Old, older and too old: age limits for medically assisted fatherhood?

Andrea Mechanick Braverman, Ph.D.

Department of Obstetrics and Gynecology, Thomas Jefferson University, Philadelphia, Pennsylvania

How old is too old to be a father? Can you be a little bit older or "old-ish" to be a dad without being considered an "older dad"? At some point, does one simply become too old to be a father? Unless a man requires medical assistance in family building, that answer has historically turned solely on his opportunity to have a willing female partner of reproductive age. As with so many other aspects of family building, assisted reproductive technologies have transformed the possibilities for—and spawned heated debates about—maternal age. Much attention has been given to this contentious topic for potential mothers, with many programs putting age-related limitations in place for their female patients. This article considers whether there should also be limits—and how we should approach that question—for men who require and seek medical assistance to become fathers. (Fertil Steril® 2017;107:329–33. ©2016 by American Society for Reproductive Medicine.)

Key Words: Paternal age, counseling, psychology, age limits

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Age is relative. As philanthropist, educator, and financier Bernard Baruch famously said, "To me, old age is always ten years older than I am," which reflects an emotional reality but differs greatly from the reality of reproductive physiology. Until very recently, the discussion of age and advanced maternal age in family building did not exist and pushing the age envelope was solely a matter of winning (depending on one's views) the genetics lottery for fertility. Before egg donation, the age of patients presenting for infertility was limited by a woman's fertility in terms of her natural ability to produce her own eggs. Men's age was not a consideration, much less a discussion with the physician, before egg donation, perhaps because of the medically grounded presumption only that the female partner need be young enough to conceive. Historically, there was always the assurance that at least one parent was most likely under the age of 45 years and presumably would be available to raise the child.

What's considered "older"? The World Health Organization has written that the generally accepted age to be considered an older or elderly person in a developed country had been set at age 65 and above (www.who.int/healthinfo/survey/ageingdefnolder/en/).

The media portrayal of older fathers has promoted the concept that an older father is something to regard as remarkable or an achievement to celebrate. From celebrity actor Tony Randall, who became a father for the first time at the age of 77, to 79-year-old Mohinder Singh Gill, whose wife created international headlines by delivering their son at approximately age 72, these accomplishments are reported with positive exclamation. In the case of Mr. Gill, the media attention was almost exclusively focused on his wife, the 72-year-old mother, and not on him as a 79-year-old-father, and the media storm and debates over age limits for parents ensued largely over age limitations for egg donation for women. Clearly a double standard for men and women exists for the social acceptance of older parenting.

Cultural norms about parental age change over time, as frequently seen through the lens of fictional family portrayals. Consider and compare the average ages of parents portrayed in film or television in the middle twentieth century to the present day: Today, it is hard to find a parent in their child-rearing years in television or film who would have had children in their early 20s.

Another force shaping the culture around acceptable parental age is egg freezing. With a growing number of companies, including Apple, Facebook, Citigroup, and J. P. Morgan (http://time.com/3509930/company-paid-egg-freezing-will-be-the-great-equalizer/ accessed 11/2/2016) offering employee benefits for egg freezing, the potential for both women and men to parent at a preferred older age shifts to become normative.

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Reprint requests: Andrea Mechanick Braverman, Ph.D., Clinical Associate Professor of Obstetrics and Gynecology, Clinical Associate Professor of Psychiatry and Behavioral Medicine, Department of Obstetrics and Gynecology, Thomas Jefferson University, 833 Chestnut Street, Mezzanine, Philadelphia, PA 19107 (E-mail: andrea.braverman@jefferson.edu).

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The American Society for Reproductive Medicine (ASRM) Ethics Committee document on oocyte or embryo donation to women of advanced reproductive age (2016) strongly discourages or advises denying embryo transfer to any woman over age 50 who has increased obstetrical risks (1). There is no parallel statement for men discouraging embryo transfer for partners of men over age 50. Obviously for women there are the separate considerations of medical risks to the mother and to any resulting child, particularly the risk of premature birth, owing to increased risks caused by advanced maternal age. Beyond pure obstetrical risks of advanced maternal age, however, the Committee document also affirms that there are psychosocial concerns that should be considered, such as parental loss of one or both parents and/or the availability of older parents to meet the emotional and physical demands of parenting. These concerns clearly apply to the male partner of advanced age as well as the female. The Committee does a skillful job of valuing all stakeholders' needs by addressing the respective patient's autonomy along with the concerns owed to those children born to older parents.

CONSIDERATIONS FOR THE CHILDREN

Advanced paternal age may create anxiety about the loss of a parent or the burden of caring for an aging or ill parent (2). Health concerns can be very different for those in the sixth or seventh decade of life than for those into their eighth and ninth decades of life. This issue is an additional parenting consideration that warrants discussion. Expecting children of older parents to juggle the developmental steps of separation and individuation as they enter college or the work force while at the same time caring for an aging father in his 80s or 90s may be a largely unexamined and undue burden. The ethical issues and discussions surrounding having a baby in your 60s are different than those surrounding being a parent to a grade school–, middle school–, or high school–age child with his or her changing developmental and psychosocial needs.

Zweifel et al. (3) point out the burden on a child who has to care for their older or elderly parent. They highlight the limited research that suggests that these children mature more quickly than their peers and have higher rates of depression and behavioral problems while being more vulnerable to stress and anxiety. The authors point out that the concerns that children of older parents have about their parents' health status can translate into their own general lack of a sense of security. The authors go on to suggest that this may lead to a whole host of issues for these children, including absences from school owing to poor parental support, social problems, and delay in forming relationships, marriage, or childbearing owing to the responsibilities of caring for an aging parent when these stage of life choices are occurring. These issues have not been well studied but are provocative factors in arguments favoring limiting procreative liberty. Conversely, many of these concerns are occurring against a documented worldwide increase in age at marriage and childbearing in general. Offspring in their 30s today may be juggling dating and marriage now while having parents who may have delayed having them until their 40s or later. This may result in a cultural shift wherein the tasks and demands of the child's own adulthood potentially co-occur with their care for aging or elderly parents.

Some have argued that the loss of a parent is so destructive that it justifies creating a parental age limit cutoff policy (2, 4). Research has been quite compelling on this subject despite the paucity of prospective population-based studies. In a large Swedish registry-based study, researchers followed 862,554 children born from 1973 to 1982 regarding hospital admissions and outpatient care for depression within a 7-year period from 2006 to 2013 (5). The authors found that parental loss from natural deaths (the largest concern for older parents) was associated with a small increased risk for mental health consequences for the children in adulthood. They also found that losing a parent at a younger preschool age was associated with higher risks for hospitalization ($P=.006$) and outpatient mental health care ($P=.001$). Although that study could only show associations between parental loss with increased mental health risk for children, the large registry gives weight to these considerations.

Zweifel (6) analyzed the United States Life Tables to calculate the probability of the age of death of a father based on the father's age when the child was born (Table 1). Zweifel argues that the risk of loss of a father before the child's age of 20 dramatically increases when fathering a child after age 55. In the 2011 Life Tables, there was no increased life expectancy overall from the 2010 data, nor was there an increase from difference in life expectancy between the sexes (www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_11.pdf). Although there is a marked difference in overall risk to a child to losing a father as the father's age increases, as Zweifel argues, the increased risk between having a child at age 50 and having a child at age 60 is small (a 13% increase).

Parental death has been found in several studies to be associated with an increased risk of the child's suicidality and suicide (7). A particular risk factor is a sudden loss of a parent. Specifically, the loss of a father before school age was associated with higher risk of self-inflicted injury or poisoning resulting in a hospitalization than loss when older. A rigorous meta-analysis of 28 studies with tight inclusion and exclusion criteria also found no systematic gender patterns for children with parental loss (8). When considering maternal loss, losing a mother before school age was associated with a higher risk only for male offspring and more so if that death was due to natural causes. Regardless of maternal or paternal loss, the presence of another parent was not found to be protective of the identified increased risks to the child.

INCREASED MEDICAL RISKS TO OFFSPRING AND CHANGING SOCIAL NORMS

Recent attention has focused on the potential for increased risks of autism, schizophrenia, and other disorders due to older parents. As evidence accrues, it suggests that these may be small but significant risks to offspring; it does not necessarily answer the question as to whether this should be a consideration for providers of family-building services to older fathers (3). Bray et al. (4) analyzed the growing trend in England and Wales of older fathers and saw that, within

TABLE 1

Child's age at time of father's death.

Father's age at child's birth (y)	Father's expected age of death at time of child's birth (y)	Child's expected age at time of father's death (y)	Probability of father's death by child's age 5 (%)	Probability of father's death by child's age 10 (%)	Probability of father's death by child's age 15 (%)	Probability of father's death by child's age 20 (%)
20	76	56	0.74	1.45	2.19	3.10
25	77	52	0.71	1.46	2.38	3.77
30	77	47	0.75	1.69	3.08	5.17
35	77	42	0.94	2.34	4.45	7.56
40	78	38	1.42	3.54	6.69	10.91
45	78	33	2.16	5.34	9.63	15.69
50	79	29	3.26	7.63	13.83	22.19
55	80	25	4.52	10.93	19.57	31.46
60	81	21	6.71	15.76	28.21	44.91
65	82	17	9.7	23.05	40.94	61.72
70	84	14	14.79	34.60	57.61	79.02
75	85	10	23.25	50.26	75.38	91.98

Note: Source: Zweifel 2015 (6).

Braverman. Age limits for fatherhood. Fertil Steril 2016.

a 10-year span, live births within marriage to men under age 35 decreased from 74% to 60% while fathers 35–54 years of age increased from 25% to 40%. They argue that adverse health outcomes need to be balanced against any social, economic, or other advantages of having an older father when informing social policy. It is also important to consider, even if there is a proven risk to an offspring of mental or physical health problems because of older parents, whether this should preclude medical assistance for conception. The question arises as to how older parentage is or should be viewed differently from other potential increased risks to offspring that other parents are not prevented from electing, such as disabilities, single parenthood, and genetic histories. Any determination to prohibit or restrict assisted reproductive technology (ART) or other family-building services based on paternal age must be strenuously evaluated or measured against policies for ruling in or ruling out other categories of prospective patients.

A related issue is the impact on single fathers. Many reproductive endocrinologists have observed a trend of an increased number of intended single fathers presenting with plans to use an egg donor and gestational carrier. Single fathers appear to trend to an older age, which may owe, in part, to having only a social rather than a biologic clock consideration as well as likely owe in part to being more financially established to shoulder the anticipated costs of third-party arrangements. This group would obviously be disproportionately affected by any age-related limitations in ART programs.

HOW DO PROVIDERS MAKE DECISIONS ABOUT AGE LIMITATIONS?

In Klitzman's 2016 interviews with 27 ART providers composed of physicians, mental health professionals, and nurses, these ART providers stated that making decisions about age of a parent was not an evidence-based decision but involved following "your gut feeling" and "comfort" (9). Some providers considered patients' autonomy and others considered the welfare of the unborn child. There was variance among providers about whether any or all of these decisions should be made on an individual, committee, or patient level. Based on these qualitative interviews, Klitzman outlines several key areas of how providers make their decisions about age limits: gut feelings, perceptions of public opinion, fears of discrimination, persisting uncertainties, and inconsistent or changing policies. Although interesting, that study may have had response bias, given that recruitment was done through professional meetings, listservs, e-mails, and word-of-mouth, so the generalizability of this information may be limited. A qualitative approach to information gathering is helpful to inform more high-quality future quantitative studies.

As noted earlier, psychosocial risks and concerns about the offspring of an older parent encompass both immediate concerns as well as anticipated future implications for the school-age or adult child. The peril of using this approach to include or exclude potential patients is that these decisions are mediated by perceptions, whether of fairness to the child or even by what constitutes old age (always 10 years older than the one making the decision?). We must be thoughtful about whether these perceptions may change or be influenced by personal experience, changing cultural norms, or changing life expectancy. There is a risk to trusting one's own perception, as aptly observed by Oscar Wilde: "I am not young enough to know everything." Our opinions are informed by age and experience, but our policies may not be best served by relying exclusively on them.

ETHICAL AND LEGAL CONSIDERATIONS

Does procreative liberty preclude limits on medically assisted treatment to become a parent? Ethicists and legal scholars disagree on this issue, and although a debate about legal age limits is beyond the scope of the present article, it is a critical component of any policy decisions that a clinic or professional society would reach. John Robertson has written on the concept of procreative liberty: "It is widely accepted that the

right to have or not have children is an important personal liberty. As a result, the state can not restrict decisions about reproduction except in cases of serious harm" (p. 19) (10). He argues that if the harm to offspring is questionable, then there is no legal support to limit or prohibit the use of ART.

Applying such an unlimited view of procreative liberty might result in no age cutoffs, arguing that having a pulse is a sufficient criterion to be an effective parent. If it is a given that loss of a parent has lifelong consequences, then the need for fairness and balancing risks is still in play. Yet, what about the preteen or teenage parent? There is also much in the literature about the negative impact on children of young parents who do not have an emotional or financial base to be effective parents. We have publicly funded early-intervention programs and provide both social and other supports to help these children; we do not have prohibitions on preteens or teens becoming parents. On the other hand, we do not typically offer them medical assistance to become parents, either.

Caplan and Patrizio in 2010 waded into the mêlée concerning age with a medically based argument that the increased risks to offspring from older sperm is far less than those caused by using older women's eggs or the increased obstetrical risks to older women (11). They also address the concerns about longevity and capacity for parenting at an older age. The authors address whether there is a basic right to reproduce and argue there is a difference in negative versus positive rights, and that no international covenant or treaty requires that individuals have access to reproductive technologies. They do not address specific discrimination laws that may be found in different states. Finally, they argue that providers have a moral imperative to consider the best interests of the child and thus both undertake a medical assessment of older intended parents and place restrictions on the number of embryos to be transferred to older women.

So the difficult question is whether or not medical providers should interfere with their patients' autonomous decision about when, i.e., at what age, to become a parent? Consider that society has not chosen to impose a social or legal prohibition to parental age and remove children from teenage or even younger parents. Equity and fairness suggest we should approach the question as to the autonomous choice of when to be a parent without regard to age with both very young and older fathers. Yet, as with other restrictions, the insertion of medical professionals and medical assistance into the act of procreation, introduces additional factors that need to be acknowledged if not weighed. Nonetheless, in a society that values individual procreative liberty and where ART clinics seldom refuse treatment to a wide range of intended parent patients, making an argument to limit one group because of age and not another may be inconsistent with current values in American culture.

CONCLUSION AND RECOMMENDATIONS

The concern about whether to limit medical assistance for men of advanced paternal age gives rise to the question of whether medical providers are being appropriately protective or just creating parental interference. Perhaps reflecting my professional bias and training as a psychologist, I suggest education and counseling of advanced paternal age patients in three specific areas: 1) the potential burden of the loss of a father to a child; 2) the emotional and other burdens of a child caring for an aging parent at a relatively young age and formative stage; and 3) the increased risk of known and suspected genetic dangers of older sperm to a resulting child. Potential fathers of advanced reproductive age, whatever that is determined to be in the changing landscape of life expectancy, should be informed of and professionally counseled to consider all of these factors.

As recommended in both the ASRM ethics statement (1) and in the Zweifel paper (3), I also propose that any intended parent—male or female—over the age of "natural" conception should have this counseling to be given the opportunity to thoughtfully consider the emotional impact and/or risks to a child without risking claims of parental interference or undue burden by medical providers. The discussion should be comprehensive and not narrowed to, or ended prematurely by, the simplistic refrain of many older intended parents of reassurances about their longevity. By requiring the discussion to include broader considerations beyond just "having a pulse," intended parents are given the opportunity to make more conscious parenting decisions. Professionals still retain the ability to refuse to provide treatment based on their assessment of concerns to a future child, as outlined in the ASRM Ethics Committee document on child-rearing ability and the provision of fertility services (12).

The limits to counseling must be acknowledged. Counseling does not guarantee that information will be heard or that potential issues will be considered. As has been observed, fertility education about the impact of age on a woman's fertility may be limited by complex social and cultural circumstances as well as opportunity (13). It is reasonable to anticipate that men's perceptions may be similarly influenced by these circumstances. This does not make an argument for eliminating counseling. Just as intended parents are educated and counseled for increased risk to their children for chromosomal anomalies when the intended mother is of advanced maternal age, so should intended parents be counseled about the three areas described above when the intended father is of advanced paternal age. The goal is not to dissuade or persuade intended parents, but rather to have them make a fully informed decision and the ability to anticipate and prepare for a future child's needs around these potential issues.

Offering counseling neither confers permission nor constitutes prohibition. Education by, and a full discussion with, a qualified medical or mental health professional is our best opportunity to both support individual procreative choices and optimize setting up these children and families for success.

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