A CLOSER LOOK AT REPRODUCTIVE TECHNOLOGY AND POSTMENOPAUSAL MOTHERHOOD

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Abstract • Résumé

Although reproductive technologies have been aimed at young, infertile women, evidence suggests that postmenopausal women are also taking advantage of them. Dr. Eike-Henner Kluge asserts in an article in *CMAJ* (1994; 151: 353–355) that there are ethical reasons to deny older women access to these technologies. Kluge's comparison of postmenopausal women with prepubescent girls is fallacious. His assertion that older parents harm children by denying them a "normal" childhood is not supported by any empiric data. Kluge's distinction between medical intervention, in offering reproductive technologies to a woman in her reproductive years, and "improving on nature," by offering these technologies to a postmenopausal woman, is spurious. Unless technologies that are expensive and minimally successful, such as in-vitro fertilization, are denied to everyone, there are no grounds for denying them to postmenopausal women.

Même si les techniques de reproduction sont destinées aux jeunes femmes inféconds, des données probantes indiquent que des femmes ménopausées en profitent aussi. Le Dr Eike-Henner Kluge affirme dans un article du *JAMC* (1994; 151 : 353–355) qu'il y a des raisons éthiques pour refuser aux femmes âgées l'accès à ces techniques. Kluge compare les femmes ménopausées à de jeunes filles prépubertaires, ce qui est fallacieux. Il affirme que des parents âgés portent préjudice aux enfants en leur refusant une enfance «normale», mais aucune donnée empirique n'appuie ses affirmations. La distinction qu'il établit entre l'intervention médicale du médecin qui offre des techniques de reproduction à une femme en âge de procréer et qui offre à une femme ménopausée «d'aider la nature» par ces techniques est fausse. Si l'on ne refuse pas à toutes les femmes des techniques coûteuses qui donnent des résultats minimes comme la fécondation in-vitro, aucune raison ne justifie de les refuser aux femmes ménopausées.

Although reproductive technologies have been largely aimed at young, infertile women, it is evident that postmenopausal women are also taking advantage of them.[1] In response to this trend, some critics wish to deny older women access to these technologies.[2] One such critic, Dr. Eike-Henner Kluge, writing in *CMAJ* ("Reproductive technology and postmenopausal motherhood," *Can Med Assoc J* 1994; 151: 353–355), argues against postmenopausal motherhood on the basis of concern for biologic norms, children's interests and the use of reproductive technologies to "improve on nature." Kluge gives ethical reasons for refusing to offer reproductive aid to women in their postreproductive years; these differ from the fiscal and medical reasons given by the Royal Commission on New Reproductive Technologies.[3] However, his restrictive conclusions are the same as those of the Royal Commission. I contend that there is no good ethical, medical or economic basis for denying postmenopausal women access to reproductive technologies, unless expensive and minimally successful reproductive technologies, such as in-vitro fertilization (IVF), are denied to women of all age groups.

MENOPAUSE AND PUBERTY

Kluge claims that the reasons for denying reproductive technologies to postmenopausal women can be seen more clearly by comparing menopause with puberty. Among both prepubescent girls and postmenopausal women, he claims, it is inherent to their biologic development that they cannot produce children.

That a prepubescent girl may want a child is insufficient reason for giving her access to the technologies. She is neither physi-

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cally nor emotionally mature enough to have children. . . . Prepubescent girls are not able to give infants the care and nurturing that is necessary and appropriate.

This comparison between women younger and older than their reproductive years is problematic on several counts. First, to compare mature, autonomous adult women with young, dependent girls is to denigrate the maturity and the experience of postmenopausal women. The dissimilarities between these two groups far outweigh the comparison that Kluge attempts. Second, the fact that prepubescent girls cannot care for and nurture infants appropriately has little to do with their biologic stage and much to do with their lack of maturity, emotional development and life experience. Postmenopausal women, on the other hand, have the maturity and life experience essential for stable and reliable mothering.

A "NORMAL" CHILDHOOD

Kluge's second argument, that children have the right to "as normal a childhood as possible," also raises concerns. Who decides what is "normal"? Kluge presumably makes a case that postmenopausal mothers deny their children a "normal" childhood because of their advanced age; that is, that children of older parents are denied something essential to a normal childhood. He supports his position by appealing to adoption criteria, which deny postmenopausal adoption on the basis of "decades of social data and experience." Empiric data on children's best interests must support any normative claims, yet Kluge admits that there are no data indicating that children of older parents are harmed as a result of their parents' age. Similar dire predictions were made concerning same-sex couples raising children, but current data suggest that children reared by same-sex couples are no worse off, and in some cases better off, than those reared by heterosexual couples.[4] Therefore, we should be wary of appeals to "decades of social data and experience" that fail to reflect current social and technologic reality. Dire predictions that postmenopausal mothering will harm children should be given no credence without the accompanying empiric data to support such claims.

IMPROVING ON NATURE

Any reproductive medical intervention tends to "improve on nature," whether the cause of infertility is advanced age or a "health-related reason." Kluge's insistence on a distinction between treating women in their childbearing years for reproductive health problems and "improving on nature" by applying technology to help postmenopausal women bear children is therefore spurious. Moreover, many postmenopausal women now seeking oocyte donation experienced reproductive-health problems during their reproductive years, but had no access to reproductive technologies at that time. Paulson and Sauer[5] provide this example.

An individual who was 35 in 1978 and was found to have irreparable tubal disease would have been considered sterile. By 1983, when she reached 40 years of age, in-vitro fertilization was still in its infancy and many programmes did not accept women over the age of 40. Finally, in 1993 when she became 50 years old it became possible for her to attempt oocyte donation. This scenario is not uncommon in our practice.

The distinction that Kluge would like to make between using reproductive technologies to "improve on nature" and as "health care" is a difficult one that does not justify denying reproductive technologies to postmenopausal women. On the contrary, many of the postmenopausal women availing themselves of this technology are simply making up for lost opportunities.

Although Kluge claims to be merely asserting the biologic contraindication to the use of these technologies among postmenopausal women, he makes value judgements concerning their suitability as parents and concerning social norms for mothering. In effect, he mixes an argument from nature with an argument from social norms. His argument is not simply that postmenopausal women are biologically unsuited to motherhood but that such biologic unsuitability further engenders a social and moral incapacity for motherhood.

EFFECTIVENESS OF IVF

IVF has proven less effective among postmenopausal women than among younger women; however, it has a very low success rate among women of any age.[6] The use of hormones to enrich the uterus of a postmenopausal woman and the donation of oocytes increase her chances of successful embryo implantation and gestation.[7,8] Furthermore, some centres have had very successful results in achieving pregnancy among postmenopausal women. A clinical trial conducted by Sauer, Paulson and Lobo[9] has shown that "the ageing ovaries, not the uterus, are responsible for most adverse fertility events." As a result of 21 embryo transfers to 14 postmenopausal recipients, eight pregnancies were established. Of these pregnancies, three resulted in term deliveries, four were continuing at the time of the study, and one ended in miscarriage. The implantation rate among embryos transferred to a uterus was 19%. There is, then, no basis for arguing that IVF should not be applied to postmenopausal women because of the lower success rate: a woman's chance of carrying a baby conceived through IVF to term is low whether she is 25 or 50 years of age.

Fiscal and medical concerns about IVF and older women

The Royal Commission on New Reproductive Technologies, in its final report, recommends against applying reproductive technologies to older women, for reasons different from those given by Kluge. The commissioners do not deny postmenopausal women access to IVF on ethical grounds but on the grounds of fiscal concerns and low success rates. Patricia Baird,[10] chairperson of the commission, states the following view.

> Although there are concerns about the physical demands of motherhood on older women and the best interests of the resulting child, the commission's objections to implantation of ova in postmenopausal women were based on a fundamental principle concerning the appropriate use of finite societal resources.

The commission argues that, since IVF is at least somewhat more successful when applied to younger women, and its provision is a finite public resource, we should give priority to these younger women. If payment for treatment is to come from public coffers, as the commission recommends, rather than from individuals' private funds, then the public should have some control over who has access to such social goods.

However, if fiscal restraints and success rates are factors in how we determine the availability and provision of public health care, then the low success rates and great expense of IVF may militate against its provision to anyone. This view may lead us to conclude that IVF should not be publicly available at all, given the current fiscal situation, but it does not lead us to exclude postmenopausal women in particular. The Royal Commission may have offered fiscal and medical reasons against providing reproductive technologies such as IVF publicly, but it has not convincingly argued that we should specifically deny the procedure to older women. Yet the commission is rightly dedicated to maintaining public provision of reproductive technologies, since we do not want a society in which "people or their reproductive capacities are treated as commodities."[10] So, if public provision of reproductive technologies is to continue, we should not have a policy denying their use by postmenopausal women. Instead, we should assess each request for reproductive assistance on its own merits: some women, postmenopausal or not, may have physical or medical conditions that preclude reproductive aid; others may not.

Conclusion

We should take a closer look at the assumptions and stereotypes underlying our restrictive policy against access to reproductive technologies for postmenopausal women. As Sauer and Paulson[5] point out, men who become fathers in their 70s do not face the societal taboo or reproaches levelled at postmenopausal mothers. When young women whose life expectancy is affected by a medical condition decide to have children, there is no interference. However, it is suggested that older women be denied access to reproductive technologies precisely because of their age and their life expectancy. Clearly, ageism and sexism are alive and well in our culture. Let's guard against these influences in our delivery of health care, our policy making and our laws.

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