Reproductive technology and postmenopausal motherhood

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Résumé : Les femmes devraient-elles avoir accès aux techniques de reproduction après la ménopause, ou ces techniques devraient-elles être réservées aux femmes stériles en âge de procréer? Cette question d'éthique a été soulevée à la suite de la grossesse de deux Européennes qui ont reçu des ovules fertilisés de donatrices. L'auteur aborde la question en faisant une comparaison avec les jeunes filles prépubères.

A 59-year-old British woman gave birth to twins recently after a physician in a private Italian clinic implanted her with ova donated by a 29-year-old woman. The physician has performed a similar procedure on a 63-year-old woman.

These cases raise a serious ethical question: Should postmenopausal women have access to new reproductive technologies, or should they be reserved for infertile women of childbearing age?

There are arguments on both sides. Some have argued that the technologies were developed to deal with medically diagnosed infertility during childbearing years; such infertility is an illness, but menopause is *not*. Therefore, the use of these technologies to treat postmenopausal women is medically inappropriate. Furthermore, some have argued that postmenopausal mothers will be old by the time their children reach puberty and this will cause socialization and developmental problems. In any case, the strain of pregnancy is too great for these women and to make this technology available to them would be bad medicine.

Others respond that long before the new reproductive technologies appeared, women in their 50s sometimes had children. No one suggested they were bad mothers because of their age, or said that the children were disadvantaged because they had older mothers. Furthermore, one should restrict access to therapies only if their use is medically contraindicated. In the case of reproductive technologies, this may be true for some postmenopausal women but not for all. To refuse postmenopausal women access to these technologies as a matter of policy is to discriminate on the basis of age. In any case, if people can pay for a health service, then they should have it; the state has no right to interfere.

However, are there general rules that should guide the use of reproductive technologies? Should they only be used to "correct" a health problem, or is it permissible to use them to "improve on nature"?

It may be useful to compare menopause with puberty. Prepubescent girls are not *yet* able to have children; postmenopausal women are no *longer* able to have children. In both cases, one is dealing with something inherent in the biologic development of human beings. One could, by way of comparison, ask whether it is ethically defensible to allow prepubescent girls access to reproductive technologies.

When considered this way, several ethically interesting points emerge. That a prepubescent girl may want a child is insufficient reason for giving her access to the technologies. She is neither physically nor emotionally mature enough to have children; to provide her with the technology would be to harm her, and that is ethically indefensible.

Prepubescent girls are not able to give infants the care and nurturing that is necessary and appropriate. Of course, some girls may be able to do this and suffer little, if any, harm from the pregnancy itself. However, when society is faced with the task of developing a policy on these matters, it cannot develop it on the basis of exceptions but must make decisions based on what is likely to happen. Therefore, as a matter of general social principle, prepubescent girls should not have access to reproductive technologies.

Similar points emerge if we apply this reasoning to postmenopausal women. A physician's obligation not to harm a patient is not automati-

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cally overruled by a patient's request for treatment — when it comes to ethics, they are not bound solely by their patients' wishes. Medical standards and ethical concerns remain relevant and in some situations are decisive. If there are clear indications that a postmenopausal woman would be physiologically or psychologically harmed by the use of these technologies, physicians should not provide her with access to them. Many postmenopausal women fall into this category and they should be refused access.

Furthermore, reproduction involves more than one person — minimally, it involves the woman and the child. Consequently the woman's interests must be balanced against the interests of the child. If there are reasonable grounds to believe that the interests of either party will be harmed, then the situation has to be re-evaluated.

Some have suggested that there are such grounds in this situation. They maintain that children have the right to as normal a childhood as possible and that this is what underlies welfare legislation that mandates the apprehension of children in need of protection.

There are no data about whether children of postmenopausal women sustain harm as a result of being born to such mothers, so such experiences cannot be used as a guide. However, adoption criteria do provide a guide that is based on decades of social data and experience. They argue against allowing postmenopausal adoptions; if these criteria were applied, postmenopausal women should not have access to reproductive technologies.

This is not invalidated by the claim that everyone has the right to have children. That right is not like the right to a commodity. Children are persons, and considerations of their best interests are always appropriate in matters of reproduction — especially if that reproduction requires explicit intervention and falls outside the social and biologic norm.

What does it mean to state that, with the possible exception of artificial insemination, reproductive technologies are health care technologies? It means that because they are a type of health care, they should be treated like all other types of health care. This in turn means they should not be used to "improve on nature" but to try to bring about as biologically normal a situation as possible.

In other words, it means that the technologies should be used to give infertile women the opportunity to have children during a stage of their lives when biologically this should be possible. It does not mean that they should be used to provide them with an opportunity that would have disappeared in the normal course of events. Therefore, health-related reasons, not private values, should be the only grounds for providing access to the technologies. This rules out the use of reproductive technologies for postmenopausal women.

The CMA took an essentially similar stance in 1990 in its presentation to the Royal Commission on New Reproductive Technologies, and reaffirmed this stance as a matter of formal policy in 1991 (Kluge E-H, Lucock C: *New Human Reproductive Technologies: A preliminary perspective of the Canadian Medical Association*, CMA, Ottawa, 1991).

The underlying reasons for adopting this position are as valid today as they were then. Postmenopausal women should not have access to these reproductive technologies any more than prepubescent girls should. ■