From Altruism to Monetisation: Australian women’s ideas about money, ethics and research eggs


Abstract

We report the results of a qualitative study carried out in metropolitan Australia between 2009 and 2011 that canvassed the issue of payment for research oocyte donation with participants drawn from three potential donor groups; fertility patients, reproductive donors and young, non-patient women. Research oocytes are controversial tissues because women around the world have proved largely unwilling to donate them altruistically. In the ensuing international debate about procurement, the issue of money and its appropriate and inappropriate uses in tissue donation has taken centre stage. While there is now an abundance of expert commentary on this matter, there are almost no studies that probe this issue with potential donor populations. Our study asked the three groups of women about their understandings of altruistic, reimbursed, subsidised, compensated and paid donation for both reproductive and research eggs. We identify a resistance to the introduction of money into the sphere of reproductive donation, which the majority of respondents felt should remain an area of personalised gift relations. In the area of research donation we find a strong relationship between degrees of liquidity (the extent to which money is constrained or unconstrained) and a sense of ethical appropriateness. We also describe a culturally specific sense of fairness and equity among participants, associated with the relatively high public subsidisation of fertility treatment in Australia, which they used to benchmark their sense of appropriate and inappropriate uses of money. While the participant responses reflect the regulatory environment in Australia, particularly the absence of a US style market in reproductive oocytes, they also make an important contribution to the global debate.

Keywords: Australia, tissue donation, research oocytes, money, ethics, fertility medicine, liquidity

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Highlights
This study provides insight into the feelings of potential research egg donors.
It draws on the sociological study of money to analyse donor ethics.
It shows that lay ethical reasoning is shaped by ideas of distributive justice.
It explores the ways potential donors understand commodification of human tissues.
It contributes to the feminist analysis of ‘exploitation’ in research egg donation.

Introduction
Since the mid-twentieth century in the advanced industrial nations, two methods have been used to procure human tissues for research. The first is altruistic donation through formal consent. The second is the harvesting of so-called ‘abandoned’ or ‘waste’ tissue, left behind in the clinic after surgical procedures, diagnostic tests or biopsy, in which the patient is assumed to lack interest. While regulatory reform and increasing concern over patient’s rights have made the category of abandoned tissue more residual, for the most part the principle of altruistic donation for public benefit remains intact, despite assorted controversies over the patenting or commercialisation of human tissues after donation (Waldby and Mitchell 2006).

In this paper we will examine a kind of research tissue that has proved inaccessible to these two procurement systems: human oöcytes. Since the development of mammalian cloning and human embryonic stem cell lines in the late 1990s, human oöcytes have become objects of intense scientific interest. Oöcytes are essential elements in a type of stem cell research termed somatic cell nuclear transfer (SCNT), which, in theory at least, could be used to produce patient specific tissues suitable for transplant. In SCNT, a nucleus from a patient’s body cell, such as a skin cell, is introduced into an unfertilized oöcyte from which the original genetic material has been removed. The oöcyte is then used to produce a blastocyst (an early embryo) whose stem cells could be used to create tissue that would be compatible with that of the patient. Human SCNT research remains highly experimental. The first human embryos were generated through somatic cell nuclear transfer in 2013 (Tachibana, Amato et al. 2013) and considerable research will be required before clinical applications are feasible. This research requires large numbers of fresh, unfertilised oöcytes, as techniques are developed and refined. However, clinics that have attempted to secure strictly altruistic donation report either complete failure or very small numbers (Baylis and McLeod 2007).

The reasons for this are complex, but the succinct explanation is that oöcytes do not readily constitute a surplus tissue for women. Historically the system of altruistic donation, such as blood donation, depends on the donor being able to readily part with the material, in both a biological and a social sense. They are both healthy enough to do without the tissue, and the method of donation itself is tolerably simple and without significant risk. In practice the determination of what counts as a surplus is often very involved, and intimately tied into broader social systems of equity and inequity (Waldby and Mitchell 2006). Surpluses can be elicited as an effect of power relationships, particularly those associated with poverty. Hence we see the phenomenon of live kidney vending, where the precarity of the seller forces them into exchange for money, to the detriment of their health (Cohen 2001).

Even in more equitable circumstances, the determination of a tissue surplus is not necessarily transparent. For example, recent research into the ways couples in fertility treatment designated their embryos as available for research donation, found that it depended on a
multitude of factors including; the clinic freezing policies, its facilities for blastocyst culturing, grading procedures, and the woman’s age and risk for pregnancy complications (Scott, Williams et al. 2012). Nevertheless, this formulation has largely been successful in securing altruistic donations of embryos to stem cell research (Parry 2006).

However, the biological and social qualities of oöcytes do not readily lend themselves to altruistic donation. Both IVF embryos and oöcytes are onerous to produce, involving several weeks of hormonal treatment, clinic visits and surgical collection. Nevertheless, oöcytes occupy a more critical position in the IVF trajectory. Their numbers and degree of fertility set the initial conditions for any chance at subsequent success in the creation of a child, and fertility patients express a strong preference to retain and fertilise them all, rather than divert them to research. Moreover, while a proportion of embryos are routinely frozen during a treatment cycle, and can be donated after treatment is completed, oöcytes are used fresh and all at once. Hence, they do not lend themselves readily to deliberation, because they are not preserved over time (Waldby and Carroll 2012).

A small number of empirical studies investigate altruistic oöcyte donation, mostly for reproductive proposes, and they confirm both a low willingness to donate and something of a preference for reproductive over research donation. So, Byrd and colleagues surveyed 113 reproductive egg donors in the UK, and found that their overwhelming motivation to donate was a desire to help childless couples, with litter interest in research donation (Byrd, Sidebotham et al. 2002). Murray and Golombok in their UK study found that three-quarters of potential reproductive oöcyte donors in IVF clinics changed their mind about donating after receiving information about the procedures (Murray and Golombok 2000). An Australian survey of 2269 IVF patients found that only two percent had donated oöcytes for research. The most common reason for not donating (48%) was a reduction in the number of eggs available for the respondents themselves to conceive (Access Australia 2008). So we can see that women already in fertility treatment have proved unwilling to designate oöcytes as surplus tissues and divert them from their own reproductive path.

**Money and Ethics Debates**

In short, the gift relation (Titmuss 1997 [1970]), which underpins the statutory regulation of tissue transfer in West European, Canadian, Australian and many other jurisdictions, has failed spectacularly in the case of research oöcytes. This failure has thrown open the assumptions underpinning such regulation to unprecedented revision and debate. In particular, debate centres on the role of money in the regulation of supply. It is this feature of the debates which are perhaps most compelling for sociological and bioethical analysts, precisely because of the complex status of money in the history of post-war research ethics. Since the adoption of the Nuremberg Code, money has been allocated a highly circumscribed place among the standardised elements of bioethical reason. In the 1960’s in particular, both sociologists and moral philosophers, most notably Titmuss (1997 [1970], and Hans Jonas (1969) argued forcefully that citizens should participate altruistically in research because they had a moral obligation to contribute to the public good. The approach to compensation was subsequently liberalised by Institutional Review Boards in the USA during the 1970s, partly to increase the number of participants for clinical trials and partly in response to the construction of this issue as simply a matter of informed consent (Lemmens and Elliot 2001). However, compensation again became a matter of debate after 1980 following the death of Bernadette Gilchrist. Gilchrist was a National Institutes of Health nurse who was found to have concealed her history of bulimia from trial clinicians in order to receive payment made to trial participants (Kolata 1980). Since then,
money has been central to debates about ‘undue inducement’, and posed as a potential threat to the principles of autonomy, justice and consent (Emanuel 2004; Halpern, Karlawish et al. 2004).

It is notable that Georg Simmel, in his magisterial analysis The Philosophy of Money, also recognises this coercive and singular power. In his account, money facilitates exchange, changes in ownership and the transfer of a surplus from one party to another. It does this precisely in its role as incentive, forcing the less willing party into trade once the price point is sufficiently high. Money disentangles objects from their owners by providing equivalence, while also facilitating impersonal circulation (Callon 1998). As Simmel (1990, 1900: 293) puts it, ‘exchange itself is embodied in money’. Buyers and sellers strike price, complete their transaction and are quits. It is for this reason that money transactions are posed as the opposite of the gift relation, substituting an antagonistic commodity market for the ethically and socially preferable gift for the public good (Titmuss 1997 [1970]; Waldby and Mitchell 2006). Money transactions around tissues are further constrained by various Tissue Acts and Directives. For example, EU member states are signatories to the Oviedo Convention and the EU Tissue and Cells Directive, as well as various national statutes that prohibit the exchange of body parts for money (Council of Europe 1997).

Hence, money may only be admitted into bioethical regulation in certain constrained forms that are understood to avoid the exercise of undue inducement and the formation of markets associated with frank monetisation. We refer here to the operation of money as pure liquidity, infinitely and instantly substitutable for other objects and infinitely mobile; the unconstrained conversion of assets into cash for example, or the striking of price purely as an effect of supply and demand, rather than the storing of value in more embedded forms. Liquidity is an expression of money’s rapidity of flow, exchange and circulation (Bryan and Rafferty 2013). Instead of this free, anonymous circulation of monetary value, money may be used in bioethical practice as reimbursement, the recovery of direct costs incurred in the act of donation (for example, travel costs) and the somewhat more vexed compensation. As a bioethical principle, compensation is intended to recognise less tangible costs to research participants, elements like inconvenience and risk, and to return the participant to a position of social and economic equilibrium through equivalent payment or in-kind services.

In the case of research oöcyte procurement, however, the role of money, as compensation, as subsidy and as frank payment, has been opened up to unprecedented scrutiny and debate. This is in part due to the existence since the 1980s of a transactional market for oöcytes in some states in the USA and more recently in transitional economies like Russia and the Ukraine (Almeling 2011), so that debates about research are necessarily shaped by the existence of such markets. It is also due to the 2005 Hwang scandal, in which Professor Hwang was revealed to have purchased large numbers of research oöcytes from commercial reproductive brokers in his failed attempts to create the world’s first human SCNT cell lines (Leem and Park 2008; Baylis 2009). This context has led some prominent ethicists, particularly feminist ethicists, to argued that no payment in any form should be permitted for research oöcytes, because the risks are too great, the research is too experimental, and any form of payment (including compensation) would lead some women to overlook such risks (Dickenson and Idiacez 2008; George 2008).

Other bioethical commentators have argued that women who provide oöcytes for research should be considered as human research subjects, rather than donors. They argue that non-patient donors should be recruited and compensated for risk endured and time invested in the
same way that healthy subjects are recruited for phase one clinical trials to test new drug toxicity (Thompson 2007; Ballantyne and de Lacey 2008). However, Baylis and McLeod, in their critique of this approach, argue that there is no equitable way to avoid undue inducement, because the same rate of compensation has differential effects when considered by poor women or more wealthy women. (Baylis and McLeod 2007). Indeed the incentive effect of even comparatively modest compensation rates has been demonstrated in field studies of reproductive oöcyte donation, among young unemployed or relatively impoverished women in Romania (Nahman 2012), Spain and the Czech Republic (Bergman 2011). To put it another way, in a global economy, the boundary between compensation and monetization is difficult to stabilize.

Money and Regulation

While these ethical debates continue, different jurisdictions have adopted widely varied regulatory options. Many national policies simply do not permit SCNT research. In the United States, New York has defied US National Academies of Science guidelines to mandate a $10,000 fee for research oöcytes, funded from the state’s public research budget. This approach makes New York the first state in the world to ‘affirmatively allow’ payment, rather than compensation, for research oöcytes (Foohey 2010). In Britain the Medical Research Council has funded an egg sharing pilot program in Newcastle-on-Tyne, which gives women a £1,500 rebate on their IVF fees, in exchange for providing a proportion of their oöcytes to research (Roberts and Throsby 2008). This subsidization model introduces another constrained form of money into the policy mix.

In short, there is little consensus about the best way to ethically procure oöcytes for stem cell research, and what role, if any, money should play in this process. The logistic and ethical difficulties of procurement has seen SCNT research go into something of a decline, and a recent study has identified only a handful of laboratories, mostly in the United States, that continue the work (Braun and Schultz 2012). Nevertheless, the unprecedented centrality of money in the related debates throws an informative light on tensions in tissue donation more generally. While there is an extensive social science literature on the broad theme of bodily commodification and tissue exchange, particularly studies which consider the history and ethics of gift and commodity systems and the ever shifting, unstable distinction between them (Titmuss 1997 [1970]; Healy 2006; Sharp 2006; Waldby and Mitchell 2006), the area of oöcyte donation facilitates a more specific investigation of the ways that different money forms, with different degrees of liquidity and constraint, are understood as ethical categories. Hence, it gives nuance to the literatures on medical commodification and ethics, opening up the black box of commodification to more specific kinds of critique.

At the same time, while there is an abundance of expert commentary around these concerns, the ideas of those women who form the donor populations for research oöcytes has been poorly represented. In what follows, we report the results of a qualitative study that canvassed the issue of payment for research donation with participants drawn from three potential donor groups; fertility patients, reproductive donors and young, non-patient women.

Oöcyte donation for research in Australia

Australia has adopted comparatively permissive legislation around SCNT, while also retaining a conservative approach to the regulation of research donation. Under Section 21 of the
Prohibition of Human Cloning and the Regulation of Human Embryo Research Amendment Act 2006, the exchange of oöcytes for money is illegal and punishable by imprisonment, but ‘donors may be compensated for any reasonable expenses incurred relating to collection, storage or transport of donated oöcytes or sperm’. Such expenses may include those associated with attending appointments, including the cost of time off work, childcare, and transport. In relation to research donation, currently two laboratories, Sydney IVF and Fertility Australia holds SCNT licences (NHMRC Embryo Research Licensing Committee 2011). Other IVF clinics are yet to embark on research procurement.

Methods

The Human Research Ethics Committee of the University of Sydney granted ethical approval for this research. Three participant cohorts provided the empirical data for this research: twenty women who were ex-IVF patients, five women who had previously donated oöcytes to other women for the reproductive purposes, and eighteen non-patient women aged between 18 and 30, including women with a family member or friend with a medical condition potentially treatable with stem cell therapies. Our aim in canvassing these three groups was to engage with those who have been identified as potential donors in various policy models, where IVF patients are usually associated with altruistic donation or egg-sharing approaches, reproductive donors with altruistic donation and young, non-patient women with the compensated research subject model. We also wished to identify the ideas of women at different points in their experience of fertility. The first two groups had direct experience of super-ovulation and egg harvesting, while the third group was provided with detailed information about these procedures.

Ex-IVF patients and reproductive oöcyte donors were recruited through the patient database of our research partner organization, a Metropolitan fertility clinic. The clinic is not currently involved in stem cell research or the procurement of eggs for research. Before providing the patient details to the researcher, clinic staff screened the database to exclude women who had a traumatic experience of IVF treatment (11 women). They also screened for women who would require a translator (32 women) and for women living in rural Australia (46 women), as no funding was available to facilitate face-to-face interviews with these groups. Hence, specific experiences of non-English speaking and non-metropolitan women are not represented in our sample. We recruited in two rounds, the first among patients and donors who had treatment between January 2008 until mid-2009, and the second among patients and donors who had treatment from mid-2009 until February 2010. These dates were chosen to ensure that, first, the IVF experience was no more than two years old and second, interviewees were not actively engaged in treatment during interviewing. The first round of recruitment identified 193 potential participants, while the second round of recruitment identified a further 100. A “consent for contact” letter was then sent to approximately 300 women inviting them to participate in the study. The response rate of twenty-five women who proceeded to interview is consistent with other qualitative studies with IVF patients (Haimes and Taylor 2009).

The young non-patient women were recruited through advertisements placed on campuses noticeboard and in student publications of two large universities in the Sydney region, inviting both staff and students to participate in a two-hour discussion. In the end, recruitment only proceeded at one campus. The following table sets out the demographic information gathered about the respective cohorts.
Table 1. Demographic data interviewees

<table>
<thead>
<tr>
<th></th>
<th>IVF patients (n = 20)</th>
<th>Reproductive egg donors (n = 5)</th>
<th>Young women (n = 18)</th>
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</thead>
<tbody>
<tr>
<td>Age (years)</td>
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<tr>
<td>26–30</td>
<td>3</td>
<td>1</td>
<td>9</td>
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<td>31–35</td>
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<td>36–40</td>
<td>7</td>
<td>1</td>
<td>3</td>
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<tr>
<td>41–45</td>
<td>3</td>
<td>0</td>
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<tr>
<td>46–50</td>
<td>1</td>
<td>0</td>
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<tr>
<td>Highest educational qualification</td>
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<tr>
<td>Postgraduate degree or diploma</td>
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<td>2</td>
<td>3</td>
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<tr>
<td>Bachelor degree</td>
<td>4</td>
<td>1</td>
<td>8</td>
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<tr>
<td>Advanced diploma, diploma or certificate</td>
<td>8</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Secondary Education</td>
<td>3</td>
<td>1</td>
<td>6</td>
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<tr>
<td>Number of children</td>
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<tr>
<td>0</td>
<td>8</td>
<td>3</td>
<td>18</td>
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<td>1</td>
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<td>1 + currently pregnant</td>
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<tr>
<td>2</td>
<td>2</td>
<td>1</td>
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<tr>
<td>2 + currently pregnant</td>
<td>2</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Participants who have Family Member/s with Medical Condition/s Potentially Treatable by Stem Cell Therapies</td>
<td>N/A</td>
<td>N/A</td>
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</table>

The majority of participants (65%, n=28) were under the age of 35 years of age, arguably still in peak years of fertility. However within the cohorts there is significant variation in age, with the majority of IVF patients being in the 30s (65%, n=13,) and the young women in their 20s (50%n=9). 67% (n=29) of the women did not have children at the time of research participation. 53% (n=23) of participants had a Bachelor degree or higher, with the most highly educated cohorts being the Egg Donors and Young Women with 60% and 61%, respectively, holding a bachelor or higher degree. Hence we can say that the cohorts were considerably better educated than the Australian average of 27% of women with a University Degree (Australian Bureau of Statistics 2012), and while we did not collect information about ethnicity, we can say that our participants spoke fluent English.

We used in-depth interviews in relation to the ex-patient and reproductive donor groups, and focus groups in relation to the young, non-patient women. Interviews were used for the first two groups because they had extensive personal experience of fertility treatment and oocyte extraction. We anticipated that more time for these cohorts would be needed in order to draw out the implications of their experience. The majority of interviews were conducted in the homes of participants, and lasted between 60 and 90 minutes. All interviews were audio-
recorded. Interviews were semi-structured, with open-ended questions (Kvake 1996: 129). We used focus groups for the young women because this is an appropriate technique when participants are not well informed about the field. They allow the facilitator to provide an overview and generate understandings and reasoning through group interaction (Rice and Ezzy 2001). The focus group data was hence somewhat more dialogical and speculative than the interview data, however as we describe below, each of the three groups were presented with very similar regulatory scenarios regarding money, so that the content of their responses can be compared. Focus groups were conducted on University premises, and participants were reimbursed $25 for their time. One focus group had eight participants, the second six and the third, four participants. In each case, the focus groups were provided with information about the logistics of oöcute provision and stem cell research. Focus groups were audio-recorded.

The idea of money exchange in relation to research oöcute donation was an explicit part of the interview and focus group schedules. The women were told about the UK egg-sharing scheme, the US market in reproductive and research oöcytes and the Australian reimbursement model and asked their attitudes to each model. They were also asked if they thought Australian egg donors should be paid, and if payment was appropriate for either reproductive or research donation, and for either public or commercial research. We drew on these various scenarios in order to generate a full range of responses to the different policy settings used around the world and to the various professional bioethical debates. We were interested to encourage a participant contribution to these global debates, even when the policies themselves were unlikely to be introduced into the Australian setting. All interview and focus group data were transcribed verbatim by a professional transcriber and checked by the researchers. Data analysis followed thematic coding (Boyatzis 1998) using NVivo software. All names used in this paper are pseudonyms.

**The Value of Oöcytes**

Issues of money in relation to oöcute donation need to be located in a broader framework regarding the ways women value their eggs. As we will see, this valuation is contextual, and depends on the kinds of significance that oöcytes have for the participants, their capacities, their meaning for the self and for possible recipients, and the different systems available to transfer them from one party to another. In turn, these different significations condition the extent to which the women regarded their oöcytes as having exchange value, a degree of substitutability quantifiable in money terms. This sense of value is also shaped by broader understandings of social equity, the national health and distributive fairness, articulated most clearly in the discussions of UK egg-sharing programs and the commercialisation of stem cell research. In the following discussion, we organise the responses according to a spectrum of exchange value, moving from the most embedded and least liquid intimate gift exchange to the most liquid and monetised forms of frank payment. We discuss the various cohorts’ responses within these categories.

**Altruistic Gift Systems**

The IVF patient group placed the highest value on their oöcytes, in the sense that most stated that they would not donate for any reason during a treatment cycle. They expressed an acute sense of the difficulties in obtaining fertile oöcytes during the treatment process, and of the way the odds of success rapidly dwindled at each stage. This account is typical of this group’s experience.
The first [treatment] cycle, it was something like twelve eggs, nine fertilised, five divided .... one fresh, four in the freezer, all four successfully thawed and transferred... Then the second [cycle] one was something like nine [eggs] out, six fertilised, and four grew to blastocyst stage. One in – miscarriage; one in – miscarriage; two in the freezer.

(Caroline, ex-IVF patient)

For this group of women the value of oöcytes is primarily instrumental, a means to a reproductive end and a way to fulfil their longed-for identity as mothers. Their value is also beyond price, in the sense that oöcytes are not commensurable with any other object. They have the singular capacity to produce the woman’s genetic child, and hence cannot be substituted for anything else or diverted to other uses. To put it another way, for this group, oöcytes are completely beyond calculations of exchange value, and hence without money equivalence (Appadurai 1986).

Eight of the twenty did introduce a specific qualification into their refusal to part with their oöcytes. They stated that they would donate to a family member or close friend if the circumstances were ‘desperate’.

“If it was...a loved one that desperately wanted a child, then yes. Other than that, I would struggle to do that again.” (Francesca, ex-IVF patient).

They were prepared, in other words, to give oöcytes as part of a personal relationship, and in response to a need expressed as intensely as their own desire for a child. The value of the relationship was such that even precious eggs could be sacrificed to the other woman’s need.

The reproductive donors and the young non-patient women did not demonstrate such an acute sense of the preciousness of their eggs. Both groups were prepared to assist another woman in her bid to realise her reproductive identity under certain circumstances. The reproductive donors had an abstract commitment to assist in this way, in the sense that in most cases they did not know their recipient beforehand, but responded to an advertisement seeking a donor. They expressed a general sympathy for women suffering infertility, and considerable enthusiasm about ‘giving’ a child to another couple.

I remember just feeling very intensely that if I could help them, I would like to, because it’s something that she wanted so much. ... I just thought [to] myself how awful it would be, having had two children, to feel that I couldn’t have fulfilled being a parent. (Gillian, reproductive donor)

The young women did not share this open-ended preparedness, but placed conditions upon donation that were quite similar to the fertility patients. The recurring scenario was for reproductive donation to a close friend or family member, someone the woman knew. Frances draws an analogy between live kidney donation and reproductive oöcyte donation. Oöctye donation, she states, involves responsibility for the quality of the life that you help bring into being, and so the donor has a duty to vet the intending parents.

Just to help someone else...if it was somebody asking for one of my kidneys when I was still alive, I’d have to actually know them, I think, because the whole surgery that would be involved for someone I didn’t know – I’m not sure I could do that, and that’s kind of
the same for IVF egg donation. I think I’d actually have to know the person that it was for. ...It’s partly because of the procedure involved, and also because if it’s for something that’s going to end up as a child, as a person, then I think if it’s my genetic material, it should go to someone I trust to bring it up properly. ... But for scientific research, I wouldn’t have the same qualms about it. (Frances, young non-patient woman)

Frances makes a significant distinction between reproductive donation to a loved one and research donation, which is less loaded with issues of obligation and comparatively impersonal. We note that her reasoning resembles that of some sperm donors, who in a similar scenario-based study expressed considerably more willingness to donate altruistically to research than to reproduction, and a concern about the fate of a child conceived from half of their genetic material (Emond and Scheib 1998). Grace in our study makes a similar distinction. She does not need to be concerned about the fate of her tissue if it is given to science, because it will not become a child ‘with half my DNA’.

If it’s for science, it’s for science, you know? It’s so not important that it’s my DNA. But if somebody is raising a child with half my DNA ... I’d probably want to know they’re going [to a good home]. Not necessarily be involved in their life or anything. . (Grace, young non-patient woman).

For the participants, reproductive oöcytes are invested with the powers of kinship, the capacity to create children and a reproductive identity for oneself or others. With the exception of the reproductive donors, this capacity was only transferable between intimates, either family or close friends. These intimate forms of oöcyte circulation did not involve money, but rather were a form of highly personalised, affective exchange. The exception to this was the reproductive donors, who were in a less personal relation with the recipients. It is notable that two of the five donors indicated that they would have welcomed some form of material recognition, including the reimbursement of travel, time off work and medical costs.

Exchange Value – Time and Wages

The less personal and enduring the relationship between donor and recipients, the more likely some form of money came into acceptable play. Once oöcytes are detached from their primary value, which is as a source of potential children for the donor or her intimates, they begin to acquire exchange value, in the sense that they become calculable in other terms. This was particularly marked in relation to research donation. The participants repeatedly described oöcyte donation as difficult because of the time-consuming nature of the procedures. In particular, the extended duration of donation displaced other possible uses of the donor’s time.

If circumstances were different, I would look at it [donate oöcytes] differently. And not working sort of thing! (laughs) You know, it’s such a difficult thing to manage. For eight weeks, you have to be regimented that at twelve-hourly intervals you’re doing a medication thing. And it extremely affects your mood: you can’t work and manage the drugs and manage a family life. (Nadia, ex-IVF patient)

Nadia and many other participants from all of the cohorts pointed out that the time demands of oöcyte donation displace other forms of productive time, particular the time necessary to earn an income. Hence, the time involved in producing oöcytes takes on an implied equivalence with
work, that is, with paid time. Respondents repeatedly argued that compensation should be calculated according to this equivalence.

I think compensation should be given according to the amount of time that’s involved, [which]…. would be two to three weeks. …I think it would probably make people more prepared to do it, if they don’t have to combine it with the stresses of work… if it takes someone two weeks to go through an IVF process, or sixteen days or whatever, that they be given that time off work on full pay. (Philippa, ex-IVF patient)

Two of the five reproductive donors considered that they should receive compensation equivalent to productive time lost to the donation process. Faith reports that her partner considers she should have been paid ‘a hundred dollars an egg’, while she herself thought she should be paid for working days lost.

There were two days there – the Friday in which I had to go in for – because I only work Mondays and Friday – the Friday I had to go in to the ultrasound, and the Monday they did the egg collection. That was about $240 from my salary. … I would expect to have been paid for my days off. (Faith, reproductive donor)

Most respondents were unable to name a specific amount that would constitute fair compensation. Suggestions ranged from ‘a few hundred dollars’ to ‘a few thousand’. However, when asked to respond to the UK compensation rate (at the time of interview) of £250 for research donation, most of the patient group considered that it was too low.

£250 [is] not enough – knowing what it’s about, and what you go through, I don’t think five hundred dollars is worth the pain you go through at egg pick-up! Knowing that you’re not going to get a child through it – just for the good of the human race! This is personally. Some other people would probably do it for nothing. (Isabel, ex-IVF patient)

The most commonly mentioned amount was $1000, although suggestions ranged as high as $2500. Respondents suggested that around $1000 was commensurate with the time taken. In one participants words,

Someone in their early twenties would be quite happy to earn a thousand dollars for two weeks’ work. It is two weeks’ work to them. (Sarah, ex-IVF patient)

**Egg-Sharing Models**

The ‘Newcastle egg sharing for research scheme’ (NESR) described earlier, provides another form of exchange value for research oöcytes; the subsidisation of fertility treatment in exchange for donation of a proportion of the patient’s oöcytes. While the subsidy is set at a precise monetary value (£1,500), it nevertheless constitutes a constrained form of money in that no funds are given to the patient directly and there is no possibility of bargaining over price. Of particular interest to our discussion, Erica Haimes and colleagues explored the question of inducement and exploitation directly with twenty-nine women who had decided to egg-share for research and twenty-one women who egg-shared for reproduction (Haimes, Taylor et al. 2012). The majority of respondents conceded that the scheme could potentially be exploitative if women were emotionally vulnerable, but that given the donor’s capacity for autonomy and rational decision-making the scheme was, in fact, perceived as both useful and equitable. It was
not imposed upon patients and it ultimately succeeded in widening access to infertility treatment in a system where private fees were high and NHS funding was very limited. Furthermore, because it facilitated medical research it was seen as contributing to a public good.

A small minority of our Australian respondents agreed with this analysis.

If you didn’t have much money, you’d think, “yeah, well this is a great opportunity; we can try to have our child and we’re maybe giving to stem cell research, or we’re giving another couple, you know, a chance as well.” (Mira, ex-IVF patient)

However, most of our respondents were quite critical of this model. The majority of both the patient interviewees (16 out of 20) and the reproductive donors (4 out of 5) said they would not divert oöcytes to research during infertility treatment or a donation cycle in exchange for subsidized treatment. The grounds for opposition were twofold. The first was the possibility that only the diverted oöcytes were fertile, while those retained by the donor proved unviable.

I have nothing against egg sharing, except you’d be pretty mad if...you’d donated eggs and discovered somewhere along the way that your embryos didn’t produce anything, and you’d given away the ones that did. (Philippa, ex-IVF patient)

The second reason revolved around a more general sense of inequity; that fertility treatment should be affordable, and that research egg-sharing took advantage of the fact that, in the UK, it was not.

to say that I have to give you this so I can afford IVF, because if it’s that expensive that people have to go down that road...your forcing people to do that. I think you should give people the choice, a proper choice, not a financial choice, because people with money don’t have to. (Joanna, ex-IVF patient)

So in contrast to the respondents in Haimes’ study, our respondents for the most part did consider research egg-sharing as exploitative, in the sense that it took advantage of women’s decreased choice in an expensive treatment field, which compared unfavourably with the better subsidization of fertility treatment in Australia. They regarded subsidised treatment as indicative of an inequitable situation, rather than as a remedy for an inequitable situation, and as inducement for women to go against their own interests. Haimes and colleagues note that, while their study respondents did not consider the Newcastle scheme exploitative per se, they did express a strong desire for more NHS funding for fertility treatment, and regarded the eggs provided to the research program as ‘exchange commodity[ies]’ used to leverage more treatment (Haimes, Taylor et al. 2012: 9).

So in summary, Australian respondents considered egg-sharing as a form of undue inducement, although they did not use this term. They considered it as an indicator of an inequitable health system if women were forced to put an exchange value on their oöcytes, to trade them for further treatment, at a time when they could least afford to part with them. To this extent, they concurred with the policy approach that has seen fertility treatment in Australia more fully subsidised through the national health system than in most other nations, and with a conservative approach that has continued to classify oocytes with other kinds of tissue donation as strict gifts. Hence, we suggest that our respondents’ consistent refusal to place an exchange
value on oöcytes during fertility treatment reflects a culturally specific sense of fairness and equity in the national health.

**Compensation, Payment and Commercial Exchange Value**

Among the young non-patient group, there was also a strong sense of the potential commercial value of biomedical research. They made a strong distinction between personal acts of reproductive or research donation to a loved one, and the more anonymous provision of biological material to a research facility. Perhaps reflecting their experience with the contemporary commercialised university, they regarded medical research as a business, and hence an appropriate location for some form of money transaction. As Grace puts it,

> I have less of an issue with [payment for] research than for reproduction. ... Like, for research, it seems more like they should pay me for it, because you pay when you do research. You pay for things. You pay for materials, you pay study subjects to do focus groups with you...! (laughs). So it just seems more fitting for there to be payment for research than it does for there to be payment for [reproduction]. (Grace, young non-patient woman)

The purpose of research is not the creation of a child, but the creation of knowledge. The young women were aware of the commercial potential of biomedical discovery, and considered that altruistic donation of materials that could give rise to profitable knowledge and patent would be inherently unfair. The excerpts below express on the one hand the need for compensation for potentially profitable donation, and on the other, an unwillingness to donate altruistically to for-profit medical research and a general sense of the social inequity involved in such business models.

> I’d want them to pay me! (laughs) If I thought that some profit was going to come of it in the end, I would at least want something more than reimbursed travel, I guess. (Rose, young non-patient woman)

> I would have a real problem with donating eggs that would then be used to create technology that was then patented and charged prohibitive prices for [sic]. (Frances, young non-patient woman)

So the young women feel entitled to some equity in potentially profitable research, and that compensation rates should reflect this. Here the exchange value of oöcytes is moving closer to a monetised model of value, in the sense of deriving from commercial conditions and the patentability of research tissues, rather than simply a notion of time equivalence. At the same time, this group were aware of the issue of undue inducement, and the ethical problems raised by higher rates of compensation that bled over into frank payment. They expressed concerns regarding the power of money to attract impoverished or simply opportunistic donors, who might overlook the dangers of participation or be unconcerned about the public good aspects of the research itself. Raphaelle expresses this paradox very precisely.

> I agree that it’s a concern that women who wouldn’t otherwise donate eggs would do so for financial reasons... they may sign the consent forms without .... acknowledging or being able to understand or incorporate the actual risks because they’re just looking at the money because they’re in financial distress. But on the other hand, I don’t see why women
shouldn’t be paid to go through a surgical process and to go through and basically contribute to scientific research. ... On a bit of a cynical note, if a drug company or a medical research company does come up with a solution that’s going to cure Alzheimer’s or whatever ... the pharmaceutical company, are going to recuperate significantly more revenue than it cost to develop the research, so why should they get a free ride? (Raphaelle, young non-patient woman)

Here we can see an expectation of equity in the context of commercial medical research in something of a conflict with the community ethics of donation.

A significant proportion of the ex-fertility patients (13 out of 20) also considered that young women should be paid for research donation, and their reasons were for the most part similar to those of the young women; that commercially driven, profitable research organisations should be obliged to pay tissue providers accordingly. This group also expressed a quite high level of certainty that young women would be responsive to money incentives, particularly students and the unemployed.

University students would definitely be up for – they’d be more likely to get more women through that than anywhere else. ... People who go to university, obviously they’re educated, they understand the risks, they have probably better quality eggs, and yeah, they need money. (Caroline ex-IVF patient)

However the young women in the focus groups were strikingly concerned about the state of their fertility, and indicated that they would not consider compensated research donation until after they had established their own families.

Mathilde: If I had three kids, I think I could donate all my eggs to research, because I’d be sure I don’t want any other children.

Julia: Yes, I was just thinking that as well. Once I’ve had my children, then I would possibly consider donating my eggs for research.

So we can see here that, while the older, ex-patient women considered that young women’s oöcytes were relatively fungible, responsive to monetised exchange and readily constituted as a surplus through payment, the young women themselves, at least in our focus groups, were much more circumspect. Their valuation of their oöcytes as reproductive in the first instance, and hence outside exchange until their reproductive potential was realised, converged more closely with the ex-fertility patients’ evaluation of their own oöcytes than might have been expected. However, elsewhere in the world, young women do indeed respond to payment incentives and sell their oöcytes (Bergman 2011; Nahman 2012). Our focus group participants reflect a relatively advantageous economic position as students and staff at a prestigious metropolitan University, and are hence less economically vulnerable than are some other young women.

**Conclusion**

We can see that, for our participants, different forms of money carried strong ethical associations when discussed in relation to oöcyte donation. Broadly speaking, the more liquid its form, the closer it approximated to a cash nexus and to transactional, impersonal relations of
exchange, the more concerns were raised about its coercive powers and its inappropriate uses. In the case of their own oöcytes, most respondents thought that reproductive donation should remain within the realm of kinship and intimacy, as an exceptional act of generosity to a needy sister or friend. Because reproductive donation produced irreplaceable benefits, children and family, it constituted a non-fungible, singular good. To follow Simmel’s (1990, 1900) analysis, it could not enter into any form of commensuration, nor the creation of value through calculated exchange, and hence it remains outside the realm of money transaction. This is a striking reassertion of the values of the gift relation, particularly given the proliferation of transactional markets for reproductive oöcytes in other parts of the world. However, it is not an expression of the anonymous gift relation between citizens advocated by Titmuss (1997 [1970]). Rather, gift relations for oöcytes are mapped onto kinship relations, and kin-like relations, keeping their reproductive substance within family networks.

In comparison, research donation was generally regarded as an acceptable realm for constrained forms of money. Oöcyte donation displaces other kinds of time, particularly productive, paid work time, and our respondents considered that this displaced time should be properly compensated. Here we can see that for our respondents, ethical equilibrium involves distributive fairness, the sense that potential donors should not be economically penalised for their generosity.

While the young, non-patient women demonstrated a keen sense of the potential commercial value of research oöcytes, and considered that compensation rates should recognise this potential, they nevertheless were not prepared to advocate for a frank payment system, like that of New York. They considered that such unconstrained money would have deleterious effects on potential donors, pressuring them into unwise forms of exchange. Here we can see the respondents grappling with not only the ethics of donation itself but also its place in a larger social economy. They are well aware of the paradoxes and ethical dilemmas thrown up by the commercialisation of biomedicine, and are eloquent about the absence of simple solutions to the problems of equity posed by the commercialisation of tissues after donation. In the responses to the UK egg-sharing scenario, we can see a similar grappling with broad issues of equity and fairness, particularly the responsibility (in the respondents’ eyes) of the state to make fertility treatment accessible to all, through national health subsidy.

In summary, our respondents’ expressed considerably unease about the coercive effects of monetised, transactional markets on vulnerable donors, while also demonstrating a sophisticated grasp of the ethical complexities of less liquid forms of exchange. The primary value of reproductive tissues for our respondents, their capacities to create the conditions for family life, kinship and family intimacy was in some degree of conflict with their other possible values in the worlds of medical science and commercial biotechnology. While in the family world, their reproductive tissues were beyond price, in the world of biomedical innovation and regenerative medicine they acquired a transaction value that potential donors had to negotiate and translate into their own sense of equity, distributive fairness and ethical appropriateness. This sense was in turn shaped by a national ethical context that has positioned affordable fertility as important to the national health, and reproductive tissues as non-transactional objects. This context sensitivity is an important methodological point, as it suggests that the elements of ethical reasoning, often treated as universally applicable, acquire culturally specific meanings and applications as they are used in different locations and traditions. It suggests a strong relationship between everyday health ethics and the broad shape of healthcare systems, a relationship that, in the Australian case, propelled our respondents into advocacy for
decommodified reproductive health care. Certainly, this relationship could be explored in future research concerned with the formation of ethical reasoning in other areas of health practice and other locations. While Simmel (1990, 1900) proposes that money disentangles objects from their owners, we can see that it does not disentangle people from their social context, economic position and access to treatment. Rather they decide issues of value and equity in tissue donation in relation to larger systems of distributive justice and the national health.

References


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