The Postmenopausal Mother

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Introduction

The most famous woman becoming a mother at late post-reproductive age was Sarah, thus fulfilling the wish and order of God and Abraham:

"Sarai, Abram's wife, had borne him no children. But she had an Egyptian slave named Hagar;

So she said to Abram, 'The Lord has kept me from having children. Go, sleep with my slave; perhaps I can build a family through her.'

Abram agreed to what Sarai said.

So after Abram had been living in Canaan 10 years, Sarai his wife took her Egyptian slave Hagar and gave her to her husband to be his wife……

……the promise of God to Abraham was fulfilled.

'Is anything too hard for the LORD? At the appointed time I will return to you, about this time next year, and Sarah shall have a son' [1].

The solution was based on God's given nature of female fertility.

In postmodern times, reproductive medicine offers new solutions.

Women can become pregnant almost without age limits.

A typical news in the new book of books (Internet) reads like this [2]:

"….But nature has been overruled. It has recently been announced that a 63-year-old woman gave birth late last year to a healthy baby girl. A doctor implanted into her hormonally primed uterus an embryo created in a test tube with her husband's sperm and a young donor's egg.

The woman's doctor, Dr. Richard J. Paulson, said she had lied about her age to get around his age limit of 55 years for in vitro fertilization.

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J. G. Schenker et al. (eds.), *Hot Topics in Human Reproduction*, Reproductive Medicine for Clinicians 3, https://doi.org/10.1007/978-3-031-24903-7_9

The 63-year-old woman was not the first postmenopausal woman to have a baby, only the oldest. In the last several years, progressively older women have given birth through in vitro fertilization.

So we now must contemplate the curious possibility of women on Medicare becoming pregnant" [2].

There is already a list of records of the oldest woman becoming pregnant which is led for the moment by a lady who got pregnant through reproductive medicine technology at the age of 70 years in India.

These citations point already to the various scientific, cultural, philosophical, and ethical discourses around this subject depending on different perspectives

- Man takes the place of God or his angels.
- Man overrules nature and natural laws and limitations.
- Men and in this case women hide their age and misinform doctors, or doctors act in hidden places.
- Natural and social life course concepts (age and aging) are put aside.

We are confronted with

- The normative question regarding the transgression of borders and limits given to us by nature (are we allowed to do what is feasible) [3, 4].
- The empirical questions about risks and benefits of such a transformation (transgression) for the individuals involved and the society as a whole [3, 4].

The Normative Question

The basic normative question here is: In which situations **of individual or collective suffering** should doctors (healthcare professionals) **not act although** methods of diagnosis and therapy are available and could be used?

There is no "objective" or scientific answer to this question, but as a normative question, the answer will depend on the underlying concepts about the world and human existence.

With those who believe in a preexisting stable and enduring order given by God, by nature, or a global mind (idealism) to which humans are subdue and should follow, they will view medical interventions to overcome post-reproductive infertility as opponent to the given order and therefore potentially destructive and dangerous (Hybris, Sin, Blasphemy).

This position is the basis for warnings about the belief that for every problem humans may have, there is a technological or scientific solution which may lead to disastrous consequences [3, 4].

The alternative view sees humans as constantly progressing and transforming themselves and their environment. There are no eternal and stable laws, but it is up to the humans to define their aims and their values depending on the specific environment they live in and in which the individual should have the opportunity to decide (autonomy).

The basis for this decision is then a question of benefits and risks and thus accessible to objective research (empiricism). There are no absolute a priori values.

Based on this autonomy (self-definition), the responsibility regarding the consequences of the decision to become a mother in the post-reproductive phase rests with the individual (freedom of will) [3, 4].

In medicine this approach has been operationalized in the bioethical principles of Beauchamp and Childress [5]

- Respect for the autonomy
- Non-maleficence; do not harm
- Beneficence; do good and promote health
- Justice; make no differences in providing help

Bioethics of Late Motherhood

The postmenopausal woman wants to become pregnant and have a child and she asks for medical help.

The reason for this request is not a disease. She is suffering from an unfulfilled personal wish, an aim in life she cannot attain without medical help.

In other words, the woman is suffering from her loss of her fertility.

Is it the task of medicine to restore lost capacities necessary for the individual to feel good, to achieve a goal in life and give back a meaning to life [6, 7]?

The answer is a clear yes. In many fields of medicine, the interventions aim at restoring lost functions and improve quality of life (from orthopedics to psychotherapy, from sexual medicine to rehabilitation) [8].

According to WHO, health does not only mean the absence of disease but also physical and mental well-being and quality of life including the attainment of goals (especially regarding sexual and reproductive health) [9].

The special issue in this situation is however that the wish, the goal, and the restoration of fertility aims include another human being thus going beyond the person asking for help. This human being (the desired child) does not yet exist, cannot be included into the decision-making process, and thus presents a special challenge to which there are several possible answers [10].

In one perspective, this not (yet) existing being cannot be the subject of the ethical principles mentioned above. There is no person with autonomy, and therefore questions of harm or beneficence or justice are not applicable for the medical team.

The woman alone has the autonomy and is object of the principle of no harm. It is the mother's responsibility to ensure no harm and beneficence for the child to be.

In the alternative perspective, the desired child is integrated into the ethical consideration taking into account the complete dependency from the mother and thus focusing on the environment into which the child is born.

Applying bioethical principles to both—the mother and the child to be—can help clarify the role, tasks, and responsibilities of reproductive medicine in the context of the pregnancy and childbirth in postmenopausal women.

The Woman

Her wish for a child is an essential part of her reproductive autonomy. She decides when and how many children she wants to have with a partner of her choice.

Giving the individual the autonomous decision about reproduction is a central element of reproductive rights [9].

In the respective laws, the focus is on the protection against interventions from outside—like forced sterilization, prohibition of contraceptives, etc.

Reproductive medicine focuses more on overcoming biological barriers to reproductive aims.

The woman has independent of her age the right to get help for realizing her reproductive autonomy. It follows from the autonomy principle that the medical professionals will do their best to achieve a pregnancy [3–5].

What About the Second Principle? Do Not Harm

There are no studies indicating that late motherhood would increase maternal mortality significantly neither during the pregnancy nor during delivery. There is nonetheless an age-related risk increase for complications like gestational diabetes, preeclampsia, etc.

In one study among women in their sixth decade of life [11], 35% experienced pregnancy-induced hypertension, 20% developed gestational diabetes, and 78% underwent a cesarean section [11]. The risks were even higher in women more than 55 years old, compared with those 50–54 years old.

The higher complication rate can however be largely compensated, thus making postmenopausal age not a contraindication to the use of modern reproductive technology [12].

The same is true for pregnancy independent morbidity and mortality which does not seem to be significantly different between pre- and postmenopausal women at least until the age of 60 [12].

This means that we can assume that the life expectancy of pregnant women in the post-menopause is more or less the same as in the same age cohort. Life expectancy is thus not an issue for the woman but possibly for the child to be born (see below).

It is however important to stress the point that information about risks is based on scientific evidence and it is still the individual woman who should be enabled to give individual weight to the numbers (shared decision-making).

What About Mental Health?

Postmenopausal women have a higher risk to develop a postpartum depression [13].

Theoretically (there is a lack of empirical evidence), it could be assumed that there is an age-related decrease in the resilience to stress.

During the aging process, the capacity to fulfill different tasks at the same time declines.

At the same time, the frequency of mood changes and anxiety seem to increase [13].

Another aspect which has received not so much attention in research is the concept of age-related developmental steps or tasks and related life phase developmental crisis.

In general, we differentiate between different so-called life phases which follow one after the other: childhood, puberty and adolescence, adult life, and aging [14, 15].

The early phases of human development have been extensively explored, and it is generally agreed upon that the development from the child to the adult is an upward dynamic with an increase in competencies (cognitive behavioral, social, etc.) [15].

The aging process is considered to be a dynamic characterized either by general decrease in some of these capacities (performances) with a possible shift to other qualities (maturation perspective) with the final point of death.

In the developmental model, the human being fulfills specific steps or better tasks of development whereby the successful mastering of one step has an important influence on the following one [15].

The child and adolescent psychology and psychiatry has provided a huge amount of knowledge and insight which has become part of our general understanding of these life phases [15].

Regarding the so-called second phase of this developmental curve, there are different models of understanding the questions about the challenges and responses regarding aging and the respective "developmental tasks" [15].

A frequently cited model is the one described by Erikson [16].

Erikson differentiates the reproductive phase from the two post-reproductive phases whose developmental tasks are generativity and integrity.

The previous developmental goals regarding identity, work, and family are getting less important, and new tasks emerge like summarizing life experience and to give knowledge and the work done to others (creativity and generativity), the reflection about age and death, the limitations of time, and potency leading to an acceptance and inner serenity (integrity).

Taking this as a more general background, the question can arise whether these developmental tasks in the confrontation with aging, the limits, and limitations are eventually simply put aside and hinder thus the maturation process of the individual.

From a theoretical point of view, this "moving back in time" might have a different impact on different women with differences in their personality and life circumstances but especially also in their reproductive biography.

The woman who already has children is in a different position compared to the nulliparous woman.

In line with this, the post-reproductive phase can be considered the phase of grand-parenthood, the phase in which there is less responsibility for and involvement with the small completely dependent child thus creating room for a different relationship (the grandparent as the admiring and supporting companion liberated from the everyday stress).

The postmenopausal mother who already has adult children creates a new family structure with new social interactions and role definitions which demands adaptions and flexibility in the family system which may be perceived as continuous stressors.

To summarize, it can be stated that based on the present knowledge the medical assistance in fulfilling the wish for a child of a postmenopausal woman carries increased risks during pregnancy for her physical health, but that modern obstetrics can in general manage these risks according to studies up to the age of 55–60 years this preserving her physical health.

The possible risks for her psychosocial health are not well explored and researched until now. This will be an important task for the future; on one hand, it will help to counteract possible myths and prejudices (older-age is per se a psychological or psychiatric contraindication), and on the other hand, it can help the woman to evaluate her individual risks in relation to late motherhood.

The Child To Be

Including the "child to be" into the ethical discourse, the basic fact which has to be taken into account is the complete dependency of the child on the care by others, this radical external determination being completely at the mercy of the mother or others [17].

For all reproductive interventions, be it contraception, pre-conceptional genetic test, the preimplantation and prenatal diagnosis, the donation of germ cells, or surrogate motherhood, the common denominator is the fact that the involved parents may have obtained more freedom regarding their will and decisions but they do not change the radical lack of freedom of the child which continues during the early years of life.

The child cannot warm itself; it must be warmed; it cannot feed itself but must be fed; it cannot move by itself but must be moved [17].

The child is put into a network of human relationships outside of its own control or the capacity to create such a network by itself.

Therefore, we cannot assume any sort of autonomy of the "child to be."

This lack of interaction with an autonomous partner poses the question of the ethical-moral status of the child to be and which rights for the future child can be derived from that [17, 18].

In early stages of development, laws have mainly the function to protect the embryo and the newborn from external damage and interventions [19]. Society or better the state exerts a sort of "negative" duty of care by issuing rules and regulations aiming to ensure the physical integrity of the embryo and the newborn, thus assuming that the embryo and the fetus would have the autonomous wish to be healthy and to survive (an ontological autonomy).

This concept is the base also for the "in the future projected" autonomy, for example, for intersex babies who cannot decide about interventions on their body when they are born but should have the autonomy to decide at later age (as adolescents or adults), thus prohibiting early sex determinant interventions.

This protective approach is mainly focusing on the do not harm principle, but is not adequately addressing the principle of beneficence for the child to be.

The principle of beneficence poses a challenge to all those involved in bringing this child into life [20].

The more we intervene and modify the process of coming into the world of this human being completely depending on a network of relationships, support, and love, the more the question comes up whether the newborn child has some inborn right to be born in an environment that provides safety and allows growing and flourishing, in other words "good and responsible parenting" [20].

But what is "good parenting?" Are those external norms and concepts not discriminating against the autonomy of the couple who needs help to achieve a pregnancy and have a child and who has the right to evaluate these couples with respect to their "parenting?"

This tension and possible conflict between the respect for the autonomy of the future parents and the beneficence duty toward the future child is up till now not resolved with generally agreed guidelines.

Three basic requirements for ensuring the future well-being and psychosocial health of the child seem to be agreed upon [21–24].

Health Conditions and Life Expectancy of the Parents

This relates to the presence and availability of "mother" and "father" roles (physical and psychological). Those are the persons having responsibility for the child. There is some uncertainty how this age limit should look like. But there is some agreement that a probable time span of 20 years regarding the availability of the parents is desirable.

Stressful Life Conditions and Resilience of the Parents

Small children need affection, time, and patience, being prepared to put one's own interests behind and the needs of the child in front.

"Parenting, the most complicated job in the world" (Virginia Satir) [25].

The interpersonal skills are empathy, positive encouragement, and feedback, serving as a role model, helping the child to regulate emotions (esp. negative

emotions), helping the child to cope with failures and getting disappointed, becoming aware of self-harming behavior, establishing relationships and learning social behavior, development of cognitive skills, etc.

Future parents who live under conditions of chronic stress (physical, psychological, social) or those who suffer from affective disorders or other psychological problems leading to a reduction of their capacity to care are in danger to not being able to provide the necessary conditions for a healthy development of the child.

Resources and Family Structures of the Future Parents

Besides the stressors, resources play an important role for the environment in which the child is born. Resources include other family members and other individuals in the environment of the child who can provide reliable availability and allow the establishment of relationships, interpersonal learning, and encouragement.

These three dimensions may serve as an orientation regarding the ethical question of the well-being (Kindeswohl) of the child to be.

The realization of the ethical duties of not doing harm to the child and of promoting health will depend on the balance of these dimensions.

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