

How old is too old? Challenges faced by clinicians concerning age cutoffs for patients undergoing in vitro fertilization

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Objective: To study how IVF providers view and make decisions concerning age cutoffs and fertility (e.g., whether they establish clear cutoffs, and if so, where).

Design: In-depth interviews of approximately 1 hour.

Setting: Not applicable.

Patient(s): Interviewees: 27 ART providers (17 physicians, 10 other providers) and 10 patients.

Intervention(s): Not applicable.

Main Outcome Measure(s): Attitudes and decisions concerning age cutoffs were assessed.

Result(s): Providers face several challenges and dilemmas concerning both the content and the process of decision-making about age cutoffs—what age cutoff to use for potential parents (women both using and not using their own eggs) and potential fathers (whether to consider the father's age, and if so, separately or only with the mother's age); what criteria to use in these decisions (how much to consider and weigh the mother's autonomy vs. the future child's well-being); how to make these decisions (e.g., "gut feelings" or perceptions of public opinion); who makes these decisions (e.g., physicians on their own vs. a formal ethics or Quality Assurance committee); and how to present/frame these issues to patients (e.g., how much to discourage older women). Patients' responses to age limitations vary (e.g., minimizing or feeling exceptions to the risks; or lying about their age).

Conclusion(s): These data, the first to explore how providers make decisions about age cutoffs for patients, raise several critical issues. Although the American Society for Reproductive Medicine has addressed several concerns, the present data suggest additional questions and challenges, including inherent uncertainties and ethical conflicts, and have important implications for practice, policy, research, and education. (Fertil Steril® 2016;106:216–24. ©2016 by American Society for Reproductive Medicine.)

Key Words: Age, ethics, risk/benefit, medical decision-making, provider–patient communication

Discuss: You can discuss this article with its authors and with other ASRM members at <http://fertstertforum.com/klitzmanr-age-cutoffs-ivf/>

Older patients are increasingly seeking and obtaining IVF (1), but have higher rates of complications, posing medical, ethical, and psychological challenges. Women more than age 40 years who use IVF have elevated rates of preeclampsia, gesta-

tional diabetes, preterm and very preterm delivery (2). Yet many older women are delaying childbearing to pursue careers and the population as a whole is aging. Nationally, from 2000–2010, most donor egg recipients were ≥ 41 years of age, and 24.7%

were ≥ 45 years. Among women using their own eggs, 13.7% were ≥ 41 years (9.1% 41–42 years, 3.7% 43–44 years, and 0.9% ≥ 45 years) (3). The success rate of IVF has recently been increasing overall, but still decreases markedly with age (1). For women 44 and 45 years using their own eggs, Gleicher et al. (1) report that live birth rates were of 1.4% and 2.7%, respectively. Despite these low odds, some investigators argue that patient autonomy dictates that such a patient nonetheless should receive treatment if she wishes. Recent research also suggests possible associations between a father's age and the number of genetic mutations in his children, although these rates of mutations appear low overall (1).

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Given the risks involved, the American Society for Reproductive Medicine (ASRM) stated in 2004 that, “postmenopausal pregnancy should be discouraged,” but that physicians should “carefully consider the specifics of each case” (4). In 2013, ASRM expanded and clarified its guidelines concerning egg donation to say that providers should implant embryos in women >50 years only after medical evaluation; and should discourage women >55 years from doing so; and that prospective parents should be counseled about these issues (5). The ASRM has not recommended upper-age limits for women using their own eggs, but has issued guidelines concerning treatment that has a poor prognosis or is futile, defining “futility” as interventions with less than a 1% likelihood of a live birth, and “very poor prognosis” as odds of >1% but ≤5% (6). The ASRM states that in these instances, physicians should develop “explicit,” “evidence-based” policies and “may refuse to initiate a treatment option they regard as futile or having a very poor prognosis” (6). The ASRM adds that in these cases, “[r]eferral information should be offered, if appropriate,” and that “[c]are should not be provided solely for the financial benefit of the provider or center.” Providers “may treat” such patients after assessment of risks and benefits, and “fully inform[ing]” (6) patients of these low odds of success. But key questions emerge concerning how providers view and approach these issues—whether and when each of these scenarios occur, and whether these relatively general and flexible guidelines should instead be stronger, fuller, or more specific or robust.

Other countries vary in whether they have age limits, and if so what. In the United Kingdom, the Human Fertilisation and Embryology Authority and laws do not specify an upper age limit for treatment. Rather, clinics make their own determinations about patients (7). Australia bars IVF after the average age of natural menopause, “usually interpreted at 52 years of age” (8). Jurisdictions that publicly cover IVF costs also differ concerning maximum age limits. In 2010, Quebec decided to cover up to three IVF cycles, but did not specify a maximum age. Older women with very poor prognoses consequently received treatment, prompting plans to alter the legislation to cap the age at 42 years, yet allowing older women to receive treatment if they pay out-of-pocket (9).

Reproductive-aged men and women generally overestimate the likelihood of becoming pregnant at all ages, have low awareness of the rapid decrease in fertility with age (10), and overestimate the age when women’s fertility decreases, and the odds of success of IVF treatments (11).

Extensive literature searches have revealed no studies examining how providers view these issues—what challenges, if any, they confront, and how they respond to these. Although the ASRM has recommended that assisted reproductive technology (ART) providers develop policies concerning age cutoffs and treatment futility, critical questions arise of how clinicians in fact view and make decisions about upper-age limits, and weigh the age of patients—whether they establish clear cutoffs, and if so, when, where, and how, and what challenges they confront in doing so.

Thus, these issues were examined as part of a study of how providers and patients view and make decisions about several critical aspects of ART. Consistent with ASRM’s recommendation for provider policy development, the present article examines clinicians’ attitudes and practices regarding age cutoffs and determinations of treatment futility through a qualitative study design. At present, no data exist regarding how providers view these issues, and a qualitative study can provide important preliminary information to guide further inquiry.

MATERIALS AND METHODS

A qualitative method was chosen because it can best elicit the full range and typologies of attitudes, interactions, and practices involved, and can inform subsequent quantitative studies. Qualitative methods have been used successfully to reveal critical aspects of patient attitudes and practices concerning ART (12).

In brief, as summarized on Table 1 and described fully in the Supplemental Material, available online, 37 in-depth semistructured interviews of approximately 1 hour each were conducted with 27 ART providers (17 physicians and 10 other providers [7 mental health providers, 2 nurses, and 1 other]) and 10 patients. One physician and three other providers were also themselves patients. Patients and providers were recruited through listservs, e-mails, and word-of-mouth. Providers were also recruited through national ASRM meetings (e.g., preimplantation genetic diagnosis and mental health provider interest group meetings). The Principal Investigator approached these meeting attendees to ascertain whether they might be interested in participating in an interview study, and if so, the Principal Investigator subsequently e-mailed them information about it. Most of those asked agreed to participate, and did so. A mental health listserv was also used, which is received by approximately 60 members (not all of whom are active), of whom 15 responded, and the first 8 respondents were then interviewed. Additional interviews were conducted as background, for informational purposes, with 8 physicians, 9 mental health providers, and 14 patients; and informed, but were not included in the final

TABLE 1

Characteristics of sample.

Characteristic	Male	Female	Total
Physicians	14	3	17
Physicians who are also patients	0	1	1
Type of practice			
University affiliated	5	1	6
Private practice	9	2	11
Other ART providers (e.g., mental health providers, nurses)	1	9	10
Other providers who are also patients	0	3	3
Patients	1	9	10
Total	16	21	37

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