

Access to IVF in the Time of Covid-19

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Following the cessation of all fertility services (except fertility preservation for cancer patients) on 23 March 2020, fertility patients have been waiting to learn when they will be permitted to recommence treatment.

For many, this has been a time of anxiety and frustration. One IVF consultant [reports](#) having had to make mental health referrals during the lockdown for patients who are suffering mentally and emotionally as a consequence of their treatment being postponed.

This anxiety is particularly acute for those whose treatment outcomes are time-[sensitive](#): for some patients, the delay might be the difference between success and failure.

The government's decision to allow an additional two years storage of gametes and embryos for patients having fertility treatment during the pandemic will help some, but for many will not redress the impact of halting treatment on their outcomes.

Dr Marco Gaudoin, medical director at Glasgow's GCRM clinic, explained to the [BBC](#): 'Statistically from the age of 34 onwards, for every month that passes your chances drop by around 0.3 percent. So after six months it's about two percent...If you are only starting at a level of 14 percent chance of it working and 6 months later you are down to 12 percent'.

As we begin to see the tide turning, we must now consider when, how and for whom, treatment will begin again.

The Human Fertilisation and Embryology Authority (HFEA) confirmed on 1 May that fertility clinics will be able to apply to reopen in the week beginning 11 May 2020.

HFEA Chair Sally Cheshire [acknowledged](#) the distress cessation had caused, and emphasised that the HFEA's 'priority throughout the pandemic has been to consider how treatment could resume quickly and safely for as many patients as possible and our clear plan sets out how clinics can treat and care for patients safely during the continuing COVID-19 pandemic.'

The HFEA is issuing revised [directions](#) which will require centres to develop a written COVID-19 strategy before resuming treatment provision. This should detail how COVID-19 risk will be managed, including compliance with current guidance on safe and effective treatment and how treatment will be delivered in a manner that mitigates risk for both staff and patients.

The resumption of fertility services raises numerous ethical questions that will need to be addressed. The most fundamental is whether, in the face of the risk to life and health posed by the pandemic, IVF treatment is sufficiently important for it to recommence if doing so might undermine response efforts. Given that the UK continues to endure the economic, emotional, physical and social burdens of lockdown to reduce the impact of COVID-19 – central to which is social distancing – restarting IVF services will necessarily entail contact of some kind. Even with protective measures in place, this creates risk for staff and patients, and potentially contributes to the ongoing spread of the virus. We need to engage with whether this is a risk worth taking, for staff, the wider community, and for the sake of patients wanting to have children.

Staff will need access to adequate protective equipment and supplies, such as hand sanitiser and disinfectants. When there is considerable pressure on supply of such equipment, there are hard questions to be asked about where they are best deployed and whether it is right to use scarce supplies for IVF if it undermines availability in other contexts.

Bringing centre staff back into work may place them at risk of contracting COVID-19 from patients. At present, furloughed staff's salaries are protected, but if centres re-open too quickly, there will likely be an expectation (or requirement) that staff return to work. For some – especially those from households including people at high-risk – this will create a stark choice between being exposed to risk or refusing to work and losing their employment.

However, against each of these issues, there is much to be balanced. Centres are currently facing substantial economic pressure, and recommencing operations will enable them to maintain their business and keep workers employed. On the use of scarce resources, it may be that supplies improve, or that centres can operate effectively without substantial use of such equipment.

And of course, the importance to patients of pursuing their reproductive goals must be considered. It is demonstrably clear that having children is highly important to many people, and this is particularly true of those who pursue fertility treatment. To prevent them accessing that treatment is potentially harmful, but for most a few months delay will not be fatal to their chances of having children. It depends very much of the age, condition and situation of the patient.

It is welcome that the HFEA is developing clear guidance on what centres must do to address safety concerns. It is also welcome that centres will not be permitted to open without meeting these requirements, and that an auditing tool for ensuring compliance will be used.

However, we might wonder how likely it is that staff will have access to adequate personal protective equipment (PPE) (which the Department of Health and Social Care (DHSC) has said will be made available), given the track record so far on the adequacy of supply of PPE. It is vital to protect both staff and patients that the government does provide the PPE needed to support the strategies for safe provision of services that centres put in place.

It is unlikely that centres will be able to open at the same capacity as previously, given the constraints social distancing and availability of PPE will place on them, particularly NHS clinics.

'The procurement of PPE required at increased levels and the supply of some medications and consumables may also have an impact on centres' abilities to resume work as well as their capacity when they do,' the [British Fertility Society](#) pointed out. 'The work undertaken in centres, their local facilities and capacity and their NHS status and commitments are very varied, the timing of opening for each is likely to be quite different.'

Some patients, particularly at private clinics, will see their treatment resume before others. The DHSC has recognised that private clinics will be better able to adapt quickly, and has pledged to work on ensuring there is no inequity in access. However without proactive steps, NHS patients will be likely to receive treatment less quickly than those in private care. The DHSC should consider ways to support NHS clinics to adapt as rapidly as possible.

Regardless of adaptation speed, it is unlikely centres will return to full capacity. How, then, ought they to prioritise patients? Who should be treated first?

Older patients face much greater time pressures, but such patients may well also have lower chances of success, and if access to services is now more limited, these factors must be balanced. If

older patients are given priority on the assumption that their chances are decreasing faster, other patients pushed further down the waiting list will be exposed to the same time pressure risks.

Clinics will need to strike a delicate balance based on need and evidence about the impact of waiting to determine who to treat first. Ideally, those who can bear a delay should have their treatment postponed, enabling those who cannot to be treated first. Prioritisation decisions should be evidence-based and applied equally across patients, although discretion will clearly be needed to deal with individual cases and space should be left for clinical judgments to be made by each centre.

Such an approach is most likely to ensure the best overall outcomes for the greatest number.

Even with clinics taking steps toward reopening, many patients will need to wait longer for treatment, and for some this will reduce their chances having the baby they hope for. This will be deeply distressing, and centres must do what they can to give the most people the best chance of achieving their reproductive goals.