
Guest editorial

Procuring gametes for research and therapy

Donald Evans *University of Wales, Swansea*

In the United Kingdom the Human Fertilisation and Embryology Authority (HFEA) has statutory responsibility for regulating practice in the areas of assisted procreation and research on human embryos. As such it has an almost unique responsibility in the United Kingdom for ethical review of both clinical research and practice in a given field. It is therefore interesting to ask whether it has a useful role to play in resolving some pressing practical and ethical problems which have arisen in both of these areas, *viz* the lack of supply of gametes (notably oocytes) for both therapeutic and research purposes, the question of the selling and buying of gametes and, finally, the inequality which exists between male and female donors in terms of recompense made for donation of gametes.

Problem 1: The shortage of donated gametes

Let us first consider the question of the shortage of oocytes which reveals itself in the waiting lists of couples needing assisted procreation services due to the inability of the female partner to produce oocytes. As a result of such lists the chances of successful therapy for couples is severely reduced during the prolonged waiting period and some who might have benefited from such services are denied therapy altogether. In addition, less than desirable solutions to the infertility of some couples will be adopted, as in the case sanctioned by the HFEA where the oocyte of a white donor was employed due to the inability of practitioners to procure an oocyte from a black donor (1). Two of the questions posed at the recent discussion meeting convened at St Anne's College, Oxford by the HFEA were: 'How could the levels of donation be improved to meet this shortfall?' and 'Should the HFEA or some other body be responsible for a promotional programme of procurement?' I made a proposal to that meeting which I shall present here in more detail (2).

It is fairly clear from published research (3) that the withdrawal of financial inducement to donors would, at least in the short term, seriously threaten the supply of sperm, the gametes which currently present the least problems in terms of supply. The

investment of the further time and resources necessary to increase substantially the supply of oocytes on a voluntary basis, or in return for infertility services or hysterectomies would be prohibitive as increased effort in these directions would be subject to the law of diminishing returns. As these avenues offer a small return for the investment already made by treatment centres the realistic hopes of marked improvement of supply seem to lie elsewhere. It is fairly clear that a financial inducement to donors, using the male donor programme as a comparator, offers the most likely solution to the problem. This probable gain is noted even by opponents of payments for gametes (4).

But this solution raises the other two problems listed above, *viz* the ethical problems of the differential treatment of male and female donors in terms of financial rewards and the negative responses to the suggestion of the buying and selling of gametes.

Problem 2: The differential treatment of male and female donors

The resort to financial inducements to female donors of gametes would not create a differential between male and female donors out of nothing. In fact such a differential already exists and, as currently practised, it is one which is impossible to justify. On average a male donor is paid, subject to various controls, about £15 per donation. If a clinic takes two donations per week for a five-month period this amounts to costs of inducement of about £600. Female donors are paid nothing for donation, though some of them are offered payments in kind in the form of medical treatments which they need. This differential treatment is especially problematic as the physical and social invasiveness of the techniques necessary to farm female gametes is vastly greater than that experienced by male donors. In addition there is a real measurable physical risk involved in donating oocytes which could have grave repercussions on the health of the donor and her family which has no parallel in sperm donation.

The differential which already exists also demonstrates that gamete donation as currently practised already involves the controversial activity of buying

and selling gametes. Part of the payment made to sperm donors is withheld for a sixth-month period after the last donation, the incubation period of the AIDS virus, to facilitate screening for HIV. Only when the provided sperm is cleared as acceptable for use in assisted procreation therapy is full payment made for the donations. This is tantamount to a payment for the gametes in question for if those provided do not meet the advertised standards of the goods promised by the donor then payment is withheld.

Problem 3: Buying and selling gametes

In some countries, including the United Kingdom, the proposal to buy gametes is met with considerable resistance. Indeed the HFEA had made it clear that it is reluctant to permit payments for gametes. The HFE Act (Section 12(e)) states that 'no money or other benefit shall be given or received in respect of any supply of gametes or embryos unless authorised by Directions'. The authority issued its Direction in 1991, allowing the kinds of payments listed above. It made it clear at the time that this was a compromise designed to minimise disruption to current treatment services and to control any new payment system. However, it then gave notice that its intention was to allow these payments for the supply of gametes for a few years only and that it would then wish to phase them out.

It might be claimed that the Direction asserts that payments are for the supply of gametes and not for the gametes themselves. That is, they are inconvenience payments for the procedures necessary for their supply rather than for the goods supplied. This would constitute a somewhat unnatural reading of the Direction, however, and the way in which the Direction is executed most certainly places another interpretation upon it as shown above. As the authority has permitted the practice described above then it can be fairly concluded that it has condoned, until now, the buying and selling of gametes, though not at any price. Now that the few years are up the question arises as to whether the buying and selling should be allowed to continue. Without raising the ethical question of whether donated gametes should be harvested and used for assisted procreation services at all, an ethical issue already dealt with in the public sphere by the HFE Act in terms of which the authority has to regulate practice, we can still properly ask whether payment for such is ethically justified and whether the HFEA should continue to permit it. It is a difficult question which provokes rival camps to present arguments concerning the nature of persons, slavery (the selling of people), commodification of people (manufacturing people), the body as property and so on, on the one hand, and the freedom of people to make independent choices, the relief of suffering, the greatest happiness of the greatest number and so on on the other hand

(5). If the HFEA awaits the resolution of these arguments before restricting or expanding the practice of payment for gametes then it will wait forever.

What then should the HFEA do, if anything, in the face of this impasse?

The analogy with healthy volunteers

I think that the regulatory authority could do much to address all three problems and that it is ideally placed so to do. It could best address each of them by the adoption of a method of compensation already worked out in some detail in another area of medical activity. I have in mind the recruitment of healthy volunteers in clinical trials. These people offer the use of their bodies and body products (such as numerous blood samples) for the purpose of furthering medical knowledge with a view to benefiting others. They stand to gain no medical benefit from their involvement in the procedures in question, and are expected to take no more than minimal risk. Though there are some important differences between their activity and that of providers of gametes, in that the status of the gamete and its relation to the provider is somewhat more complex, the similarities are striking. The provider of the gametes stands to gain no medical advantage from his or her involvement in the procedure and ultimately the point of the provision is to attempt to provide a benefit to others. Clinical research using healthy volunteers would almost certainly come to an abrupt halt if financial arrangements were not made with the volunteers and important developments in medicine and improvements in the welfare of future patients would be jeopardised. There is clear evidence that a similar fate awaits assisted conception services if adequate financial considerations are not introduced.

Though the recruitment of healthy volunteers and the ethical review of research trials is not controlled by statutory authority a system of self-regulation has developed which is highly commendable. It does not pretend to avoid the offering of financial inducements to candidates for trials. However, it does seek to produce firm controls over those payments so as to protect the subjects from undue pressure to engage in activities which are not in their best interests. For example, payment is not calculated according to risk. Neither does it relate to the success or otherwise of the trial. It is based purely on the inconvenience endured by the subject in the course of the research. The payment is calculated on the basis of a tariff which lays down maximum payments for various procedures and activities. For example, in one such tariff £2 is paid for each venepuncture, £60 for each twenty-four-hour stay in an observation unit, £15 per visit to the unit plus all expenses, and so on. In this way all volunteers are treated equally though they are paid greatly varying sums of money depending on the length of the trial

and its complexity, all of which affects the number of procedures and activities in which the volunteers are engaged. Monies are paid in full at the end of the trials to all subjects who have complied with the conditions of the trial. Those who have been withdrawn are paid for the procedures undergone up to withdrawal and those who voluntarily withdraw at any point are paid *pro rata* at the discretion of the researchers, depending on their reasons for withdrawal. The Association of Clinical Research Contractors endeavours to keep the tariffs of member research organisations roughly in line so that rogue units will not exert improper pressures on certain population groups, such as the unemployed, to engage in something they would rather not do. Thus, though the sum of £600 for a trial will certainly induce an unemployed father to put up with the inconvenience of involvement in a trial, the manner in which the sum is calculated acts as a protection for that man against undue exploitation.

A similar tariff could be devised for the providers of gametes for use in research or in therapeutic services. Payment would be according to numbers of visits made to the unit, numbers of procedures undergone of varying degrees of invasiveness, such as the taking of super-ovulatory drugs, the extraction under anaesthetic of oocytes and so on. The HFEA would be an ideal body to impose such a tariff on all assisted conception units and centres of research. Conformity to the tariff could be made a condition of licensing. The tariff could be made public so that justice would always be seen to be done. The inconvenience allowances need not exceed the scale of those currently offered as payments. How would the adoption of such a scheme meet the problems outlined above?

Problem 1: The shortage of gametes

We have noted that in order to maintain the supply of provider sperm it is generally agreed that the withdrawal of financial considerations would prove to be disastrous. Given that the total sums of money involved would remain much the same as at present the tariff system would not constitute a threat to the service but it would remove the appearance of making payments for sperm. I shall say more about this in the next section.

With respect to the supply of oocytes the present system of recompense to current providers would be greatly improved. Instead of offering medical services of which the provider stands in need allowances would be offered for procedures and activities undergone in the provision of gametes which would doubtless amount to sums with which the provider could, if she wished, purchase such medical services given that the character of the procedures in which she must engage are so intrusive both physically and socially. This would avoid the appearance of blackmail which the offer of much

needed medical services in lieu of donation of oocytes unfortunately provokes. In addition it would offer precisely the same incentive to large numbers of women who do not stand in need of such services but who would, for this kind of consideration, be prepared to put up with the inconvenience involved. The same degree of counselling would apply as at present, enabling a responsible decision on the part of the provider. It would not be unacceptably coercive, for payments would always be capped by the maxima laid down by the HFEA. It would be surprising if, given the much wider field of women for whom such payments would constitute a considerable benefit, such a system did not markedly improve the rates of provision of oocytes.

Problem 2: The differential treatment of male and female providers

Given the invasiveness and complexity of the procurement of oocytes and the limits imposed on the number of offspring produced from one provider's gametes it is inevitable that female donors will receive financial allowances in excess of those received by male providers. This differential is not unjust in any sense, however, as it is based on a tariff system where payments for like inconveniences are recompensed at the same rate as between male and female providers.

The tariff system does remove the present injustice of denial of financial recompense to oocyte providers whilst it is a standard provision for male providers. Such a revision of practice may render much of the burgeoning discussion of gender differences in respect to attitudes to assisted reproduction less important in relation to gamete procurement than they are currently thought to be (6). The tariff scheme makes room for those seeking no financial return and those desirous of a modest financial return to engage in the important activity of gamete provision whatever their gender. Such gender differentiations become unimportant from the point of view of establishing motives for provision. Indeed, these would not really be the business of the clinicians or recipients involved in assisted procreation services, even if it was possible to divine them accurately, which it rarely is.

Problem 3: The problem of buying and selling gametes

In some countries there is no such regulation of the procurement of gametes and private advertisements for oocytes often appear in public newspapers. For example, *The Times* recently reported (7) that the following advert appeared in the Yale and Columbia University student newspapers:

'Donor sought: empathetic, intelligent, healthy, attractive (preferably dark-haired Jewish) woman 21-28.'

for which a payment of \$2,000 and a free physical examination was offered.

The Direction of the HFEA already makes this kind of activity difficult though not impossible in that no one can offer infertility services without a licence from it as the regulating authority. It has been argued that exchange of money for gametes compromises the altruistic character of donation and that by definition donors cannot receive money (4). This is little more than a semantic problem. If the sources of gametes were called **providers** then the group could include donors and others. That money changes hands for the provision does not necessarily impugn the morality of the provision. No one can be expected to be generous, though generosity is a quality we admire when we find it in people. Consequently, we might admire someone, who for no financial consideration, provides oocytes for use in assisted conception services for others, more than we would someone who makes such provision for a financial consideration. This does not, however, rule out the possibility of our admiring the latter provider, for altruism may vary in degree and a person's motives may well be mixed. Indeed this is usually the case, as saints are few and far between. It hardly seems to be the business of the regulatory authority to become an inspector of people's motives and a protector of their saintliness. In any case, even where there was no particular concern to ease the suffering of others and the provision was made purely for the financial consideration we may not admire the act but we need not condemn it simply because it has that character. After all, people constantly do things for financial considerations when their heart is not in those activities. They are not seeking admiration but neither are they thus deserving of condemnation. So long as such people are protected against harms and injustice it is surely a matter for them to decide whether they engage in work of various kinds or whether they provide gametes or not.

Such protection against harms and injustices would be built in to the tariff system outlined above. Further, the system would not rule out the possibility of the donation of gametes in that the tariff payments would not have to be accepted by the provider. What the tariff system clearly removes is the activity of buying and selling gametes as the possibility does not even arise given that providers would be paid not for the gametes produced but for the inconvenience suffered in their provision. This can be best illustrated by contrasting the scheme with the current method of paying sperm donors. In that scheme a proportion of their payment is withheld until such time as the provided sperm is cleared for use in therapy. I have argued above that this makes the payment a payment for the gametes. On the tariff system the payment would be made in full for the inconveniences endured in the provision and not for the provided gametes. This would have

the effect of increasing slightly the cost of procuring useful male gametes from male providers but maybe these increases could be cut by more careful screening of providers at the recruitment stage.

In the case of female providers the position would be similar. For example, a woman who undergoes the drug regime, who complies with all the observation requirements, who is anaesthetised, who undergoes invasive procedures to extract follicles and so on will be paid for each of those procedures and not for the number of follicles extracted. Indeed at each stage of the process she will be due the inconvenience allowances earned to that point whether or not she is able to go on successfully to provide useful gametes. Thus she will in no sense be selling oocytes to the clinic.

Conclusion

Thus whilst it may not be agreed that it is the business of a regulatory authority to take responsibility for promoting the activity it regulates, the HFEA could do both providers of gametes and the assisted procreation services a favour by means of a fresh directive regarding payments to providers. It could at one and the same time resolve the injustices that exist in the differential treatment of male and female providers, protect providers against harms and injustices arising from undue pressure to provide and encourage a considerable increase in the numbers of female providers by the one measure of adopting a tariff-type payment system such as has been well tried in facilitating clinical research and protecting health volunteers who are the subjects of the research.

Donald Evans, BA, PhD, is Director of the Centre for Philosophy and Health Care, University of Wales Swansea.

References and notes

- (1) Fletcher D, Muir H. Doctors defend mixed-race baby for black woman. *The Independent* 1994 Jan 2: 3.
- (2) Human Fertilisation and Embryology Authority Conference on payment for donors. St Anne's College Oxford, 1995 Jun 1.
- (3) See, for example, Cook R, Golombok S. A survey of semen donation: phase II – the view of donors. *Human reproduction* 1995; 10, 4.
- (4) See Shenfield F, Steele S J. Why gamete donors should not be paid. *Human reproduction* 1995; 10, 2: 253.
- (5) See, for example, Harris J. *Wonderwoman and superman* ch 6 and reference (4): 253.
- (6) See, for example, reference (3): Haines E. Issues of gender in gamete donation. *Social science and medicine* 1993; 36, 1: 85–93; and Schover L R, Rothmann S A, Collins R L. The personality and motivation of semen donors: a comparison with oocyte donors. *Human reproduction* 1992; 7: 575–579.
- (7) Bone J. Ivy League women targeted for eggs. *The Times* 1995 Feb 8.