

3-1-2001

Golden Eggs: Towards the Rational Regulation of Oocyte Donation

Kenneth Baum

Follow this and additional works at: <https://digitalcommons.law.byu.edu/lawreview>

 Part of the [Bioethics and Medical Ethics Commons](#), [Family Law Commons](#), and the [Medical Jurisprudence Commons](#)

Recommended Citation

Kenneth Baum, *Golden Eggs: Towards the Rational Regulation of Oocyte Donation*, 2001 BYU L. Rev. 107 (2001).
Available at: <https://digitalcommons.law.byu.edu/lawreview/vol2001/iss1/1>

This Article is brought to you for free and open access by the Brigham Young University Law Review at BYU Law Digital Commons. It has been accepted for inclusion in BYU Law Review by an authorized editor of BYU Law Digital Commons. For more information, please contact hunterlawlibrary@byu.edu.

Golden Eggs: Towards the Rational Regulation of Oocyte Donation

*Kenneth Baum**

I. INTRODUCTION

A. Seeking Egg Donor: 5'5" or Taller, Athletic, SAT 1400+ . . .

The story is, unfortunately, nothing new. A woman and a man long to bring a child into the world, but they are unable to do so because the woman is infertile.¹ So they turn to the scientific stork—the field of assisted reproductive technology (ART)²—to deliver their baby. Some infertile couples choose surrogacy;³ others choose *in vitro* fertilization (IVF).⁴ It all depends on the particular roadblock to

* Visiting Lecturer, Yale College. University of California, Berkeley, B.A. 1994; Yale University School of Medicine, M.D. 2001; Yale Law School, J.D. 2001. Two years ago, while sitting in American Legal History and, as always, taking copious notes, I came across the \$50,000 advertisement for egg donors in the Yale Daily. Needless to say, it sparked my interest and led to this article. I would like to thank Professor Robert A. Burt, Honorable Guido Calabresi, Dean Ruth Katz, and Professor Eugene Volokh for their generous and thoughtful comments. Lastly, this article, and many other things in my life, would not have been possible without the continued love and support of my family and Julie, my bride-to-be.

1. Infertility affects over 6 million Americans, representing approximately 10% of the reproductive age population. American Society for Reproductive Medicine, *Fact Sheet: In Vitro Fertilization* (visited May 15, 2000) <<http://www.asrm.org/Patients/FactSheets/invitro.html>>.

2. Assisted reproductive technologies, or ARTs, are treatments or procedures that involve physical or pharmacological augmentation of the procreative process. They involve controlled ovarian hyperstimulation, artificial insemination (AI), *in vitro* fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and other emerging techniques, including the reimplantation of ovaries to postmenopausal women. See *generally* REPRODUCTIVE ENDOCRINOLOGY, SURGERY, AND TECHNOLOGY (Eli Y. Adashi et al. eds., 1996) [hereinafter REPRODUCTIVE ENDOCRINOLOGY].

3. Surrogacy is an arrangement where a woman is artificially inseminated and then carries a fetus to term with the expectation of relinquishing parental rights to the biological father and his wife following the birth of the child. See BLACK'S LAW DICTIONARY 1008 (1991). See also *Matter of Baby M.*, 537 A.2d 1227 (1988) (finding illegal a surrogacy contract where a woman accepted financial remuneration in exchange for a binding relinquishment of her parental rights to the resultant child).

4. *In vitro* fertilization is "an assisted reproductive technique wherein oocytes are retrieved from the ovaries and fertilized extracorporeally with subsequent embryo replacement."

coital conception. This couple chooses egg donation, which has existed as a form of ART for over a decade. It will allow the couple to share genetic ties with their child (through the father), as well as gestational ties (through the mother). Again, nothing new. The difference is in the details.

In this country, women who volunteer to “donate”⁵ their eggs, or *oocytes*,⁶ have traditionally been compensated only for their inconvenience, not for the oocytes themselves. Financially, this has translated into payments ranging from \$1,000–\$5,000 per donation. But this particular couple offers \$50,000 to donors—if they meet certain criteria.⁷

The couple desires a child that reflects their union as much as possible, even if the mother is incapable of directly contributing to the genetic building blocks. Therefore, they look for a donor who resembles the woman—physically, athletically, and intellectually. They are willing to pay for their specificity. The concept seems simple enough: find a donor with the desired characteristics, and, hopefully, the offspring will share those characteristics. Whether it really is this simple is doubtful, but the couple is hopeful, and grateful. So grateful, in fact, that they want to match the donor’s generosity with copious financial remuneration.

The couple targets their advertisement towards college women in a set of prestigious universities,⁸ capitalizing on the financial con-

Owen K. Davis, *In Vitro Fertilization*, in 2 REPRODUCTIVE ENDOCRINOLOGY, *supra* note 2, at 2321.

5. I qualify this word with quotes to draw attention to its absurdity. Traditionally, the word “donation” refers to the altruistic act of voluntarily giving a good or service without requesting or receiving any valuable consideration in return. Here, by contrast, the assisted reproduction profession, and society at large, has misapplied that term to a situation in which the “donor” expects and receives valuable consideration. It is a misnomer but one that has become entrenched in popular diction and one that I will adopt throughout this article. It is interesting to consider why we have latched on to the language of donation here, when it is clearly inapplicable. Are we trying to deceive ourselves in order to lessen our moral conflicts with the fact that we, as a society, approve of the commodification of human life?

6. “Oocyte” is the scientific term for what is commonly known as an “egg.” Oocytes are the female contribution to the reproductive process, the male counterpart being sperm. Oocytes develop and are released from the ovaries during the cyclical process of ovulation. *See generally* Paul M. Wassarman, *Oogenesis*, in 1 REPRODUCTIVE ENDOCRINOLOGY, *supra* note 2, at 341–55.

7. According to the advertisement, women would be considered only if they were 5’5” or taller, athletic, intelligent (scored 1400 or higher on the SAT), and did not have significant family medical histories. YALE DAILY, Oct. 1, 1999, at 5.

8. The advertisement ran in student newspapers at Yale, Harvard, Princeton, MIT, Co-

straints of education and college life. The response is overwhelming. Over 300 tall, intelligent, athletic college women inquire further. Some withdraw their applications; some maintain their interest. The list is narrowed, and the finalists undergo comprehensive examinations. Doctors perform medical histories, physical and psychological exams, and genetic analyses. Finally, one woman is chosen.⁹ And all of this amid a media circus.

B. E-donors

Later that same year, egg donation found its way back into the media spotlight. In October 1999, a Web site began advertising an online egg and sperm auction, with fashion models filling the roles of donors. The Web site, www.ronsangels.com, was the brainchild of Ron Harris, a Playboy photographer, erotic Web site owner, and self-proclaimed expert on society and beauty. The idea for the auction came to Harris after he read an article about the couple described above. It struck the business-savvy Harris that, as a model photographer, he was in the perfect position to play procreative matchmaker. In a society obsessed with appearance and perfection, couples were seeking gamete donors who possessed socially desirable characteristics, particularly physical beauty. Struggling models were eager to make extra money to support their fledgling careers.¹⁰ It was a match made in heaven.

For just \$24.95, prospective buyers—fertile or infertile, single or married—could browse the site and view pictures and personal biographies of the various donors. And, at no extra charge, members could bid on the gametes in \$1,000 increments, with the starting bid around \$30,000. Couples would have their children, models would get their money, and the world would be a prettier place.¹¹

lumbia, Stanford, the University of Pennsylvania, and the California Institute of Technology. Irene Sege, *A \$50,000 Dilemma on Campus: Top Students Wrestle with Egg Donor Lure*, BOSTON GLOBE, Mar. 6, 1999, at A1.

9. Due to privacy considerations, little data is available on the identity of the chosen donor or the outcome of the procedure.

10. According to the donor profiles, financial compensation was one of several motivations for donating gametes. In addition, some cited the altruistic desire to help infertile couples have the child of their dreams, and some admitted to the more narcissistic desire to propagate their “beautiful” genes without the responsibility of rearing the child. See <<http://www.ronsangels.com>>.

11. Mr. Harris had a financial stake in the venture as well. In addition to the \$24.95 membership fee, Mr. Harris would receive a commission, or finder’s fee, amounting to 20% of

C. Struck a Nerve

Oocyte donation is old news. Society has long viewed assisted reproduction as an acceptable and valued form of procreation.¹² But something about the two events recounted above struck a societal nerve, rekindling old debates and generating novel ones regarding the morality and appropriateness of certain aspects of noncoital reproduction. What made these two events so inflammatory, so captivating, was their blatant commodification of human tissue and potential life.

Both the advertisement and the Web site immediately stirred tremendous public interest and discussion. There was extensive media coverage—countless articles in newspapers from the *New York Times* to the *Yale Daily*,¹³ feature articles in periodicals like *Newsweek*,¹⁴ television spotlights on *Face The Nation* and the *Today Show*,¹⁵ and numerous political cartoons depicting the realities and

any eventual gamete donation contract price. *Id.*

12. On July 25, 1978, British fertility specialists announced the birth of Louise Brown, the product of the first successful human pregnancy through the use of IVF. *See* Kenneth J. Ryan, *Ethical and Legal Implications*, in 2 REPRODUCTIVE ENDOCRINOLOGY, *supra* note 2, at 1941–42. In 1981, the American Fertility Society (since renamed the American Society for Reproductive Medicine) announced that IVF should no longer be considered an experimental procedure. *Id.* at 1942–43. By 1990, over 12,000 successful IVF deliveries had been recorded. *Id.* at 1943. More directly, scientists have investigated oocyte donation for over 100 years, resulting in successful human pregnancies since 1983. Zev Rosenwaks & Mark A. Damario, *Contemporary Treatment Strategies: Egg Donation*, in 2 REPRODUCTIVE ENDOCRINOLOGY, *supra* note 2, at 1429–30.

13. *See, e.g.*, Judith F. Daar, *Physical Beauty Is Only Egg Deep*, L.A. TIMES, Oct. 28, 1999, at B15; Bruce Horowitz, *Selling Beautiful Babies*, USA TODAY, Oct. 25, 1999, at 1A; Gina Kolata, *\$50,000 Offered to Tall, Smart Egg Donor*, N.Y. TIMES, Mar. 3, 1999, at A10; Sydney Leavens, *Yale U. Students and Professors React to Egg Donation Ad*, YALE DAILY NEWS, Mar. 4, 1999, at 1; *Photographer Puts Up Models' Genes For Sale*, L.A. TIMES, Oct. 24, 1999, at A16; Irene Sege, *A \$50,000 Dilemma on Campus: Top Students Wrestle With Egg Donor Lure*, BOSTON GLOBE, Mar. 6, 1999, at A1; Barbara Vobejda, *Egg Donation: A Growing Business: Fertility Successes Raise Demand, Price*, WASH. POST, Mar. 7, 1999, at A1.

14. *See, e.g.*, Claudia Kalb, *Baby Boom: The \$50,000 Egg*, NEWSWEEK, Mar. 15, 1999, at 64; Tara Weingarten & Mark Hosenball, *A Fertile Scheme*, NEWSWEEK, Nov. 8, 1999, at 78.

15. *See, e.g.*, *48 Hours: The Baby Makers; Choosing What Kind of Baby to Have* (CBS television broadcast, Dec. 30, 1999); *CBS This Morning: Egg Donor Sharise and Dr. Arthur Caplan Discuss the Issue of Charging for Human Egg Donations* (CBS television broadcast, Mar. 4, 1999); *CNN Morning News: Internet Auctioning of Human Eggs May Become Big Business* (CNN television broadcast, Oct. 26, 1999); *Face the Nation: Professor Susan Wolf, University of Minnesota, Discusses the Ethics of Asking for Specific Types of People to Donate Eggs to Infertile Couples* (CBS television broadcast, Mar. 7, 1999); *Today: Infertile Couple Searching for Egg Donor Places Half-Page Notice in Ivy League Newspapers* (NBC television broadcast, Mar. 3, 1999).

perversities of a market-driven system of gamete donation. As expected, the public and experts voiced ethical and moral outrage.¹⁶

But then, as usual, the novelty of these new versions of the same old story, new applications of old technologies, began to wear off and lose its grip on the religious, philosophical, economic, and ethical consciousness of the country.¹⁷ A little bit ironic, isn't it? As soon as it stops selling papers and airtime, the commodification of human existence becomes yesterday's news—uninteresting and tired. If the issue cannot be commodified, who cares if the subject is? So the voices faded, and the debate ebbed.

But troubling issues of individual rights and societal morals remain. Should individuals have the right to contract freely for the sale of human oocytes, or are there sufficient arguments to support a blanket prohibition on the commodification of human gametes? If commodification is allowed, should society sanction it through legal enforcement of donation agreements, or should such contracts be unenforceable—void as against public policy? Should individuals such as Ron Harris be in the business of gamete brokerage, or should the transactions be limited only to the contracting parties? Should we protect participants through safety regulations and information dissemination, or should it remain a truly private enterprise?

16. For example, Dr. Arthur Caplan, a bioethicist at the University of Pennsylvania, stated, "We don't allow a woman to go and sell her baby to some couple who is infertile, but if you're buying all the ingredients—the egg, the sperm and maybe even a surrogate mother—then I think you're basically doing the same thing, and I think buying babies is a bad idea." *CBS This Morning: Egg Donor Sharise and Dr. Arthur Caplan Discuss the Issue of Charging for Human Egg Donations* (CBS television broadcast, Mar. 4, 1999). Dr. Glenn McGee, also a bioethicist at the University of Pennsylvania, said, "Well, \$50,000 for a human egg, in reproductive medicine, is about a 9.9 on my ethics creepometer." *Saturday Morning: Ethics of Specifying Superior Qualities and Paying Extremely Large Sums for Egg Donors* (CBS television broadcast, Mar. 6, 1999). Dr. Zev Rosenwaks, director of the Center for Reproductive Medicine and Fertility at Cornell University, said of the \$50,000 advertisement, "I think it's a coercive amount of money . . . This is something that should not be done." David Lefer, *An Ad for Smart Eggs Spawns Ethics Uproar*, N.Y. DAILY NEWS, Mar. 7, 1999, at 38. Commenting on Ron Harris' website, Sean Tipton, spokesman for the American Society for Reproductive Medicine, stated, "It's unethical and it's distasteful." *Photographer Puts Up Models' Genes For Sale*, *supra* note 13, at A16.

17. Describing this typical plot line for tales of modern baby-making, columnist Sheryl Gay Stolberg has stated, "The drama typically unfolds as follows: Whiz-bang scientists develop new technique (in vitro fertilization, donated eggs, frozen eggs, frozen ovaries) that makes it possible for childless woman (subtext: *old* childless woman) to conceive. Media circus ensues. Ethicists ponder potential abuse. Media circus subsides. Family life goes on." Sheryl Gay Stolberg, *Buying Years for Women on the Biological Clock*, N.Y. TIMES, Oct. 3, 1999, § 4 (Week in Review), at 1.

The remainder of this article focuses primarily on the first of these questions: Should we, as a society, continue to tolerate the commodification of human oocytes that currently exists, or should we strictly regulate or entirely prohibit the compensation paid to oocyte donors? Part II provides a brief overview of oocyte donation, including the procedures involved, its genetic underpinnings, and the current regulatory state both in this country and in England, Israel, and Australia. Part III addresses the prominent arguments offered against the sale of organs and tissues in general, as well as their relevance to oocyte donation. Part IV looks at arguments on both sides of the debate specific to assisted reproduction and oocyte donation. Part V brings the discussion to an end with the conclusion that although there exist thoughtful reasons to regulate oocyte donor compensation, they are outweighed by the arguments for free alienability. The legitimate rationales for the prohibition of the commodification of organs are not applicable to oocyte donation, and oocyte-specific arguments fall short of justifying paternalistic regulation. Arguments in favor of treating such arrangements as enforceable contracts are then presented. Finally, a call is made for other forms of regulation within the gamete donation industry, and broader social implications of the regulatory debate are highlighted.

II. BACKGROUND

A. What Is Oocyte Donation, and Why Is It Necessary?

Oocyte donation—like sperm donation, embryo donation, in vitro fertilization, artificial insemination, and surrogacy—is a form of noncoital, or assisted, reproduction. All are procreative methods that sidestep, for whatever reason,¹⁸ the traditional form of sexual reproduction, in which male and female gametes are united inside the female reproductive tract through the act of sexual intercourse.¹⁹ All,

18. Some people turn to assisted reproduction due to infertility, which can have many differing etiologies, such as low sperm count, impaired sperm motility, ovarian failure, or anatomic blockage of the female reproductive tract. Others, while fertile, may be physically incapable of gestating (carrying a pregnancy to term). Some wish to procreate without passing on genetic diseases they harbor to their offspring. In addition, individuals and same sex couples often turn to assisted reproduction to overcome obvious roadblocks.

19. Unless the gamete donor actually has intercourse with the fertile member of the couple. Although that method is arguably the most ancient recorded form of assisted reproduction, as chronicled in the tales of Abraham, Sarah, and Hagar, this is rarely the case nowa-

therefore, effectively separate the natural linkage between intercourse and reproduction, thereby leading to the foundation of much of the religious objection to such procedures.²⁰

The first question that society must answer is why we have assisted reproduction at all. Why shouldn't individuals who desire children but are unable to reproduce sexually turn to adoption instead? Unfortunately, an adequate treatment of this question is beyond the scope of this article, and the interested reader is directed to writings devoted to this topic.²¹ In short, the strongest rationales for the existence of assisted reproductive technologies are the implications of procreative liberty and the social desirability of preserving the unique nature of the genetic and gestational bonds between parents and children.

The concept of procreative liberty, as championed by John Robertson, maintains that all individuals should have the right to decide whether or not to exploit their reproductive capacity and that, absent strong justification for limiting this right, such as clearly identifiable and tangible harms, they should have at their disposal all possible means of effectuating that choice.²² This is so because the decision whether or not to procreate is so fundamental, so personal, that its denial would be antithetical to the pursuit of life, liberty, and happiness.²³ Robertson and most others conceive of this right to procreative liberty as a negative right only—the right to be free from

days. *Genesis* 16:1–4 (King James).

20. Because the Roman Catholic Church views intercourse and reproduction as morally inextricably intertwined, it has concluded that assisted reproduction (the inclusion of a third party into procreation) is morally corrupt and unacceptable. The current Vatican position states, "These procedures are contrary to the human dignity proper to the embryo, and at the same time they are contrary to the right of every person to be conceived and to be born within marriage and from marriage. Also, attempts or hypotheses for obtaining a human being without any connection with sexuality through 'twin fission,' cloning or parthenogenesis are to be considered contrary to the moral law, since they are in opposition to the dignity both of human procreation and of the conjugal union." JOHN D. ARRAS & BONNIE STEINBOCK, *ETHICAL ISSUES IN MODERN MEDICINE* 425–34 (5th ed. 1999) (quoting Vatican, Congregation for the Doctrine of the Faith, *Instruction on Respect for Human Life in Its Origin and on the Dignity of Procreation*, 40 *ORIGINS* 16, Mar. 19, 1987, abridged).

21. See, e.g., JOHN A. ROBERTSON, *CHILDREN OF CHOICE: FREEDOM AND THE NEW REPRODUCTIVE TECHNOLOGIES* (1994); John A. Robertson, *Technology and Motherhood: Legal and Ethical Issues in Human Egg Donation*, 39 *CASE W. RES. L. REV.* 1 (1989).

22. See generally ROBERTSON, *supra* note 21.

23. In the words of Professor Robertson, "Procreative liberty should enjoy presumptive primacy when conflicts about its exercise arise because control over whether one reproduces or not is central to personal identity, to dignity, and to the meaning of one's life." *Id.* at 24.

governmental interference—not as a positive right to governmental assistance in the pursuit of any and all forms of reproduction.

The reason that adoption falls short of satisfying this claimed right is that it fails to provide for the genetic or gestational bonds normally present between parents and children. Many individuals' reproductive motivation stems in part from their perhaps narcissistic desire to pass on their genes, to use their genetic material to bring into the world a new being that shares and reflects their biological history. After all, argues evolutionary biology, is not the perpetuation of genetic lineage the fundamental basis of reproduction?

Much has also been made of the symbolic and developmental importance of the mother-child bond formed during gestation. In fact, one of the primary arguments against surrogacy arrangements stems from the belief that the woman who carries a child during pregnancy is undeniably its "mother" and that any attempt to renounce this reality is unethical and untenable.²⁴ But adoption does exactly that; it makes parents out of people who share no genetic or gestational tie with the child. This point is not meant to deny or disparage the loving bond that obviously exists between parents and their adopted children. It is only to argue that limiting noncoital reproductive choices to adoption denies individuals incapable of coital reproduction the opportunity to experience the parent-child bond in its entirety.

If one does accept these arguments for the availability and option of assisted reproduction, another question follows: Do we need so many different types of assisted reproduction? As noted above, reproductive medicine currently offers artificial insemination, *in vitro* fertilization, gamete donation, embryo donation, and surrogacy to its patrons. And, like clockwork, new techniques continue to emerge.²⁵ Are they all necessary in the name of procreative liberty, or are some of them unnecessarily redundant?

24. See generally BARBARA KATZ ROTHMAN, RECREATING MOTHERHOOD: IDEOLOGY AND TECHNOLOGY IN A PATRIARCHAL SOCIETY (1989) (propounding that, regardless of the source of the gametes, the woman who gestates a child is that child's "mother," and, therefore, institutions such as surrogacy, which treat the gestating mother merely as a "rented womb," are inappropriate).

25. Most recently, scientists have perfected techniques for reversing menopause and its attendant infertility by re-implanting ovaries into such women. See, e.g., Stolberg, *supra* note 17, at 1.

The answer is they all are necessary—if one accepts the proposition that all individuals have the right to procreate, even if doing so requires technological assistance. This is because the various techniques serve patient populations with differing procreative needs. Take, for example, artificial insemination (AI). Sperm from the partner is artificially deposited into the fallopian tube of an ovulating woman in order to maximize the chance of oocyte fertilization. This is done primarily to counter so called “male factor” infertility, such as low sperm count or impaired sperm motility. It allows the couple to maintain all of the traditional genetic and gestational ties with their child.²⁶ *In vitro* fertilization (IVF), on the other hand, in which oocytes are removed from a woman, fertilized in the laboratory, and reimplanted in the uterus, is usually employed to overcome “female factor” infertility, such as anatomical blockage of the fallopian tubes. Like AI, this technique allows the parents to maintain both genetic and gestational ties to the offspring.²⁷

But what about individuals who, for whatever reason, are either unable to produce their own gametes (oocytes or sperm) or are unwilling to use their gametes in conception due to fear of transmitting genetic disease to their offspring? This is where gamete donation comes in. Sperm from a third-party donor may be used for AI, or an oocyte from a third-party donor may be used for IVF. Such techniques do not provide for all of the traditional genetic and gestational relationships, as one of the parents no longer provides a genetic contribution. But it comes as close as possible. One parent is still genetically related to the offspring, and the gestational relationship remains intact. In embryo donation, both the sperm and the oocyte for IVF are donated by third parties, so no genetic relationship remains, but, again, allowing the rearing mother to carry the child maximizes parent-child biological ties.

Lastly, there is surrogacy, in which couples arrange for a third-party female to carry the pregnancy when the woman is unable to do so for anatomic or physiologic reasons. Here, the gestational bond is lost, but genetic ties can be maintained, provided that both the oocyte and the sperm come from the couple, not third party donors.

26. Unless the sperm is obtained from a donor, in which case only the mother maintains a genetic tie to the offspring. This is discussed *infra*, Part II.C, as a form of gamete donation.

27. Again, this assumes that the infertile couple themselves, and not third-party donors, donates both the oocyte and the sperm.

If the rights to procreative liberty and to the maintenance of biological connections between parents and children justify the existence of assisted reproduction, then the same arguments justify the existence of different ARTs to overcome corresponding procreative roadblocks. Having briefly surveyed the justifications for the various ARTs, we now turn to take a closer look at oocyte donation.

B. How Does It Work?

The first step in oocyte donation is the selection of a donor.²⁸ This can be accomplished in one of three ways. First, the recipient couple (or individual) can seek the oocyte from a close friend or family member, potentially obviating the need for an arms-length market transaction. Other benefits include personal knowledge and trust of the donor. However, finding such a donor is not always possible, and it may not be desirable even when it is an option. Genetically related family members may not be suitable if the risk of genetic disease transmission was the impetus for oocyte donation in the first place. In addition, close pre-existing donor-recipient relationships may lead to awkward and difficult familial and/or social relationships after a successful or unsuccessful donation.

Understandably, recipients may prefer to avoid these potentialities and instead seek a disinterested donor, which leads to the other two options for donor selection: pooled brokerage or individual advertisement. There are multitudes of companies across the country that have amassed oocyte donor databases, catering to the needs of those in search of the “ideal” donor.²⁹ Such companies lay the

28. Couples must also select a supervising physician at the outset, but this is not a difficult hurdle. Over three hundred fertility clinics now exist across the country that specialize in assisted reproductive technologies, most of which offer oocyte donation as an option. For a comprehensive list of these clinics, see CENTERS FOR DISEASE CONTROL AND PREVENTION ET AL., 1997 ASSISTED REPRODUCTIVE TECHNOLOGY SUCCESS RATES: NATIONAL SUMMARY AND FERTILITY CLINIC REPORTS (1999).

29. Two of the largest providers, now accessible through the Internet, are Egg Donation, Inc., which can be found at <<http://www.eggdonor.com>>, and Options, located at <<http://www.fertilityoptions.com>>. Both sites provide extensive explanations of the medical protocol, associated costs, legal and ethical issues, and frequently asked questions. They also have online donor registries, complete with photographs and profiles, which clients can search in order to locate donors that most suit their needs or preferences. Ron Harris's online gamete auction also belongs in this category, but it differs in important aspects from the sources noted above. First, it fails to provide much in the way of educational materials. Second, it does not guarantee that each of its donors is actually available for donation. Third, it does not have a pre-set, standardized donor compensation structure.

groundwork for the recipient, seeking out a pool of potential donors, cataloging their various characteristics, and conducting the appropriate medical, genetic, and psychological histories and tests. For a fee,³⁰ the company will provide clients with access to the donor database—complete with photographs and characteristic catalogs—execute the contract once the client selects a suitable donor, and oversee the associated administrative and legal processes. The advantages of using these pooled brokerages are the simplicity and the knowledge of working with experienced professionals. The drawback, however, is that the recipient is bound by the company's regulations and limited to a particular donor pool that may not contain a "perfect match."

The final option is individual advertisement. In this case, the recipient, either alone or, more often, through some sort of third party representation, circulates targeted advertisements in search of donors that meet specific criteria, as did the couple discussed in Part I. This way, recipients can set their own terms, including qualifying criteria and donor compensation structure. The drawbacks, however, include a more labor-intensive search and lack of experienced guidance.

Whichever process is used, individual donor selection is usually driven by the donor's genetic, physical, psychological, and intellectual characteristics, which, as discussed below, may or may not have any bearing on the resultant offspring's characteristics. Once a donor is selected, the medical protocol begins.³¹

In order for oocyte donation to work, the donor and recipient must synchronize their menstrual cycles. That way, the recipient's uterus will be prepared to accept and house the embryos just after the oocytes are retrieved from the donor and fertilized in the laboratory.³² Therefore, both the donor and the recipient must undergo

30. For example, based on May 1998 figures, Egg Donation charges clients \$4,000 for its services. However, this figure excludes the \$2,500 donor fee, as well as medical bills, doctor's fees, medications, laboratory fees, air travel and accommodations. See *Estimated Cost Sheet* (visited Oct. 28, 2000) <<http://www.eggdonor.com/ercost.html>>. By contrast, as of Dec. 10, 1999, Fertility Options charged clients approximately \$3,500 for the same services. See *Fee Schedules* (visited Oct. 28, 2000) <http://www.fertilityoptions.com/html_pub/guid_fa.htm>.

31. Although briefly summarized below, the medical protocol of oocyte donation is highly technical and complex. For an in-depth review of the process, see MARK V. SAUER, *PRINCIPLES OF OOCYTE AND EMBRYO DONATION* (1998).

32. I use plurals—embryos and oocytes—because fertility clinics typically reimplant as many fertilized oocytes as possible into the recipient, knowing that most will fail to survive the process. The more fertilized oocytes that are reimplanted, the better the chance that a success-

hormonal manipulation.

At the beginning of the donor's cycle, she undergoes an ultrasound to examine her ovaries, as well as blood tests for relevant hormone levels. If the results are normal, the donor then begins a 10–14 day course of subcutaneous injections of an ovulation suppressant to guarantee that she does not enter the ovulatory phase before the recipient is ready to accept the donation. Following a second round of ultrasound and blood tests, the donor then begins a 7–10 day course of intramuscular injections of an ovulation stimulant that will cause her to produce an abnormally large quantity of oocytes during that cycle. Progression is monitored by repeat ultrasounds.

During this time, the recipient's menstrual cycle is also brought under medical control through hormonal manipulation. When donor ovulation stimulation begins, the recipient is given estrogen-containing pills to promote the development of the endometrial lining of her uterus, so that it will be receptive to embryo implantation.

When the donor oocytes have fully developed, the donor receives a final injection of human chorionic gonadotropin (HCG), an endogenous hormone that helps prepare her oocytes for retrieval. The recipient receives a final injection of progesterone, another endogenous hormone, which further prepares the endometrium for embryo implantation. The oocytes are then removed from the donor during an outpatient procedure via a long needle inserted through the reproductive tract and into the ovaries. The oocytes are sucked through the needle into a test tube and fertilized with the sperm from the recipient's partner. Approximately three to five days later, the embryos are implanted into the recipient's uterus.³³

Clearly then, this is not a quick and easy solution to the problem of infertility, and there is certainly the potential for adverse consequences—both for the donor and the recipient—including anesthesia complications, hemorrhage, infection, ovarian hyperstimulation, and even death, although serious complications are exceedingly rare.³⁴

ful pregnancy will result. In rare cases, more than one will survive, resulting in a multiple pregnancy. If more than three embryos survive, patients must decide between commencing with an inherently high-risk pregnancy or selectively reducing the number through abortive techniques.

33. Occasionally, if the yield is large enough, several of the embryos are frozen and stored in liquid nitrogen, in the event that the transfer does not lead to a successful pregnancy. In that case, the extra embryos are unfrozen and a second attempt is made at implantation.

34. See Rosenwaks & Damario, *supra* note 12, at 1435. In addition, it has been suggested but not proven that an association exists between the use of fertility agents in ovarian

Granted, there are no invasive surgical procedures involved, and the risk of serious injury is small, but there is the discomfort of the daily injections and oocyte removal, and it is always possible that some unforeseen complication may arise.

Having looked briefly at the costs and risks associated with the endeavor, what are the realistic benefits to be gained by particularized donor selection? To answer this, we must first look at the genetic principles that underlie the concept of oocyte donation.

C. Genetic Realities and Misconceptions

As was discussed earlier, the justification for the very existence of oocyte donation, as with all ARTs, is the exercise of procreative liberty and the maintenance, as much as possible, of the biological ties between parents and children. Because the oocyte recipient is unable to share a genetic link with the offspring, what is to be gained by the selection of a particular donor?

The theory, at least, is simple. By selecting a donor who shares particularly salient or relevant traits with the infertile woman, a couple can maximize the similarity between the resultant offspring and themselves. For example, the couple with the \$50,000 advertisement decided that the most defining characteristics of the infertile woman were her height, her intellect, and her athleticism. Therefore, they sought potential donors who shared these characteristics, hoping that the resultant offspring would likewise possess these characteristics, and thereby “fit the familial mold,” so to speak.³⁵

As straightforward as this matching theory sounds, it is premised on distortions and misconceptions of the laws of genetic inheritance. At its base, the matching theory conflates phenotype and genotype,

hyperstimulation and ovarian carcinoma. *See id.* See Joan Hamilton, *What Are The Costs?*, STANFORD 52–8 (Nov./Dec. 2000) for a synopsis of a particularly unique adverse outcome in the case of an egg donor whose previously undiagnosed, benign pituitary tumor rapidly enlarged due to the hormonal injections involved in the donation, resulting in a temporary coma and permanent brain damage.

35. Of course there is no guarantee that all, or even most, couples using oocyte donation will limit their donor criteria to characteristics reminiscent of the infertile woman. Perhaps couples will instead seek donors who possess socially desirable characteristics, regardless of whether or not the infertile woman shares those characteristics. In fact, this “genetic engineering” conception of oocyte donation, as discussed in Part IV, is the basis of one of the most popular criticisms of such technology. For now, let us assume that the couples are picking donors to match the infertile woman.

fails to appreciate the limitations of genetic determinism, and ignores the implications of multi-factorial inheritance.³⁶

An individual's genotype is the set of genetic sequences that comprise the 46 DNA chromosomes in the normal human genome. These sequences are in turn comprised of billions of base pairs organized in random, sometimes repeating, strings. These base pairs can be thought of as individual letters in one's genetic biography. However, there are only 4 different bases to choose from when constructing this story, akin to an alphabet that contains only four letters. These strings of base pairs are then organized as triplets, or 3 letter words, called codons. Now imagine an incredibly long run-on sentence comprised of thousands of these three letter words. This is a gene. And distributed throughout the human genome are thousands of genes, which together contribute to, and even directly determine many of, the salient characteristics of individuals.

Phenotype, on the other hand, is the catalog of an individual's outwardly observable characteristics. For example, eye color, height, intelligence, and athleticism are all phenotypic characteristics. And while it is true that one's genotype strongly influences one's phenotype, the two are not synonymous.

Some phenotypic traits, such as eye color, are determined almost entirely by genotype. If an individual carries two genes that code for blue eyes, then she will have blue eyes. If an individual possesses two genes for brown eyes, then she will have brown eyes. And if she inherits one gene for blue eyes and one gene for brown eyes, due to the dominance of the brown eye gene, she will have brown eyes. This is simple Mendelian inheritance.

Infertile couples can exploit such predictable genotype-phenotype relationships when selecting donors. If the couple desires a child with blue eyes, and the husband has two genes for blue eyes, then selecting a donor with two genes for blue eyes virtually guarantees that the resultant offspring will have blue eyes too. On the other hand, selecting a donor with two genes for brown eyes virtually guarantees that the child will have brown eyes. However, only a small proportion of phenotypic traits enjoy such genetic simplicity. Predominately, the one gene-one trait model does not hold true, for two reasons—the bounded validity of genetic determinism and the reality of multi-factorial inheritance.

36. For an overview of basic genetic theory, see BENJAMIN LEWIN, GENES VII (2000).

First, genotype is not the sole determinant of most phenotypic characteristics. Belief to the contrary is an oversubscription to the theory of genetic determinism. Countless studies, specifically studies of identical (or monozygotic) twins, demonstrate that even genetically identical individuals are just those—individuals.³⁷ Despite the fact that such twins have identical genotypes, they often exhibit marked disparities in a wide range of phenotypic characteristics. Clearly, factors other than genotypic profile play a role in phenotype, proving that the xeroxing myth—the belief that identical genotypes result in identical persons—really is just a myth.³⁸

Genetic endowment is only part of the equation. External factors, such as environment, also play a large role in the phenotypic development of individuals. Intellect and athleticism must be fostered and achieved, not merely inherited. This is not to deny that certain individuals are genetically predisposed to keener intellect or better coordination, but the role genes can play in these realms is only so large. Intuitively, the child whose mind and body are stimulated develops greater intellect and athleticism than the child who is ignored or discouraged, regardless of identical underlying genotypes. Environmental factors can also have detrimental effects on phenotypic development. For example, childhood exposure to lead can decrease intelligence,³⁹ and certain pesticides can damage the nervous system, leading to loss of coordination.⁴⁰

37. See Peter McGuffin & Neilson Martin, *Science, Medicine and the Future: Behaviour and Genes*, 319 BRIT. MED. J. 37, 38 (1999) (summarizing results of twin studies showing significant discordance among monozygotic twins along various disease dimensions such as childhood fatigue, attention deficit hyperactivity disorder, bulimia, depression, autism, and schizophrenia); Louis Keith & Geoffrey Machin, *Zygosity Testing: Current Status and Evolving Issues*, 42 J. REPRO. MED. 699, 704–06 (1997) (noting numerous mechanisms by which monozygotic twins can become discordant during gestation and delivery).

38. Therefore, even if one were to clone oneself, resulting in a second being with identical genotype, that clone would still likely differ phenotypically from the primary.

39. Michael V. Johnston & Gary W. Goldstein, *Selective Vulnerability of the Developing Brain to Lead*, 11 CURRENT OPINION IN NEUROLOGY 689 (1998); Herbert L. Needleman & Constantine A. Gatsonis, *Low-Level Lead Exposure and the IQ of Children: A Meta-Analysis of Modern Studies*, 263 JAMA 673 (1990); Wei-Tsuen Soong et al., *Long-Term Effect of Increased Lead Absorption on Intelligence of Children*, 54 ARCHIVES ENVTL. HEALTH 297 (1999); Shilu Tong et al., *Lifetime Exposure to Environmental Lead and Children's Intelligence at 11–13 Years: The Port Pirie Cohort Study*, 312 BRIT. MED. J. 1569 (1996); Gail A. Wasserman et al., *Lead Exposure and Intelligence in 7-Year-Old Children: The Yugoslavia Prospective Study*, 105 ENVTL. HEALTH PERSPS. 956 (1997).

40. See Donald C. Cole et al., *Assessment of Peripheral Nerve Function in an Ecuadorian Rural Population Exposed to Pesticides*, 55 J. TOXICOLOGY & ENVTL. HEALTH 77 (1998);

A second genetic reality that complicates the predictability of offspring's phenotype is the existence of multifactorial inheritance. Even when a particular phenotypic trait, such as height, is primarily determined by genetics, it is likely that the ultimate phenotypic resolution is a result of complex interactions between many different genes, not just one or two.⁴¹ Traits whose transmission depends on such genetic interplay are said to be multifactorial in nature. Unlike eye color, such traits cannot be reliably predicted because the presence or absence of a particular gene is only part of the equation.

In addition to the genetic limitations discussed above, incomplete understanding and information also bind any phenotypic predictions. Science has yet to identify all of the genes that play roles in the development of each phenotypic characteristic, so any predictive model promises to be incomplete. This will, of course, change dramatically as the Human Genome Project proceeds and the entire complement of human genes is cataloged.⁴² This project, which endeavors to map the entire human genome, will provide us with a much more detailed and accurate understanding of the genetic determinants of human existence. As more and more genes are delineated, it will become possible to select for more and more phenotypic traits, within the constraints of the aforementioned limitations of genetic determinism.

The relevance of all this for oocyte donation is clear. Despite common misconceptions, a couple cannot meaningfully guarantee through targeted donor selection that resultant offspring will possess complex phenotypic traits such as tall stature, sharp intellect, or ath-

Elizabeth A. Guillette et al., *An Anthropological Approach to the Evaluation of Preschool Children Exposed to Pesticides in Mexico*, 106 ENVTL. HEALTH PERSPS. 347 (1998).

41. Physical size, for example, depends on the interaction of a large set of genetic products, including the cells that produce certain growth factors, the receptors through which those growth factors exert their influence, and the substances that normally act to down-regulate growth factor responsiveness at the end of puberty. The presence of abnormal forms of any of these genes could result in abnormalities in height at either end of the spectrum. Particularly unpredictable are the effects of non-dominant, or recessive, traits.

42. The Human Genome Project is a federally funded, joint public-private venture to map the entire human genome. Although the first phase of the Project, the initial sequencing of DNA base pairs, is almost finished, much remains to be done before significant genetic applications will emerge. Most importantly, researchers must now determine which strands of DNA code for functional proteins and what roles these proteins play in normal and diseased physiology. For a brief explanation and overview of the project, see Albert H. Teich & Mark S. Frankel, *Introduction: Genetic Testing and the Human Genome Project*, in *THE GENETIC FRONTIER: ETHICS, LAW, AND POLICY* xiii (Mark S. Frankel & Albert H. Teich eds., 1994).

letic prowess. Simple genetic sequences do not determine complex phenotypic traits. Granted, children do tend to resemble their parents, even with respect to complex traits, such that tall donors are more likely to produce tall offspring than short donors.⁴³ However, as discussed above, this outcome is far from certain.

So what are the normative implications of these genetic realities? Does the attenuated link between genotype and phenotype justify some sort of restriction on oocyte donor compensation? Should we prohibit couples from paying so much money for so little certainty? No. Short of factors such as fraud, misrepresentation, or illegality, who are we to say that \$50,000 is an unreasonable amount to pay for the chance of a baby that resembles its parents? And maybe that is all these couples are paying for—a chance, not a guarantee. As will be discussed in Part V, some sort of regulation may be needed to ensure that infertile couples fully understand what it is they are purchasing. However, uncertainty, in and of itself, is no reason to ban such transactions. Certainly, other compelling justifications may exist. For example, maybe institutions such as oocyte donation further intolerance of disabilities or undermine the pluralistic values so central to our democratic and diverse nation. But without further exploration and analysis of these potential insidious consequences, paternalistic regulation solely in the name of uncertainty serves only to undermine autonomy and procreative liberty.

With an understanding of the genetics and processes that underlie oocyte donation, it is time to survey the current regulatory climate, both domestic and foreign.

D. Current Regulatory State

Despite the prolonged existence and growing popularity of oocyte donation, there is a surprising paucity of legislation on the matter in the United States. Legislation that does exist is variable and ambiguous, tending to confuse more than clarify. Much of the relevant regulation consists of the few federal and state statutes concerning IVF, which necessarily implicate oocyte donation because of its reliance on IVF technology. These statutes generally fall into three

43. Due to the statistical reality of regression to the mean, however, the offspring of two very tall parents are likely to be shorter than the parents themselves. This is the same for any character trait. Each successive generation tends to regress towards the social mean for any particular trait.

categories: 1) gamete donor medical screening guidelines, 2) clinic reporting requirements, and 3) insurance coverage guidelines.

Several states require that all gamete donors undergo medical screening prior to donation to avoid the transmission of genetic or infectious disease.⁴⁴ Some require IVF clinics to report various success rates to potential clients and the Department of Health.⁴⁵ The United States Congress has also intervened at this level via the Fertility Clinic Success Rate and Certification Act of 1992.⁴⁶ The Act, among other things, mandates that each fertility clinic report annually its pregnancy success rates achieved through fertility programs to the Centers for Disease Control and Prevention (CDC). The CDC, in turn, publishes these rates in a yearly national report on assisted reproduction and fertility clinics.⁴⁷

A number of state statutes address insurance coverage of IVF costs.⁴⁸ The majority of these laws mandate insurance coverage of the

44. *See, e.g.*, N.H. REV. STAT. ANN. § 168-B:14 (1999) (“No gamete shall be used in an *in vitro* fertilization or preembryo transfer procedure, unless the gamete donor has been medically evaluated and the results, documented in accordance with rules adopted by the division of public health services, demonstrate the medical acceptability of the person as a gamete donor.”); VA. CODE ANN. § 32.1-45.3 (Michie 1999) (“Any person using donor gametes to treat patients for infertility by artificial insemination, *in vitro* fertilization, gamete intrafallopian tube transfer, or zygote intrafallopian tube transfer or any other gamete, zygote or embryo transfer or other intervening medical technology using sperm or ova, shall, prior to using any donor gametes for such procedures, ascertain the HIV status of the donor through testing as provided in Board of Health regulations.”).

45. *See, e.g.*, ARK. CODE ANN. § 23-85-137(e) (Michie 1999) (stating that *in vitro* fertilization clinics must demonstrate “a reasonable success rate with both fertilization and births” in order to maintain certification for insurance purposes); 18 PA. CONS. STAT. § 3213(E) (1999) (requiring all persons conducting *in vitro* fertilization to file quarterly reports with the Department of Health, including the number of eggs fertilized, the number of fertilized eggs destroyed or discarded, and the number of women implanted with a fertilized egg); VA. CODE ANN. § 54.1-2971.1 (Michie 1999) (requiring physicians to disclose to all IVF patients the rates of success for the procedure at the clinic or hospital where the procedure is to be performed, including the total number of births, the number of live births as a percentage of completed retrieval cycles, and the rates for clinical pregnancy and delivery per completed retrieval cycle bracketed by age groups).

46. 42 U.S.C. §§ 263a-1 to -4 (Supp. V 1993).

47. For 1997, the report found that, nationally, approximately 40 live births were achieved per 100 transfers of fresh (as opposed to frozen) donor oocytes (i.e., a national success rate of 40% for fresh oocyte donation). CENTERS FOR DISEASE CONTROL AND PREVENTION ET AL., *supra* note 28, at 41.

48. *See, e.g.*, ARK. CODE ANN. § 23-85-137(a) (Michie 1999) (“All disability insurance companies doing business in this state shall include, as a covered expense, *in vitro* fertilization.”); CAL. HEALTH & SAFETY CODE § 1374.55(a) (Deering 1999) (“[E]very health care service plan contract . . . shall offer coverage for the treatment of infertility, except *in vitro* fertilization . . .”); HAW. REV. STAT. ANN. § 431:10A-116.5 (Michie 1999) (“All individual

costs of IVF, but they also set qualifications for provider reimbursement. As a means for quality control, clinics are typically required to conform to the IVF guidelines of the American College of Obstetrics and Gynecology (ACOG) or the American Society for Reproductive Medicine (ASRM) (formerly known as the American Fertility Society) in order to qualify for reimbursement.⁴⁹ However, a few states explicitly exclude oocyte donation from these insurance regulations by further restricting coverage to the fertilization of the insured individual's *own* gamete with that of his or her spouse.⁵⁰ Therefore, IVF procedures that use third-party donors, such as sperm and oocyte donation, are specifically excluded from mandatory insurance coverage in these states.

and group health insurance policies which provide pregnancy-related benefits shall include in addition to other benefits for treating infertility, a one-time only benefit for all outpatient expenses arising from in vitro fertilization procedures"); 215 ILL. COMP. STAT. ANN. 5/356m(a) (West 1999) (requiring that all group health insurance policies providing coverage for more than 25 employees and providing pregnancy-related benefits must contain coverage for the diagnosis and treatment of infertility, including in vitro fertilization and embryo transfer); MD. CODE ANN., INS. § 15-810(b) (1999) (forbidding health insurance policies that provide pregnancy-related benefits from excluding benefits for all outpatient expenses arising from in vitro fertilization); TEX. INS. CODE ANN. art. 3.51-6 (West 1999) (stating that all health insurers shall offer and make available coverage for expenses that arise from in vitro fertilization procedures).

49. *See, e.g.*, ARK. CODE ANN. § 23-85-137(d) (Michie 1999) (limiting insurance coverage for IVF to procedures performed at medical facilities that are certified by the Department of Health and either conform to the American College of Obstetricians and Gynecologists' guidelines for IVF clinics or meet the American Fertility Society minimal standards for IVF programs); HAW. REV. STAT. ANN. § 431:10A-116.5 (Michie 1999) (limiting insurance coverage of IVF to procedures performed at medical facilities that conform to the American College of Obstetric and Gynecology guidelines for IVF clinics or to the American Fertility Society minimal standards for IVF programs); 215 ILL. COMP. STAT. ANN. 5/356m(b)(1)(C) (West 1999) (limiting IVF coverage to procedures performed at medical facilities that conform to either the American College of Obstetric and Gynecology or the American Fertility Society standards for IVF clinics); MD. CODE ANN., INS. § 15-810(c)(5) (1999) (limiting insurance coverage of IVF to those procedures performed at medical facilities that conform with either the American College of Obstetricians and Gynecologists or the American Fertility Society guidelines for IVF clinics); TEX. INS. CODE ANN. art. 3.51-6 (West 1999) (limiting insurance coverage to IVF procedures performed at medical facilities that conform to the American College of Obstetric and Gynecology or the American Fertility Society guidelines for IVF clinics).

50. *See, e.g.*, HAW. REV. STAT. ANN. § 431:10A-116.5 (Michie 1999) (limiting insurance coverage to IVF cycles in which the patient's own oocytes are fertilized with the patient's spouse's sperm); MD. CODE ANN., INS. § 15-810(c)(2) (1999) (limiting insurance coverage to IVF cycles in which the patient's own oocytes are fertilized with the patient's spouse's sperm); TEX. INS. CODE ANN. art. 3.51-6 (West 1999) (limiting insurance coverage to IVF cycles in which "fertilization or attempt at fertilization of the patient's oocytes is made only with the patient's spouse's sperm").

Of course individual IVF clinics have their own internal regulations and policies, including donor screening criteria and the provision of relevant data to prospective clients, but such guidelines are variable and entirely voluntary.

Turning to the narrower topic of oocyte donor compensation, federal law is entirely silent, and only a handful of state statutes directly address the issue. Louisiana is the only state that explicitly prohibits the sale of human oocytes,⁵¹ and Virginia is the only state that explicitly sanctions the sale of human oocytes.⁵² Some states, while not expressly mentioning oocytes, have statutes that broadly ban the sale of all body parts for valuable consideration,⁵³ usually with exceptions for blood products and human hair.⁵⁴

51. LA. REV. STAT. ANN. § 9:122 (West 2000) (“The sale of a human ovum, fertilized human ovum, or human embryo is expressly prohibited.”) A Florida statute explicitly bans the transfer of any “human embryo” for valuable consideration, but this does not apply to isolated gametes like semen and oocytes. FLA. STAT. ch. 873.05 (1999).

52. VA. CODE ANN. § 32.1-289.1 (Michie 1999) (exempting “ova” from the general ban on the sale of body parts for any reason).

53. “Valuable consideration” is typically defined so as to exclude associated medical costs, the donor’s out-of-pocket expenses, and lost wages incurred by the donor in connection with the donation.

54. *See* CONN. GEN. STAT. § 19a-280a (1999) (banning the “transfer for valuable consideration any human organ for use in human transplantation” but excluding hair, blood, or blood components from the definition of “human organ”); FLA. STAT. ch. 873.01 (1999) (banning the transfer of any human organ, tissue, or body part for valuable consideration and leaving the parameters of coverage of these terms up to the Agency for Health Care Administration); 720 ILL. COMP. STAT. ANN. 5/12-20 (West 1999) (making the sale of “any part of the human body” a crime but excluding blood and its components, other body fluids, and human hair from the ban); IND. CODE ANN. § 35-46-5-1 (Michie 1999) (prohibiting transfers of human organs for use in human transplantation but limiting definition of “human organs” to kidneys, liver, heart, lung, cornea, eye, bone marrow, bone, pancreas, or skin); MD. CODE ANN., HEALTH-GEN. I § 5-408(a) (1999) (banning the sale or transfer of any human organ or part of a body); MICH. COMP. LAWS § 333.10204 (1999) (proscribing the transfer of human organs or part of human organs for valuable consideration for any purpose, but limiting the definition of “human organ” and exempting blood, blood components, other self-replicating body fluids, and human hair from the ban); NEV. REV. STAT. ANN. § 201.460 (Michie 2000) (prohibiting the “transfer for valuable consideration any human organ for use in human transplantation” but excluding blood from the definition of “human organ”); N.Y. PUB. HEALTH LAW § 4307 (Consol. 1999) (prohibiting the “transfer for valuable consideration any human organ for use in human transplantation” but excluding blood from the definition of “human organ”); OHIO REV. CODE ANN. § 2108.12(A) (Anderson 1999) (prohibiting the transfer of “a human organ, tissue, or eye for transplantation”); TENN. CODE ANN. § 68-30-401 (1999) (banning the transfer of “any human organ for valuable consideration and for use in human transplantation if the transfer affects commerce”); TEX. PENAL CODE ANN. § 48.02(b) (West 1999) (making transfers of “any human organ for valuable consideration” a crime but excluding hair, blood, or blood components from the definition of “human organ”); W. VA. CODE § 16-19-7a (2000) (banning the “transfer for valuable consideration any human

Other states limit commercial bans to solid organs or nonrenewable or nonregenerative tissues,⁵⁵ which arguably do not apply to human oocytes. Unlike solid organs, oocytes are, for all practical purposes, replenishable.⁵⁶ The average woman has approximately 400,000 pre-oocytes (cells capable of becoming oocytes) in her ovaries at puberty.⁵⁷ While it is true that this number is finite, the supply of oocytes is, in reality, unlimited. Under normal conditions, every month that a woman menstruates, only one of these precursor cells differentiates into a mature oocyte under the influence of an intricate set of hormone-driven processes.⁵⁸ The average woman menstruates for about 35–40 years, or 500 months.⁵⁹ Therefore, under normal conditions, a woman never comes even close to using up all of her potential oocytes. Every month, a new set of precursors begins to

organ for use in human transplantation,” leaving the definition of “human organ or tissue” to the director of health but explicitly exempting blood); WIS. STAT. § 146.345 (1999) (stating that “[n]o person may knowingly and for valuable consideration . . . transfer any human organ for use in human organ transplantation” but limiting the definition of “human organ” and explicitly excluding blood, blood components, and semen from the definition). It is noteworthy that many of these statutes only prohibit such sales for the single purpose of transplantation, raising the interesting question of whether oocyte donation for IVF qualifies as transplantation. However, the broad definition of “transplantation” generally used by the medical profession suggests that it does. *See, e.g.*, STEDMAN’S MEDICAL DICTIONARY 1840 (Marjory Spraycar ed., 26th ed. 1995) (defining transplantation as “[i]mplanting in one part a tissue or organ taken from another part or from another individual”). Then again, one could argue that oocytes are not implanted.

55. *See, e.g.*, CAL. PENAL CODE § 367f (Deering 1999) (banning the transfer of “any human organ, for purposes of transplantation, for valuable consideration” but excluding from “human organ” plasma, sperm, and any other renewable or regenerative tissue not otherwise specified); MICH. COMP. LAWS § 333.10204 (1999) (excluding “self-replicating body fluids” not otherwise named from the general ban); 35 PA. CONS. STAT. § 10025 (1999) (banning the “transfer for transplantation or other medical therapy [of] any human organ or nonregenerative tissue for valuable consideration”); S.D. CODIFIED LAWS § 34-26-42 (Michie 2000) (excluding plasma, sperm, and any other renewable or regenerative tissue not otherwise named from the definition of “human organ” for purposes of the ban).

56. It is true that livers are now somewhat replenishable, perhaps blurring the line suggested here. But the fact that almost all of the relevant statutes expressly include livers within the ban makes that observation somewhat immaterial. Regardless of the regenerative capacities of the liver, legislatures have unambiguously established their intent to include livers within the ban. The same cannot be said of oocytes.

57. *See* F. GARY CUNNINGHAM ET AL., WILLIAMS OBSTETRICS 58 (20th ed. 1997).

58. Although only one mature oocyte is produced per menstrual cycle, as many as 30 precursors will begin to differentiate and mature. At some point, one of these candidates becomes the dominant follicle, resulting in the death of the others. Therefore, although only one oocyte is produced per cycle, many of the precursors are destroyed. For a general description of the physiology underlying menstruation, see *id.* at 81–84.

59. *Id.* at 58.

differentiate, and, every month, one mature oocyte emerges from the ovaries. Although limited at some point by the finite number of pre-oocytes, oocytes are entirely replenishable throughout a woman's reproductive life. It is therefore unlikely that oocyte donors will prematurely run out of oocytes prior to menopause.

As noted above, other replenishable tissues, such as sperm and blood, are traditionally exempted from the general ban on the commodification of tissue. Thousands of sperm banks exist across the country, offering modest yet significant financial remuneration to donors. And despite the Red Cross's impressive volunteer blood donor network, a notable market exists for blood, particularly rare blood types. In fact, some individuals with extremely rare blood types have commanded so much money for their scarce biological resource that they have supported themselves entirely through such donations.⁶⁰ Most states have chosen to ban the sale of only organs or nonreplenishable tissues, and exceptions based on regenerative capacities or replenishable reservoirs should logically apply equally to blood, sperm, and oocytes.

Beyond the few state and federal IVF statutes and the highly variable and ambiguous state statutes that regulate the sale of human body parts, there is no legislation in the United States that regulates the practice of oocyte donation. In contrast, many other countries not only have extensive national oocyte donation regulations in general but also possess guidelines that specifically address oocyte donor compensation.

In England, IVF clinics, including those that provide oocyte donation, are licensed and regulated by the Human Fertilisation and Embryology Authority (HFEA) pursuant to the Human Fertilisation and Embryology Act.⁶¹ In addition to licensing and setting practice and screening standards, HFEA also collects and publishes success rates of fertility clinics in its patient's guide. More important for this discussion, HFEA enforces a 15£ (\$25) limit on donor compensation, in addition to expenses incurred, for the express purpose of

60. See *United States v. Garber*, 607 F.2d 92 (5th Cir. 1979) (reversing the conviction of Dorothy Garber for tax evasion when she failed to claim the income she received from repeated sales of her rare blood, which she used to support herself and three children); *Green v. Commissioner*, 74 T.C. 1229 (1980) (determining the taxable nature of income derived from the sale of blood by Margaret Green, who supported herself through repeated sales of her rare AB-negative blood).

61. Human Fertilisation and Embryology Act, 1990, ch. 37 (Eng.).

107] *Towards the Rational Regulation of Oocyte Donation*

preventing the commodification of oocytes.⁶² As one HFEA member said, “In this country we have a 15 [pound] limit because we don’t believe egg donation should be subject to the same whims as any other product in the market place.”⁶³

In Israel, the Ministry of Health oversees fertility practices, limiting both oocyte donor eligibility and compensation. Under present ministry guidelines, only women undergoing IVF themselves may donate oocytes,⁶⁴ and no payment beyond expenses incurred may be made for a donated ovum.⁶⁵

In Australia, Commonwealth regulations require fertility clinic licensure, extensive participant screening, and mandatory outcome reporting.⁶⁶ In addition, regulations forbid the giving or receiving of valuable consideration in exchange for donation of reproductive material, beyond reimbursement for costs incurred.⁶⁷

Clearly then, many countries do not share the United States’ lack of federal governmental oversight of fertility practices and donor compensation. But what are the implications of this reality? Should the United States government play a more active role in the regulation of oocyte donation? What are the arguments for and against greater governmental intervention? Many of the central arguments derive from the more general debate over the commodification of transplant organs. The following part therefore surveys the legislation and underlying policy arguments concerning the sale of organs. The subsequent part addresses arguments specific to the reproductive context.

62. Through a controversial new project, women can also receive free IVF treatment for themselves if they donate half of the oocytes retrieved to other infertile women. The oocyte recipients then finance the procedure. See Sarah Chalmers & Becky Morris, *Scandal of the Egg Donations*, DAILY MAIL (London), Sept. 21, 1999, at 37.

63. Nicole Veash, *Internet Donors Offer Perfect Babies to Order*, THE OBSERVER, Aug. 15, 1999, at 3.

64. See generally Judy Siegel, *Groups Voice Support for Liberalizing Ova Donations*, JERUSALEM POST, Feb. 2, 2000, at 4. A recently introduced bill would remove the current eligibility requirement and thereby allow any woman to donate oocytes for IVF. See *id.*

65. See *id.*

66. See Infertility Treatment Act, 1995 (Austl.).

67. See Reproductive Technology Code of Ethical Clinical Practice, 1995 (Austl.).

III. THE SALE OF ORGANS AND TISSUES IN GENERAL

*A. Current Legal Environment*⁶⁸

Federal law prohibits the sale of human organs. The Uniform Anatomical Gift Act (UAGA)⁶⁹ and the National Organ Transplant Act of 1984 (NOTA)⁷⁰ set out the federal government's position on donor compensation. Both NOTA and UAGA contain anti-commodification provisions that illustrate congressional concerns over subjecting life-saving organs to market forces. For example, UAGA section 10 states, "A person may not knowingly, for valuable consideration, purchase or sell a [human body] part for transplantation or therapy, if removal of the part is intended to occur after the death of the decedent."⁷¹ The language expressly limits its application to situations in which the body part in question is removed after the death of the donor and hence does not apply to oocyte donation.

NOTA section 274e states that "[i]t shall be unlawful for any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce."⁷² The authority to promulgate the precise inclusion criteria for "human organ" is delegated to the Secretary of the Department of Health and Human Ser-

68. For an excellent and comprehensive history of legislation in the realm of body parts prior to 1980, see RUSSELL SCOTT, *THE BODY AS PROPERTY* (1981).

69. Unif. Anatomical Gift Act (1987). The UAGA was originally enacted in 1968 in response to the need for a consistent and coordinated organ donation system in the United States. For more information about the Act, see Alfred M. Sadler, Jr., et al., *The Uniform Anatomical Gift Act: A Model for Reform*, 206 JAMA 2501 (1968). See also SCOTT, *supra* note 68, at 66-74 (providing history of the development of the UAGA).

70. 42 U.S.C. §§ 273-74 (2000). NOTA established the current organ donation and allocation system that is run by the United Network of Organ Sharing (UNOS). UNOS is a private, non-profit organization that contracts with the Department of Health and Human Services to implement transplant organ trafficking.

71. Unif. Anatomical Gift Act § 10(a) (1987). Section 10(b) goes on to state that "[v]aluable consideration does not include reasonable payment for the removal, processing, disposal, preservation, quality control, storage, transportation, or implantation of a part." Section 10(c) makes violations of this section a felony subject to a fine up to \$50,000, imprisonment up to five years, or both.

72. 42 U.S.C. § 274e(a) (2000). Section 274e(b) sets forth the same penalties for violation as the Uniform Anatomical Gift Act, and § 274e(c)(2) provides a definition of "valuable consideration" that is similar to that contained in the UAGA. Of note, however, is the inclusion in this definition of "expenses of travel, housing, and lost wages incurred by the donor of a human organ in connection with the donation of the organ."

107] *Towards the Rational Regulation of Oocyte Donation*

vices,⁷³ who, as of yet, has not extended the definition to include human oocytes.

In addition, the states have adopted the UAGA anti-commodification provision as part of their own anatomical gift acts.⁷⁴ Further, the U.S. Task Force on Organ Transplantation espouses the view that compensation should not be allowed for transplant organs.⁷⁵ However, as with NOTA and UAGA, the language of these statutes and position statements arguably foreclose their application to oocyte donation.

Existing case law has little to add to this discussion. The leading case is *Moore v. Regents of the University of California*.⁷⁶ Plaintiff John Moore underwent treatment for leukemia at the UCLA Medical Center. As part of this treatment, doctors removed Moore's spleen. Although the splenectomy was medically indicated to treat the disease, Moore's doctors failed to disclose their ulterior motives for doing so. Because of the unique nature of the diseased cells, the doctor's were able to establish an immortal cell line from the tissue (named the Mo cell line, after Moore), which had tremendous scientific commercial value—estimated to run into the billions. However, the doctors never disclosed their economic interests to Moore, and he did not discover the truth until years later. When he finally did learn of the financial motivations behind his splenectomy, Moore sued the doctors, the Medical Center, and the University of California for damages based on theories of conversion, breach of fiduciary duty, and lack of informed consent.

73. See 42 U.S.C. § 274e(c)(1) (2000).

74. See, e.g., ALA. CODE § 22-19-40 to -47 (2000) ("Alabama Uniform Anatomical Gift Act"); ARIZ. REV. STAT. § 36-841 to -852 (2000) ("Revised Arizona Anatomical Gift Act"); CAL. HEALTH & SAFETY CODE § 7150-57 (West 2000) ("Uniform Anatomical Gift Act"). One state recently enacted legislation that provides families of deceased donors with up to \$3000 "for reasonable hospital and other expenses, funeral expenses and incidental expenses incurred by the donor or donor's family in connection with making a vital organ donation." 20 PA. CONS. STAT. § 8622(B)(1) (2000). The legality of these payments, intended to increase donation rates, is still in doubt, as it is not yet clear whether such payments would violate NOTA. In an attempt to circumvent this prohibition, the Pennsylvania plan transfers the money directly to a funeral home, hospital, or other service provider, not to the family of the donor, so that arguably no valuable consideration goes directly to the donating party. See *id.*

75. See U.S. TASK FORCE ON ORGAN TRANSPLANTATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ORGAN TRANSPLANTATIONS: ISSUES AND RECOMMENDATIONS (1986).

76. *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479 (Cal. 1990).

The trial court sustained the defendants' general demurrer to the causes of action. After a court of appeals reversed, finding that Moore had adequately stated a cause for conversion,⁷⁷ the California Supreme Court heard the case on review. First, the court held that a cause of action for conversion could not be sustained. Conversion requires that the plaintiff establish interference with ownership or rights of possession.⁷⁸ The court reasoned that, since Moore did not expect to retain possession of his cells following their removal, his conversion claim could only be maintained on a theory of ownership interest.⁷⁹ However, the court found that neither case law nor state statutory law supported the claim that Moore maintained an ownership interest in his excised tissue.⁸⁰ Further, the court concluded that policy considerations counseled against extending the conversion tort to encompass the present claim.⁸¹ Most compelling to the court was the prospect that assigning ownership rights to those in Moore's situation would have a chilling effect on medical research and technological progress, endeavors that significantly outweigh any individual's right to share in the profits derived from his or her excised tissue.⁸²

Second, the court reasoned that the law could protect patients such as Moore without resorting to the theory of conversion.⁸³ As the court stated, "Liability based upon existing disclosure obligations, rather than an unprecedented extension of the conversion theory, protects patients' rights of privacy and autonomy without unnecessarily hindering research."⁸⁴ As fiduciaries, Moore's doctors had an obligation to disclose all conflicts of interest and material information to their patient in order to obtain truly informed consent. Because they had failed to do so, Moore could successfully maintain

77. *Moore v. Regents of the Univ. of Cal.*, 249 Cal. Rptr. 494 (Cal. Ct. App. 1988).

78. *See Moore*, 793 P.2d at 488.

79. *See id.* at 488-89.

80. *See id.* at 488-93.

81. *See id.* at 493-97.

82. *See id.* at 493 (noting that important policy considerations dictate that "we not threaten with disabling civil liability innocent parties who are engaged in socially useful activities, such as researchers who have no reason to believe that their use of a particular cell sample is, or may be, against a donor's wishes").

83. *See id.* at 493-95.

84. *Id.* at 494.

107] *Towards the Rational Regulation of Oocyte Donation*

causes of action for breach of fiduciary duty or lack of informed consent.⁸⁵

The importance of this case in the context of oocyte donation is the proposition that individuals do not maintain a property interest in removed body parts sufficient to maintain a cause of action for conversion, at least according to the California Supreme Court. Such a conclusion raises the possibility that, like Moore, oocyte donors lack a significant property interest in their tissue once it is removed. Therefore, it is conceivable that courts could preclude donors from maintaining an action for breach of contract in the event that the recipients failed to honor the compensation clause of the donation contract. It is not at all clear, however, that the similarities between these two scenarios sufficiently outweigh the differences to justify parallel legal treatment.⁸⁶

Though problematic, this analysis suggests a possible alternative to free alienability or strict anti-commodification regulation, which will be expanded upon later. In short, though, society could allow market-based oocyte donor compensation but at the same time limit or foreclose legal enforcement of such contracts based on this implication of the *Moore* decision. Oocyte donors would have no standing to bring suits for breach of contract if a recipient failed to honor the contract once the oocyte was removed. Likewise, courts could hold that recipients have no property interest in the tissue of others, such that they could not bring suit if donors failed to honor the contract once the compensation was provided. Again, this possible resolution will be revisited later.

While it appears that the current federal and state guidelines that prohibit the transfer of organs for valuable consideration do not

85. *See id.* at 483–85.

86. Central to the *Moore* Court's position was the realization that Moore had at no time prior to its removal conceived of his spleen as a valuable commodity. Indeed, he most likely viewed it as a diseased excrescence to be discarded for the good of his own health. Therefore, endowing Moore with a property interest in the tissue once it was excised made little sense. But oocyte donors, quite to the contrary, do conceive of their oocytes as valuable commodities from the very beginning. It is the commercial value attached to the oocyte that leads many women to donate in the first place. This differs markedly from the *Moore* scenario and may therefore warrant disparate legal treatment. But still, numerous other legal lines speak against a strict property right in the body, even in commercial contexts. Surrogacy contracts in which women receive money in exchange for binding relinquishment of parental rights are void in many jurisdictions. *See infra* note 125. Further, state and federal laws prohibit compensation in exchange for transplantable human organs. *See* 42 U.S.C. § 274e (2000); Uniform Anatomical Gift Act § 10(a) (1987).

technically apply to oocytes, that is not the end of the analysis. Acknowledging the limitations of the current statutory environment, the question of whether policy considerations counsel for or against extending the commodification ban to oocytes must be addressed. Surveying and critiquing the major policy considerations underlying the ban on the sale of organs, and considering their validity in the oocyte context, is an appropriate place to start.

B. Policy Rationales for the Legal Ban on the Sale of Transplant Organs

1. Commodification of the human body belittles the human existence

It is argued that the blatant commodification of the human body inherent in a market-driven system of organ allocation belittles the human existence.⁸⁷ According to this argument, it is morally and ethically suspect to treat derivatives of the body like any other good.⁸⁸ The human body is to be cherished, not set afloat in the mechanistic stream of commerce. While it may be acceptable and even appropriate to reimburse donors for their inconvenience and costs incurred in donation, remuneration over and above the amount needed to make the donor whole again is objectionable. When this happens, financial motivations become an incentive to donate, blurring the line between altruism and profit-maximization, and between

87. Margaret Jane Radin, an outspoken opponent of the universal commodification of the human body, has argued that “the characteristic rhetoric of economic analysis is morally wrong when it is put forward as the sole discourse of human life.” Margaret Jane Radin, *Market-Inalienability*, 100 HARV. L. REV. 1849, 1851 (1987). She further argues that “[t]o speak of personal attributes as fungible objects—alienable ‘goods’—is intuitively wrong.” *Id.* at 1880. See also THOMAS H. MURRAY, *THE WORTH OF A CHILD* (1996); MARGARET JANE RADIN, *CONTESTED COMMODITIES* (1996).

88. Professor Radin differentiates goods that are appropriate for commodification from goods, such as the human body and its derivatives, that are inappropriate for commodification because the latter are irrevocably intertwined with our concepts of personhood so that commodifying them would alter our existence to one of chattel. This re-definition of the body and individuals themselves would therefore hinder what Radin refers to as “human flourishing” by replacing interpersonal relationships with emotionless market associations. It is her opinion that “[s]ystematically conceiving of personal attributes as fungible objects is threatening to personhood, because it detaches from the person that which is integral to the person. . . . Market rhetoric, the rhetoric of alienability of all ‘goods,’ is also the rhetoric of alienation of ourselves from what we can be as persons.” Radin, *supra* note 87, at 1881, 1884–85.

person and property.⁸⁹ The market is driven by efficiency, not morality, and is therefore irreconcilable with integral, non-efficiency-based aspects of human existence. For these reasons, the sale of organs guarantees to undermine the expressive aspects of the human body and human existence.

But this argument proves too much. Its basic premise—that society should not foster or even condone the commodification of the human being—is itself irreconcilable with reality. The fact is that we live in a market economy. Competition and commodification are cornerstone economic philosophies to which we subject the entire population every day, in numerous ways.

Intelligence is the best skill to possess in our labor markets. Professionals, such as doctors, lawyers, and businesspersons are paid handsomely for the use of their intellect. Sharp intellect equals prestigious education, which in turn leads to a well-paying job. Entertainers are paid for their personality, good (or at least interesting) looks, and wit. Athletes are paid for their athletic prowess. Research subjects are paid for “volunteering” their bodies for scientific experimentation and advancement. Genetic sequences are patented, just like any other product, leading to multi-billion dollar industries. Damages in personal injury cases derive from standardized charts that place values on various body parts. And if one is looking for unequivocal evidence of society’s commodification of the physical body, one need look no further than the latest issue of *GQ* or *Vogue*. The fashion and modeling industries are founded on the reality that beauty sells. Just ask Ron Harris.

To argue that the commodification of individual attributes, even physical attributes, is antithetical to our conception of personhood or human flourishing is to indict our entire way of life. In reality, the majority of wealth in this world is distributed along lines of human capital. Our bodies and our abilities are the most valuable commodi-

89. Again, quoting Radin:

In our understanding of personhood we are committed to an ideal of individual uniqueness that does not cohere with the idea that each person’s attributes are fungible, that they have a monetary equivalent, and that they can be traded off against those of other people. Universal market rhetoric transforms our world of concrete persons, whose uniqueness and individuality is expressed in specific personal attributes, into a world of disembodied, fungible, attribute-less entities possessing a wealth of alienable, severable “objects.” This rhetoric reduces the conception of a person to an abstract, fungible unit with no individuating characteristics.

Id. at 1885.

ties we possess. Of course, this reality does not preclude one from mounting a coherent and convincing Marxian argument that all forms of human commodification are inappropriate. But faced with the pervasiveness and nearly unanimous acceptance of such commodification across so many realms, it seems entirely arbitrary to draw the line at organs. How is selling one's kidney any more injurious to our collective conception of personhood than selling one's body for scientific experimentation?

Of course, even if there is some inherent moral weight to consistency, it is not absolute. If unique circumstances surrounding organs or oocytes counsel against the presumption of consistency, then differential treatment may be justified. But this argument against commodification of the body for the sake of preserving conceptions of personhood and human flourishing encounters further, not fewer, difficulties when applied to the specific context of oocyte donation.

It cannot be denied that reproduction and child rearing are integral to our conceptions of personhood and human flourishing. For many, such practices are the ultimate goal and validation of their very existence. Therefore, in addition to the arbitrary line drawing, proponents of anti-commodification must overcome the inescapable consequence that they are denying many infertile individuals the ability to fully experience human flourishing as we understand it. This is so because the absence of markets for oocytes is likely to lead to a shortage of donors. As will be discussed in greater detail in the following section, the experience of countries that remove oocyte donation from market control, like England and Israel, is one of drastic shortage. Lacking sufficient financial incentives, potential donors are unwilling to subject themselves to the retrieval process, leaving thousands of infertile couples on long waiting lists. There is no reason to believe that the American experience would be any different.

Considering the criticisms and consequences of a strictly moral objection to the commodification of reproductive tissues, it becomes somewhat of a strawman. If any rational basis does exist for distinguishing organs and oocytes from the myriad other socially condoned commodifications of the human body, it must lie elsewhere.

2. Commodification will undermine the altruistic and communitarian motivations that currently underlie charitable donations

It has been argued, primarily in the context of blood donation, that providing financial remuneration to donors would result in a de-

crease in the number of charitable donations. In his book *The Gift Relationship*, Roger Titmuss suggested that paid blood donation would undermine the altruistic motivations that lead individuals to donate their blood for free.⁹⁰ By paying for such donations, society would implicitly devalue the meaning of charitable donations by inappropriately putting a price tag on them.⁹¹ Individuals who would have otherwise donated their blood for free would be persuaded by self-interest to ask for the compensation they now thought they deserved. The intrinsic, altruistic reward would be displaced by the extrinsic, self-interested lure of financial compensation.

Whether or not such a shift would lead to an overall increase or decrease in donations is arguable and likely depends on the amount of compensation provided. But Titmuss was concerned with more than just decreasing numbers of blood donors. He was also concerned with the broader social implications that such a shift would endorse. Moving from a blood donation system based on altruism to a system based on compensation would lead society further away from communitarian, collectivist attitudes and conceptions and more towards the self-interested, individualist existence that Titmuss feared. For him, a charitable system of blood donation exemplified and reinforced the sense of community that was appropriate and necessary for our continued existence and prosperity.

Variations of the same argument can be made in the context of oocyte donation. Such arguments typically posit that the introduction of financial compensation into the oocyte donation process will both inappropriately alter the meaning of donation and lead to a reduction in charitable donations. However, there are difficulties with this analysis, and they apply with equal force to blood and oocytes.

90. RICHARD M. TITMUSS, *THE GIFT RELATIONSHIP: FROM HUMAN BLOOD TO SOCIAL POLICY* (1971).

91. As Titmuss states:

Where are the lines to be drawn—can indeed any lines at all be pragmatically drawn—if human blood be legitimated as a consumption good? To search for an identity and sphere of concern for social policy would thus be to search for the non-existent. All policy would become in the end economic policy and the only values that would count are those that can be measured in terms of money and pursued in the dialectic of hedonism. Each individual would act egoistically for the good of all by selling his blood for what the market would pay. To abolish the moral choice of giving to strangers could lead to an ideology to end all ideologies.

Id. at 12.

With regard to blood donations, the status of our nation's blood reserves has undergone change since Titmuss' book—change that requires a reevaluation of Titmuss' contentions.⁹² Originally, blood donation was compensated. However, when the Red Cross began soliciting the charitable donation of blood, it was thought that demand could be adequately met without resorting to financial inducements. Although paid collections continued to exist, they were significantly outpaced by the Red Cross's charitable donation service.⁹³ At the time that Titmuss wrote his book, charitable donations were generally sufficient to satisfy demand, and there was occasionally an annual surplus.⁹⁴ It was from this perspective of excess that Titmuss made his argument against compensation for blood donation.

Since then, however, trends in blood donation have shifted. Charitable donations have declined, resulting in a shortage of blood.⁹⁵ Reserves are shrinking, and demand now outpaces supply.⁹⁶ This new reality requires us to view the charitable versus compensated donation debate from a different perspective than Titmuss did in 1970. Unlike then, we no longer have the luxury of assuming that charitable donations will be sufficient to meet society's need for blood.

So what does this mean for the Titmuss argument? On an analytical level, it is hard to say. The fact that charitable donations have declined could be seen as support for his central thesis. It is possible that the existence of a compensated system of blood donation even-

92. For an in-depth history of blood donation practices and legislation, see SCOTT, *supra* note 68, at 190–96.

93. *See id.*

94. For instance, in 1967, over 6.6 million units of whole blood were collected, while only 4.3 million units were transfused. TITMUSS, *supra* note 90, at 58.

95. *See, e.g.*, Jonathan Curiel, *Call for Blood Donations in 'Very Critical' Situation*, S.F. CHRON., Jan. 5, 2000, at A13; Irene Garcia, *Blood Shortage Prompts Sherman, Others To Roll Up Sleeves; Health: Attributed in Part to Flu Outbreak, Deficiency Is Said To Be the Worst in More Than Two Decades*, L.A. TIMES, Jan. 25, 2000, at B2; Jacqueline L. Salmon, *Search for Blood Donations*, WASH. POST, Feb. 17, 2000, at V03; *Saturday Early Show: Nation's Blood Supply Reaching Critically Low Levels* (CBS television broadcast, Jan. 15, 2000); *CNN Your Health: Government Warns of a Blood Shortage* (CNN television broadcast, Oct. 23, 1999).

96. *See, e.g.*, *Dire Blood Shortage*, S.F. CHRON., Dec. 13, 1999, at A24 (noting that "Californians needed an estimated 1.1 million pints of blood this year but only 898,000 pints were collected by the state's blood banks"); Jacqueline L. Salmon, *Donors Needed as Area Reports Blood Shortages*, WASH. POST, Feb. 19, 2000, at V03 (noting that blood donations in the Washington, D.C. area are not keeping pace with demand).

tually led to a devaluation of altruism and ultimately undermined communitarian values, just as Titmuss proposed. On the other hand, the decline in charitable donations could have been due to some factor other than a compensation-induced paradigmatic shift towards self-interested values and behavior. Without well-controlled and detailed longitudinal studies of societal values and attitudes towards blood donation, it is impossible to tell.

But this analytical debate is merely peripheral. What is of central importance and concern is the practical effect of the decline in charitable donations and the consequent shortage with which we are now faced. From our current position of shortage, knowing that we cannot rely on charitable donations to meet our blood demands, what is the appropriate moral stance to take? Do we, in the name of altruism and communitarian values, ban compensation for blood donations and thereby likely worsen the shortage? Or, for the sake of maintaining our blood supplies and minimizing the number of people who must go without, do we offer adequate compensation to entice sufficient donations?

The same moral question can be asked in the context of oocyte donations. As noted earlier, and as expanded upon in Part V, countries that prohibit oocyte donor compensation find themselves facing severe donor shortages, resulting in waiting lists of several years. These shortages preclude couples from exercising their procreative liberty and realizing their reproductive desires. The United States, by contrast, with its currently unregulated, market-driven system of oocyte donation, has a donor pool that adequately meets demand.⁹⁷ Assuming that procreative liberty is a right worth protecting, then what is the appropriate path to take? Do we deprive couples from exercising that liberty in the name of altruism and communitarian values, or do we allow for sufficient compensation to guarantee a stable source of oocytes?

In an ideal world, charitable donations, whether of blood or oocytes or any other valuable resource, would prove sufficient to meet societal needs. And in such an ideal world, a strong argument could be made that the prohibition of compensation for the donation of such resources is the appropriate moral stance. Under these condi-

97. The long lists of available donors at each clinic and website that are ready and willing to begin the protocol evidence this fact. Accordingly, there is no data relating to the average waiting time for recipient couples in the United States.

tions, reinforcement of communitarian values would have no adverse effect on supply. But this is not the ideal world, and, as the domestic blood shortage and foreign oocyte shortages illustrate, we cannot rely on charitable donations to provide adequate supplies. Therefore, the reinforcement of communitarian values is now at odds with the maintenance of adequate supplies of blood or oocytes, and we are faced with a dilemma that did not plague Titmuss: Which is more important, reinforcing charitable, communitarian values or minimizing the number of individuals who must go without blood or oocytes? Under such circumstances, the fostering of altruistic ideals should not trump compensation-induced increases in supply. We defeat the ideal of altruism when its direct consequence is harm to others.

Furthermore, Titmuss was concerned that financial incentives would jeopardize the quality of the donated blood.⁹⁸ Because of the lure of money, poor individuals harboring infectious diseases would have reason not to disclose their medical history and donate blood that could harm or even kill its recipient. But again, we must re-evaluate Titmuss' argument in the light of present day.

The transmission of infectious diseases through tissue or blood is no longer a major threat. We have extremely accurate screening techniques for the major blood-borne infectious diseases, eliminating that concern. In addition, specific to the oocyte context, quality assurances are built into the selection process. Unlike blood donors, oocyte donors are carefully screened through histories, physicals, and diagnostic and genetic testing. Recipients choose their donors on the bases of health and fitness. Therefore, quality is much less of a concern, even if oocyte donors donate for financial reasons.

Because of these practical and technical constraints on an exclusively charitable system of oocyte donation, this line of argument appears insufficient to sustain a ban on the commodification of oocyte donation, just as it failed to sustain a ban on the commodification of blood donation in this country.

98. TITMUSS, *supra* note 90, at 76 ("As a market transaction, information that might have a bearing on the quality of the blood is withheld if possible from the buyer; such information could be detrimental to the price or the sale.").

3. Markets in body parts can and do lead to coercion, theft, and murder

Another rationale offered for the current ban on the sale of transplant organs is that the creation of markets in body parts will generate dangerous incentives for abuse.⁹⁹ The existence of such a market would transform organs into extremely valuable commodities. First, the market would quickly lead to stabilization of the monetary values associated with organs, i.e., the creation of a market price. With price stabilization comes the reliable assurance that any particular organ can be sold for a specific value. Such assurances would make the sale of organs more desirable than a system under which the compensation received was uncertain. Second, a market would provide liquidity in organs. A structured market centralizes transactions: it brings sellers and buyers together. Consequently, someone who has an organ to sell does not have to worry about finding someone to buy it. Again, such assurances would make the sale of organs more reliable, and hence more desirable. This combination of price stabilization and liquidity would therefore facilitate and provide incentives for the sale of organs for valuable consideration.¹⁰⁰

Assuming that this proposed market influence is accurate, what is wrong with creating incentives for transactions in transplant organs? The argument is that once a stable market exists in which to sell high-priced organs, individuals desperate for money will either co-

99. See, e.g., ALAN HYDE, *BODIES OF LAW* 67 (1997) (“I assume that treating organs as commodities would indeed increase the supplies available for transplantation, but I express no opinion on whether this would come about primarily through benign incentives for voluntary transfers or, instead, through the murder and dismemberment of the powerless, though my instincts run to the latter rather than the former.”); SCOTT, *supra* note 68, at 183 (noting that “[m]any people disapprove of the sale of human body parts on the ground that it is . . . filled with possibilities of abuse, ranging from the exploitation of children and other helpless people to encouragement to murder”).

100. To illustrate this market effect, imagine that you are urgently in need of \$20,000, for whatever reason. You own two cars, and you consider selling one of them to obtain the money. You know that car A is worth \$20,000 because it is bought and sold all the time, and there are numerous advertisements from buyers and sellers in the newspaper. However, there are no advertisements from sellers or purchasers of car B. You have no idea how much it is worth or if you could even find an interested buyer. Which car are you more likely to sell? Now imagine the reverse scenario. You have \$20,000 with which to buy a car, and you are considering two different models. One is commonly bought and sold, so you have a good idea how much it is worth and know that you can easily find a seller. The other is not commonly bought or sold, resulting in uncertainty of value and availability. Which car are you more likely to buy? The point is, when a market exists in a certain good, there is much more of an incentive for both buyers and sellers to transact.

erces others to sell their organs or will steal organs for profit.¹⁰¹ Hence, a market in organs will constitute a danger for all by effectively placing price tags on our bodies.¹⁰² There are, however, several reasons why such concerns may miss the mark.

First, there is little reason to assume that similar dangers are not equally prevalent in the absence of an established, publicly endorsed market in human organs. Thieves, murderers, and coercive individuals are not likely to be dissuaded merely by the lack of a legitimate organ market. As long as a black market exists, the financial incentive to obtain organs exists. In fact, such concerns have already been borne out in several countries, where defenseless individuals, both living and dead, have been harvested for organs that were then sold on the black market.¹⁰³ Urban legend posits similar atrocities in the United States,¹⁰⁴ but, thankfully, there have been no verified cases

101. The dangers are different, but of similar nature, for living and dead donors. For living donors, the fear is that family members or acquaintances will coerce the donor into “donating” an organ out of financial necessity or greed. It is also possible that individuals could murder for this money. For dying donors, the fear is that financial motives of family members or physicians could inappropriately influence decisions to withdraw or withhold life-saving care. For dead sources, the concern is that doctors and hospitals might harvest organs without consent.

102. Again, using the automobile analogy, which are you more tempted to steal—a popularly traded car with a \$20,000 price tag on it or a car of unknown value that is not commonly traded?

103. See, e.g., Lance Laytner, *The Organ Trade: The Illegal Selling of Body Parts for Transplants Is Big International Business*, IRISH TIMES, July 5, 1999, at 10 (chronicling the arrest of two Chinese men in New York when they attempted to sell human organs harvested from executed Chinese prisoners to undercover FBI agents); *Organ Thefts Investigated*, HOUSTON CHRON., Sept. 18, 1999, at 25A (reporting that Turkish Prime Minister Bulent Ecevit was instigating a probe into reports that groups were cutting open bodies of people killed in the August 1999 earthquake to illegally harvest their organs); *Orphanage Accused of Organ Theft*, SEATTLE TIMES, Mar. 20, 1999, at A5 (reporting that Egyptian authorities were investigating Parliamentary allegations that an orphanage sold the organs of some of its children to hospitals that cater to wealthy Arabs, resulting in the death of a number of children); *CNN Saturday: International Authorities Investigate Human Organ Market* (CNN television broadcast, Nov. 13, 1999) (discussing the founding of Organ Watch, a Berkeley, California based group that tracks the international organ market, watching for human rights abuses).

104. Many have heard of “the friend of a friend” who woke up in a bathtub full of ice, having been drugged and had his kidney removed. However, there have been no verified incidents of this nature, and such stories are believed to be merely myths. See, e.g., Jill Burcum, *Health Rumor Reality Check*, MINN. STAR TRIB., Apr. 4, 2000, at 1E (dispelling a number of domestic health rumors, including “The Kidney Heist” myth); Benjamin Radford, *Bitter Harvest: The Organ-Snatching Urban Legends*, 23 SKEPTICAL INQUIRER 34 (1999) (dispelling domestic myths of organ theft); Angela Shah, *Somebody Stole My Kidney! (and Other Urban Legends)*, AUSTIN AM.-STATSMAN, Sept. 11, 1999, at D1 (uncovering the falsehoods behind various rumors of kidney theft in the United States).

yet. It appears then that the threat of abuse is somewhat independent of an established market in organs.

Second, it is quite possible that the development of a stable market in organs would mitigate, rather than facilitate, opportunities for abuse. Like a monopolist, sellers in a black market benefit from the absence of buyers' alternatives. With nowhere else to turn, buyers are held hostage by the demands of the only available supplier. This power dynamic allows those "who have" to force unilaterally beneficial terms on those "who need." Two characteristics specific to the transplant context further undermine buyer empowerment: the urgency inherent in the need for a life-saving organ transplant and the drastic shortage of transplant organs in this country.¹⁰⁵ Both of these realities serve to increase the sense of desperation on the part of buyers, making them even more susceptible to supplier coercion.

But with a market comes competition. And with competition comes choice, which leads to a shift in buyer-seller power dynamics. Illegitimate suppliers are no longer able to extort inflated prices from desperate buyers, and no longer enjoy the luxury of knowing that they can find a willing buyer at all, due to the presence of competing suppliers. Thus, the creation of a market could actually lead to disincentives for abuse.

Third, to continue the use of market rhetoric, organs are not entirely fungible goods, whether or not a market exists. Due to physical¹⁰⁶ and immunologic¹⁰⁷ constraints, particular organs are of value

105. As of 2000, the number of patients on organ transplant waiting lists had grown to 72,582. United Network for Organ Sharing, *Critical Data: U.S. Facts About Transplantation* (visited Oct. 30, 2000) <http://www.unos.org/Newsroom/cridata_main.htm>. To put this growth into perspective, the current list is more than twice as large as it was at the end of 1993—33,394—and approximately four times its size at the end of 1988—16,026. United Network for Organ Sharing, *Waiting List* (visited Oct. 30, 2000) <http://www.unos.org/Newsroom/cridata_wait.htm>. And these numbers reflect only those who are already on the waiting lists. In reality, there are many more in need of organ transplantation who are not yet registered. The reason that the waiting list continues to grow year after year is because donation rates, despite their consistent increases, are failing to meet the demand. During the same time period noted above, the number of organ donors increased as well but not at nearly the same rate. In 1988, there were 5,907 total organ donations. United Network for Organ Sharing, *Donors* (visited Oct. 30, 1999) <http://www.unos.org/Newsroom/cridata_wait.htm>. In 1993, this number had climbed to 7,766, and in 1998, it had grown to 10,073. *Id.* This 68% increase sounds impressive, but it is dwarfed by the concurrent 300% increase in the total size of the waiting list.

106. Physically, organ donors and recipients must be of similar size in order for the organ to fit in the appropriate space. Therefore, adult organs are usually too big for pediatric recipients.

only to particular recipients. Therefore, extensive matching analyses are necessary prior to any donation. In addition, donors must undergo medical histories and exams to assure their suitability as donors.¹⁰⁸ This means that the source of the organ must be verified at the outset. The need for such identification and documentation serves as an intrinsic protection against unconsented, anonymous transactions.

The proposition that the establishment of a market in organs would lead to increases in abuse is therefore highly speculative. But even assuming the validity of that assertion, there is ample reason to believe that the same concerns are not relevant to the oocyte context.

First, due to the technical realities of oocyte harvesting highlighted in Part II, oocytes are not as susceptible to theft as transplant organs. One cannot just abduct a woman and steal her oocytes. It requires a month-long series of hyperstimulation injections just to reach the point of accessibility, and, even then, only a short window of opportunity exists for harvesting oocytes. Therefore, unless society is worried that women will be kidnapped, restrained for a month, and subjected to ovarian hyperstimulation, and then harvested for oocytes, there is little cause for concern. The fact that we currently have a free market in oocyte donation and there have yet to be any claims or documentation of oocyte theft should, at the very least, be comforting. And if we really are concerned about such abuses, why are we comfortable with women undergoing IVF at all? The poten-

107. Organ donors and recipients must also match immunologically. As an eminent textbook on the subject notes, "The immune system has evolved elaborate and effective mechanisms to protect the organism from attack by foreign agents, and these same mechanisms cause rejection of grafts from any other individual except one who is genetically identical to the recipient." RICHARD A. GOLDSBY ET AL., IMMUNOLOGY 517 (4th ed. 2000). Essentially, the success of organ transplants depends heavily on the degree of matching of specific genes between the donor and the recipient. The products of these genes are proteins that regulate the immune response to the presence of foreign tissues. The more similar the profile between donor and recipient, the less intensely the recipient's immune system attacks the newly transplanted organ. Therefore, identity is everything in organ transplantation, such that all donors and recipients must undergo extensive genetic testing prior to transplantation. This process is called "matching." For an excellent review of transplant immunology, see *id.* 517-35.

108. Solid organs can harbor infectious diseases and even undetected cancers, which can then be transmitted to the organ recipient. Therefore, donors must undergo the appropriate medical screening tests before qualifying as a viable donor. Both state legislatures and the industry itself impose such requirements. For examples of state statutes necessitating donor screening, see *supra* note 44. For typical industry guidelines, see *Screening Criteria* (visited Dec. 2, 2000) <http://www.fertilityoptions.com/html_pub/guid_sc.htm>.

107] *Towards the Rational Regulation of Oocyte Donation*

tial for theft and murder is exactly the same for a woman undergoing ovarian stimulation for her own IVF cycle as for a woman undergoing ovarian stimulation for oocyte donation. But no one is calling for a ban on IVF in the name of safety. Clearly, then, any line drawing must be based on some other concern.

Second, the life-or-death urgency faced by those in need of transplant organs is not present in the oocyte context. A person will die immediately without a life-saving organ.¹⁰⁹ However, without an oocyte, no similar irreversible line is crossed. True, infertility remains, but it can be resolved just as well a month later. This reduced sense of urgency makes resort to desperate measures, such as theft and murder, less likely.

Third, as in the transplant organ context, the need for donor identification and documentation serves as an intrinsic protection against unconsented, anonymous oocyte transactions. The basic premise of a market in oocytes is that all oocytes are not of comparable worth. Some oocytes are more valuable than others, and this value derives from the identity of the source. At the most basic level, oocytes carrying particular genetic diseases are virtually worthless for donation.¹¹⁰ But further distinctions are drawn depending on the social and personal desirability of particular genetic characteristics. For instance, recall the couple introduced in Part I. For them, an oocyte from a donor with particular intellectual, physical, and athletic characteristics was worth substantially more than an oocyte chosen at random from a group of medically appropriate donors. The point is that the value of a particular oocyte in a market depends entirely on the identity of the source, such that anonymous donor oocytes are of little value. Therefore, there is no room for theft, unless the thief reveals and guarantees the identity of the source. But by doing that, the thief would all but seal his or her conviction. Fourth, for the reasons noted above, it could again be argued that the existence of an established market would decrease, not increase, the incentives for abuse.

109. Kidneys, of course, do not fall into this category of "life-saving organs," due to the presence of dialysis.

110. No individual wants to select an oocyte that harbors a genetic disease, because that disease could then be transmitted to the offspring. Therefore, oocytes that harbor serious diseases, such as Huntington's chorea, Tay-Sachs disease, or sickle-cell anemia are of no value at all for oocyte donation. For this reason, the identity and genetic profile of the oocyte donor are paramount.

In the end, it is difficult to say with certainty whether or not a significant possibility for abuse inheres in a free market for oocytes, over and above the dangers presented by the alternative black market. This being the case, such concerns seem to be an insufficient justification for depriving individuals both of procreative liberty and the right to make freely what is not clearly an unreasonable or irrational decision—to donate their oocytes for partially or even purely financial reasons.

4. Free alienability of organs will have a discriminatory impact on both donors and recipients

A fourth argument central to the organ commodification debate focuses on the disparate effects that subjecting life-saving resources to market control will have on differing socioeconomic groups. The general proposition is that a system of free alienability would favor those who have financial resources at the expense of those who do not.¹¹¹ On the demand side of the equation, only those who could afford to pay the market price would receive the organs, effectively precluding access to the poor. On the supply side, due to the declining marginal utility of money,¹¹² donor compensation would create disproportionately greater incentives for poor individuals to donate

111. See, e.g., ROBERTSON, *supra* note 21, at 225 (noting that “the distribution of wealth operates as a prime determinant of who exercises reproductive rights”). Professor Robertson goes on to explain that

[c]lass and money may also influence the roles individuals play in the collaborative reproductive process. . . . Since donors and surrogates are usually paid for their contribution, the danger is that only the middle class and wealthy will have the resources to hire them, while only the lower classes will be inclined to assume these roles. If this is so, money and class will greatly skew the distribution of roles and services in collaborative reproduction.

Id. at 226. See also TED PETERS, FOR THE LOVE OF CHILDREN: GENETIC TECHNOLOGY AND THE FUTURE OF THE FAMILY 68–69 (1996); SCOTT, *supra* note 68, at 183 (noting that “[s]ome critics claim that, under free enterprise, only the poor will sell body parts and only the affluent will be able to buy them, so that the possibility of buying a body or burying one intact could become a luxury available only to the wealthy”).

112. The concept of “declining marginal utility of money” refers to the fact that the more money one has, the less an additional dollar is worth to that person because it only minutely increases overall wealth. For example, imagine that person A has \$1,000,000 dollars, and person B has \$1,000. Due to the declining marginal utility of money, an additional \$1,000 is worth less to A than B. For A, that additional money only increases net worth by 0.001%. However, that same money would increase B’s net worth by a full 100%.

than wealthy individuals.¹¹³ This would lead to a situation in which the poor served as paid organ reservoirs for the wealthy.¹¹⁴ Distribution according to wealth thereby promises to discriminate against poor populations, both as organ donors and recipients.

Even if this simplistic economic analysis were true, and there are reasons to doubt that it is,¹¹⁵ it is far from clear that it closes the door on the commodification position.

a. Demand side. Focusing first on the demand side, equality of resource distribution across socioeconomic levels is certainly not a general guiding principle in our society (or any market economy for that matter). If it were, we would tolerate no expensive commodities that only some could afford. But this is clearly not the case, as almost any example will illustrate. Consider the Rolls Royce. Luxury, prestige, and comfort at its finest. Accessible only to the lucky few but tolerated nonetheless because the existence of the Rolls Royce does not preclude the less wealthy from buying a Honda, a Saturn, a bicycle, or taking the bus. We generally tolerate that only the wealthy can afford access to the best, as long as there exist reasonable alternatives—albeit lower quality alternatives—for the rest. If there is any force behind the discriminatory organ distribution argument then, it must be because organs are distinguishable from other goods in some relevant respect.

Are organs different? They are arguably different because their distribution impacts much more than just creature comforts. Indeed, the distribution of organs directly determines who may live and who may die. There can be no graver consequence than this, and maybe that is why organs deserve preferential treatment. Perhaps life or

113. For organs such as the heart and pancreas that are necessary for life, the monetary incentives of donation would fall on the family members, not the potential donor himself, because the donor would obviously no longer be living. But this arguably changes little, as families are likely to be in the same socioeconomic class as the potential donor and will hence face the same incentives.

114. See ROBERTSON, *supra* note 21, at 227 (“Carried to extremes, a breeder class of poor, minority women whose reproductive capacity is exploited by wealthier people could emerge.”).

115. First, such a conclusion assumes that the costs of obtaining organs would fall on the patient. However, it is possible that insurance companies would shoulder such costs. This may still not solve the discrimination problem, because many of the nation’s poorest groups lack insurance and would hence still be left out in the cold—unless universal health care eventually becomes a reality. Second, by turning the organ market loose, there may be enough incentive to donate that supply would meet and even exceed demand, thereby driving down costs to manageable levels, such that all could afford.

death decisions should not turn on a criterion such as wealth. It could be that the application of such a criterion in this context is inappropriate because it articulates the unambiguous message that society categorically values the lives of one group (the wealthy) more than the lives of another group (the poor). In the end, it is nothing more than another form of the “social worth” criteria that were originally employed to determine the distribution of scarce chronic dialysis resources.¹¹⁶ Such criteria were universally condemned as failing to make morally relevant distinctions and acknowledge the similar value of all individual lives. Maybe a market in transplant organs sends the same message and should therefore be banned.

But even if this argument was correct, it loses its significance when translated into the oocyte context. What makes the organ context unique—what differentiates it from oocytes—is the life-or-death, all-or-nothing nature of organ allocation. Because people will die without life-saving transplants, and because there are not enough organs available to save everyone, no matter how we allocate organs, some people are effectively left for dead.¹¹⁷ Every person who re-

116. In the early 1960s, Dr. Belding H. Scribner, a nephrologist on the faculty of the University of Washington School of Medicine, established the first chronic dialysis center to treat individuals with end-stage renal disease. Unfortunately, the center could only accommodate nine beds. Because demand far outstripped this capacity, the center had to decide who to treat and who to exclude. In order to make these difficult decisions, two committees were established. The Medical Advisory Committee, composed of physicians, selected patients who were medically and psychiatrically suitable. The Admissions and Policy Committee, composed of seven anonymous community members from various backgrounds, then chose which of the pre-qualified candidates would receive the dialysis treatment. Instead of using strict and abstract selection criteria, the committee undertook a case-by-case analysis of each applicant, considering extensive personal, social, psychological, and economic factors (such as age, gender, marital status, number of dependents, income, educational background, occupation, past performance, and future potential). For several years, the committee used these “social worth criteria” to decide who would receive the treatment. When word of this selection process spread, public outcry brought it to an end. See ALBERT R. JONSEN, *THE ETHICS OF ORGAN TRANSPLANTATION AND ARTIFICIAL ORGANS* 211–14 (1999). See also RENÉE C. FOX & JUDITH P. SWAZEY, *THE COURAGE TO FAIL: A SOCIAL VIEW OF ORGAN TRANSPLANTS AND DIALYSIS* (1974) (providing a vivid and complete portrayal of the committee).

117. As a result of the growing gap between the supply and demand of life-saving transplant organs, the number of individuals who die while awaiting transplant continues to grow. In 1988, 1,494 individuals lost their lives while on the waiting lists. United Network for Organ Sharing, *Waiting List: Number of Patients Removed from the OPTN Waiting List Due to Death* (last visited Nov. 16, 2000) <http://www.unos.org/frame_Default.asp?Category=News-data.htm>. By 1993, that number had risen to 2,883. See *id.* And by 1998, despite the fact that nearly 22,000 transplants were performed, the number of deaths while waiting had reached 4,855. See *id.* Currently, approximately 14 people die every day waiting for a transplant. See *id.*

ceives an organ diminishes the chance that some other person will receive an organ and thereby increases the chance that someone else will die. Only in the context of kidney disease, where it is possible to keep a person alive with dialysis, is there a viable alternative to transplantation. But in the majority of transplant cases, there are no long-term options, either of comparable or lesser quality: you either receive an organ, or you die. There is no middle ground. There is no less expensive, lower quality substitute. Therefore, allocation of organs along lines of wealth results not in a distribution where the wealthy get the best and the poor get the rest but a distribution where the wealthy get life and the poor get death. It is this lack of a cheaper, alternative means for the poor to achieve the same ends as the wealthy—the all-or-nothing aspect of organ allocation—that makes market controlled distribution of life-saving transplant organs unconscionable.

Oocytes do not share this critical characteristic of all-or-nothing, life-or-death concerns. To begin with, oocytes, unlike organs, are not scarce resources in this country, at least not currently. Presently, the supply of oocytes meets their demand, such that one couple's purchase of an oocyte does not decrease the chances that some other couple will find a donor. In addition, oocytes of varying value exist, such that "lower quality," less expensive alternatives exist for those who cannot afford to pay \$50,000 for the ideal donor. Even in the face of recent skyrocketing in donor compensation, most fertility agencies and individual donors continue to ask only a few thousand dollars for the provision of oocytes, enough to compensate the donor for costs and inconveniences, but no more. True, this probably means that only the wealthy will have the luxury of hand-picking donors with the most socially and personally desirable characteristics, but it does not foreclose those with fewer resources from achieving the same ends via less expensive means. Unlike organ allocation, oocyte allocation offers options. Oocyte allocation is not an all-or-nothing, life-or-death proposition, and that is the key distinction.

Furthermore, there is a significant moral difference between saying, "Sorry, we do not have enough of this vital resource to support us all, so unless you have enough money available, we are going to let you die," and saying, "Sorry, only those who can afford it will receive the most valued reserves of this important, yet not scarce or vital, resource. The rest of you can still have access, but only to the lesser valued reserves." The two statements express very different

ideas. The former, again, expresses the proposition that the lives of the poor are not worth as much to society as the lives of the wealthy. The latter expresses the proposition that the opportunities of the poor are not as expansive as the opportunities of the wealthy. One is an arbitrary, categorical devaluation of a diverse group of individuals, while the other is a sad, but true, tenet of a market economy. The right to procreative liberty is qualitatively different than the right to equal access to life saving transplant organs.

The current supply surplus could change, of course, and probably would if donor compensation were banned as in other countries. And if this were the case, then allocation by wealth could preclude the poor from any access at all. But this is an argument for, not against, market-based compensation rates for oocyte donors. Banning compensation erases the wealth distinction, but forces us all into a situation of scarcity such that some are guaranteed not to have any access at all. Permitting compensation, on the other hand, does allow for more expansive options for the wealthy than the poor but at least provides access for all.

There is no positive constitutional guarantee for the right to procreate, only a negative right,¹¹⁸ and this reality is consistent with the analysis above. Individuals should be free from governmental interference with procreative pursuits, and market-based donor compensation achieves that goal by eliminating barriers to access that regulated compensation would erect. But individuals do not have the right to positive governmental assistance in obtaining oocytes for procreative pursuits. Government should not obstruct procreation, but it is not required to make sure that it is available to all.

118. Numerous Supreme Court cases make reference to the right to procreate. *See, e.g.*, *Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992) (stating that “our law affords constitutional protection to personal decisions relating to marriage, procreation These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment.”); *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972) (stating that “[i]f the right of privacy means anything, it is the right of the *individual*, married or single, to be free of unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child”); *Stanley v. Illinois*, 405 U.S. 645, 651 (1972) (stating that “rights to conceive and raise one’s children have been deemed ‘essential’ [and] ‘basic civil rights of man’”) (citations omitted) (quoting *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923) and *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942)); *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942) (stressing the importance of marriage and procreation as among “the basic civil rights of man” and asserting that “marriage and procreation are fundamental to the very existence and survival of the race”).

In reality, the costs of many, if not most, forms of assisted reproduction are already exclusionary. IVF costs several thousand dollars, and surrogacy can cost over \$40,000.¹¹⁹ While commodification could potentially exacerbate this problem, it is incorrect to think that regulation of oocyte donor compensation would eliminate this reality. The wealthy will always have more procreative liberty than the poor, unless we alter our constitutional understanding of the right to privacy and declare a positive right to procreative liberty. But for now, it appears that market-based compensation is entirely consistent with our conception of the right to procreation.¹²⁰

b. Supply side. Turning now to the supply side of the equation, we again run into serious difficulties extending the discriminatory effect argument from the organ context to oocyte commodification. To refresh, the supply side of the argument holds that the possibility for financial remuneration will disproportionately attract poor individuals to donate organs. This will occur because the same amount of money will be valued more by people with scant financial resources than by people with substantial holdings. Such a system will therefore result in a type of caste system where the poor serve as organ repositories for the wealthy.

Such an argument is without reason in either the organ or the oocyte context. First, the general trend in society is to allow individuals to take whatever risks they feel are justified by the compensation, even when those risks are much more serious and likely than those associated with oocyte donation.¹²¹ To rebut the presumption of acceptability then, there must be something different about transplant organs or oocytes. Risks are risks, whether associated with or-

119. For example, Fertility Options estimates a cost of just under \$45,000 for surrogacy recipients. *Fee Schedules* (visited Oct. 28, 2000) <http://www.fertilityoptions.com/html_pub/guid_fa.htm>.

120. It is also consistent with our allocation of health care resources generally. We do not treat access to health care as a fundamental right, and our nation accordingly lacks a system of universal health care. Further, even if universal health care were the rule, it is not likely that the provision of oocytes for assisted reproduction would rise to the level of "basic health care" and would therefore still not create a positive right for infertile couples or an obligation for governmental assistance.

121. See ROBERTSON, *supra* note 21, at 141 ("[M]arkets for the sale of gestational services are no more exploitative than the sale of other kinds of physical labor. If people are free to sell their labor as petro-chemical workers, cleaning persons, or construction workers in the hot Texas sun, why should the sale of gestational services be treated any differently? Much paid labor is equally or even more risky to health.").

gan removal, construction work, or oocyte donation. There is no reasoned way to draw this line.

Second, even if the concern is valid for the organ context, realities of oocyte donation again support disparate legal treatment. Wealthy people will happily accept organs from poor people because, provided that the donor passes the medical screening, an organ from a poor donor is worth just as much as an organ from a wealthy donor. It is equally life saving. But wealthy infertile couples are playing a different, and rather elite, game. Most often, their goals are to find a donor whose physical and personal profile matches that of the infertile woman or buy “designer genes.” University admission, however flawed that process may be, is a reasonable proxy for characteristics like intelligence and athleticism, as well as intangibles like creativity and motivation. Just as people want their children to attend these institutions, it follows that they also want oocytes—elite, promising oocytes—from students who attend these institutions. True, these universities are microcosms of society, and some students do come from poor and disadvantaged backgrounds. Perhaps they will feel more pressure to respond to the \$50,000 advertisements that appear in college newspapers, but perhaps not. Women donate oocytes for a variety of reasons, some having to do with finances, some not. But the argument that poor populations, on the whole, are apt to be exploited is an unlikely scenario. That is not where infertile couples are looking for potential donors. In any event, a system where oocytes may be bought and sold for market value is much less likely to lead to the sort of caste system feared by opponents of compensated organ donation. It appears then that neither the demand nor the supply side arguments justify a ban on the commodification of oocytes.

Surveying and analyzing the major arguments against the commodification of transplant organs leads to the conclusion that they are either internally untenable or inapplicable to oocyte donation. Therefore, in the following section, this article turns to look at arguments specific to the reproductive tissue and oocyte donation contexts.

IV. ARGUMENTS SPECIFIC TO ASSISTED REPRODUCTION

*A. Arguments for Non-Commodification**1. Allowing for the commodification of reproductive tissues, such as oocytes, will start us down the slippery slope to targeted genetic enhancement*

Much of the hesitation to expose reproductive tissues to the whims of the market stems from a fear of the potential for inappropriate applications and extensions. This consequentialist perspective maintains that, even if commodification is justified on grounds of procreative liberty, its potential application to targeted genetic enhancement, or eugenics, counsels against opening that door.¹²² Simply put, there is no reason to believe that society will use oocytes solely for the benefit of otherwise infertile couples. What is to stop fertile individuals from brokering for oocytes with desirable genetic characteristics in an attempt to produce some sort of “designer baby?” It is one thing for a couple to select a particular oocyte in order to match the characteristics of the infertile woman but something entirely different for fertile couples to search out oocytes that will genetically enhance their offspring in some way.

In order to critique this anti-commodification argument, we must deconstruct it further. Clearly, the presence or absence of a market in oocytes does not make or break the potential for targeted genetic enhancement. Even without a market, the opportunity exists for couples to seek out desirable oocyte donors in order to confer genetic advantages to their offspring. With or without a market, we already possess the technological capabilities. So what is it about the presence of a market in oocytes that makes this potential more likely?

Perhaps the message sent by a socially condoned market in reproductive tissues paves the way for eugenic pursuits. While societal norms and values certainly contribute to the form that legislation takes, the reverse is equally true: our laws inform and even help

122. Speaking in the context of direct genetic manipulation on the embryonic level, Professor Robertson has noted that “[t]he main slippery slope fear is that parents will want genetic interventions not only to prevent severe defects, but to enhance offspring characteristics as well.” ROBERTSON, *supra* note 21, at 163. The same argument applies to oocyte donation.

shape our norms and values.¹²³ This is not to argue for legal centralism. Clearly law is not the only, or maybe even the primary, source of norms and values in society. But the law certainly plays some role in shaping values. For example, consider the role of hate-crime legislation. In addition to making hate-motivated abuses illegal, the presence of such legislation serves to reinforce an important social judgment—that disparate treatment based on superficial characteristics, like race, gender, or sexual orientation, is unacceptable. The fact that we have democratically decided to punish crimes against “others” more severely than comparable abuses against “similars” informs us of the societal importance of this norm.¹²⁴

Maybe this is the source of anxiety that oocyte commodification conjures up for so many people. Legislation that allows for the free alienability of oocytes sends the message that it is socially acceptable to pick and choose among human characteristics for future generations. Once we are lulled into accepting that proposition, we have considerably weakened the moral barriers to full-blown eugenics.

But again, this argument proves too much. First, if it is the selection of future human characteristics through genetic means that bothers our conscience, then how can we draw a distinction between selecting among uncompensated oocyte donors to match a couple’s genetic preferences and selecting among compensated oocyte donors for the same purpose? In either case, individuals are selecting human characteristics for future generations. Why does the provision of compensation make any ethical or moral difference? If it is the use of genetic preferences by parents in selecting their offspring’s gametic precursors that bothers us, then we should not tolerate either compensated or uncompensated oocyte donation. The money should not matter. But instead, we have embraced uncompensated oocyte donation.

Further, what should we make of the reality that we, both as humans and more generally as sexually reproductive creatures, have always selected our mates, and hence our offspring’s genetic underpinnings, based on observable indicators of fitness and genetics? Is this not the same thing? What about genetic screening of fetuses for

123. Scholars typically refer to this as the “expressive” aspect of law. *See generally* Dan M. Kahan, *Social Influence, Social Meaning, and Deterrence*, 83 VA. L. REV. 349 (1997); Dan M. Kahan, *Social Meaning and the Economic Analysis of Crime*, 27 J. LEGAL STUD. 609 (1998).

124. *See, e.g.*, Dan M. Kahan, *The Secret Ambition of Deterrence*, 113 HARV. L. REV. 413, 460–64 (1999).

107] *Towards the Rational Regulation of Oocyte Donation*

the purpose of elective abortion in the case of genetic anomaly? Again, this is not to argue for consistency merely for the sake of being consistent. There is no inherent moral weight in consistency. But there does not appear to be any relevant basis on which to distinguish compensated oocyte donation from any of the myriad other socially-condoned instances of gene-based reproductive selection.

One could of course argue that the normative bite of this expressive account lies in the bottom line; that is, as a society we abhor the association of genetic selection with money. Maybe at its base this is just an objection to what is perceived as “baby selling.” But in the end, this line of reasoning just devolves to the argument that commodification of the human body—or more specifically, parts of the human body that have the potential to create new life—belittles the human existence. This argument was already considered and dismissed in the previous section and is not repeated here.¹²⁵

Lastly, addressing the slippery slope argument more generally, such concerns fail to recognize the reality that selective oocyte donation represents only a small step, if a step at all, towards genetic engineering. Selective oocyte donation is an extremely rudimentary and imprecise method of genetic engineering. As explained earlier, it relies on gross simplifications and misconceptions of genetic inheritance. Direct genetic manipulation, in which individual genes are deleted or inserted to match parental preferences, would certainly be the eugenic method of choice. Clearly, the road to eugenics does not

125. However, even if one does not accept the counter-arguments to these expressive concerns, the possibility for legislative resolution remains. If concerns regarding the message sent by socially sanctioned markets in oocytes lie at the heart of the opposition to commodification, then a continued lack of positive legislation on the subject could present a compromise. Allowing individuals to buy and sell oocytes, but at the same time treating such transactions as unenforceable contracts, should resolve or at least mitigate expressive concerns. Like the legal treatment of surrogacy arrangements in many states, contracts regarding the sale of oocytes could be permitted but held void as against public policy. Parties would be free to enter into these arrangements, but they could not seek judicial enforcement in cases of dispute. There would be no legislative stamp of approval, and hence no expressive message. Part V considers this resolution further. On the legal treatment of surrogacy arrangements, see, e.g., MICH. COMP. LAWS § 722.855 (1999) (“A surrogate parentage contract is void and unenforceable as contrary to public policy.”). Such contracts are contrary to public policy because they fail to base custody on the best interests of the child. See *In re Baby M*, 537 A.2d 1227 (N.J. 1988). But some states explicitly forbid even the making of surrogacy arrangements that include compensation. See, e.g., WASH. REV. CODE ANN. § 26.26.230 (West 2000) (stating that “[n]o person, organization, or agency shall enter into, induce, arrange, procure, or otherwise assist in the formation of a surrogate parentage contract, written or unwritten, for compensation”).

go through selective oocyte donation, and such slippery slope arguments thus have little merit here.

2. Donor selection relies on faulty genetic assumptions regarding the propagation of complex characteristics

As discussed in Part II, the selection of oocyte donors based on complex phenotypic characteristics such as height and intelligence for the purpose of having tall, smart children is somewhat misguided. It fails to consider genetic realities such as multifactorial inheritance and the role of the environment in the shaping of individual character traits. Because many infertile couples do not appreciate these constraints, one could argue that it is inappropriate to let desperate couples be swept away by the allure of unlikely outcomes. In essence, it is substantively unconscionable to let individuals pay so much money for so little guarantee.

But while society's simplistic misconception of genetic inheritance is indeed problematic, it is not a reason to forbid the commodification of oocytes. As long as these couples realize that they are paying only for a genetic *chance*, and not a genetic *guarantee*, there is no reason why they should not have the right to decide for themselves whether it is reasonable to enter into such probabilistic transactions. The solution is not to take away the choice but instead to make a concerted effort to educate the participants about the underlying genetic realities. Although one should never overestimate the benefits of informed consent, it seems reasonable enough to assume that fertility clinics and physicians are capable of adequately clarifying these issues so as to provide participants with meaningful and realistic choices. Further, the addition of appropriate legislation, requiring sufficient genetic counseling to prospective oocyte recipients, can safeguard against poorly informed decision-making.

3. Treating oocytes like commodities may cause psychological damage in the resultant offspring

Some have argued that a market in oocytes could have adverse psychological effects on the resultant offspring.¹²⁶ The split between biological and social rearing could confuse conceptions of family and

126. See generally ROBERTSON, *supra* note 21, at 120–22.

lineage to the detriment of the offspring.¹²⁷ Knowing that their genetic make-up was bought and sold may cause children to doubt their own self-worth and question their parents' love and motivations. In addition, knowing that parents paid handsomely for a gamete could create pressures and unrealistic expectations for the child, while knowing that they paid only a small sum may erode self-esteem.

These arguments should sound familiar to those who have followed the assisted reproduction debate for the past few decades. They are the same arguments that opponents have advanced against surrogacy and sperm donation.¹²⁸ The issue is identical: Do contractual arrangements in the reproductive context have adverse psychosocial effects on the resultant offspring? Because no studies have examined this hypothesis in the oocyte donation setting, we must look elsewhere for empirical evidence. Looking to our experience with the products of sperm donation should provide beneficial insight, allowing us to test the hypothesis.

The studies have not found the children of sperm donation to have unusually high risks of psychological damage, decreased self-esteem, or increased maladjustment.¹²⁹ In fact, they have fewer social and psychological problems than adopted children.¹³⁰ There is much reason to anticipate similar outcomes for the children of oocyte donation, suggesting less psychosocial detriment in oocyte donation than even adoption. Further, oocyte donation should have less of a psychosocial impact than surrogacy. With surrogacy arrangements, money is exchanged for a newborn—a tangible, identifiable child. It is the closest that we come to “baby-selling” in our society. But with oocyte donation, couples pay only for one of the gametes that might eventually lead to the creation of a child. The money is somewhat removed from the actual child, dampening the association, at least partially. Therefore, it would be logical to expect that oocyte donation would be less likely than surrogacy to promote feelings of self-commodification among children.

Beyond surrogacy, it is tough to argue that any form of assisted reproduction has the potential to create more psychological danger

127. *See id.* at 121.

128. *See id.* at 120–22.

129. *See generally* R. SNOWDEN ET AL., *ARTIFICIAL REPRODUCTION: A SOCIAL INVESTIGATION* (1983).

130. *See id.*

than adoption. Adoption suffers from the same monetary association as assisted reproductive technologies, but it goes further. To even be adopted, one must first be given up. Although rarely is it the case that the biological parents did not love their child, the dynamics of adoption foster the possibility that such children will feel rejected or abandoned and possibly blame themselves. Further, while oocyte donation lacks this potential for psychological damage, it shares the positive element of adoption—children know that their rearing parents very much wanted to have them in their lives and were willing to spend time and money to make that dream come true. Maybe this actually serves to strengthen self-esteem and familial bonding. Arguably, children who are the products of “natural” coital procreation, but are unwanted or accidents, are more at risk of psychological problems than those children who result from some form of ART. In the end, the lack of any support for the hypothesis that oocyte donation will psychologically damage the resultant offspring severely limits its bite.

B. Arguments for Free Alienability

1. Without a market in oocytes, supply will fail to meet demand, leaving many infertile couples without the possibility of procreating

Perhaps the strongest justification for unregulated oocyte-donor compensation comes from the comparative analysis of supply and demand trends in countries that do and do not limit compensation. As mentioned previously, Israel and England severely limit donor compensation or ban it altogether. Having eliminated these incentives to donate, both countries are mired in drastic oocyte shortages.¹³¹ Altruistic supply has not kept pace with demand, and infertile

131. See, e.g., Sarah Chalmers & Becky Morris, *Scandal of the Egg Donations*, DAILY MAIL (London), Sept. 21, 1999, at 37 (acknowledging that in England “the fundamental problem IVF faces . . . is a shortage of egg donors”); Judy Siegel, *Groups Voice Support for Liberalizing Ova Donations*, JERUSALEM POST, Feb. 2, 2000, at 4 (quoting Professor Neri Laufer, a fertility specialist and head of OBGYN at Hadassah-University Hospital in Jerusalem as saying, “The current situation, in which over 2,000 women desperate for a baby are waiting for donated ova, brings shame on Israeli medical practice”); Nicole Veash, *Internet Donors Offer Perfect Babies to Order*, THE OBSERVER (London), Aug. 15, 1999, at 3 (noting the imbalance between supply and demand of oocytes in Britain).

107] *Towards the Rational Regulation of Oocyte Donation*

couples must wait up to five years just to gain access to any donor at all, let alone a donor of their choice.¹³²

Granted, it is not entirely clear whether this relationship between capped compensation and supply shortage is truly causal or instead merely correlational. It is quite possible that unidentified confounding variables are responsible for the differential supply dynamics in the United States, Israel, and England. For example, it is conceivable that local social norms, religious beliefs, or health care delivery systems contribute to the supply differentials. Without controlled studies, in which a single country holds all other possible variables constant while switching from capped to uncapped donor compensation, it is impossible to know for sure. Undeniably, this is an area ripe for further research. Nevertheless, for now, based on available circumstantial evidence that emerges from comparisons both between and within countries, the best we can do is speculate.¹³³

If we are committed to procreative liberty and the use of assisted reproductive technologies to combat infertility, it follows that we should structure the system, in the context of appropriate ethical guidelines and quality care standards, so as to maximize the incentives to donate. Doing so will best allow couples to achieve their reproductive goals, which is the fundamental basis of assisted reproduction in the first place. This is not to say that there should be no limits. That is not the thesis of this article. If there are rational reasons to draw lines, then we should draw lines. But in the absence of compelling justifications otherwise, it is misguided to limit the effectiveness of these technological advances by dampening the incentives to donate. The empirical evidence is clear: supply does not meet de-

132. See, e.g., Susan Mansfield, *The Gift of Life*, ABERDEEN PRESS & J. (Aberdeen, Scotland), Oct. 5, 1999, at 13 (noting long waiting lists for oocytes due to the “desperate shortage of donors”); Kathleen Morgan, *Babies For Sale*, DAILY RECORD (Glasgow), Aug. 17, 1999, at 8 (discussing the two-year waiting list for donor oocytes at the Assisted Reproductive Unit in Aberdeen).

133. As noted, comparisons between the United States, with its unregulated compensation, and England and Israel, with their regulated compensation, yield powerful evidence of the supply side effects of donor compensation schemes. It is also clear that within the United States compensation scheme affects supply. Recall the couple discussed in the Introduction. Before the famous \$50,000 advertisement, they attempted to entice potential donors with a much smaller, typical, amount of money. They received only a few responses, and none of the respondents fit the couple’s donor profile. See Sheila Weller, *Is This Egg Worth \$50,000?*, SELF, Dec. 2000, at 164. When they increased the compensation to \$50,000, hundreds of replies flooded in. Clearly, compensation has a direct effect on supply, but the magnitude of that effect remains unclear.

mand when donor compensation is regulated. Without other justifications, regulation of donor compensation may be one step forward, but it is at least two steps back.

2. As long as there is no identifiable threat to individual or public health, the primacy of procreative liberty should prevail

What makes oocytes, and all reproductive tissues for that matter, unique is that they have implications, not only for those parties directly involved in the transaction, but also for future individuals. Selective reproduction alters the genetic make-up of future generations and therefore can impact global public health. For example, genetic selection could conceivably lead to normalization of genetic profiles, resulting in stagnation of the gene pool. This, in turn, could decrease our adaptability and survivability as a species. From a utilitarian perspective, this could affect the calculus. The cost to future lives could potentially outweigh the benefits to present parties but only if there is a cognizable, tangible harm that should and could be prevented.

In fact, there is no such harm here. First, the numbers are insignificant. In 1997, a little over 2000 live births resulted from oocyte donation, including both fresh and frozen donor oocytes.¹³⁴ Compared to the total number of live births in the United States that year, which was 3,880,894,¹³⁵ this is a trivial statistic. This is not wide-scale genetic selection and is not likely to significantly affect the diversity of human genetic make-up.

Second, there are no data to suggest that recipient couples tend to choose the same phenotypic and genotypic profiles in donors. It may be that couples undergoing oocyte donation vary in selection criteria just as much as they vary in their own genetic profiles. Perhaps these couples choose donors based on similarity to the infertile woman, not based on objective standards of social desirability. Without adequate studies, we do not know, and we should not presume the worst if doing so interferes with procreative liberty.

Lastly, as mentioned earlier, oocyte donation is neither effective nor efficient at achieving targeted genetic selection. Choosing a particular woman to serve as the source of one-half of the gametic material in no way guarantees the propagation of complex characteristics.

134. CENTERS FOR DISEASE CONTROL AND PREVENTION ET AL., *supra* note 28, at 41.

135. CENTERS FOR DISEASE CONTROL AND PREVENTION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, NATIONAL VITAL STATISTICS REPORTS 47 (1999).

Vastly superior technology already exists in that regard through gene replacement and gene therapy. Oocyte donation will therefore never be the vehicle for selective enhancement. It is too uncertain to be worthwhile.

For all of these reasons, oocyte donation cannot be the lynchpin of genetic drift. It will not result in significant shifts in our collective phenotype. And on an individual basis, it is more likely to result in benefit than harm. When individuals carrying undesirable inheritable disease turn to gamete donation, offspring are spared. In fact, the disease frequency is reduced for future generations as well. Because there is no identifiable threat or harm to individual or public health, there is insignificant justification for trumping individual autonomy and procreative liberty in the name of paternalism.

3. Restricting a woman's reproductive choices infantilizes adult women

Coherent feminist arguments exist that speak against market-driven reproduction. Such arguments posit that commodification of surrogacy and oocyte donation is the commodification of women generally and is yet another example of the subjugation and exploitation of women for the purposes of men.¹³⁶ Margaret Jane Radin summarizes this view, saying that “[t]he feminist argument against the market is roughly that in this nonideal world of ours, treating women like anonymous fungible breeders objectifies them and recreates subordination.”¹³⁷

But equally compelling feminist arguments speak in favor of market-based assisted reproduction. These arguments tend to view the market as a source of power and liberation for women. From this perspective, exclusion from the market for paternalistic concerns amounts to infantilization of women and serves to maintain the gender-based power inequities that have become our status quo.¹³⁸

136. See, e.g., ROBERTSON, *supra* note 21, at 228–31 (discussing why the “feminist critique . . . calls into question all reproductive technologies that redound to the benefit of a male-dominated society at the expense of women”). See also Maura Ryan, *The Argument for Unlimited Procreative Liberty: A Feminist Critique*, HASTINGS CENTER REP., July-Aug. 1990, at 6.

137. RADIN, *supra* note 87, at 149.

138. See, e.g., ROBERTSON, *supra* note 21, at 229–31. Professor Robertson states that the view that a rights-based view of reproductive technology places power increasingly in the hands of men to the detriment of women overlooks the many ways in

Again, Professor Radin summarizes these arguments:

The feminist argument in favor of . . . the full-blown market, is roughly that in this nonideal world of ours, power in the market is power, and power is liberating. Women, like men, the argument runs, should now be free to get out of their protected sphere and enter the market on an equal basis. Men in power should not tell them what to sell and what not to sell. Whatever is problematic . . . should be for women to deal with as a matter of their own moral deliberation and choice.¹³⁹

Women should be free to make the same decisions, and possibly the same mistakes, as men. That society is so concerned with the commodification of surrogacy and oocyte donation, while simultaneously lacking similar concern for the commodification of sperm donation, devalues women as autonomous equals. Therefore, it is for the benefit of all women that some have the opportunity to voluntarily enter this market.

While it is not clear which way these arguments cut, it is clear that feminist objections to commodification that fail to address these pro-commodification positions also fail to provide sufficient justification for a ban on market-based compensation.

V. CONCLUSION AND RECOMMENDATIONS

Surveying and analyzing the ethical, policy, and legal arguments for and against a market-based system of compensation for oocyte donors leads to the following conclusion: although thoughtful reasons to regulate oocyte donor compensation exist, they are outweighed by the arguments for free alienability. The rationales for the prohibition of the commodification of organs are either internally irrational or are not applicable to oocyte donation due to its unique technical and social aspects. Additionally, oocyte-specific arguments

which technology offers options that expand the freedom of women. It also overlooks how a rights-based approach, despite its contextual limitations, assures women a large measure of control over their reproductive lives.

Id. at 229. See also Sharon Elizabeth Rush, *Breaking With Tradition: Surrogacy and Gay Fathers*, in *KINDRED MATTERS: RETHINKING THE PHILOSOPHY OF THE FAMILY* 102, 127 (Diana Tietjens Meyers et al. eds., 1993) (“Outlawing surrogacy, as a practical matter, would do little if anything to promote the demise of patriarchy. Allowing a woman to become a surrogate contract mother arguably could do more to promote women than would a ban. . . . [A]llowing fee-paid surrogacy enhances a woman’s economic power.”).

139. RADIN, *supra* note 87, at 149 (citations omitted).

misconstrue the potential applications of such technology and fail to conform with broader social treatments of noncoital reproduction and freedom to contract. Because such arguments are unable to identify reasons why society should treat oocyte donation differently, they fall short of justifying paternalistic regulation that severely infringes upon autonomy and procreative liberty.

If assisted reproduction is to make a meaningful difference in the lives of the infertile, the system must create appropriate incentives for donor participation. Market-driven compensation is not the only available avenue, but it appears to have effect. Supply shortages in countries that limit or ban donor compensation make it clear that such regulation is counterproductive and ill advised. And again, this is not to imply that there should be no regulation or oversight at all. The end result of the current patchwork legislation is a highly autonomous field of egg donation that basically operates on the principle of *caveat emptor*. Despite the highly technical nature of this industry, in addition to the emotional urgency of its consumers, there is no systematic consumer protection. The system should still seek to promote participant safety and procedural efficacy. This means standardized procedures, quality control mechanisms, and wide-scale dissemination of relevant information like risks, benefits and genetic realities. That kind of knowledge is crucial to making an informed decision. We should allow women to donate oocytes, despite the attendant medical risks, so long as adequate efforts are made to clarify the variables in the risk-benefit equation. We should permit couples to pay large sums of money for this technology, so long as they are informed of the possible outcomes, particularly the established success rates of the clinic at issue. But allowing these decisions to be made in the absence of adequate information does a disservice to all involved.

Still remaining, however, is the question of how to treat oocyte donation arrangements. Even if compensation is market-based, that does not resolve the issue of the legal status of the “contracts” between donors, recipients, and fertility clinics. The thesis of this article necessarily contemplates that society will not prohibit individuals from entering into these arrangements, but that is not the end of the inquiry. Options still remain, and choices must be made.

Assuming that society condones making these contracts, the most obvious approach is to treat them as legally binding and hence judicially enforceable. If one party breaches contractual obligations,

the other could then sue for damages.¹⁴⁰ Breaches of contract could arise when, for example, the recipient pays the donor up front but the donor never undergoes the retrieval process or when the donor provides oocytes but the recipient fails to pay either the donor or the broker. The other option, alluded to earlier, is to treat such contracts as unenforceable, void as against public policy, similar to our general treatment of surrogacy arrangements. Individuals would still be free to enter into these arrangements, but they could not turn to the legal system for enforcement. Despite one particular attraction of the latter approach, the former is preferable.

The major strength of the unenforceability approach is the expressive implication of treating these contracts as void as against public policy. Expressive concerns appear to lie at the heart of many of the anti-commodification arguments considered in this article. Professor Radin's argument that commodification of the human body would belittle the human existence assumes that society would treat commodified body parts the same as any other commodity. Doing so would blur the line between personhood and property to the detriment of human flourishing. Likewise, the concern that commodification of oocytes will send us down the slippery slope to full-blown eugenics assumes that such commodification will send the message that selective enhancement is socially sanctioned.

But holding such contracts unenforceable and void as against public policy mitigates these expressive concerns. Although individuals could avail themselves of assisted reproductive technologies in the pursuit of procreative liberty, there would be no explicit imprimatur of social acceptance. Oocytes, although exposed to the market,

140. Damages would likely be the only remedy available, as the nature of these arrangements does not make them amenable to enforcement by specific performance. Not only are these personal services contracts, which courts are generally loathe to enforce by specific performance, but they involve physically invasive procedures. How would a court carry out specific performance with a noncompliant donor? Would we physically restrain the individual, force her to undergo ovarian hyperstimulation, and then forcibly remove her oocytes? This is undesirable and unacceptable. Presumably, however, damages are not what these couples would be seeking. They would want the child, not compensation. Further, the prolonged litigation process may undermine the couples' objectives. For a discussion of the general legal trend of avoiding specific performance of personal service contracts, see, e.g., FRIEDRICH KESSLER ET AL., *CONTRACTS: CASES AND MATERIALS* 1069–108 (3d ed. 1986) (chronicling the history of judicial treatment of specific performance and stating, "It is true, or at any rate a truism, that in Anglo-American law, from at least the seventeenth century, specific performance has been regarded as an exceptional remedy in equity, available only when a judgment at law for money damages is, on some theory, 'inadequate.'").

would continue to be treated, and thus viewed, as distinct from all other commodities. Therefore, expressive concerns and line blurring would be minimized.

Despite this conciliatory quality of the unenforceability approach, it is inconsistent with the weight of logic and the thesis of this article. As argued throughout, the benefits of the commodification of oocyte donation—namely increased supply and the resulting enhancement of procreative liberty—outweigh any associated costs. Lacking sufficient justification for disparate treatment, oocytes should be treated like commodities, and that includes providing for the legal enforcement of donation contracts.

Indeed, doing so will likely add to the incentives to donate, thereby increasing supply even further. Judicial recognition of the commercial value of oocytes will provide *ex ante* protections to both potential donors and recipients, alleviating concerns of breached contracts and uncompensated sacrifices. In fact, maybe courts should inspect these contracts even more closely than those of other commodities. Maybe there should be less reliance on default rules and greater scrutiny of the terms; perhaps that would be the best way to protect the interests of the parties. But without the promise of enforceability, many potential donors would likely be dissuaded from donating, fearful that recipients might change their mind once the retrieval process had already commenced. And recipients, desperate to procreate, would be at the mercy of legally unrestrained donors. Although the unenforceability approach might ease the minds of some, it would undermine the very purpose of commodification itself by providing disincentives to enter into such arrangements, and it would leave all parties vulnerable to misrepresentation and deceit.

Further, it appears that the expressive argument cuts both ways. It may very well be true that socially sanctioned oocyte commodification sends undesirable messages about our conception of the sanctity of human life. But social prohibition of oocyte commodification has expressive dangers as well. It sends undesirable messages about the social and self worth of those who want to donate oocytes and those who cannot procreate otherwise. It degrades their desire to participate in the reproductive context. Therefore, it is not an entirely stable ground on which to mount an objection to commodification.

Certainly, treating these arrangements as legally enforceable contracts leads to further questions and forces further decisions. Should the courts recognize express, or even implied, warranties in the con-

tracts? If so, what should be the permissible parameters of such clauses? For example, if the resultant offspring does not turn out to be 5'5" or athletic, or fails to break 1400 on the SAT, should the recipient have the right to sue the donor for breach of warranty? How should parties structure the compensation clauses, and how should parties and courts determine appropriate damages? And how should the best interests of the child affect the analysis? We must make these and many more difficult choices if we are to recognize the legality of oocyte donation contracts. But this is no reason to pass on the opportunity before us. Rest assured, the debates will ensue, and the decisions will be made.

Regardless of how we ultimately resolve the oocyte donation dilemma, the discussion serves to inform and instruct society in all of its technological deliberations. Consistent with countless prior technological advances, compensated oocyte donation has been met with reflexive opposition and emotion-based disapproval. Although informative, such appeals must give way to reason and rationality. We have seen it before, and we will see it again, because technology will continue to progress. If we are to make the most of it, novelty must not become synonymous with depravity.