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In our article “Sleepwalking Into Infertility: The Need for a Public Health Approach Toward Advanced Maternal Age” (Lemoine and Ravitsky 2015; hereafter, advanced maternal age is AMA), we argue in favor of recognizing this issue as an area of concern—and sensitive intervention—for public health. We are grateful to our commentators for their valuable contributions to the debate surrounding our position. We see some of these commentaries as strengthening, enriching, and expanding our argument, by adding additional dimensions to our basic approach.

EXPANDING THE SCOPE OF THE VISION SURROUNDING ADVANCED MATERNAL AGE

One of our key messages was that AMA should not be perceived and addressed solely as an individual preference of individual women, but rather in the context of socio-cultural forces and economic structures that shape and influence these choices. We are thus pleased that overall our commentators seem to agree with this framing and are joining us in the search for solutions that appropriately address AMA on the social and policy levels, not just by offering individual medicalized solutions (as successful as these may be). We particularly value a few points raised by some commentators that expand, in a way that we endorse, the scope of the vision for addressing AMA.

We thus welcome Power’s view that invites us to consider AMA as embedded in cultural trends affecting not only childbearing, but also relationships and marriage more broadly. We agree with Power that it is crucial to recognize the shifts in the way adults today form their expectations of life, to appropriately address the informational gaps and the social barriers that may allow them to integrate childbearing decisions into their life plans. Indeed, our focus is on promoting free and informed decisions that reflect individual values and preferences. An important part of what shapes these values and preferences are precisely those cultural trends Power describes, and therefore these must be integrated into any public health intervention that wishes to successfully inform and empower.

We similarly welcome Petropanagos’ emphasis on the role men play, not only in childbearing decisions, but later in child rearing. Indeed, social attitudes and practices surrounding fatherhood play a key role—as we described in the context of parental leaves—in any attempt to allow or facilitate the choice of earlier parenthood. The cultural shift required to level the playing field in this regard goes far beyond the public health agenda. But public health justifications can play a role in the cultural evolution that can eventually lead to increased equality and freedom for all, and as a by-product perhaps to a reduction in the aggregate negative health effects of AMA.

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We also welcome Lucke’s suggestion to integrate information regarding the implications of AMA into sex and relationships education programs for teenagers. This is a time in life when the message being conveyed is that pregnancy is easier to achieve than they may have thought, a message that may remain with them well beyond their reproductive peak and that may linger as they “sleepwalk into infertility.” Lucke’s proposal is a concrete way to achieve many of the informational goals we describe.

Finally, we are grateful to Su for expanding the debate beyond Western cultures and inviting us to consider the circumstances of women in cultures that—for a variety of reasons—put an increased emphasis on reproduction as an essential element of adult life. We recognize that such cultural contexts create increased pressures on women, putting them in a “crunch” whereby they are expected to achieve certain milestones prior to childbearing, but then feel that they must procreate at all cost. Such circumstances pose particular challenges for women and require special protections at both ends of the reproductive life span.

PUBLIC HEALTH AS AN IMPERFECT PARADIGM FOR ADVANCED MATERNAL AGE

Are the Effects of AMA Prevalent Enough to be Considered a Public Health Issue?

Petropanagos questions the relevance of a public health approach to AMA on the basis that its negative health outcomes affect “the health of some individual women and their offspring [and] does not directly affect the health of all women and offspring.” First, we note that not all members of a population have to be concerned for a phenomenon to deserve public health attention. Verweij and Dawson use the term “aggregate health” as a first criterion for an issue to belong within the public health arena. While “aggregate health” is used in opposition to “individual health,” it does not imply “the health of all people.”

We would like to point out that using assisted reproductive technologies (ART) is a “choice” made by the parents that can ultimately affect the health of their offspring (Soini et al. 2006), who does not have a say. These potential consequences for the health of the child constitute a shift from “individual” to “aggregate,” as a child is not merely an extension of his or her parents. To be clear, we do not endorse the view expressed by Epstein and Zosmer’s regarding the moral condemnation of AMA (or ART). However, we believe that recognizing such potential negative consequences does not necessarily involve condemning ART and AMA choices. At the individual level, the choice stems from a balance between risks and benefits for the mother and the child. At a societal level, possible health impacts should be considered as a justification for a public health approach.

Another case for the relevance of a public health approach to AMA can be made based on the estimated long-term (intergenerational) effects of increased ART use on aggregate health. As we briefly mentioned in our article, research increasingly shows that ART may cause epigenetic changes that might be passed from one generation to the next (Katari et al. 2009; Li et al. 2011; van Montfoort et al. 2012). For Instance, Kateri et al. (2009) have demonstrated the presence of epigenetic variations in ART conceived individuals that predispose them to conditions such as obesity and type II diabetes. These variations may be attributable to direct effects of the procedures just as much as the genetic background of the parents undergoing ART. Li et al. (2011) have further postulated that these changes may have even more detrimental effects if two ART-conceived individuals were to conceive together (Li et al. 2011).

Thus, despite current modest numbers, as pointed out by Petropanagos, the aggregate effect of increasing numbers of women postponing motherhood and using ART, and their children sustaining epigenetic variations, can be significant for aggregate health.

Second, the “aggregate” nature of the health impact is only one of three criteria of public health. Thus, despite its current modest impact on “aggregate health,” AMA poses greater immediate challenges for the “distributive health” and “social determinants of health” criteria, as described in detail in our article.

Should We Educate Without Empowering?

We advocate for a public health approach to justify educational and empowering measures. Daniluk sees educational initiatives as urgent and believes that empowering conditions need not be completely fulfilled before they are launched. We are sensitive to this urgency and agree that information alone may encourage some people to factor reproductive life span into their life plans, even before empowerment is achieved or social barriers removed. Indeed, Lucke’s suggestion to include fertility matters in sex-education curricula would allow information to be provided in the spirit of “prospective responsibility” proposed by the ethics of empowerment we present in our article.

We believe that social change is a work in progress and do not suggest that the perfect economic and social conditions must be attained before education efforts are initiated. What we call for is a social recognition that change is required and for policy initiatives to be underway. We believe that the stigmatization and blame effects can be better controlled if educational and empowerment initiatives are developed hand in hand in a coherent manner. We argue in favor of a public health approach to AMA because no other arena is better positioned for coordinating comprehensive solutions that encompass its health, social, and educational dimensions.
Do We Risk “Demonizing” Older Mothers and Further Medicalizing Reproduction?

Commentators also drew attention to the potential negative effects of public health interventions. Power highlights the risk of public health initiatives “demonizing” older mothers, a point that we addressed in our article when discussing risks of stigmatization and blame. Our analysis suggests that such effects can be mitigated when educational initiatives use adequate terminology, and when they endorse prospective rather than retrospective responsibility.

Adapting the focus and language of sex-education courses in high-school, as proposed by Lucke, would indeed be an excellent way of promoting awareness and providing information in a way that is sensitive to these risks, and at an age when much time remains to consider reproductive decisions without feeling cornered. More importantly, we argue, these effects are mitigated when educational initiatives are accompanied by recognition of the social and cultural factors that shape reproductive decisions, and by implementing measures that empower individuals and communities to make decisions that are not only informed, but also free of pressures and barriers. We developed this argument in more detail elsewhere, in the broader context of infertility (Lemoine and Ravitsky 2013).

We are sympathetic to the notion that a public health approach to AMA might “reinforce the medicalization of women’s reproduction.” But the truth is that AMA itself reinforces the medicalization of reproduction, as it involves higher risks of pregnancy complications. As we pointed out, addressing this at the policy and education levels demands much tact and diplomacy, to avoid stigmatizing and blaming effects. Similar caution can be paid to avoiding portraying pregnancy as a medical condition.

Isn’t It All About Finding the Right Partner?

Power highlights the issue of “not finding the right partner” as key to the growing trend of AMA. We agree with her analysis, but take greater interest in economic and workplace incentives since they belong in the realm of policy intervention, where state power can be employed to promote a public health agenda. As Power points out, the difficulty finding the right partner hardly falls within the scope of direct intervention for public health, or within the public domain altogether. Indeed, the Singapore government has been quite creative in attempting to tackle this issue by trying (with an elitist twist) to foster mingling among academics and professionals through organized “mixers” (Saywell 2003; Singapore Government 2015), but we mention this tongue in cheek, adding explicitly that we do not endorse this type of government intervention. The statistic cited by Petropanagos showing that 90% of women who choose to delay motherhood do so for having yet to find a partner is telling, but we argue that the inappropriateness of trying to address this specific barrier does not justify leaving other barriers unaddressed.

Moreover, Power’s description of the contemporary relationship dynamics strongly indicates that “not finding the right partner” is not a result of women passively “awaiting Prince Charming,” but rather the result of a fundamental social shift in the way relationships—and marriage—are perceived and construed. This social shift affects women and men alike. We thus argue that better informing both men and women about the implications of AMA (and in fact, of advanced paternal age as well), as eloquently articulated by Lucke, can allow and encourage them to factor their reproductive desires into the relationship dynamics described by Power. Then economic and workplace incentives can appropriately address the needs of those who do choose to start their families earlier in life.

Petropanagos mentions studies showing little impact of social and workplace initiatives on childbearing decisions. We acknowledge that such studies are of great interest for policymakers since, as we noted in our article, indeed not all initiatives have proven to be effective. However, we emphasize the fact that some have. It would be up to public health officials or other policy instigators to review those stories of success and failure, assess their components, and decide on policies that have potential for success in their specific population. Furthermore, we highlight that educational initiatives are unlikely to succeed (and likely to cause social backlash) in the absence of empowering measures. Conversely, providing women and couples with a significant degree of support for earlier childbearing may be ineffective if men and women remain in the dark about what is at stake with regard to reproductive lifespan and health.

What’s Men Got to Do With It?

In many instances in our text, we may have omitted to write “women and men” in places where it would have been relevant. While we did mean to specifically empower women regarding their reproductive options, in no way did we mean to exclude men as part of the dialogue, as part of the solution, and as beneficiaries of educational and policy initiatives. For instance, we have mentioned policy solutions that propose imposing paternal leaves, and explained how these proposals are facing challenges due to misconceptions about gender roles and masculinity. We concluded that these misconceptions must remain the focus of broader social change.

TAKING A MORAL STANCE REGARDING ADVANCED MATERNAL AGE

In our article we clearly stated that we do not condemn an informed choice in favor of AMA: “While delaying childbirth despite associated risks is a personal choice that is in no way condemnable, the principle of autonomy requires that this choice be informed” (43). We therefore disagree with Epstein and Zosmer, who argue that AMA is a choice that should not be supported in our society. First, we could embark on an empirical scuffle and provide ample
literature showing that children of older mothers fare just as well as others, and sometimes better than average (Barnes et al. 2013; Gardiner et al. 2015; Goisis 2013; Sutcliffe et al. 2012). We could also note that Epstein and Zosmer’s analysis does not address the nonidentity problem and fails to recognize the distinction between our moral obligations toward existing and future children (Heyd 1992; Parfit 1984).

Weinstock introduces an important distinction—between “perfectionist” and “value-neutral” visions of public health. The “perfectionist” means that some goals have enough value to justify using the coercive and incen-
tivizing power of the state, while the “value-neutral” means that the regulated practices are not in and of them-
selves perceived as having moral value or as reprehensible,
but rather in a “neutral” way. He then points out that our article fails to address this distinction and that our stance regarding AMA thus remains unclear.

Weinstock invites us to imagine a world where all health risks associated with AMA have been minimized; where public information campaigns have appropriately reached and educated all women and men regarding the implications of AMA; and where state funding of ART has removed access barriers. In such a world, he argues, there would be no public health justification for social policies related to economic and labor-force conditions, unless one ascribes to a “perfectionist” view that sees AMA as an inherently undesirable choice that ought to be discouraged by state intervention.

Our endorsement of such policies seems to Weinstock as an indication that we have a “perfectionist” view of public health and that we assign a negative moral value to AMA. We welcome the explicit introduction of this important distinction into the debate, as it allows us to clarify unequivocally our value-neutral stance in relation to AMA.

Our value-neutral stance regarding AMA emerges from our article, as we often refer to it as a choice that ought to remain personal, informed, and free of pressures. However, we do advocate for policy changes related to economic and labor-force conditions, because we see the current reality as impeding free choice and therefore view such changes as removing barriers (not as creating incen-
tives per se) and as compensating for current inequalities (between genders, and between mothers and childless women). The policy initiatives we are proposing are justi-
fied not based on a particular value assigned to earlier motherhood, but rather because only their implementation can achieve a social reality where individual preferences can be not only informed but also free of pressures and barriers. As such, these policy changes are part and parcel of what justice and equity would require, and they go hand in hand with Weinstock’s proposal to remove barriers of access by funding ART.

Put differently, the three conditions suggested by Weinstock can indeed promote an informed and acces-
sible choice of AMA, but for this choice to be truly autonomous the social and economic barriers imposed on women must also be removed. In the absence of medical complications related to AMA, and in the absence of financial costs related to ART, many may still express a personal preference for earlier parenthood but feel thwarted by socioeconomic and work-
place pressures.

We would also like to tackle a few other points made by Weinstock. First, even in an “ideal” world such as the one he describes, the risks associated with AMA will still be present and significant (some are related to fundamental biological processes that cannot be “fixed”) and access to ART will still be problematic. When all barriers to access are removed, the cost of state funding for ART is so high that it can become prohibitive from the perspective of the health budget. As we recently witnessed in Quebec, a program that offered coverage for all became within a few years so expensive that consulting bodies and the government have proposed drastic cuts that will once again create barriers to access (Assemblée Nationale du Québec 2014; Commissaire à la santé et au bien-être 2014).

Lastly, Weinstock seems to read our thesis as if we argue that—because of the health risks associated with AMA—women should not be allowed to make this decision for themselves without state interference. However, our claim is precisely that women should be able to make this choice on their own, based on individual preferences and accurate information. State intervention is needed to ensure the autonomous and individual nature of this choice because (a) there are widely held misconceptions about AMA health risks and ART-related health and success rates that need to be addressed for this choice to be fully informed, and (b) there are social and cultural factors that pressure women into making this choice.

If as a result of providing accurate information on reproductive life span and removing the social and cul-
tural pressures to delay childbearing more couples would choose to have children earlier in life (as suggested by research showing the discrepancies between fertility desires and actual reproductive behavior; Duvander, Ferrarini, and Thalberg 2005), this could ultimately lead to a reduction in the proportion of births to older mothers. This, and its impact on aggregate health, would be a by-
product of the individual choices of empowered couples, and not a goal in itself.

It could be argued that if improving aggregate health is more of a by-product of improving informed and autono-
mous choice, the relevance of public health in this area is questionable. However, the question postulated earlier remains: Who else is better positioned to address this phe-
nomenon, which does have aggregate and distributive health ramifications, as well as significant social dimen-
sions, in addition to deeply personal components that demand much finesse and sensitivity to avoid stigmatiza-
tion and blame?
CONCLUSION
The various points made by our commentators, and our answers in the preceding, show that indeed the marriage of AMA and public health is imperfect and requires a somewhat expansive view of public health goals. This is largely explained by the highly complex and value-laden nature of this social phenomenon.

Of note, many classic public health issues entail social dimensions. Smoking and sexually transmitted diseases are good examples of that. The enhanced complexity lies in the fact that AMA is not (and should not be) conceived of as an undesirable choice in and of itself, such as smoking or unsafe sex. From our point of view, this does not justify foregoing measures to foster informed and autonomous choices that may ultimately lead to positive health outcomes. Instead, it reinforces the need for an approach that reflects the ethics of empowerment—that is, an approach that not only provides information, but also reduces stigmatization and blame by using prospective responsibility rhetoric, while involving communities in fostering the social changes required to promote individuals’ capacity for action. Such an approach defines the very core of health promotion, which is one of the core functions of public health.

REFERENCES


