

MONETARY RELATIONSHIP IN GAMETE DONATION – THE ETHICAL VIEW

¹FATEMEH SHIDFAR, ¹SAEEDE SADEGHI

¹ Medical Ethics and History of Medicine Research Center, Tehran University of Medical Sciences, Tehran, Iran

ABSTRACT

During the last decades, gamete donation has been known as an assisted reproductive treatment for infertile couples. This method has raised many ethical issues; one of the dilemmas is the payment between the donor and recipient. In this article we discuss the payment issues in gamete donation. For compiling this article, we searched keywords of “gamete donation, monetary relationship and ethics” in Pubmed and Ovid.

After reviewing the history of gamete donation, the risks and benefits of gamete donation, the motivations of donation and the financial incentives were reviewed. Then the ethical debates were discussed; the possibility of undue inducements, coercion and exploitation, the quality of informed consent, commodification of donation, compensating the risks and troubles, the results of not paying the donors and other ethical aspects were also explained.

Payment is one of the inevitable problems in gamete donation. Considering the scarce supply of gametes compared to its demand, the current policies of gamete donation without any payment leads to increasing numbers of infertile couples and also the longer waiting times for treatment. Moreover, the essential and immediate needs of couples for gamete leads to significant expenditures in illegal outlines. It is necessary to compile an arranged schedule to organize the financial relationship between the donor and recipient in a legal outline.

Key words: Gamete donation, Monetary relationship, Ethics.

INTRODUCTION

Assisted reproductive technologies has made child bearing possible in infertile couples who were previously thought to be untreatable. They have also helped infertile partners to reach the wish to have a child of their own. (1, 2) Gamete donation, as a method yielding the couples to procreate (3), has resulted in thousands of babies during last decades (4).

Over the years, the profile of couples interested in gamete donation has been changed. In earlier times, donors, dominantly relatives or friends typically presented with the main motivation of altruism. However, approval and progresses in this method of fertility has led to significant demands. As the demand for gamete donation continued to escalate, the pressure on programs to provide gamete donors have dramatically increased (5).

One of these programs is establishing payment for donors. In some surveys it has been mentioned that men donating spermatozoa have been paid a nominal fee, while women donating oocytes have not. The issue of payment has attracted attention following the suggestion that such payment may be withdrawn. Some authorities argue that donation should be a freely and voluntarily action and any risk that the decision to donate might be influenced by financial inducement is not desirable. This issue

has been widely debated (4). Some countries prefer the donation without any payment (6), while others accept a compensation for troubles that donor goes through (7).

But there is a vast range of concerns especially in ethical aspects. In this article, we discuss motivations of the donors and the ethical debates.

MATERIALS AND METHODS

For compiling this article, we searched keywords of “gamete donation, monetary relationship and ethics” in Pubmed and Ovid. We went through the articles that were published during the last decade. We also searched different books for this topic.

RESULTS

During the last decade, oocyte donation has increasingly been accepted as a method of assisting women without healthy oocytes to have children (3). Oocyte donation was first reported in 1983 in Australia. Since then, using this procedure has grown rapidly (8, 9). Pregnancy following sperm donation was mentioned in western literature as early as 1790, when the Scottish surgeon John Hunter was said to have artificially inseminated a woman in London. J. Marion Sims, a New York doctor, is believed to have carried out the first sperm insemination in the United States in 1899

(8). He artificially inseminated 55 infertile women with sperm of their husbands. His efforts resulted in one pregnancy (but later miscarried) (10). The first confirmed case of sperm donation took place in the United States in 1884, when William Pancoast, a physician in Philadelphia, inseminated a woman using sperm from a medical student. In 1953, scientists demonstrated that human sperm could be frozen and thawed for insemination to produce a normal child, paving the way for the first commercial sperm bank, which was opened in 1970 in Minnesota. By 1993 it was estimated that more than 80,000 women had been undergoing the procedure each year, resulting in approximately 30,000 pregnancies annually (8).

Risks and benefits of donation process

The process of egg donation is more complicated and risky than sperm donation. Egg donation process is very time-consuming. The donor may involve several visits and she undergoes physical, gynecological, psychological and lab examinations. The medications may cause hot flashes, vaginal dryness, fatigue, sleep disorders, vague pains, mood swings, breast tenderness, headaches and visual disturbances. These complications may put physical and psychological burdens upon the donor (7). There are surveys which have shown these medications result in "ovarian hyperstimulation syndrome", in which the ovaries swell and fluid builds up in the abdominal cavity. If the hyperstimulation is mild, it will recede after the donor's next menstrual period. If the hyperstimulation is moderate, careful monitoring, bed rest, and pain medication might be necessary. Severe hyperstimulation is infrequent, but may cause serious medical complications, such as blood clots, kidney failure, fluid accumulation in the lungs, and shock. This condition can be life-threatening (11). This syndrome also raises the possibility of deep vein thromboses (6). Severe hyperstimulation occurs in about 1-10% of cases. It may result in removal of one or both of the donor's ovaries (11). According to some studies, there is an association between the use of ovulation stimulating drugs and malignant tumors (11) which isn't documented yet, but some surveys have shown an increased risk (12-14). Furthermore, sperm donation is a very time consuming procedure requiring periods of abstinence from sexual activity prior to donation, screening at least four occasions including repeated venipuncture and urethral swabbing. There is also a considerable psychological aspect for being a donor (15).

Financial incentives and donation motives

There have been debates on financial issues. It is routine to pay the donors to compensate the direct

and indirect expenses (16).

Ovum retrieval is possible from three categories: 1) the women who undergo IVF and the amount of eggs are more than their needs, 2) the women who undergo a surgery due to other reasons and take ovulation stimulating drugs in advance, 3) the women who voluntarily undergo superovulation and will supply eggs for others.

In a survey on gamete donors two types of motivations have been mentioned:

1) Financial, 2) Altruistic.

A survey was performed in two centers. One of the centers which paid the donors showed that the majority of donors were young, single and in their 20's. They mentioned the financial motive as the main reason for sperm donation. In the other center without any payment, the donors were mostly in the range of 30-40 years old, married and having children. These donors mentioned that their aims were to help the infertile couples (17).

A survey carried out in Denmark concluded that the motivation of 8% of sperm donors was purely altruistic, 32% purely financial and 60% a combination of both (18). Another survey from the USA found that donors were motivated by money, with the majority (69%) unwilling to participate if financial incentives were withdrawn. In the UK, a study on the motivation and attitudes of semen donors reported that both a wish to help others and the offer of payment influenced male donors' decision to donate (15). Moreover, a recent survey in the UK centers licensed for infertility treatment involving donated spermatozoa showed that almost all centers (97%) paid donors and that 88% of centers surveyed believed that they would lose at least 89% of donors if payment was to be withdrawn (19).

Different surveys show some egg donors have a personal reason for helping, such as having friends or relatives who have struggled with infertility or have undergone miscarriages. Others are attracted by the idea of giving the gift of life. But while most egg donors are motivated in part by altruistic consideration, most women would not be egg donors for strangers without financial compensation. Many say that egg donation would be impossible if they were not compensated for lost work time. Two types of financial motivations exist in egg donation. One is the payment for women undergoing the procedure exclusively to supply egg for infertile couples, and the other is known as oocyte sharing program, in which the infertile woman who undergoes IVF, instead of sharing some of her eggs with others pays less for IVF (3).

A survey in 1993 showed that 60% of centers were paying the egg donors (20). The number of

centers using the egg sharing method in 1997 was 23% (21). In some countries the gamete donors are chosen by advertisements in colleges, local magazines and internet. In egg sharing program the patients who undergo IVF, donate half of their eggs and in return they are rewarded a 50-60% decrease in IVF expenses (22). This program is confirmed in countries such as the USA, England, Spain, Australia, Denmark, Greece and Israel (23).

During the last decades, the sum of money which have been paid in the USA to donors increased progressively. In mid 80's, the egg donors were paid \$250 per cycle, but today it has reached to \$1500-3000. Some of the donors are being paid higher amount from \$50,000 to \$100,000 because of particular characteristics such as physical attractiveness, intellectual, athletic, or musical abilities (4, 8, 24). Financial payment is less routine in European countries. The majority of European countries oppose this debate (4). In the UK the egg donors are paid a low amount of \$23.

Payment and ethics

Financial relationship may result in undue inducements, coercion and exploitation (3). The involvement of payment might affect the culture of donation adversely and it reduces openness and honesty about genetic origins and family relationships. There is also concern that payment, particularly large payments, might tempt donors to hide factors that could be detrimental to recipients and their potential children (8, 25).

Payment to egg donors (including compensatory payment for inconvenience or suffering) could stimulate women for donation and could prejudice fully informed, freely given consent. The quality of consent is important to prevent donors from future regrets (25).

There is growing concern that egg donation, in particular, is being adrift amidst a stream of commerce, and that procreation is being commodified. The current marketing of egg donation, critics contend, relegates human beings to the status of commercial objects and their gametes to that of products. Some people consider the current practice of paying significant sums to egg donors as coming uncomfortably close to baby buying, and they maintain these flies in the face of the accepted view of children as individuals endowed with an underlying dignity. Several commentators have observed that gametes, as the means for making new life possible, are not negligible body products that ought to be bought and sold in the open market (3, 8).

Children produced by egg donation could be adversely affected psychologically if they knew that payment had been made as part of their creation (7, 25).

However disapproval of payment and delay in infertility treatment can destroy relationships and break up families, and every so often it might result in suicide (26).

One of the main concerns in paying the gamete donors is the possibility of coercion and exploitation. Payments to egg donors should not be so high as to become coercive or so low that they provide inadequate reimbursement for time and inconvenience.

It might be coercive if the money were offered to terribly poor women whose lives, or the lives of their children, depended on their donating eggs. A woman whose only choice was to give away her eggs otherwise her child die of starvation might well be considered as the victim of coercion. However, poor women are not usually sought out as egg donors. Typical egg donors are middle class, often professional, young women. It is simply not true to say that they have no choices but to sell their eggs.

Very large offers of money could be quite tempting to any woman, not just those in desperate need of money. Offers are not coercive because they are so good that it would be irrational to refuse. It is not coercive to offer someone a great job at double the salary that she is currently earning.

However, if offers of large sums of money are not coercive, they may still be criticized as being "undue inducements." Offering too much money may be an attempt to manipulate women into becoming donors. The lure of financial gain may lead them to discount the risks to themselves and to make decisions they will later regret. Taking advantage of this will be considered as a form of exploitation (7).

One of the concerns attributed to high amounts of payment is Eugenism. Donors with particular characteristics such as physical attractiveness, intellectual, athletic or musical ability may be offered far larger sums (24, 3). Offering larger amounts of money for special donors is not genuine. All of the donors are similar regarding to the fact that all of them encounter the same risks (7, 10). Determining a fixed fee for compensating the donor burden and risks decreases the possibility of Eugenism (10). Very low amounts of money can lead to exploitation of donor, so justice have to be guaranteed and the amount adjusted with the risks and burdens have to be paid (4, 7).

If the egg donation without financial reward be accepted, then the demand for eggs far outstrips the supply from women who donate for altruistic reasons. The end results are an inordinate delay often of 1-2 years, for treatment of women who are destined to be barren, and the proliferation of private and illegal organizations that put donors and recipients in contact for financial reward (26,

27) and the donors may be chosen without adequate screening tests (10, 27).

Restricting donor payment may lead to a growing number of patients who seek care outside the borders of their country because of prohibition and restrictions on the practice of oocyte donations. There may be no greater drive than the desire to reproduce. Patients will seek out services. Restricting payment will lead to an even greater demand for donors than that which already exists. More and more patients will travel to other countries where they can procure what they need. Doctors will continue to struggle with the problems of their patients created by a shortage of oocyte donors, and women who cannot afford care abroad will be left untreated (28).

In today world, where money determines health care, restricting payment to donors is unrealistic. The prime concern is to provide an efficient clinical service. It is suggested that if infertility represents a health care need, then restriction of a service through reducing the availability of gametes constitutes a dereliction of duty and is unethical because it restricts the ability of practitioners to provide the duty of care to patients (15). The persons, who participate in clinical trials, are paid, so it is realistic to pay the donors who participate in donation process to help the infertile couples (27).

Donation is not without risk, and it is unreasonable to assume that on a large scale donors will be willing to provide the time and accept the risks required by a burdensome treatment regimen without compensation. Actually the greater is the risk, the higher will be the compensation (28). It is moral for donors to receive an inconvenience allowance. More donors would come forward if there were some recompense for the troubles that they might get involved (26). Proponents from the other side of the argument suggest that payment should be increased and not decreased and that the donor should be paid inconvenience allowances similar to payments made to health volunteers who take part in drug trials and it is reasonable to

compensate donors for their expenses, journeys, lost wages, and, to some extent, the risk that they incur ingoing through the donation procedure (8).

CONCLUSION AND RECOMMENDATION

Gamete donation has been used to treat the infertile couples in recent years in our country. This method has its own ethical debates; of which one of the most widely discussed debates is the monetary relationship. As the number of infertile couples increases, the growing shortage of donors attracts a significant attention to this dilemma. Financial compensation for the burdens and risks is reasonable (2), considering the fact that the procedure has its risks and it is unrealistic to expect the donors to undergo the procedure exclusively for altruistic motives (28).

The payment must equitably compensate risks, inconveniences and the troubles involved (7, 18, 26). Very high or low amounts of money can alter the gamete process. In places, where payment is limited or prohibited, the practice of oocyte donation will continue to be plagued by a shortage of available donors. Payment fosters the growth of fertility treatment and continues to make it a viable therapy. Without payment, long waiting lists are inevitable and compromised matches replace thoughtful choices. There will be also an inordinate delay, often of 1-2 years, for treating the couples, and the proliferation of illegal private organizations that put donors and recipients in contact for financial reward (26, 27).

To solve the problem, arranging programs to pay for the possible expenses is necessary. The sum of money has to be a fair amount that reduces the possibility of exploitation and coercion (3). Arranging a fixed fee in a legal format and with the support of law will be the best way for the monetary relationship of the recipient and the donor.

REFERENCES

1. Kolibianakis E, Tournaye H, Osmanagaoglu K, Camus M, Van Waesberghe L, Van Steirteghem A, Devroey P. Outcome for donors and recipients in two egg – sharing policies. *Fertil Steril* 2003; 79(1): 69-73.
2. ESHRE Task Force on Ethics and Law. Gamete and embryo donation. *Hum Reprod* 2002; 17(5): 1407 – 1408.
3. The Ethics Committee of the American Society for Reproductive Medicine. Financial incentives in recruitment of oocyte donors. *Fertil Steril* 2000; 74(2): 216 – 220.
4. Lyall H, Gould G, Cameron I. Should sperm donors be paid? A survey of the attitudes of the general public. *Hum Reprod* 1998; 13(3): 771-775.

5. Lindheim S, Chase J, Sauer M. Assessing the influence of payment on motivations of women participating as oocyte donors. *Gynecol Obstet Invest* 2001; 52(2): 89-92.
6. Guerin J. Payments to gamete donors. *Hum Reprod* 1998; 13(5): 1129 – 1132.
7. Steinbock B. Payment for egg donation and surrogacy. *Mt Sinai J Med* 2004; 71(4): 255 – 265.
8. Post Stephen G. *Encyclopedia of Bioethics*. New York: MacMillan; 2004.
9. Assisted Reproductive Technologies, Analysis and Recommendations for Public Policy. New York: The New York state task force on life and the law; 1998. p.237.
10. Pence Gregory E. *Classic Cases in Medical Ethics*. New York: McGraw-Hill; 2004.
11. Aronson D. Resolving infertility: understanding the options and choosing solutions when you want to have a baby. New York: Harper; 1999.
12. Rossing MA. Ovarian tumors in a cohort of infertile women. *N Engl J Med* 1994; 331: 771-776.
13. Venn A. Breast and ovarian cancer incidence after infertility and in vitro fertilization. *Lancet* 1995; 346: 995-1000.
14. Mosgaard B. Infertility, fertility drugs, and invasive ovarian cancer: a case– control study. *Fertil Steril* 1997; 67: 1005-1011.
15. Gazvani Mehmet R, Wood Simon J, Thomson A. Payment or altruism? The motivation behind gamete donation. *Hum Reprod* 1997; 12(9): 1845-1846.
16. Borrero C. Gamete and embryo donation. Gamete source, manipulation and disposition. <http://www.who.int/reproductive-health/infertility/19.pdf> (accessed: 18 June 2006)
17. Mc Laughlin E, Day J, Harrison Sh. Recruitment of gamete donors and payment of expenses. *Hum Reprod* 1998; 13(5): 1130-1132.
18. Pedersen B, Neilsen A, Lauritsen J. Psychological aspects of donor insemination. Sperm donors—their motivations and attitudes to artificial insemination. *Acta Obstet Gynaecol Scand*.1994; 73: 701-705.
19. Golombok S, Cook R. A survey of semen donation: Phase I—the view of UK Licensed centers. *Hum Reprod* 1995; 10: 882-888.
20. Braverman AM. Survey results on the current practice of ovum donation. *Fertil Steril* 1993; 59: 1216-20.
21. Centers for Disease Control and Prevention. Assisted reproductive technology in the United States: 1997 Assisted reproductive technology success rates national summary and fertility clinic reports 1999. American Society for Reproductive Medicine. <http://pediatrics.aappublications.org/cgi/content/abstract> (accessed: 18 June 2006)
22. Peskin BD, Austin C, Lisbona H, Goldfarb J. Cost analysis of shared oocyte in vitro fertilization. *Obstet Gynaecol* 1996; 88: 428-30.
23. Ahuja KK, Simons EG, Mostyn BJ, Bowen–Simpkins P. An assessment of the motives and morals of egg share donors: policies of payments to donors require a fair review. *Hum Reprod* 1998; 13: 2671-8.
24. Lopez KJ. Egg heads: young women in need of cash are increasingly deciding to sell their bodies. *Natl Rev* 1998; 50(16): 26.
25. Johnson MH. The Culture of unpaid and voluntary egg donation should be strengthened. *BMJ* 1997; 314: 1401-1402.
26. Craft I. An “inconvenience allowance” would solve the egg shortage. *BMJ* 1997; 314: 1400-1401.
27. Sauer MV. Exploitation or a woman’s right? *BMJ* 1997; 314: 1403.
28. Sauer MV. Reproductive prohibition: restricting donor payment will lead to medical tourism. *Hum Reprod* 1997; 12(9): 1844-1845.