Sophia, single and successful,
believed it was nobody's business but her own
that she was having a baby, at 51.
Medical technology can defy nature.
So how old is too old?

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Sophia sits in a booth in a dimly lighted Chinese restaurant, reluctantly talking about the details of her life. She is beyond tired, as she has been for several months, and as she is likely to be for several more. The weathered brown of her hair, the weary brown shadows under her eyes, even the muted brown of her maternity dress over her very pregnant lap, all of these things somehow magnify her exhaustion.

It is a Friday night, and she did not leave the office until nearly 6:30, working until the last moment, tying up the loose ends in her high-powered job. On Monday, she will have a Caesarean section, which she scheduled months ago because her doctor did not think her body could withstand the rigors of labor. She will be in the operating room with just an obstetrician, a pediatrician and a nurse. There will be no spouse, no partner, because she has none; she is planning to rear her child alone. There will be no friends or family at the hospital, either. She fiercely believes that her most unusual pregnancy is nobody else's business.

"People look at me and say, 'How are you doing?'" she says, rubbing her belly where it all but meets the table — the protective, absent-minded gesture of so many pregnant women. "I say: 'I'm doing fine. I am O.K.'"

"But you're not O.K.?" I ask.

"No, I'm not O.K.," she says, shaking her head and shrugging her shoulders. "You can't be O.K. till you see that everything is O.K. with the baby. I just want to see him — it's been such a long wait."

A lot longer than for most women. Sophia is having her first baby. She is 51 years old.

Sophia and her baby boy, last month. Photograph by Dana Fineman.

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PREGNANT AT 51

For thousands of years, female fertility was largely limited by age and was ended by menopause. That was a law of nature, inescapable and unchangeable. Now it no longer holds.

Like so many seemingly sudden changes, this one actually evolved slowly, and only by looking back do we see how far we have come. The first successful in vitro fertilization, in which sperm and egg are mixed in a petri dish and then transferred into the uterus, was done in England in 1978. It took another decade for the procedure to become commonplace in the United States, and at first, it was available only to women in their 20's or early 30's, those thought to have the greatest chance of becoming pregnant. Not until the early 1990's was the technology offered to those in their later 30's or early 40's, and only in the past six or seven years has the use of donor eggs become widely available to women approaching, experiencing or even past menopause. Just 10 days ago, researchers in Atlanta announced the first successful pregnancy in this country using an egg that had been frozen, and one consequence of this will be that women will be able to freeze their eggs when they are young for use later, when they are older and their eggs are of poorer quality.

As with much new technology, the tools of fertility are governed by few rules. Each fertility clinic sets guidelines of its own for the women it will treat. Menopause usually occurs between the ages of 45 and 55. Only a handful of the 300 clinics in the country accept patients over the age of 50, meaning a vast majority of doctors in the United States would have turned Sophia away. Not that hordes of menopausal women are knocking down the clinic doors, though the numbers are likely to grow once women can use their own frozen eggs. The best estimates are that 100 women over 50 have had babies through the intervention of fertility doctors. "I'm a member of a small sorority," Sophia says.

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"We're in the Wild West of medicine," Sher says.

It was, until recently, also an unnoticed one. And it might have remained that way if Arceli Keh, a 63-year-old California woman, had not lied to the doctors at her fertility clinic, telling them she was 10 years younger than she was. The news of the birth of her daughter earlier this year caused a firestorm of public reaction. She was called an emblem of feminism and a repudiation of it, a symbol of medicine's triumph and misuse, a heroine and a confused soul. You would have thought that a 63-year-old postmenopausal woman had never given birth before, and barring the story of Sarah begetting Isaac in the Book of Genesis, there is little documented evidence that one ever has.

Sophia was halfway through her pregnancy, and just beginning to show, when Keh made news. Sophia had never thought of her life as a morality tale or a social statement, but now she wanted to hide. A private, inward woman, she became even more so, determined to keep the details of her baby's conception almost completely to herself. Not even her own father knows that the egg came from a stranger, chosen from a book of potential donors, and that the sperm was donated by a relative so that Sophia might have a genetic link to the baby.

But along with the desire for privacy there is anger. "How dare they talk about that woman that way," she says. "Men have babies until they're old — people wink and say, 'Atta boy, way to go.'

"How can they be so judgmental?" she asks. The rage in her voice softens, but it is still there. "I was probably very judgmental when I was very young," she continues, "but not any longer. When my son is 20, I'll be 71. That doesn't sound too old to me. People say, 'Oh, it's so tiring, it's overwhelming,' but some of the most worthwhile things we do in life are tiring and overwhelming."

That volatile mix of fury and fear is what led Sophia to this restaurant. She has agreed to talk about her pregnancy in the hope "that it will make people understand, that it will show another woman like me that this is not an unnatural choice." Our conversation is one that comes with many rules. I must promise not to use her full name — she asked to be called simply Sophia. Nor can I name the city where she lives or the details of her job. "Few people know that I am 51 years old," she says, and even this tired and this pregnant, she does look like a woman four or five years younger. "I don't want people to know how old I am. I'm 51 and I'm having a child. This is my business. I don't have to explain anything to anyone. I don't want to be a trailblazer, I want to be a mother."

Is Sophia too old to have a baby? My mother was 22 when she had her first child. When I had her first grandchild, I was 31, and she thought *that* was too old.

That child, my son, is now in first grade, and when my neighbor, nearing 40, announced weeks ago that she was pregnant, my son asked, "Isn't Cathy too old to have a baby?" No, I told him. There is a time when bodies are too old to have babies, but Cathy, I said, is not there yet.

"How old is too old?" he asked.

It was a question that had an answer when I was 6. Today it only raises more questions. If 63 is thought to be too old, but 43 is not, where is the dividing line? It is a moving boundary, and in 1997 Sophia is standing on it.

WHEN THE STORY OF THE 63-YEAR-OLD WOMAN GIVING birth was in the news in May, I was a worried and weary mother. My husband was away on business for a week, and my son was confined to complete bed rest for three days because of an excruciating postviral inflammation of his hip. When I wasn't carrying him to the bathroom, I was running up and down the stairs retrieving toys, books and videotapes. Throughout it all I was suffering for him, grateful that this was temporary, exquisitely aware that there were other children with other ailments who were not so lucky.

I heard about Arceli Keh on the news during that weekend. By the time *her* son became a 45-pound 6-year-old, she would be almost 70, and I tried to imagine what all those stairs and all that strain would do to a woman nearly twice my age. "Why does she want to do this?" I wondered. Months later, when I meet Sophia in the Chinese restaurant, it is the first question I ask her. "Why do you want this? Why?"

"I always wanted to have children," she says simply. "For me it was never a question of 'Why?' First it was a question of 'When?' then a question of 'How?'"

Her answer, her story, is not typical of the "small sorority" of old-

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'How can they be so judgmental?' Sophia asks. 'When my son is 20, I'll be 71. That doesn't sound too old to me.'

er mothers to which she belongs. There *is* no typical story. Women who make this most unusual choice are, by definition, unusual. The second-oldest woman to conceive with the aid of technology, for instance, was a 62-year-old Italian who had lost her only son in a car accident. The actress Adrienne Barbeau had twins at age 51 because she was in a second marriage to a younger man and wanted to start a second family.

For Sophia, the reason seems to be that time went by too quickly. One day she realized she was nearly 50. She was a corporate executive living with her elderly parents. She was healthy — exercising regularly, eating right. And with a job she loved and a family she was close to, she was relatively happy. But she wanted more.

Life has "never been easy for me," she says. "Whatever I achieved, I worked hard to achieve it." Her childhood was "someplace where life is tougher than it is here," but she refuses to tell me the country of her birth for fear that it will identify her.

Wherever it was, it was not a place where she felt free to follow her dreams. "I wanted to be a surgeon," she says, "but a relative came to visit from the United States and said that the medical schools in my country weren't very good."

She was 25 when she moved to the United States with her family. A young man proposed to her then, but she turned him down. "I didn't think I could get married and also pursue the other goals in my life," she says. "It was too soon for me to get married at that time. I thought marriage and children would come later."

They did not. Four years ago, worrisome abdominal cramps sent her to the doctor, and she learned that she had fibroids; the doctor recommended a hysterectomy. "They said, 'We just have to remove your uterus,'" she remembers, "and I said, 'No, I haven't had my children yet.'" The memory nearly brings her to tears, but she quickly regains her composure. "That was a very traumatic experience for me," she continues. "I thought I'd always have time, you know."

Her initial grief quickly turned into determination, however, and she refused to have the surgery. Instead, she read everything she could about fibroids, and about the growing evidence that the traditional hysterectomy is unnecessary in such situations. Her insistence led her to obtain a second opinion, then a third, until she found a surgeon who would remove only the fibroids, leaving her uterus intact.

When the surgery was over, she changed the focus of her research, exploring how a single, older woman (she was 47 then) goes about having a child. Everywhere she looked, she found that people tried to dissuade her, even at the places designed to provide support.

"I called Resolve," she says, referring to the national organization that provides information and encouragement to patients struggling with infertility. "They were very helpful. The lady was very nice, but she said, 'Why don't you just adopt?'"

It is more difficult for older women, particularly single women, to adopt. "But everyone kept saying, 'Why not adopt?'" she says. "I didn't want to adopt. I wanted to have a baby, to give birth to a child."

DR. CHRISTO ZOUVES IS A MAN UNAFRAID OF TECHNOLOGY. HE HAS programmed the PC in his office to bring him constant updates on the weather, the news and the stock market. He reads dozens of E-mail messages each day, most of them from patients who have learned that he prefers cyberspace to the telephone. With a click, he can access any patient's chart, each of which contains a digitally scanned photograph he can use to jog his memory before greeting the patient in a crowded waiting room.

Zouves is the medical director of the San Francisco clinic of the Pacific Fertility Center, which, when it opened in Los Angeles in 1982, was one of the first clinics in the United States to offer in vitro fertilization. Today it is one of the largest. Dr. Geoffrey Sher, the founder of Pacific Fertility, and the head of the Los Angeles office, says that of the "approximately 40,000 babies born through in vitro fertilization in the United States, 3,600 come from us alone — that's a lot of babies."

Both Sher and Zouves, who were trained in South Africa, see themselves as outsiders who are successful *because* they are outsiders. If you're not eager to question the rules and push the envelope, they believe, this is not the field for you. "We're in the Wild West of medicine," Sher says of the ungoverned world of high-tech pregnancy. "This is where things are unchecked. It's the frontier, where everything gets tested."

Pacific Fertility, for instance, is one of the most aggressive marketers in the field, recognizing from the start that traditional ways of finding patients were obsolete in this untraditional realm. Fertility treatment is elective, expensive and, for the most part, unreimbursed by insurance. Before spending up to $12,000 for each I.V.F. cycle, prospective patients tend to shop around. Pacific Fertility treats them unabashedly like consumers, an attitude apparent in everything from the clinic's glitzy Web site, to its newspaper advertisements, to its some-strings-attached money-back guarantee. The clinic prides itself on the fact that patients respond to its approach and fly in for treatment from all over the country.

Just as Pacific Fertility finds patients in ways that others don't, it also takes patients that other clinics won't. Older patients, for instance. In 1990, when one-third of the 60 programs in the country excluded women past 40, Pacific Fertility accepted them, and that year, Sher says, "We did 11 percent of all the I.V.F. women over 40 in the United States." The number of clinics has now increased more than fivefold. Fewer than a dozen of those accept patients over 50. Pacific Fertility is one of them.

These practices have caused controversy within the specialty, and some of Sher's more conservative competitors have criticized his approach. But if you are a 51-year-old woman looking to have your first child, such a clinic is exactly the place you would go. One morning last year, Sophia found herself in Zouves' office. He fiddled with her chart on his computer. She stared out the window at the view of the Golden Gate Bridge.

Zouves was not the first doctor Sophia had seen. The infertility journey is rarely a direct one, and in the time since Sophia was forced to face her reproductive mortality, she had traveled down more than one dead-end road. First, she approached her gynecologist and persuaded him to perform five cycles of intrauterine insemination, which is the simplest form of reproductive intervention, using frozen sperm purchased from an area sperm bank.

Before each of those cycles, he tried to talk her out of the idea. There was, he said, only the smallest chance that the insemination would work. She was perimenopausal, he told her, meaning that her reproductive system was starting to shut down. A previous surgery had left her with only one ovary, and this ovary was slowing down. Even when she did ovulate, her eggs were probably of such quality that they would not fertilize.

"I was stubborn," Sophia says. She approached the insemination the way she had approached the hysterectomy. When her gynecologist insisted on stopping after five tries, she found a fertility specialist who had

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'Most of this "progress" has been for the benefit of the parents, not the benefit of children,' says Daniel Callahan, a biomedical ethicist.

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the same misgivings but oversaw five more unsuccessful inseminations. Eventually that specialist also gave up. There were only two choices, she told Sophia: "Forget this whole thing, or go with a donor egg."

Egg donation is the groundbreaking advancement that made postmenopausal pregnancy possible. It is based on a simple scientific realization: the age of the egg, more than the age of the uterus, is what makes pregnancy less likely over time. If you take an egg from a younger woman, fertilize it and place it in the hormonally readied womb of an older woman, the success rate increases remarkably. A 44-year-old woman attempting I.V.F. with her own eggs at Pacific Fertility has a 3.5 percent chance of becoming pregnant. If that same woman uses a donor egg from a younger woman, her chances of giving birth are 50 percent.

Just as I.V.F. rapidly transformed reproductive medicine, egg donation rapidly transformed I.V.F. (No doubt, the advent of frozen eggs will bring about another transformation.) In 1989, the procedure was still essentially experimental, and only 328 egg transfers were attempted, resulting in 81 deliveries. By 1994, the last year for which data are available, 1,983 patients used donor eggs and 929 had children. Today, most I.V.F. clinics will only accept patients older than 43 or 44 if they agree to use a donor's eggs. Fifteen percent of all I.V.F. procedures done at Pacific Fertility include a donor egg.

But although the science of this procedure is straightforward, the practical and ethical ramifications are not. That questions are arising faster than answers is not surprising, since it took society more than 50 years to make peace with an earlier method of tinkering with Mother Nature — sperm donation. As recently as the 1950's, sperm donation was considered adultery in at least one state, although it was unclear whether the adulterous party was the donor, the recipient or the doctor. During the 60's and 70's, a number of lawsuits clarified the rights and obligations of the man donating the sperm and the man seeking to rear the child. Beginning in the 80's, however, the talk turned to morality again, as, through the sperm bank, single women and lesbian couples began forming families without men.

Egg donation can make the questions about sperm donation seem relatively quaint and simple. While 35 states have legislation or case law defining the boundaries of sperm donation — stating, for instance, that the donor has no claim on, and no financial obligations to, the child — only seven states have similar legal guidelines with regard to donor eggs. If there are legal challenges, there is every reason to believe that the courts will treat donor eggs as they do donor sperm, but there is not yet enough case law to know that with certainty.

"Everything about this is more complicated," says Arthur Caplan, director of the Center for Bioethics at the University of Pennsylvania. "It's harder to make eggs than it is to make sperm. It doesn't take much to get a guy to go into a room with a magazine and donate some sperm."

The process of egg donation involves putting the potential donor on a regimen of injections for nearly a month, stimulating her ovaries to produce far more than the usual monthly number of eggs. The woman is then put under light anesthesia and the eggs are removed via a long, thin needle inserted through the vagina into an ovary. There are some risks associated with the drugs and other risks associated with the retrieval. Egg donors are paid between $1,500 and $3,000. Sperm donors are paid $25 to $75.

"Why are we calling it egg donation?" Caplan asks. "It's egg sale. Would anyone be doing it if there was no payment involved?"

Medicine has long respected the taboo about paying for such things as organs. Even the large payments often made by adoptive parents to birth mothers in private adoptions are limited by law to medical costs and living expenses during the pregnancy. Clinics describe the fees paid to donors as reimbursement for the "inconvenience" of the donation process. "But," says Dr. Kenneth J. Ryan, a professor emeritus of obstetrics and gynecology at Harvard University Medical School and chairman of the ethics committee of the American Society for Reproductive Medicine, "the question of whether you're actually paying for the egg or paying for the inconvenience is a question of interpretation. This is as close as we have ever come to that line."

With donor sperm, it was possible for a woman to give birth to a child who had no genetic relation to the man society viewed as the father. But now it is possible for a woman to give birth to a child who has no genetic relation to its mother. And if both the gestational mother and her husband are infertile, meaning they use not only a donor egg but also donor sperm, it is possible for a woman to give birth to a child who has no genetic relation to either of the people listed on the birth certificate.

But perhaps the infertile couple wants a genetic link to the baby. If they cannot give their genes to their child, they can give the next closest thing, taking an egg from the woman's sister or sperm from the man's brother and creating a family in which the child's mother is also its aunt and its father is also its uncle. A number of lesbian couples have been known to do the following: one partner provides the egg, the second partner carries the child and the sperm donor is a close relative of the pregnant partner. The result is a child with genetic links to both parents. Should there ever be a legal challenge, one partner can prove she is the genetic mother, the other will have her name on the birth certificate.

There are no laws and few rules governing which of these combinations are appropriate uses of the technology and which go a little too far. Just as with every other specialty in medicine, doctors are given wide discretion to make decisions themselves. As a result, there are doctors who accept only married couples as patients, some who will treat single women but not lesbian couples and others who accept lesbian couples but will not help gay men find a surrogate to carry their child. Many clinics encourage relatives to be donors, many others discourage it and a few come down in the middle, allowing a man's brother to be a donor, for instance, but not the man's father.

Pacific Fertility accepts "any patient who is physically and psychologically healthy," Sher says, because he believes that "no one has the right to discriminate on the basis of age, marital status, sexual preference, and no one has the right to be judgmental of people's values.

"I don't always believe their decision is right, but I believe that I don't have the right to make that decision for others. I'm not smart enough. I'm not God, and I don't think it's fair for me to say to a couple that you may or may not do it because I say so. I'm not a philosopher. I'm not an ethicist. I'm not willing to make those calls."

Sophia had been resisting the idea of an egg donor for nearly three years. Her questions were not about ethics but about genetics. Using an egg donor required accepting the fact that her child would not have her genes. Hers was a tiny family, with no nieces or nephews. If she used a donor egg and donor sperm, her genetic heritage would die with her.

Clinic psychologists say that adjusting to this reality is often the most stressful part of the process. Wrapped up in the desire for children is a very human yearning to continue the family line, to see a part of yourself in someone else. Deciding to give that child a stranger's genes requires a change of focus and an examination of the reasons for wanting to become a parent.

Like adoption, acceptance comes more easily to some. Many can

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never get past the hurdle; in a way, Sophia never did. After her second doctor persuaded her to stop throwing away money and emotion on futile insemination attempts, she had a long talk with "a relative," she says, typically and understandably wary. "I cannot say who."

She told him she was thinking of trying donor eggs. "I said, 'The only way I will do this is if I will be using a relative,'" she remembers telling the potential sperm donor. "So he said, 'Fine.'"

If he had not agreed, she says, she would not have continued her quest. "The only reason I can go on with this is because the donor of the sperm is related to me," she says. "It's in the family. It's my genes. It's related. Our family has a good genetic history, so that's why I'm glad that the baby will have part of that genetics."

In the summer of 1996, she contacted a clinic near her home, but because she was not married, she was turned away. "They offended me terribly," she says. "They said they would not work with me, and they had not even met me."

She had met Zouves briefly at a seminar, and he had stressed that Pacific Fertility had no such rules, so she called. All the early consultations were done by telephone, fax and E-mail. Lab tests were performed near her home and the results sent to Zouves in San Francisco. Patient and doctor did not sit down and talk until two weeks before the implantation procedure, when she visited his office for the first time.

"I liked him," she says of that meeting, "because he was very compassionate. He didn't question what I was doing. He didn't judge. We didn't talk about my age at all."

JACQUELYNE GORTON WALKS UP THREE STEPS into her tastefully decorated living room in San Rafael, Calif. She is carrying an unwieldy armload of three-ring binders, and she sets them down with a thunk, rattling her glass-topped table. The books contain applications from about 70 young women, whom Gorton has divided according to hair color. "Light hair, dark hair, non-Caucasian," she says apologetically, afraid all this might sound a little like the files of the Mayflower Madam. "It was the only way I could think of to classify people."

How a woman in need of a donated egg finds a woman willing to donate that egg seems to depend on which side of the country they are on. Clinics on the East Coast generally make the match themselves, providing the patient with the basic information about any available donors who meet the patient's general requirements.

"We tell them the information they need to know," says Dr. Zev Rosenwaks, director of the Center for Reproductive Medicine and Infertility at the New York Hospital-Cornell Medical Center in Manhattan. "Height, weight, general physical characteristics, general health history. There is no real need to know more."

On the West Coast, however, the process is more *Californian* than that. "We're not just interested in the medical side of it," says Nira Ray, Gorton's assistant at her independent egg-donor agency, one of three or four such groups in Northern California. "We're interested in matching people up and having it be a good-quality match, something we could feel good about."

Gorton, who has been in this business since 1992, advertises in small local newspapers and circulars, particularly those in college towns. "Women Needed as Egg Donors," her ads say. "Childless couples need help to start families. $3,000+ costs paid upon retrieval if you're 21-29, healthy, nonsmoker, average weight and previously pregnant."

Gorton is very choosy about whom she puts in her books, she says, because her clients are. "We have a solid pool of people," she says. "I've heard, compared to other pools, we have a really good pool, and you have to keep the quality of donor really high because I feel that it reflects on the agency."

It is an application process unlike any other. Candidates must meet height and weight restrictions ("100 pounds for the first five feet and 5 pounds for every inch over that," Gorton says, adding that she often allows 10 to 15 pounds above that). Ideally, they must have some schooling beyond high school; they may not have had more than three sexual partners in the past 12 months; they must have had at least one previous pregnancy.

That last question can be a tricky one. In the upside-down world of egg donation, abortion is seen as a positive thing, an indicator of a donor's fertility. "It means that she has ovaries and everything's working," Gorton says. At the same time, it can signal something else. As Gorton puts it, "If somebody has four abortions, well, we want them to be fertile, but we also want them to be responsible."

Those callers who make it through the telephone interview are sent a 16-page application requesting information on everything from their paternal grandfather's eye color to whether their aunts or uncles ever suffered a heart attack or stroke. In a way, it is a depressing form, page upon page filled with 91 things that can go wrong with a human body. It is a reminder that even in this day of medical miracles, no genetic line is perfect.

But when filled out completely, it is an eerily cheerful form, too. The young women are asked to provide photographs, including baby pictures of themselves and any children they have had, and the front page of each application is filled with the colorful shots. Here is a 25-year-old woman named Kathryn, blond hair, green eyes, 5 foot 5, 125 pounds, books under her arm, leaning against the door of her dorm room. There she is at dinner with her parents and her sister. Giggling with her grandmother. Posing with a friend.

"I spend my life seeking a more enhanced and full sense of self in an effort to experience harmony with myself and all people," she writes in the essay section near the back. Being "an ovum donor," she says, "allows me to live a flexible summer life style and have an 'income' for later expenses, while helping a loving, committed couple."

As I sit on Gorton's couch and flip through her binders, I try to imagine doing what Kathryn plans to do, as all these women plan to do. Could I give a part of myself to a stranger? Would I have helped Sophia have her baby?

I ask Gorton, "How do they get past the thought that there will be this child who, genetically, is as much theirs as the children they are raising as their own?"

Gorton looks knowingly at Ray for a moment, *Continued on page 48*

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Gorton matches would-be moms and egg donors.

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then looks directly at me. It seems that I have just told her a very central something about myself. "You couldn't be a donor," Gorton says simply. "If you think in those terms, you don't get past it, and you would never call in the first place."

"Some people don't think of it the way you describe," Ray says. "They think: 'I don't want my eggs right now. I lose an egg every month and I'm proud of my genetics. I can't imagine life without a child, and I want to help someone else have that life.' They see it as giving blood — 'Great, take it, you need it.' The people who are successful donors in this process feel the same way."

Sophia sat on this same couch and looked through these same books last year. By that point in her search, she, too, was thinking of donor eggs as a needed part, not an incipient person. Details of the donor were less important to her than the timing. "I wasn't getting any younger," she says.

As had been the case with her search for a fertility clinic, Gorton's agency was not Sophia's first stop for an egg. Pacific Fertility is affiliated with the Parenting Center, a matching service that has its own set of binders — green is the San Francisco Bay area, yellow is Southern California, red is Sacramento, blue is out of state. There were 129 donors on file in the Parenting Center binders, but Sophia did not find any that she felt would be a good match, which is why she visited Gorton.

On the morning of that first meeting, she remembers, the radio was reporting that a woman had just given birth to quintuplets conceived through in vitro

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fertilization. She took that as a sign that this was the right thing to do.

Sophia found a potential donor from Gorton's books — a college student. A few weeks later, the two women met in Gorton's living room. Gorton's agency encourages meetings between donor and recipient, but many such agencies do not. At New York Hospital-Cornell, donors are not given any details about the recipient, and recipients are given only basic information about the donor. At the Parenting Center, the recipient receives a detailed history of the donor, but the donor receives only limited information about the recipient, and meetings are rare. Ninety percent of Gorton's clients meet their donor.

It was an awkward hour, Sophia recalls of her time with the young woman. "We talked," she says. "I asked, 'How is it going?' I didn't ask her any questions about her genetics, or her family. I knew that from her application. I was just trying to get to know her as a person."

Sophia gave her final O.K. to the match, and the young woman did, too. But a short time later, Sophia says, the donor "changed her mind and decided not to do this." Sophia does not know the reason, and can only wonder whether the woman was put off by Sophia's age.

The passage of time was feeling ever more pressing to Sophia. Gorton assured her that a match could be made and called a short while later to tell Sophia about one woman who had already donated three times and wanted to donate again. Ten donations are the maximum recommended by the American Society for Reproductive Medicine in order to protect women from potential unknown effects of the fertility drugs and to protect the children from the chance of unknowingly meeting and marrying a half-sibling when they become adults.

This woman was 27 and studying to be a teacher. She had two sons, her husband had had a vasectomy and her family's medical history was relatively good. And because this woman had donated before, she had already passed the essential psychological and medical examinations, which would save Sophia some time.

"I wanted someone with a good education, and she was in school," Sophia says. "She sent a photo of when one of her children was a baby, and that was a very attractive picture. When you are close to making a decision you have to make some compromises. You can't really wait forever. You have to make some decisions."

One decision Sophia made was not to meet this donor. "It was a timing issue," she says. "I needed to move forward quickly because I lost almost four, five months with the first woman, and I know time is passing." She also knew that she had met the first donor, then lost her. She did not want that to happen again.

Under the supervision of Zouves and the Pacific Fertility staff, both Sophia and the woman gave themselves the necessary hormone injections. A month later, the donor went to the clinic, where Zouves administered anesthesia and removed 35 eggs. Sophia's designated sperm donor came in that same day, and his sperm was mixed with those eggs in a dish. Zouves wanted to insert only 4 of the 25 resulting embryos into Sophia's uterus, worried that any more would increase her chance of a risky multiple pregnancy. Sophia argued for five. She didn't mind increasing the risk, she said, if it also increased her chance for a baby. Zouves agreed.

Two weeks after the procedure, Sophia's pregnancy test was positive.

Three weeks after the procedure, Sophia slipped on a step and began bleeding heavily.

Four weeks after the procedure, a sonogram showed one healthy heartbeat, a single sac with a single baby. She was elated, but disappointed.

"I was hoping," she says, "to have twins."

RICHARD J. PAULSON, CHIEF OF THE division of reproductive endocrinology and infertility at the University of Southern California, is well known within medical circles as an expert on postmenopausal pregnancy. He has recently become known to the rest of the country, too, as the head of the team of doctors who enabled Arceli Keh to have a baby. It was his article in Fertility and Sterility, a medical journal, that broke the news of that event, and in the days after publication he talked with everyone from Katie Couric to Forrest Sawyer. If anyone should be enthusiastic about ever older pregnancy, it is Paulson. So it is surprising, and unsettling, to hear him say that all this is beginning to make him uncomfortable.

"It's hurtling along," he says. "When I was a resident we didn't treat women in the fertility clinic who are over 40. I've seen enough women in their early 50's that I'm comfortable with that. My discomfort starts with the next group, between 55 and 60. There has to be a line. Everyone finds his own line."

Where, then, to draw that line? At the moment, most clinics do so at the age of menopause.

"We draw it where nature draws it," says Richard T. Scott Jr., director of the Institute of Reproductive Medicine and Science at St. Barnabas Medical Center in Livingston, N.J. That clinic does not accept patients older than 48, Scott says, an age chosen so that pregnancy can occur before 50. "That is when nature usually shuts down a woman's reproductive system," he says. "We choose to stop there, too."

Doctors who think like Scott cite three basic reasons for turning postmenopausal patients away. First, these pregnancies risk the mother's health. In 1995, Dr. Mark Sauer, director of reproductive endocrinology at Columbia-Presbyterian Medical Center in New York, reported that 47 percent of these women suffered health complications, including hypertension, preterm labor, gestational diabetes and pre-eclampsia. The study was necessarily a small one — it looked at only 17 pregnancies — but it was enough to confirm what many doctors suspected.

The second reason is concern about the welfare of the child. Isn't the unborn baby the doctor's patient, too? When that baby becomes a teen-ager, is it in his best interest to have elderly parents?

"It's not good public policy to make orphans," Arthur Caplan says.

Daniel Callahan, a biomedical ethicist at the Hastings Center in Westchester County, N.Y., makes much the same argument: "Most of this 'progress' has been for the benefit of parents, not the benefit of children. Does anyone think that one of the problems people have identified in society is that there aren't enough older mothers?"

Third, there is the argument that the eggs these women need to become pregnant are a scarce resource. "We have a waiting list" of recipients seeking donors," says Dr. Frederic L. Licciardi, director of the donor oocyte program at the New York University Medical Center. "Under those circumstances, an age limit is necessary and appropriate."

Added to all this is a fourth reason, one rarely expressed directly — the vague sense among many doctors that it is just plain unnatural. In its 1996 statement on postmenopausal pregnancy, the ethics committee for the American Society for Reproductive Medicine came close to saying this outright. "Just as fertility is the norm during

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Zouves and his I.V.F. team at the Pacific Fertility Center in San Francisco.

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the reproductive years," the committee said, "and treating physicians are justified in their efforts to correct deficient reproductive functions ... infertility should remain the natural characteristic of menopause. Because of this, and the physical and psychological risks involved, postmenopausal pregnancy should be discouraged."

Those who draw the line at 50, however, are not comfortable with it. It's not where they've drawn that line that troubles them, but the fact that they have had to draw it at all. "Any time a physician limits care for patients, that's not a good thing," Scott says.

Fine, reply those few doctors who stand on the other side of the menopausal divide. If you don't like setting limits, don't set them.

They reject, for instance, the argument that there is an unacceptable risk to the health of the mother. Quoting the Sauer study, they point out that all the complications cited also occur, although less frequently, in younger women, and that all are treatable. Similarly, this more adventurous group of doctors is not concerned that children will suffer unduly. "If you make a decision based only on the fact that the baby will be orphaned of a mother when it's young," Sher asks, "what about the young couple where the woman has advanced diabetes and wants to use a surrogate? What about the woman who's had breast cancer and is in remission and she and her husband want to have a child? Should they be denied? What is better for the child? Is it really better for them to never have been born?"

And Sher and other doctors reject the argument that postmenopausal pregnancy is unnatural. "This upsets people because it somehow defies nature," says John Robertson, an expert in reproductive law. "Well, everything we do goes against nature, or else maybe everything we do is natural because we are nature. Why is this any more unnatural than coronary-bypass surgery?"

Maybe it isn't. But should a 95-year-old have bypass surgery? Should she have a baby? The question remains: Where is that line? Most clinics set their limit at age 50. Some have inched it up to 55. A few, only a few, say there should be no limit at all. Pacific Fertility is one of those.

"Fifty-five is not a cutoff," Zouves says. "It's just an area where we do a little more homework. Technically you can do it for an 80-year-old, but which 80-year-old is going to want to have a baby?

"The oldest patient I've personally done turned 60 the week before her C-section. That was two years ago. She called recently. She's coming back for another baby."

SOPHIA CHOSE NOT TO HAVE AMNIOCENTESIS. IT was a decision emblematic of the new reproductive math — although she was well past the recommended age of 35, her eggs were technically only 27 years old.

Her doctors did perform several sonograms, however, and that was how she learned that she was carrying a boy. It was welcome news, because, she says, life is easier for boys than for girls. A

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daughter might "have to go through what I had gone through," she explains, "to have to make choices in life and not be able to do it all."

The sonograms showed something else, too. There was amniotic fluid in the baby's kidneys, a possible indicator of Down syndrome. Every month for each of the remaining months of her pregnancy she had another sonogram, and the amount of fluid remained the same. "It doesn't increase, but it doesn't decrease," she said the night we met for Chinese food. "They say it probably isn't Down's, probably it isn't anything, but I worry about it every day."

She was right to have worried. Three days after our dinner, Sophia had her C-section, a procedure made necessary by the fact that her uterus was potentially weakened during her fibroid surgery. The baby's first breaths and cries were met with a flurry of activity, and although Sophia had never done this before, she knew there was something wrong. No one brought her the baby. Instead, they huddled over him in the warming bassinet for what seemed an eternity.

Eventually they told her. It was not Down syndrome. Her son was born with a malformation of his digestive system and would need emergency surgery. More surgeries would follow over the next few months. Everything could be fixed, they assured her, and the boy would be fine with time, but it would be a long, difficult year.

When Sophia told me this, I thought once again about the strain of one weekend with an otherwise healthy child. Older women, any women, deciding to have children, are deciding to have healthy children. We say that we understand that something can go wrong. But how can we really understand until it happens?

Were the baby's problems caused by the in vitro procedure that allowed Sophia to become pregnant? Probably not. There is an increased chance of multiple gestations with I.V.F. — in other words, twins or triplets — and Sophia says her doctors believe she lost a twin early in the pregnancy. But the problems associated with multiple gestations are not the problems her baby has.

Were the baby's problems a result of Sophia's age? That is less clear. Because so few women over 50 have become pregnant in this way, there are no large sample studies. But Sauer and Paulson have found that the environment of a 51-year-old pregnant uterus is no different than that of a 27-year-old uterus and therefore should not lead to an increase in birth defects.

In short, random complications occur when younger women give birth, too. "There is no reason," Sophia says. "This is just the way it is."

I TALK TO SOPHIA A FEW TIMES AFTER THE BABY comes home from the hospital. About colic, and breast-feeding and sleep. She will return to work soon, and she wonders where she might find a nanny who can handle her baby's complicated care. She also worries about the cost of that care. Insurance will pay for some but not all.

When I see Sophia again, she is walking across the parking lot of a doctor's office, taking her son for a checkup. She is wearing a skirt and sweater, jewelry and heels. Everything is perfectly matched. I recognize the motivation — a new mother, proving to herself and to the world that her old clothes fit and that she is still in enough control of life that she can get out of her bathrobe and into the shower.

Although her outfit is perfect, her manner is still weary. When we first met, I had wondered whether she was courageous or crazy. Now, as she walks toward me, I see that she is neither. She is just a tired, determined woman. I would not have made the choice she made. But I also would not want to live in a society in which the final decision did not belong to her.

As she crosses the crowded lot, she bangs the unwieldy infant seat into a parked car. She looks stricken for a moment, but refuses my offer of help. "I'm O.K.," she says, as she shifts the carrier to her other hand.

"Now you're a mother," I say, "and you waited so long to become a mother. Is there anything about this that surprises you?"

It is the gentlest way I can think of to ask whether she is having any second thoughts.

She looks at her baby, swaddled and sleeping. She stares at him for a long time before she answers.

"I didn't know . . . ," she says.

Regrets? Doubts?

"I didn't know," she says, "that I could ever love anyone this much." ■

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