than one standard deviation longer than the mean waiting period.

The example above refers to a point system to manage the distribution. A point system became the preferential solution in the context of organ allocation as well as in the more general context of the distribution of scarce medical products and services [39]. The main advantage of such a system is that it permits several principles to be taken into account simultaneously by balancing the weight of the relevant criteria. It also allows an accurate representation of gradual factors like age. The presence of such a system may decrease the number of special favours asked by physicians for ‘their’
patients, privileges based on idiosyncratic values and personal evaluations. In general, 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.

Conclusion

None of the morally relevant factors justifies discrimination against postmenopausal women who need donor oocytes. Even if it were demonstrated that the success rate of older women is lower than that of their younger competitors, their chances of success are sufficiently high to be acceptable. A threshold principle is proposed for ‘success rate’ and for ‘health risks’. This principle constitutes a compromise between the criterion of utility and the criterion of justice expressed in the principle of equality of opportunity. The latter strongly favours the prioritization of older women based on the medical urgency as expressed in the upper age limit. However, other factors like waiting time should also be included in the final ranking.

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NOTES

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[27] Glannon, op. cit.


