
"Never Too Late": Biotechnology, Women and Reproduction

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Postmenopausal pregnancy is an example of how "new" reproductive technology claims to "rescue" women by seemingly offering them choice, control over their bodies and equity with men. The author suggests, however, that the biomedical procedures associated with postmenopausal pregnancy may be more consistent with the oppression of women than with their liberation. Seen in context, this technology is not neutral, and these interventions are part of a larger socio-political ideology: "successful" women are those who are freed of their own biology and situated in a male biomedical model which makes childbearing possible at virtually any age. As such, postmenopausal pregnancy reflects and reinforces sexist and ageist attitudes in our culture. Some may argue that postmenopausal pregnancy is a means to eliminate the reproductive differences between men and women. However, these differences are integral to a woman's identity. What is more troublesome are the consequences that flow from these differences. Rather than adopting the quick fix that postmenopausal pregnancy offers to deal with these differences, it is safer, cheaper and more appropriate to address the consequences through social policies.

Les grossesses post-ménopausiques sont un des moyens par lesquels les nouvelles techniques de reproduction prétendent "sauver" les femmes: elles semblent leur offrir un choix, le contrôle de leur corps et l'équité avec les hommes. L'auteure suggère qu'en réalité, les procédés biomédicaux associés aux grossesses post-ménopausiques relèvent davantage de l'oppression de la femme que de sa libération. Cette technologie n'est pas neutre car ces interventions font partie d'une idéologie socio-politique plus vaste: les femmes qui "réussissent" sont celles qui sont libérées de leur propre biologie et situées dans le modèle biomédical masculin qui rend possible la gestation à n'importe quel âge. Par conséquent, les grossesses post-ménopausiques sont une façon de supprimer les différences reproductives entre hommes et femmes, alors qu'elles sont en fait partie intégrante de l'identité d'une femme. Au lieu d'adopter la solution rapide offerte par les grossesses post-ménopausiques pour résoudre les conséquences de telles différences, il est plus sûr, plus approprié et moins onéreux d'avoir recours à des politiques sociales.

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*Synopsis***Introduction****I. Pregnancy after Menopause****II. Oppression and Postmenopausal Pregnancy****III. Postmenopausal Pregnancy and the Production of Children****IV. The Pregnancy Business and Body Management****V. Rescue Marketing****Conclusion**

Introduction

"Biotechnology, women and reproduction": the phrase combines in one breath a dangerous trio. This paper focuses on but one area where these words intersect and where the dangers to women emerge clearly: postmenopausal pregnancy.¹ This area is representative of many others where reproductive technology claims to have "rescued" women by offering us body management, control and choice. In this case, the lauded "rescue" is said to be from age limitations on fertility; postmenopausal obstetrics, by managing our aging bodies, will now offer women not only pregnancy at any age but, in the process, "equity" with men.²

In this paper, I want to begin to uncover how postmenopausal obstetrics is more likely to oppress than to "rescue" or provide equity for women. Further, I want to suggest that this oppression results directly from the ideology of postmenopausal obstetrics that uses technology to adapt women to men's biographies and reinforces negative stereotypes of the aging female. The way in which this intervention facilitates an evergrowing trend towards eugenics will also be addressed briefly.

I. Pregnancy after Menopause

The spontaneous cessation of ovulation and the resulting termination of reproductive capacity in women are what we generally label menopause. For the average healthy North American woman who has not been surgically sterilized, this process

¹ In themselves, postmenopausal pregnancies may not be of greatest interest. They do, however, provide a point of entry to consider such things as what is biomedical versus what is biopolitical, or what is liberating versus what is oppressive. As well, they provide a rich context in which to assess the general meanings of new reproductive and genetic technologies, and will thus receive attention here.

² Some examples from the popular press are illustrative here: "It's hypocrisy to say a woman of 59 is not fit to bring up a child but a father of 59 is a splendid instance of British virility" (B. Rudolph, "Miracles Postmenopause" *Time* (10 January 1994) 31); "It would be a negative thing if, because of the clamor of the media and the knee-jerk reaction of the authorities, they fixed an upper age limit for women when there is no age limit for men" ("Over-50 Motherhood Issue Divides British Doctors" *The Vancouver Sun* (28 December 1993) A1-A2 [hereinafter "Over-50 Motherhood"]).

I think it is telling that when I first drafted this sentence I wrote "...equal with respect to" and then found I could not finish the phrase; the flow of words was blocked. I initially wanted to say "with respect to becoming a parent," but this did not work. People become parents through adoption and fostering, not only by giving birth to a baby, and if giving birth were the definitive experience, then all men would be out of the running for now. Then I began, "with respect to conceiving a child." Here, most men would fit in, so long as their sperm were used, but the postmenopausal woman would not, since the egg(s) from another woman would be used for *in vitro* fertilization. Thus, this formulation didn't work either. To get out of my aphasic state, I finally decided to end the sentence without the "with respect to ..." qualification. I think my problem is worth noting insofar as it demonstrates how so many of the new genetic and reproductive technologies and practices cannot even be encompassed in our current language.

usually occurs sometime between the ages of forty-eight and fifty-one, with most women's experiences falling within a range of forty-five to fifty-five years of age.³ About 0.3 per cent of women under this age have non-surgically induced lack of ovaries or of ovulation,⁴ usually called ovarian "failure",⁵ so that, with respect to reproduction, they are functionally menopausal.

Biomedical researchers are now offering to create pregnancies for these women who have experienced menopause or are functionally menopausal.⁶ This is done through: the purchase⁷ of eggs from younger women;⁸ laboratory or *in vitro* fertilization (IVF) and transfer of a woman's eggs; and the hormonal manipulation of women carrying the fertilized eggs. For simplicity, I shall refer to all of these generically as postmenopausal pregnancies.

I intend to concentrate on women over forty-five years of age and to demonstrate how these procedures reinforce the ageism and patriarchy that underlie societal attitudes to women, reinforce gendered stereotypes about women and even diminish possibilities for progressive social change. I will briefly relate the concept of postmenopausal pregnancies to the eugenic practice of preimplantation diagnosis, another of the newer reproductive and genetic technologies. I will, however, temporarily ignore how these technologies reduce parenthood to biological reproduction, privileging but one component, that of physiological gestation, in the proc-

³ D. Brambilla & S. McKinlay, "A Prospective Study of Factors Affecting Age at Menopause" (1989) 42 *J. Clinical Epidemiology* 1031 at 1031-39.

⁴ The number of women who have been rendered infertile surgically through hysterectomy is many times greater, with estimates suggesting that as many as one third of North American women under 60 may have had this operation (M. Lock, *Encounters with Aging* (Berkeley: University of California Press, 1993) at table 10, p. 260).

⁵ I will not here unpack the term "failure" when applied to ovarian function in women in their fifties, because others have done it quite eloquently already (see e.g. M. Lock, "Models and Practice in Medicine: Menopause as Syndrome or Life Transition?" in A.D. Gaines & R.A. Hatin, eds., *Physicians of Western Medicine* (Dordrecht: Reidel, 1985) 115; E. Martin, "Science and Women's Bodies: Forms of Anthropological Knowledge" in M. Jacobus, E. Fox Keller & S. Shuttleworth, eds., *Body/Politics: Women and the Discourses of Science* (New York: Routledge, 1990) 47). I cannot resist noting, however, that while the language of "failure" is evident in the professional and popular literature (see e.g. "Over-50 Motherhood", *supra* note 2), it is hardly a term to describe a natural life experience such as the age-related cessation of menstruation and ovulation.

⁶ An important distinction, considered in further detail below, is that biomedicine is not needed to make these women into "mothers" even if it is needed to create pregnancies for them.

⁷ Professionals working in these programs almost invariably refer to egg "donation" as the source of oocytes. This would hardly seem appropriate when most offer payment to those from whom the eggs will be obtained, and it is not uncommon for these services to advertise for sales. Thus, the Department of Obstetrics and Gynecology at Columbia Presbyterian Medical Center in New York City placed notices on elevators to announce: "Division of Assisted Reproduction Seeking Healthy Women to Donate Eggs — Between 21-35 Years of Age — Who are Empathetic and Wish to Assist our Infertile Patients. Compensation for Time and Efforts will be \$2,200. If interested, please call ..."

⁸ In the future, it could result from frozen ovarian tissue taken from a woman when she was younger, from the ovaries of aborted fetuses or from cadavers (see M.M. Seibel, "Cadaveric Ovary Donation" (1994) 330 *New England J. Medicine* 796).

ess of becoming a parent, and but one demographic group (likely wealthy, heterosexual and white).⁹

In clarifying these claims, I will put aside two of the most obvious problems with postmenopausal pregnancy, namely how this is but one more manifestation of the previously well-described medicalization of women's health,¹⁰ and how the experimental procedures involved have an abysmal failure rate¹¹ and pose considerable and serious risks to the woman and to the fetus. Instead, I will focus on how, despite the biomedical rhetoric of "liberating" women from their life cycles, the possibilities and practice of postmenopausal obstetrics are actually quite oppressive.

II. Oppression and Postmenopausal Pregnancy

I take as given that there is no such thing as "natural" old — or middle — age. All of us, women and men, age within a sociopolitical and cultural context that gives meaning to personal chronology. Stripped of its accompanying context, aging is but a decrease in the numerical probability of continuing to live.¹² It is a universal *experience* of all living organisms. All who are born do age, with some merely involved in the process for longer than others.

But age is never isolated to this extent other than, perhaps, in actuarial tables from insurance companies. Rather, as with gender, race, ability and other "signifiers", it is a notion of difference that comes clothed in various socially constituted presumptions and attitudes. Moreover, in North America, because it is a difference that matters, age is both socially constituted and politically invented.

⁹ I will not be able to touch on all, or even many, of the other very troublesome aspects of these interventions. We may note, however, the extent to which, beyond their race- and class-based assumptions, they allow the perpetuation of workplace hazards that make pregnancy harder to achieve for certain women, maintain the development of forms of contraception that impair women's "natural" biological fertility and fail to challenge the North American political and economic systems that encourage later childbearing for some groups of women.

¹⁰ See A. Oakley, *The Captured Womb: A History of the Medical Care of Pregnant Women* (Oxford: Basil Blackwell, 1984). Redefining natural body rhythms as barriers or deficiencies is not new in modern obstetrics. Think merely of all the women entering menopause whose hormones are seen as in need of a "fix". Will we one day think of premenstrual young women as hormonally deficient, needing a "fix" to enable them to become pregnant? (see E. Kluge, "Reproductive Technology and Postmenopausal Motherhood" (1994) 151 *Can. Medical Association J.* 353 at 355, for a recent relevant commentary).

¹¹ No more than 15 per cent of women in the "better" IVF programs actually take home a healthy baby.

¹² See S. De Beauvoir, *Old Age*, trans. A. Deutsch (London: Weidenfeld & Nicholson, 1972).

Oppression thus first emerges in the ageism and sexism of this technology.¹³ Postmenopausal pregnancy fits into the sexist and capitalist definition of women as producers of children: only because (certain) women are *expected* to be mothers regardless of age could the *inability* to be pregnant at, for example, forty-eight years or older, possibly be seen as “infertility”. Assuming childbearing is a necessary and sufficient source of fulfilment for the older woman, postmenopausal pregnancy perpetuates the ageist image of the woman in middle and older age who is no longer productive by offering to “treat” this condition.¹⁴

Postmenopausal pregnancy is also oppressive because it inverts — and otherwise plays with — notions of choice. If nothing else, women cannot “choose” to become pregnant after age fifty so much as physicians can choose (along the usual lines of discrimination such as class, ability, sexual orientation, *etc.*) those to whom to offer this technology. More troubling, however, is how *not* being pregnant after menopause can no longer be seen, because of the technological advances, as an inevitable stage in a biological cycle; rather, it too has become a “choice”.

Granted, for some women this “choice” to become pregnant after menopause, to carry out women’s traditional role in a conventional way, is an active *response* to societal sexism and ageism that has limited their other options for self-fulfilment and recognition and is not merely a passive submission to these forces.¹⁵ After all, we *do* embody social and cultural norms. Nevertheless, it remains the case that the mere availability of this technology means that a woman who does *not* undergo it can be presented as having “chosen” to forgo bearing a child, as having “chosen” not to do all she can for her partner who wants a child, as having “chosen” not to assume the womanly role expected of her or as having “chosen” not to control her biology.

The technology thereby puts additional pressure on women to conform to existing gendered norms. Those who might have found release from pressures to be pregnant with the welcome arrival of menopause now have an indeterminate sentence and become at risk for “victim-blaming” — it is now *her* fault if she is not pregnant.¹⁶ Who will have sympathy for one who has “chosen” not to control her

¹³ Some of these issues are addressed in E. Bettenhausen, “Ethical Issues in Post-menopausal Pregnancy and Birth” (1994) 3 IN/FIRE [International Network of Feminists Interested in Reproductive Health] Ethics 1.

¹⁴ See Martin, *supra* note 5.

¹⁵ A similar point pertains to motherhood in general. All women do not need to be mothers, but given prevailing myths about this status in the Western world, as well as the cultural conditioning experienced by women in these countries, (some) women may “choose” to have a child to actively resist being labelled abnormal or selfish (see A. Oakley, *Women’s Work: The Housewife, Past and Present* (New York: Pantheon, 1974)).

¹⁶ Similar questions are asked about “treatment” for infertility: when, if ever, can a woman stop the process without being seen as giving up her “choice” to bear children? In the new world that technology has created, the responsible woman is the mother-to-be who takes advantage of all technology offered to her.

body when she could? After all, surrounded by media-generated images that depict the aging woman in a battle with time, fighting against wrinkles or increased weight or her "biological clock",¹⁷ why would a financially comfortable white North American woman *not* want to enter combat and welcome the opportunity to become an alleged "winner"? With a cult of "eternal youth" generating additional pressures on us to control our bodies, it seems consistent for a woman to assent to "rescue" from her biology and release from its constraints — especially if other "escapes" from becoming devalued are foreclosed. Thus, it might be more appropriate to see having, or not having, a postmenopausal pregnancy as an individual, yet socially conditioned *action*. However, as a response to a social context that promotes this activity, it is not necessarily an individual choice.

Further, we might ask if it is liberating to circumvent a process that has been among those defining us as women, for the chance to "succeed" on men's terms.¹⁸ Is it liberating to be "rescued" from women's biology so as to be situated, for purposes of fertility, in men's biology and thus to be re-housed in the male-defined institute called "family",¹⁹ with this transfer camouflaged by the language of choice?²⁰

In general, it is useful to recall that any biomedical option made available is offered strictly on the terms of those — most often men — developing the technology. Therefore, whenever any new genetic or reproductive technology is offered by practitioners as a "choice", we must ask ourselves whose interests are advanced by this discourse and by this framing of the matter. For most women, especially those of colour, those who are poor and those who have disabilities, "choice" of this technological nature is not equally accessible. More fundamentally, "choice" appears to be a too easily manipulated notion when constructed by someone other than the women with the greatest stake in having the freedom to select among a full range of options. For these women, indeed for all of us, "free lives" need to precede "free choices" if individual autonomy is to be more than a mere abstract model, unable to accommodate and reflect the realities of women's lives. These realities, which include "choice diminishing pressures"²¹ on women to strive for perfection in themselves and in their offspring, suggest that what is called "choice" by the experts offering interventions may actually be experienced as "coerced voluntarism"

¹⁷ A. Beaulieu & A. Lippman, "Everything You Need to Know: How Women's Magazines Structure Prenatal Diagnosis for Women over 35" (1995) *Women & Health* (forthcoming).

¹⁸ See R.E. Davis-Floyd, "The Technocratic Body: American Childbirth as Cultural Expression" (1994) 38 *Social Science & Medicine* 1125.

¹⁹ The "family", true to the Latin origin of the word, refers to the servants of a household, and has historically been a means for men to control women.

²⁰ For a gender-sensitive consideration of these and related issues, see T. Joffe, "Life Begins at Sixty: Babies for the Older Woman" (1994) 98 *Bulletin of Medical Ethics* 19.

²¹ K. Morgan, Speech delivered as part of Annie Macdonald Langstaff Workshops (Faculty of Law, McGill University, 28 March 1994).

by the majority of women who undergo these procedures.²² Certainly this is "action", but it is clearly not a "choice".

Oppression also results because postmenopausal pregnancies blur important distinctions between childlessness, a social situation remedied simply by the presence of a child, and "infertility", the medical condition of a woman who is physiologically or anatomically unable to conceive. This conceptual confusion again perpetuates the institutionalized idea of a family based on male definitions.²³ This oppression extends to all women because it distracts us from adopting the necessary measures to prevent infertility and to provide social support for childlessness. If one can take eggs from a woman when she is young and freeze them for her or another woman's later use, we should question whether there would be any impetus to remove those workplace hazards that jeopardize fertility and themselves create the window of opportunity for high-tech "rescues". Here, as elsewhere when new genetic and reproductive technologies are involved, what seem to be "private" decisions actually affect us all and can easily result in public consequences, if not in collective harm. Even if the public and private realms were not sociocultural constructs with a constantly changing frontier, all of us would be affected by the development and use of these interventions.

III. Postmenopausal Pregnancy and the Production of Children

The technologies used in postmenopausal obstetrics (egg retrieval and purchase, *in vitro* fertilization, etc.) are not applied just to make a woman pregnant (and not so successfully at that), but to produce a child.²⁴ Except with respect to the physical ability of an older woman to mother, both the supporters and the critics of this technology generally ignore the ramifications to the children being created. Yet,

²² Empiric support for these speculations comes from the words of the many women we have interviewed about their use or non-use of prenatal diagnosis. Women who are tested do use the word "choice", but often qualify it by saying that once a procedure was offered, they had "no choice" but to use it. A similar expression of coerced voluntarism was echoed in the comments of women who did not get tested during their pregnancies, when they described the pressures on them to have prenatal diagnosis. Outsiders may see women freely "choosing" to have testing. From the inside, however, constraints and pressures play a crucial role.

²³ See B. Katz Rothman, *Recreating Motherhood: Ideology and Technology in a Patriarchal Society* (New York: W.W. Norton & Co., 1989); see also *supra* note 19 and accompanying text.

²⁴ Some permutations of the words "want[ing]", "child" and "create" allow us to distinguish how these technologies alter attitudes and approaches to human procreation. Where reproductive technologies are not implicated in procreation, women generally *want to create a child*. With contract pregnancies, often referred to inappropriately as "surrogate" pregnancies (see S. Sherwin, "Some Reflections on 'Surrogacy'" in G. Basen, M. Eichler & A. Lippman, eds., *Misconceptions: The Social Construction of Choice and the New Reproductive and Genetic Technologies*, vol. 2 (Hull, Que.: Voyageur, 1994) 183; M. Eichler, "Reflections on the 'Temporary Use of Normally Functioning Uteri'" in Basen, Eichler & Lippman, *ibid.*, 193), women *want a created child*. And with postmenopausal pregnancy and the attendant genetic testing of the embryo before its placement in a woman's uterus, an individual *creates a child I want*. These grammatical arrangements are telling of the values underlying these biomedical arrangements.

if we were to give the child who may be born at least as much attention as we do the woman who hopes to give birth to her, we might discover some other features that dampen the allure of these pregnancies.

Postmenopausal pregnancy is a social/psychological experiment, perhaps more than a biomedical one, on the children who are born. It must be of consequence not just to have parents of older than usual age taking care of you,²⁵ but to have been produced from the egg of, for example, a dead woman or an aborted fetus.²⁶ If nothing else, we know that adopted children often seek their roots. How will the origins of postmenopausal babies affect them? Moreover, most children probably at some time harbour fears of being abandoned, of not belonging. If these feelings occur in low-tech situations, the advent of new reproductive technologies can only increase their incidence. If the egg from which the child developed was from an abortus, what does "belonging" mean? Finally, is it justice — or arrogance — to experiment with children who will be born without their "consent"? Is postmenopausal pregnancy in their best interest? Even though parents can give consent for experimentation on their "minor" children, a parallel likely to be invoked by proponents of postmenopausal pregnancy, such an analogy may not apply. Not only must the benefits greatly outweigh the risks in such cases, but such consent is, almost always, separate from any consent a woman might give for having something done to herself. This is clearly not the situation here. Is "consent" for herself necessarily consent for the child to be born? Is the woman's sole consent sufficient or is there a more nuanced interpretation required which would address the deeper and more complex legal ramifications of consent in these situations?

These questions are especially in need of answers when we note the social relations permuted to produce many postmenopausal pregnancies. Who is who when a fifty-three-year-old woman gives birth to a baby that developed from an embryo implanted in her following *in vitro* fertilization with the sperm of her thirty-one-year-old son and an egg from an unidentified "donor" — a baby that was then given to this son and his thirty-three-year-old wife?²⁷ Is the baby her child, her

²⁵ See Joffe, *supra* note 20, for an especially interesting discussion of this matter. However, this is really not the fundamental issue at all. In fact, we should be troubled by the time spent wondering about a woman's energy and resources to take care of a child born after she has ceased spontaneously ovulating, while we generally ignore the many hundreds or thousands of older women around the world caring for grandchildren whose parents have died or are dying because of AIDS.

²⁶ For an opposing view, see G. Kolata, "Fetal Ovary Transplant Is Envisioned" *The New York Times* (6 January 1994) A16, quoting Dr. John Fletcher, an ethicist at the University of Virginia in Charlottesville:

[E]ven though a child might be troubled to learn that its genetic mother was an aborted fetus, the child would almost certainly rather have been born from a fetus's eggs than not to have been born at all.

Dismissive comments such as this one, however, hardly offer reassurance about the outcome of these experiments.

²⁷ L. Gruson, "When 'Mom' and 'Grandma' Are One and the Same" *The New York Times* (16 February 1993) B1.

grandchild or both? And should the egg be from her own daughter, notions of family "togetherness" take on especially disquieting proportions.

Although we lack formal studies to document what has been relayed anecdotally by women who had prenatal diagnosis over fifteen years ago, it appears that something about even this procedure continues to make some women sufficiently uncomfortable that they often do *not* discuss it with their adult daughters with whom they share all other details about pregnancy and birth. If this is the case for many women years after testing, perhaps we should attend to the manifest squeamishness we feel with regard to "selecting" our children. Given the possibility that something as routine for so many thousands of North American women as prenatal diagnosis is still a discomfiting subject to discuss, we may not want to assume it will be easy or inconsequential to tell a child: "your genetic mother was never born" or "your grandmother is also your mother, but your mother is not known to us."²⁸

This is but part of the story and perhaps not the most troubling. Selecting among embryos should also keep us wary about this newest step into the unknown. Postmenopausal pregnancies are symbiotically linked to *in vitro* fertilization and to preimplantation diagnosis. It is unlikely that the sophisticated, expensive and risky procedures employed for egg retrieval, *in vitro* fertilization and implantation would not be accompanied by examination of the resulting embryos to identify those "fit" for implantation. Even the crude genetic analysis of embryos available today, in which little other than the chromosomes will be assessed in most cases, is essentially eugenic, even more so than is midtrimester amniocentesis.²⁹ In this regard, the technology warrants far closer attention than it has so far received. In whose interest is such early diagnosis when it is under the control of practitioners? Who will be deciding what is a "quality" embryo that warrants a chance at developing in a woman's uterus, and what "qualities" need it have to make the grade?

Over two years ago, Andrea Bonnickson suggested that regulations and policies could likely prevent the "unethical" use of preimplantation diagnosis.³⁰ I think we should be far less sanguine. Control is a "second order" concern. It presumes acceptance of the technology, albeit within limits. But should acceptance *be* presumed when there has been no public discussion of whether this is a technology we want at all? Thus, rather than regulate its use, perhaps we might first legislate a moratorium or a ban on its use until such discussion has occurred.³¹

²⁸ See text accompanying note 27, above.

²⁹ See A. Lippman, "Women's 'Childbearing Age' as Biomedical [Re]Creation: Prenatal Testing and Postmenopausal Pregnancy" in Basen, Eichler & Lippman, *supra* note 24, vol. 2, 137.

³⁰ A. Bonnickson, "Genetic Diagnosis of Human Embryos" (1992) 22:4 Hastings Center Report (Special Supplement) 55.

³¹ The bases for this position include: the inescapable eugenic nature of the procedure; the lack of justification for expending funds for its development; the availability of other, if more stressful, options for the woman; the problematic commercial possibilities accompanying the creation of a market

IV. The Pregnancy Business and Body Management

Biomedical — and some media — enthusiasm for postmenopausal pregnancies rests primarily on the implicit assumption that if women, like men, can indefinitely retain their biological capacity to produce a child, the equity between the sexes, now impossible because women's physiology is a "natural" barrier to it, will be fostered:

When men have children in their old age, it's looked on as a kind of crowning achievement in their lives ... To say that simply because these women are postmenopausal and above the age of 50 they can't provide adequate child care to a baby, that is patently ridiculous.³²

Another assumption is that menopause is always and necessarily unwelcome although many women may, in fact, look forward to the relief it provides from such things as menstrual symptoms, worry about accidental pregnancies, and, for those who have for many years been unable or unwilling to become pregnant, from prying questions about why they are not yet pregnant.³³ Freedom from the ability to become pregnant may be, for some, even more valuable than being "free" to become pregnant at any age.

As postmenopausal obstetrics emerges, it is being promoted as a humane response to the needs of women who "chose" to postpone childbearing while they pursued education and careers.³⁴ Unfortunately, this view completely ignores how only *some* women may have the luxury to complete their educations or to establish their careers and to postpone pregnancy. It overlooks how postmenopausal obstetrics is but another franchise of the "business that caters to those who will make a

in eggs and embryos; the way in which it facilitates human germ line manipulation and a number of other equally serious concerns.

³² S. Chira, "Of a Certain Age, and in a Family Way" *The New York Times* (2 January 1994) E5, quoting Dr. Mark Siegler, Director of the Center for Medical Clinical Ethics at the University of Chicago. Popular and professional criticism of postmenopausal pregnancy, however, generally takes a contrary position when it suggests, for example, that it is "shocking that a child be 18 when his mother is 80" (Reuter, "France wants to ban 'retirement pregnancies'" *The [Montreal] Gazette* (4 January 1994) A5, quoting Philippe Douste-Blazy, France's Health Minister) and that "we cannot ignore the social consequences [when age is "no bar" to pregnancy]. Is it wise for women in middle and old age to rear young children through to adulthood?" (Editorial, "Declining Fertility: Eggs or Uterus" (1991) 338 *Lancet* 285).

³³ It should also be emphasized that in some societies menopause is welcomed because of the consequent freedom from cultural taboos associated with childbearing ability (Y. Beyene, "Menopause: A Biocultural Event" in A.J. Dan & L.L. Lewis, eds., *Menstrual Health in Women's Lives* (Chicago: University of Illinois Press, 1992) 169).

³⁴ See e.g. this quote from Dr. Severino Antinori: "I would not want to condemn either the woman or the doctor ... I can fully understand a woman being desperate for a child, even if she has left it rather late ("Twins Born to 59-year-old Woman Stir Ethics Controversy" *The [Toronto] Globe and Mail* (28 December 1993) A8.

business out of being a family.”³⁵ In this business, women’s eggs are a kind of “therapeutic” merchandise and children become luxury items to be purchased from the best suppliers, with women’s bodies the “cultural plastic” out of which they are fashioned.³⁶ This industry ignores how postponing or delaying pregnancy is not necessarily a real choice when the privileged white man’s traditional unbroken, linear career path is imposed as the norm to which women are expected to adapt. To the extent that “delay” is constructed by societal norms, postmenopausal pregnancy only offers to “resolve” what should not have even been a problem. Were there flexibility in the workplace/workpace for all, the rescheduling of working women would not be an issue. Similarly, if women were not continually defined by their biological fulfilment of the mother role, childless relations in midlife might be precious advantages of adult independence.

When first described in the biomedical literature in the mid 1980s,³⁷ postmenopausal pregnancy technologies were applied to women who were under the age of thirty-five who did not ovulate. These women were said to have “premature ovarian failure”. When the technologies were found to “work” — albeit modestly — in this group,³⁸ they were next attempted in women in their early forties who were not ovulating. Within only four to five years, they were applied to “perimenopausal” women, and now their principal use is geared to women well past this stage.³⁹

³⁵ M. Strathern, *Reproducing the Future: Essays on Anthropology, Kinship and the New Reproductive Technologies* (New York: Routledge, 1992) at 35.

³⁶ See S. Bordo, “Reading the Slender Body” in Jacobus, Fox Keller & Shuttleworth, *supra* note 5, 83. In this way, postmenopausal pregnancy joins the constructing-the-body industry along with other interventions such as cosmetic surgery and genetic engineering. Thus, postmenopausal obstetrics also makes the supposedly “natural” condition of pregnancy a luxury item to be bought from technology. Interestingly, too, other items, such as water or soap, are also now repackaged as “natural” and come with luxury price tags.

³⁷ M. Bustillo *et al.*, “Nonsurgical Ovum Transfer as a Treatment in Infertile Women” (1984) 251 J.A.M.A. 1171; P. Lutjen *et al.*, “The Establishment and Maintenance of Pregnancy Using *In Vitro* Fertilization and Embryo Donation in a Patient with Primary Ovarian Failure” (1984) 307 Nature 174.

³⁸ Some women subjected to these technologies did become pregnant, and some among this small group gave birth to children.

³⁹ See M.N. Sauer & R.J. Paulson, “Human Oocyte and Preembryo Donation: An Evolving Method for the Treatment of Infertility” (1990) 163 American J. Obstetrics & Gynecology 1421; M.V. Sauer, R.J. Paulson & R.A. Lobo, “A Preliminary Report on Oocyte Donation Extending Reproductive Potential to Women Over 40” (1990) 323 New England J. Medicine 1157; M.V. Sauer, R.J. Paulson & R.A. Lobo, “Reversing the Natural Decline in Human Fertility: An Extended Clinical Trial of Oocyte Donation to Women of Advanced Reproductive Age” (1992) 268 J.A.M.A. 1275; M.V. Sauer, B.R. Ary & R.J. Paulson, “The Demographic Characterization of Women Participating in Oocyte Donation: A Review of 300 Consecutively Performed Cycles” (1994) 45 Int’l J. Gynecology & Obstetrics 147; M.V. Sauer *et al.*, “Three Hundred Cycles of Oocyte Donation at the University of Southern California: Assessing the Effect of Age and Infertility Diagnosis on Pregnancy and Implantation Rates” (1994) 11:2 J. Assisted Reproduction & Genetics 92.

Thus, what was initially described less than a decade ago as an intervention for a very limited number of women⁴⁰ has become something for which all women are potential candidates.⁴¹ In the words of the most active practitioners in this area,

[a]pproximately 19% of all women living in the United States are between 45 and 64 years of age. Many women within this age group are still very interested in having a child. Couples of advanced reproductive age ... may in fact be *ideal* candidates for oocyte donation.⁴²

The numerical data Sauer and his colleagues present in the most recent summaries of their work suggest that couples of advanced reproductive age are indeed the group they are targeting: two-thirds of the women in their egg "donation" program were forty years of age or older. Moreover, the participation of these women would seem to be more for "social" than for "medical" reasons: 50.4 per cent of those forty to forty-nine, and 66.6 per cent of those fifty to fifty-nine were remarried and appear to have already had a child — hardly a sign of infertility.⁴³

The authors' incidental comment further suggests that postmenopausal pregnancy has come a long way from its putative origin as "treatment" for infertility. Compared to the younger women, those over forty

were more likely to have undergone cosmetic surgery, most commonly silicone breast implants. This latter phenomenon further underscores the perceived interest of many patients to appear young and vital. Their desire to reproduce may be a further attempt at challenging their chronologic age.⁴⁴

Clearly, Sauer, Ary and Paulson, and even the American Medical Association's Council on Ethical and Judicial Affairs,⁴⁵ are here to help these women with this

⁴⁰ It could even be argued, although weakly and *not* by me, that the intervention might be "therapeutic" for the 26-year-old who does not ovulate. However, this is surely not its role for the women over 50 years of age where it is instead, if anything, manipulation of their "normal" physiology.

⁴¹ M.V. Sauer, R.J. Paulson & R.A. Lobo, "Pregnancy After Age 50: Application of Oocyte Donation to Women After Natural Menopause" (1993) 341 *Lancet* 321. A similar expansion in the use of sex hormones is tellingly traced by N. Oudshoorn, "United We Stand: The Pharmaceutical Industry, Laboratory and Clinic in the Development of Sex Hormones into Scientific Drug" (1993) 18:1 *Science, Technology & Human Values* 5. These pharmacologic agents, which were first used for a limited number of specific conditions, quickly became drugs appropriate for treating enough "problems" so as to make all women eligible for their prescription.

⁴² Sauer, Paulson & Lobo (1992), *supra* note 39 at 1276 [references omitted; emphasis added]. Further, it is now claimed that eggs from another woman are even "better" than one's own for women participating in *in vitro* fertilization programs. Those women who "fail" in standard IVF programs (*i.e.* women of advanced reproductive age) should be encouraged to participate in IVF with "borrowed" oocytes because they stand a better chance at becoming pregnant.

⁴³ Sauer, Ary & Paulson, *supra* note 39; Sauer *et al.*, *supra* note 39.

⁴⁴ Sauer, Ary & Paulson, *ibid.* at 150.

⁴⁵ The Council issued the following statement:

challenge and to rescue them from age. They are bolstered by the enthusiastic support, it would appear, of some bioethicists: "The history of medicine has been devoted to overcoming the natural lottery, the hand fate has dealt each one of us ... Why draw the line at reproduction?"⁴⁶

Even without these commentaries, it is apparent that a component of this new pregnancy business centres on body management. This new industry apparently gives women options to change their bodies, to "improve" on what time and biology make possible. This "choice", as with others promoted by practitioners of postmenopausal obstetrics, primarily lets us choose homogeneity and conformity according to their designs.

To expose some of the subtle ageist oppression associated with postmenopausal pregnancy, it helps to think of postmenopausal pregnancy as a method for "passing".⁴⁷ This strategy to present/preserve an image of oneself as youthful, to pass (and therefore be valued), does not only buy into the reification of the youthful woman, but actually threatens a woman's true identity.⁴⁸ The woman with a postmenopausal pregnancy may seem to pass as "not that old, after all". But she really is; at best, her passing is illusory. Postmenopausal pregnancy may circumvent menopause, but it does nothing about aging. Sadder, however, is that passing is also oppressive because a woman distances herself from the solidarity that affiliation with other women her age can provide, and she thus becomes isolated in her individuality.⁴⁹

It is the fundamental right of all women, including post-menopausal and older women, to bear children, whether artificially or naturally. The average life-span of American Women [their caps] is nearly 79 years. Fears that, while still young, children born to older women will lose their mothers are unfounded. Moreover, our experience with grandparenting demonstrates that older adults can provide excellent care for children ... [E]ven if there were parenting abilities according to age, there would not be a reason to deny parenthood to older persons. Neither their government nor the medical profession should decide who is entitled to have children. It is the right of older persons, who are fully informed about all the medical risks, to make these decisions (American Medical Association, "AMA Opinion on Older Women's Decision to Bear Children" (1994) 7:2 Professional Ethics Report 3).

If only the government *and* the medical profession were not already deciding who is "entitled" to have children by their various practices and policies, this very problematic statement might at least have some credibility.

⁴⁶ Chira, *supra* note 32, quoting Siegler.

⁴⁷ B. Macdonald & C. Rich, *Look Me in the Eye: Old Women, Aging and Ageism* (San Francisco: Spinsters/Aunt Lute, 1983) at 55-56.

⁴⁸ A similar criticism would apply to cosmetic surgery to remove well-earned facial lines and creases.

⁴⁹ Macdonald & Rich, *supra* note 47 at 55-56.

V. Rescue Marketing

The "rescue" potential of today's biomedicine for the individual woman with a tragically told story and the usual public delight when the individual is "spared" the misery of her unassisted body are powerful selling points.⁵⁰ High-tech devices and strategies, however, are not developed only for "rare" cases, that is, women in their twenties who do not ovulate; the return on the investment of time, money or other resources is insufficient unless the technology can create a substantial niche. Creating that niche requires little effort, however, when using the "rescue" model. Moreover, when offered with the authority attributed to biomedicine and its practitioners in North America, the sales pitch is quite compelling. Marketing is easy and opportunities for expansion endless, as was likely apparent to the Italian physician, Severino Antinori, whose intervention put postmenopausal pregnancy on the front pages of newspapers in the winter of 1994: "Every woman has the right to have a child. These women come to me when they have nowhere else to go and I help where I can."⁵¹

Even if this particular *in vitro* fertilization-based technology did not fail much more often than it succeeded and, in the process, expose mother and child to serious risks which remained unmentioned in the media reports we located, we must be suspicious about interventions sold to "rescue" individuals. What is available to "rescue" the really quite rare woman born without ovaries or whose ovaries do not produce eggs, can also be used to "rescue" anyone. Moreover, to justify the investment in this technology, it *must* be used. The application of this technology for (mostly white, wealthy) women has just begun⁵² and the potential market is impressive when we consider that all women who live long enough will one day reach menopause. Postmenopausal pregnancies privilege a high-tech attempt to "rescue" women by removing their differences from men; but, the differences from which rescue may be offered are less problematic than the unequal consequences which flow from them. These consequences can be removed or managed by low-tech (and less hazardous) social policies. If women's physiology is at all an "impairment" to equity between the sexes — and this can and should be questioned — is it because our bodies' natural rhythms prevent us from spontaneously participating in the conception of a child after the age of fifty, as biomedical researchers suggest, or is it because women's "physiology" is used to maintain us in an inequitable social position and to make it impossible for us to interrupt paid-working lives to have children at earlier ages? There *are* differences between men and women, yet these differences should neither be ignored, denied nor exaggerated. Rather, the unequal consequences which stem from these differences should be eliminated. What we should look for is a social "fix" which would be far more effective, and certainly

⁵⁰ Equally powerful is the appeal to compassion and altruism in the advertisements for egg sellers (see *e.g. supra* note 7).

⁵¹ "Over-50 Motherhood", *supra* note 2 at A2.

⁵² Gruson, *supra* note 27 at B5, quoting Dr. Ida M. Campagna.

much safer than a medical “fix”, and would also be relevant to the lives of women other than those who are wealthy and white.⁵³

Conclusion

Technology is never neutral; when applied to women it is necessarily gendered in ways that reflect and support prevailing attitudes and customs. Postmenopausal pregnancy mirrors and reinforces the “production of baby” metaphor that dominates much of the recent biomedical literature about pregnancy. It is advanced as a tool to reverse, or to “rescue” us from, age-based cessation of egg production — in essence, to rejuvenate us. It partakes of a view of female aging as a disease-causing agent, a view with great potential to constrain needed social changes.

There is nothing obviously “natural” about age. Age in a broader sense, however, is a complex socially defined construct: cultural, social and political contexts influence how and when we age. Some of this complexity is revealed in the way we generally assume the existence of such things as chronological age, mental age and social ages (for example, driving-age, voting-age, drinking-age, retirement-age, golden-age). Yet, it is important to remember that all these are tied to what society allows us to do as well as to available technologies.⁵⁴ As such, ages are flexible, with boundaries that vary according to political decisions, technological developments and so on. Childbearing-age has joined this list as a category that rests on biopolitical, perhaps even more than on biomedical decisions.

Postmenopausal pregnancy is a costly way — financially, physically and emotionally — for women to conform to male biography. Oppression is more likely than liberation to result from its practice. We must learn to value the older woman and *her own* trajectory. This requires us to remove the real constraints to graceful aging for most women, those that stem from poverty, abuse and discriminatory social and economic policies that damage our health. The problems experienced by aging women are not created by the fact of living many years, but they do result from the lack of resources and the abuse and denigration that await us. Privileging postmenopausal pregnancy and other cosmetic fixes is more likely to exacerbate women’s aging-related problems. If we instead focused on these broader social problems, we might begin to reclaim our right to define ourselves on our own terms and reject the male biomedical model on which the marketing of postmenopausal pregnancy is based.

When I stop releasing eggs, it will not be because I have “failed” biologically; rather, I will have reached a perfectly expected, albeit new, stage in my life. At this

⁵³ See Lippman, *supra* note 29. Social and political changes would also go far towards removing the unequal consequences that attach to meaningful differences *between* women instead of the biomedical, postmenopausal pregnancy approach that obliterates these differences in favor of some homogeneous, conforming, ready-to-be-pregnant standard for well-to-do women.

⁵⁴ E.L. Barbec, “Worries, Aging and Desires to be Younger in a Sample of American Middle-Aged Women” (1989) 12 *Medical Anthropology* 117.

stage, I want to be free to act my age, both unconstrained and not passing as someone else. It should be liberating to accept this new limit on my body and, perhaps, even see it as an advantage.⁵⁵ Did I really enjoy menstrual cramps? Invariably searching for a tampon in unfriendly places? Has not menopause itself actually "rescued" me from these? I might even enjoy this stage if policies and their accompanying interventions eliminate poverty, abuse and isolation, and provide safety, security, value and equity — rather than pregnancy — to women fifty years and older.

Feminists have generally been critical of environmentally unfriendly behaviour towards women. We recognize threats to our health as resulting from the ideologies of patriarchy, capitalism and technological reductionism. In our response to these most recent technologies, which are imbued with the same ideologies, we must keep these threats in mind.

Menopause is not about disability, deficiency or disease. Why not reimagine this rhythm in the lives of women and refuse attempts to pass over the aging process (if for no other reason than it is probably too hard to do)? Do I really want to lop off old(er) age as if it were a bothersome skinfold? Do I want to be seen as a "perambulatory anomaly"?⁵⁶ Shall I be a "lavendar rose" or a "grey panther"; a senior citizen or a Raging Grannie? Do I want to guard an empty nest, re-stock it with fledgling dillings⁵⁷ or fly the coop? If I become a "Methusaleh mom" following a "retirement pregnancy" will I not be cheated of the wonderful things my age should allow me to do? When I am too old to work, should I not also be too old to work at staying young, as biomedicine would encourage me to do?

Perhaps there are some things which we, as individuals and as a society, are better off accepting and yielding to than struggling against or seeking to fix through biomedicine and reproductive technologies. Age seems to be one experience we might consider in this light.

⁵⁵ A now outmoded term, climacteric, was once applied to the life processes surrounding menopause. The term evokes a rung of a ladder from which women can climb upwards, which in turn suggests that a semantic return to its use might be beneficial and liberating.

⁵⁶ M. Lock, "The Politics of Mid-Life and Menopause: Ideologies for the Second Sex in North America and Japan" in S. Lindenbaum & M. Lock, eds., *Knowledge, Power, and Practice: The Anthropology of Medicine and Everyday Life* (Berkeley: University of California Press, 1993) 330.

⁵⁷ "Dilling" is a now obsolete word for a child born when parents are old.