

Financial compensation of oocyte donors

The Ethics Committee of the American Society for Reproductive Medicine

American Society for Reproductive Medicine, Birmingham, Alabama

1. Financial compensation of women donating oocytes for infertility therapy or for research is justified on ethical grounds.
2. Compensation should be structured to acknowledge the time, inconvenience, and discomfort associated with screening, ovarian stimulation, and oocyte retrieval. Compensation should not vary according to the planned use of the oocytes, the number or quality of oocytes retrieved, the number or outcome of prior donation cycles, or the donor's ethnic or other personal characteristics.
3. Total payments to donors in excess of \$5,000 require justification and sums above \$10,000 are not appropriate.
4. To discourage inappropriate decisions to donate oocytes, programs should adopt effective information disclosure and counseling processes. Donors independently recruited by prospective oocyte recipients or agencies should undergo the same disclosure and counseling process as donors recruited by the program.
5. Oocyte-sharing programs should formulate and disclose clear policies on the eligibility criteria for participants and on how oocytes will be allocated, especially if a low number of oocytes or oocytes of varying quality are produced.
6. Treating physicians owe the same duties to oocyte donors as to any other patients. Programs should ensure equitable and fair provision of services to donors.
7. Programs should adopt and disclose policies regarding coverage of an oocyte donor's medical costs should she experience complications from the procedure.

During the last 2 decades, oocyte donation increasingly has been accepted as a method of assisting women without healthy oocytes to have children. In addition to coordinating the voluntary and usually unpaid donation of oocytes from friends and relatives, a number of programs offer financial compensation to oocyte donors. These remunerations take the form of monetary payment to donors or reduced fees to IVF patients who agree to provide oocytes to others. Programs also provide services to couples who have obtained oocyte donors through their own offers of payment or through agencies that recruit oocyte donors. Finally, recent scientific

developments suggest that oocyte donation may become an important process in the field of stem cell research.

The use of financial compensation raises two ethical questions: [1] do recruitment practices incorporating remuneration sufficiently protect the interests of oocyte donors, and [2] does financial compensation devalue human life by treating oocytes as property or commodities?

When oocyte donation first became clinically available, three sources of donor oocytes were envisioned: [1] women undergoing IVF who produced more oocytes than could be reasonably employed for their own use, [2] women undergoing an unrelated surgical procedure who undertook controlled ovarian stimulation (COS) so oocytes could be retrieved during surgery, and [3] women who agreed to undergo COS and oocyte retrieval specifically to provide oocytes to others.

However, the clinical success of embryo cryopreservation led most women in the first group to choose to have all their oocytes fertilized and embryos stored for their own future use. Most women in the second group were unwilling to accept the burdens associated with COS or were excluded from donating for medical reasons. In the face of a growing medical need for donor oocytes, financial compensation of oocyte donors in the first and third groups has become routine.

TYPES OF REMUNERATION

In recognition of the significant time, inconvenience, and discomfort associated with oocyte donation, two types of remuneration are common. One is monetary compensation to women who undergo COS and oocyte retrieval for the sole purpose of providing donor oocytes. Another form of financial compensation involves an arrangement known as oocyte sharing. In this arrangement, a woman may undergo IVF at a reduced cost in exchange for providing some of her oocytes to another patient.

A survey published in 1993 found that approximately 60% of responding programs offered payment to women undergoing oocyte retrieval solely to provide oocytes to others (1). In 2004, 94% of the 411 assisted reproduction programs reporting to the Centers for Disease Control (CDC) stated that they offered oocyte donation services (2).

Received January 17, 2007; revised and accepted January 22, 2007.
Reprint requests: No reprints will be available.

Although there is some variation in compensation arrangements, they have certain features in common. Programs, infertile couples, and independent agencies recruit women for oocyte donation through advertising, often through notices in college or other local newspapers. By early 2005, some IVF programs offered as much as \$8,000 for one retrieval, although smaller sums appeared to be more common. Regional influences seem to account for these differences. Although such payments have generally not been verified, much higher sums—\$50,000 or more—have been offered in print and Internet advertisements placed by couples or entrepreneurs seeking oocytes from women with specific physical, cultural, or other characteristics and intellectual or other abilities.

Few detailed descriptions of US oocyte-sharing programs have been published. It seems that IVF patients in these sharing arrangements generally donate up to half the oocytes retrieved in a single cycle to another patient, in return for a 50%–60% reduction in the total costs of the IVF cycle (3). Oocyte-sharing programs reportedly exist in a number of other countries, including the United Kingdom, Israel, Denmark, Australia, Spain, and Greece (4).

ETHICAL CONCERNS RAISED BY REMUNERATION

Both monetary compensation and oocyte sharing create the possibility of undue inducement and exploitation in the oocyte donation process. Women may agree to provide oocytes in response to financial need. High payments could lead some prospective donors to conceal medical information relevant to their own health or that of their biologic offspring. Patients undergoing IVF who cannot afford the procedure may, because of the intensity of their desire to have children, consent to share oocytes without careful consideration of risks and burdens. With both types of compensation, there is a possibility that women will discount the physical and emotional risks of oocyte donation out of eagerness to address their financial situations or their infertility problems. Financial compensation also could be challenged on grounds that it conflicts with the prevailing belief that gametes should not become products bought and sold in the marketplace.

Concerns Raised by Payment

Women undergoing retrieval purely to provide oocytes to others are exposed to physical and psychologic burdens they would not otherwise face. There is some risk of unintentional pregnancy, because hormonal contraceptives must be discontinued for donation to occur. Donors also are exposed to risks of morbidity and a remote risk of mortality from COS and oocyte retrieval. Although the data are unclear at this time, it is possible that fertility drugs and procedures involved in oocyte donation could increase a woman's future health risks, including the risk of impaired fertility (5). Young women may be prone to dismiss the potential psychologic consequences of donation, particularly those that could arise if they later experience infertility problems themselves. In addition, they may underestimate the psychologic and legal

consequences of their agreement to forgo parental rights and future contact with children born to oocyte recipients.

Another ethical concern is that payment for oocytes implies that they are property or commodities, and thus devalues human life. Many people believe that payment to individuals for reproductive and other tissues is inconsistent with maintaining important values related to respect for human life and dignity. This view is reflected in state and federal laws prohibiting direct payment to individuals providing organs and tissues for transplantation. Yet such laws generally permit organ and tissue donors to receive reimbursement for expenses and other costs associated with the donation procedure. In the analogous circumstance of biomedical research, human subjects exposed to physical and psychologic risks are often reimbursed for expenses. Moreover, they may receive additional payments to compensate for the time and inconvenience associated with study participation. These facts support the compensation of oocyte donors regardless of the ultimate use of the oocytes (e.g., fertility therapy or research).

Compensation based on a reasonable assessment of the time, inconvenience, and discomfort associated with oocyte retrieval can and should be distinguished from payment for the oocytes themselves. Payment based on such an assessment is also consistent with employment and other situations in which individuals are compensated for activities demanding time, stress, physical effort, and risk.

As payments to women providing oocytes increase in amount, the ethical concerns increase as well. The higher the payment, the greater the possibility that women will discount risks. High payments, particularly for women with specific characteristics, also convey the idea that oocytes are commercial property. Moreover, high payments are disturbing because they could be used to promote the birth of persons with traits deemed socially desirable, which is a form of positive eugenics. Such efforts to enhance offspring are morally troubling because they objectify children rather than assign them intrinsic dignity and worth. Finally, high payments could make donor oocytes available only to the very wealthy.

Concerns Raised by Oocyte Sharing

Women participating in oocyte-sharing programs undergo COS and oocyte retrieval for their own benefit and to assist the oocyte recipient. Yet oocyte sharing presents the possibility of added burdens to such women. In some cases, few oocytes may be produced. Donors with few oocytes available for the initial IVF cycle may have their chances of pregnancy reduced. All donors will have fewer oocytes to create embryos for their own possible later use; thus, some may need to undergo additional COS and retrieval procedures.

Donors in oocyte-sharing programs also may be required to undergo the additional medical and psychologic screening required of oocyte donors. They also may experience extra

psychologic burdens. A donor who remains childless may feel added distress based on her knowledge that another couple may become the parents of a child genetically related to her. In a 1997 British survey, 8% of 79 donors who failed to become pregnant reported experiencing such distress (4).

Oocyte sharing also raises concerns related to commodification of human life. Women undergoing IVF with the hope of having their own children receive a financial benefit in exchange for providing oocytes to others. Critics of oocyte sharing argue that it involves “an indirect form of egg—and ultimately child—buying” (6).

Women undergoing IVF who agree to share oocytes accept the added time, inconvenience, and discomfort associated with the enhanced medical and psychologic screening accompanying oocyte donation. It could be argued that the reduction in their IVF costs is payment for these and other added burdens entailed in sharing oocytes, rather than for the oocytes themselves. This characterization is somewhat strained, however. The preferable approach is to acknowledge the potential for commercialization inherent in such arrangements and to consider whether the benefit of expanded access to IVF is sufficient to override this moral concern.

JUSTIFICATIONS FOR PERMITTING REMUNERATION

Although potential harm must be acknowledged and addressed, financial compensation may be defended on ethical grounds. First, providing financial incentives increases the number of oocyte donors, which in turn, allows more infertile persons to have children. Second, the provision of financial or in-kind benefits does not necessarily discourage altruistic motivations; indeed, in surveys of women receiving such benefits, most reported that helping childless persons remained a significant factor in their decisions to donate (4, 7–9). In a recent survey of donors who had been compensated up to \$5,000, 88% of subjects reported that the best thing about the donation experience was “being able to help someone” (8).

Third, financial compensation may be defended on grounds that it advances the ethical goal of fairness to donors. There is no doubt that egg donors bear burdens on behalf of recipients and society, and compensation for bearing those burdens are justified morally. Because the burdens of donation are similar regardless of the ultimate use of the oocytes, compensating egg donors for fertility therapy differently from donors for research cannot be justified. Thus, we disagree with the recommendation of the National Academy of Sciences with respect to compensation for oocyte donation for stem cell research (10).

The failure to provide financial or in-kind benefits to oocyte donors would arguably demean their significant contribution. Such an approach also would treat female gamete donors differently from sperm donors, who typically receive a financial benefit (albeit a modest one) for a much less risky and intrusive procedure. Fourth, the pressures created by

financial incentives do not necessarily exceed and may be less than those experienced by women asked to make altruistic donations to relatives or friends.

Although the physical and psychologic risks entailed in oocyte donation are real, they are not so severe as to justify intervention to limit the decision-making authority of adult women. Programs offering financial incentives should take steps to minimize the possibility of undue influence and exploitation by incorporating certain safeguards into the disclosure and counseling processes. Programs can also structure the provision of incentives in ways that reduce the likelihood that women will be improperly influenced to donate. Such steps would reflect good ethical practice and reduce the likelihood of later legal action by dissatisfied donors.

DISCLOSURE AND COUNSELING

To discourage improper decisions to donate oocytes, programs should adopt effective information disclosure and counseling processes. Regardless of how prospective donors are recruited, programs should ensure that they receive accurate and meaningful information on the potential physical, psychologic, and legal effects of oocyte retrieval and donation. The potential negative health and psychologic consequences should be openly acknowledged. In the case of oocyte sharing, it is important that the unique implications for prognosis and participant burden be addressed in the counseling and informed consent processes. Prospective donors should understand the measures they must take to avoid unwanted pregnancy during a stimulation cycle. They also should understand that they could later develop desires to establish contact with genetically related children, desires that may be difficult or impossible to satisfy because of legal or other barriers.

Donor candidates should be encouraged to explore their possible emotional responses, particularly those that could develop if they have infertility problems themselves. To reduce the incidence of subsequent psychologic problems, it would be prudent to limit donors to those who are 21 or older and have the emotional maturity to make such decisions (11).

To enhance the likelihood that information relevant to donation will be fully explored, programs are encouraged to designate an individual with psychologic training and expertise to counsel prospective donors (12). This individual's primary responsibilities are to ensure that the prospective oocyte donor understands and appreciates the relevant information and feels free to decide against donation if doubts arise at any point before completion of the procedure. The prospective donor's motivation should be explored during the session, with the goal of ascertaining whether she fails to appreciate the full consequences of her donation or is improperly discounting the risks because of her economic status or infertility problems.

Some empiric data show that egg donors may want to know whether children are born as a result of their donations.

Others may have preferences about how their donated eggs are used (13). For example, they may not want eggs to be provided to unmarried persons or unused embryos produced with their eggs to be destroyed. Program staff should discuss with prospective donors the amount of information they will be given about whether a birth occurs and any control they will have over oocyte disposition.

THE INCENTIVE STRUCTURE

Payment

Payments to women providing oocytes should be fair and not so substantial that they become undue inducements that will lead donors to discount risks. Monetary compensation should reflect the time, inconvenience, and physical and emotional demands associated with the oocyte donation process.

A 1993 analysis estimated that oocyte donors spend 56 hours in the medical setting, undergoing interviews, counseling, and medical procedures related to the process. According to this analysis, if men receive \$25 for sperm donation, which this analysis estimated as taking 1 hour, oocyte donors should receive at least \$1,400 for the hours they spend in the donation process (14). In 2000, the average payment to sperm donors was \$60–\$75, which this analysis suggests would justify a payment of \$3,360–\$4,200 to oocyte donors.

The above analysis fails to consider the time spent by sperm donors undergoing interviewing and screening. Even if this additional time is taken into account, however, the lengthier time commitment of women providing oocytes supports substantially higher payments to them than to sperm donors. Moreover, because oocyte donation entails more discomfort, risk, and physical intrusion than sperm donation, sperm donor reimbursement rates are reasonably considered to underestimate the amount that is appropriate for women providing oocytes.

It has been suggested that compensation for oocyte donors should be given for the hours spent on medication and on clinic visits, with the hourly rate based on the mean hourly wage of persons with demographic characteristics similar to those of the donor (15). This method of establishing payment rates presents practical difficulties and arguably would be unfair to women from lower income groups.

Although there is no consensus on the precise payment that oocyte donors should receive, at this time sums of \$5,000 or more require justification and sums above \$10,000 are not appropriate. Programs recruiting oocyte donors and those assisting couples who have recruited their own donors should establish a level of compensation that minimizes the possibility of undue inducement of donors and the suggestion that payment is for the oocytes themselves. A recent survey indicates that these sums are in line with the practice of most SART member clinics (16).

Payment also should reflect the amount of time expended and the burdens of the procedures performed. Thus, a woman

who withdraws for medical or other reasons should be paid a portion of the fee appropriate to the time and effort she contributed. To protect the donor's right to withdraw, oocyte recipients must accept the risk that a donor will change her mind. In no circumstances should payment be conditioned on successful retrieval of oocytes or number of oocytes retrieved. Likewise, donors should never be required to cover the costs of the interrupted cycle. To avoid putting a price on human gametes or selectively valuing particular human traits, compensation should not vary according to the planned use of the oocytes (e.g., research or clinical care), the number or quality of oocytes retrieved (11), the outcome of prior donation cycles, or the donor's ethnic or other personal characteristics.

Oocyte Sharing

Designing a fair oocyte-sharing program requires attention to a number of issues. As noted above, the general approach is to reduce the donor's total IVF costs by about half, in exchange for a donation of half the oocytes retrieved. This appears to be a reasonable allocation of benefits and costs. Because donors are still responsible for the remaining IVF costs, the difference in fees seems not so extreme as to induce women to accept risks they would ordinarily reject. In contrast, a program that charged no IVF fee to oocyte donors would raise serious concerns about undue inducement.

The discussion above illustrates that oocyte sharing involves unique issues of counseling and informed consent. Programs have an obligation to use their best medical judgment to identify good prognosis candidates eligible for oocyte sharing so that any negative impact on the donor's prognosis is minimized and cases resulting in a low number of oocytes of acceptable quality are avoided. At a minimum, oocyte-sharing programs should formulate and disclose clear policies on the eligibility criteria for oocyte-sharing participants and on how oocytes will be allocated, with particular attention to the case in which a low number of oocytes or oocytes of varying quality are produced. Because of the disproportion in knowledge and expertise between egg-sharing programs and potential donors, and because of the medical risks that donors bear, the program should commit to providing some minimal number of oocytes that is clearly compatible with a good prognosis for conception to the donor before additional oocytes are shared. If a donor is accepted into an oocyte-sharing program, the reduction in fees should not be conditioned on retrieval of a particular number of oocytes or quality of oocytes retrieved (11).

ADDITIONAL ETHICAL CONSIDERATIONS

Once the donation process begins, oocyte donors become patients owed the same duties present in the ordinary physician–patient relationship. Programs should ensure that every donor has a physician whose primary responsibility is caring for the donor. Oocyte donor program staff should recognize that physicians providing services to both donors and

recipients could encounter conflicts in promoting the best interests of both parties and should create mechanisms ensuring equitable and fair provision of services.

Programs offering either type of financial incentive should adopt and disclose policies regarding coverage of an oocyte donor's medical costs should she experience health complications from the procedure (11). Ideally, programs should ensure that donors will be covered for any health care costs resulting from the procedure. Programs also should consider whether to make psychologic services available to oocyte donors who experience subsequent distress related to the procedure.

Programs offering financial incentives should ensure that advertisements for donors are accurate and responsible. If financial or other benefits are noted in advertisements, the existence of risks and burdens also should be acknowledged. Donors independently recruited by prospective oocyte recipients or agencies should undergo the same disclosure and counseling processes as donors recruited by the program. If donors have been independently recruited, programs should ascertain whether excessive or improper incentives were offered. Programs should refuse to participate if prospective oocyte recipients or recruiting agencies have offered excessive payment that could compromise the donor's free choice or have engaged in other ethically inappropriate conduct. Programs should adopt procedures and standards for determining when independent recruitment arrangements involve unacceptable payment. Programs should not assume that known donors such as family or friends are not being compensated. In a recent study of recipients using known and anonymous donors, all but one of the known donors had been compensated, and there were no differences in amounts provided to known or anonymous donors (17).

To limit the health risks of donation and to avoid inadvertent consanguinity among offspring, programs should limit the number of times a woman may undergo retrieval procedures purely to provide oocytes to others (11, 18). A good-faith effort should be made to avoid accepting women who have already made a high number of donations elsewhere. Finally, all IVF programs offering oocyte donation should encourage further study of the medical and psychologic effects on donors. Findings from such research could improve evaluation of risks and benefits and allow programs to provide more accurate information to prospective donors.

The members of the ASRM Ethics Committee have the following to disclose:

Paula Amato, M.D., has nothing to disclose.

Frances Batzer, M.D., is a consultant for Endo Pharmaceuticals, and a clinical investigator for Organon.

Andrea Bonnicksen, Ph.D., has nothing to disclose.

Andrea Braverman, Ph.D., has nothing to disclose.

Robert Brzyski, M.D., Ph.D., has nothing to disclose.

Jeffrey Ecker, M.D., has nothing to disclose.

Ruth Farrell, M.D., has nothing to disclose.

Leslie Francis, J.D., Ph.D., owns stock in Schering-Plough.

Mark Gibson, M.D., has nothing to disclose.

Anne Lysterly, M.D., has nothing to disclose.

R. Dale McClure, M.D., has nothing to disclose.

Robert Rebar, M.D., has nothing to disclose.

John Robertson, J.D., has nothing to disclose.

Bonnie Steinbock, Ph.D., has nothing to disclose.

Sean Tipton, M.A., has nothing to disclose.

REFERENCES

1. Mechanick Braverman A. Survey results on the current practice of ovum donation. Ovum Donor Task Force of the Psychological Special Interests Group of the American Fertility Society. *Fertil Steril* 1993;59:1216–20.
2. <http://apps.nccdc.cdc.gov/ART2004/nation04.asp> (Accessed 13 March 2007).
3. Peskin BD, Austin C, Lisbona H, Goldfarb J. Cost analysis of shared oocyte in vitro fertilization. *Obstet Gynecol* 1996;88:428–30.
4. Ahuja KK, Simons EG, Mostyn BJ, Bowen-Simpkins P. An assessment of the motives and morals of egg share donors: policy of “payments” to donors requires a fair review. *Hum Reprod* 1998;13:2671–8.
5. Healy DL. Ovarian cancer, infertility and infertility therapy. In: Kempers RD, Cohen J, Haney AF, Younger JB, eds. *Fertility and reproductive medicine*. New York: Elsevier Science, 1998:1–14.
6. National Advisory Board on Ethics in Reproduction. Report and recommendations on oocyte donation. In: Cohen CB, ed. *New ways of making babies: the case of egg donation*. Bloomington, IN: Indiana University Press, 1996:233–47.
7. Ahuja KK, Mostyn BJ, Simons EG. Egg sharing and egg donation: attitudes of British egg donors and recipients. *Hum Reprod* 1997;12:2845–52.
8. Klock SC, Stout JE, Davidson M. Psychological characteristics and factors related to willingness to donate again among anonymous oocyte donors. *Fertil Steril* 2003;79:1312–6.
9. Svanberg AS, Lampic C, Bergh T, Lundkvist O. Characterization of potential oocyte donors in Sweden. *Hum Reprod* 2003;18:2205–15.
10. National Academy of Sciences. *Guidelines for human embryonic stem cell research*. Washington, DC: National Academies Press, 2005:85–7.
11. American Society for Reproductive Medicine. *Guidelines for oocyte donation*. *Fertil Steril* 2006;86:S43–6.
12. American Society for Reproductive Medicine. Psychological assessment of gamete donors and recipients. *Fertil Steril* 2006;86:S48–9.
13. Kalfoglou AL, Geller G. A follow-up study with oocyte donors exploring their experiences, knowledge, and attitudes about the use of their oocytes and the outcome of the donation. *Fertil Steril* 2000;74:660–7.
14. Seibel MM, Kiessling A. Compensating egg donors: equal pay for equal time? *N Engl J Med* 1993;328:737.
15. McGee G. Subject to payment? *J Am Med Assoc* 1997;278:199–200.
16. Covington S. What is happening to the price of eggs? *Fertil Steril* 2007;87:1001–4.
17. Greenfeld DA, Klock SC. Disclosure decisions among known and anonymous oocyte donation recipients. *Fertil Steril* 2004;81:1565–71.
18. Practice Committee of the American Society for Reproductive Medicine. Repetitive oocyte donation. *Fertil Steril* 2006;86:S216–7.