SHORT TITLE: Financial compensation of oocyte donors
FULL TITLE: Financial compensation of oocyte donors: an Ethics Committee opinion
AUTHORS: The Ethics Committee of the American Society for Reproductive Medicine, American Society for Reproductive Medicine, Birmingham, Alabama
CAPSULE:

ABSTRACT: Financial compensation of women donating oocytes for reproductive or research purposes is justified on ethical grounds and should acknowledge the time, inconvenience, and discomfort associated with screening, ovarian stimulation, oocyte retrieval, and post-retrieval recovery and not vary according to the planned use of the oocytes or the number or quality of oocytes retrieved. This document replaces the document of the same name, last published in 2016.

KEY POINTS

- Financial compensation of women donating oocytes for reproductive or research purposes is justified on ethical grounds.
- Compensation is in accord with principles of fairness, occurring within the framework of a professional relationship.
- Payment should be structured to acknowledge the donor’s time, inconvenience, and discomfort associated with screening, ovarian stimulation, oocyte retrieval, and post-retrieval recovery. Compensation should not vary according to the planned use of the oocytes (reproductive or research), or the number or quality of oocytes retrieved.
- The amount of compensation should be fair and not so excessive as to become an undue enticement that negatively impacts a donor’s ability to make an informed decision about the donation process.
- All oocyte-donor recruitment programs, including agencies, egg banks, fertility clinics, and ART practices, should adopt and implement effective processes for information disclosure and counseling in order to promote informed decision-making by prospective donors.
- Treating physicians owe the same professional duties to oocyte donors as to all other patients.
- Programs should ensure equitable and fair provision of services to oocyte donors.
- Programs should adopt and disclose policies regarding coverage of an oocyte donor’s medical costs should she experience complications associated with the oocyte-retrieval process.

The practice of paying a woman for undergoing ovarian stimulation and oocyte retrieval for the benefit of another is commonly referred to as oocyte or egg “donation,” despite the mismatch between the plain meaning of “donation” and the provision of compensation for such services. Since its introduction in the 1980s, oocyte donation increasingly has been accepted as a method of assisting prospective parents without viable oocytes to have children. Couples and individuals in need of donor oocytes can procure these
Financial compensation of oocyte donors

Financial compensation of oocyte donors in a variety of ways. Prospective recipients can seek out voluntary and often altruistic donation of oocytes from friends and relatives, though intended parents are cautioned to consider the impact of intrafamilial donation on themselves and their offspring (ASRM EC_Family Members as Gamete Donors 2017). Also, couples and individuals may arrange services of oocyte donors directly through their own offers of payment, typically accomplished through advertising or other outreach efforts. Most commonly, however, oocyte donation is arranged through recruitment programs including agencies, egg banks, and ART practices that facilitate the exchange of oocytes from donors to recipients. In addition to procurement of oocytes for reproductive use, scientific developments suggest that oocyte donation has become an important source of material for use in research involving stem-cell therapy, regenerative medicine, and genetic-based reproductive technologies (Noggle 2011, Tanaka 2013, Ma 2017).

Three decades ago, when oocyte donation first became clinically available sources of donor oocytes included: [1] women undergoing IVF who produced more oocytes than could be reasonably employed for their own use (often termed “egg sharing”), [2] women undergoing an unrelated surgical procedure who undertook ovarian stimulation so oocytes could be retrieved during surgery, and [3] women who agreed to undergo ovarian stimulation and oocyte retrieval specifically to provide oocytes to others. Today, the source for donor oocytes has shifted away from the first two groups toward a system of oocyte retrieval specifically for the purpose of donation. One reason for this shift is the clinical success of embryo cryopreservation that has led most women in the first group to choose to have all their oocytes fertilized and embryos stored for their own future use. Moreover, recent advancements in oocyte cryopreservation offer women the option of freezing excess eggs for their own future use rather than donating them at the time of retrieval (Noyes 2017). Most women in the second group were unwilling to accept the burdens associated with ovarian stimulation or were excluded from donating for medical reasons. The evolution of the oocyte retrieval procedure from a more invasive laparoscopic surgery, to a less invasive transvaginal needle aspiration, introduced an acceptably safe and attractive means for gamete donors to participate. In the face of a growing medical need for donor oocytes, financial compensation of oocyte donors in the third group has become routine and the more common standard of practice. Furthermore, improvement in the cryopreservation of oocytes has further increased demand for donor services as “egg banks,” entities that collect, freeze, and store oocytes for purchase by intended parents, have become more commonplace (Cobo 2011).

The issue of financial compensation for oocyte donors raises numerous ethical questions, three of which are discussed in this opinion: [1] do recruitment practices incorporating remuneration sufficiently protect the interests and safety of oocyte donors, [2] does financial compensation devalue human life by treating oocytes as property or commodities; and [3] do prohibitions on financial compensation to oocyte donors devalue the services woman are uniquely positioned to supply by creating a system of forced altruism?

THE PRACTICE OF REMUNERATION
In recognition of the significant time, inconvenience, and discomfort associated with oocyte donation, remuneration of donors has been a common practice. Oocyte donation utilizing the services of paid donors is now established as a component of ART. In 2016, approximately 9% of all ART cycles reported to the Society for Assisted Reproductive Technologies (SART) involved the use of donor oocytes, including both fresh and donor eggs that were previously frozen and thawed (2016 ART Report). An early survey published in 1993 found that approximately 60% of responding programs offered payment to women undergoing oocyte retrieval solely to provide oocytes to others (Mechanick 1993). In 2016, 88% of the 463 assisted reproduction programs reporting to SART stated that they offered oocyte donation services (2016 ART Report). While SART collects data on the use of donor oocytes in ART cycles, it does not ask clinics to report on their donor-compensation practices and policies.

Although there is some variation in compensation arrangements, they have certain features in common. ART programs, fertility clinics, egg banks, infertile individuals and couples, and independent agencies recruit women for oocyte donation through advertising, often using online postings and via notices in college or other local media sources. The amount of compensation offered varies and it may be difficult for prospective donors to know exactly what the compensation would be for their donation. One study indicates that disclosure of fee schedules varies depending on whether the recruiter is an agency or an infertility clinic (Holwell 2014). Concern over the consumer protection of egg donation prompted at least one state to enact legislation requiring all advertising for egg donation expressly include a warning that “not all selected egg donors receive the monetary amounts or compensation advertised” (Cal. Health & Safety Code 125325).

The Committee believes that oocyte donation advertising and remuneration representations should be accurate, transparent, and abided by all entities and individuals recruiting egg donors.

ETHICAL CONCERNS RAISED BY REMUNERATION

Concerns surrounding financial compensation of oocyte donors often focus on the welfare of women who agree to act as donors and on the impact that payment has on the characterization of gametes and any resulting offspring. Monetary compensation could create the possibility of undue inducement and exploitation of women participating in oocyte donation. Women may agree to provide oocytes in response to financial need. High payments also could lead some prospective donors to conceal medical information relevant to their own health or that of their genetic offspring to appear more attractive to recruiters. There is a possibility that women could discount the physical, social, and emotional risks of oocyte donation out of eagerness to address their personal financial interests. Financial compensation could be further challenged on grounds that it conflicts with the prevailing belief that gametes should not become products bought and sold in the marketplace. A further concern is that the commodification of gametes translates into the devaluation of donor-conceived offspring who will be viewed in relation to their market value rather than their intrinsic worth (Bayefsky 2016).

Concerns Raised by Payment
Financial compensation of oocyte donors

Women undergoing retrieval purely to provide oocytes to others are exposed to physical and psychological risks that they would not otherwise face. There is some risk of unintentional pregnancy, because hormonal contraceptives must be discontinued prior to participation. Donors also are exposed to risks of morbidity and a remote risk of mortality from ovarian stimulation and oocyte retrieval (Levi-Setti 2018). Although current data are reassuring, it is possible that fertility drugs and procedures involved in oocyte donation might increase a woman’s future health risks, including the risk of impaired fertility (Williams 2018). Young women may be prone to dismiss the potential psychological consequences of donation, particularly those that could arise if they later experience infertility problems themselves. They may also underestimate the psychological and legal consequences of their agreement to renounce parental rights and future contact with children born to oocyte recipients. The renunciation of future contact may turn out to be illusory, however, as increasingly sophisticated genetic testing coupled with the reach of the internet may enable donor-conceived offspring to contact an egg donor long into the future after she has made the decision to keep the fact of her donation private.

Another ethical concern is that payment for oocytes could imply that gametes are property or commodities that may be bought and sold, and thus could devalue their inherent linkage with human life. At the outset, it is noteworthy this critique is rarely, if ever, levied against the practice of sperm donation and appears uniquely in the realm of female oocyte donation. For some, the concern about human commodification is based on the presumption that payment to individuals for reproductive and other tissues is inconsistent with maintaining important values related to respect for human life and dignity. Arguably, this view is reflected in state and federal laws prohibiting direct payment to individuals providing organs and tissues for transplantation. Yet, such laws generally permit organ and tissue donors to receive reimbursement for expenses and other costs associated with the donation procedure. In the analogous circumstance of biomedical research, human subjects exposed to physical and psychological risks are often reimbursed for expenses. Moreover, they may receive additional payments to compensate for the time and inconvenience associated with study participation. These facts support the compensation of oocyte donors regardless of the ultimate use of the oocytes (e.g., fertility therapy or research).

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

Arguments that support a no-compensation policy often focus on the perceived impact payments will have on the donors and on any offspring born of their donation. For example, some argue as payments to women providing oocytes increase in amount, the ethical concerns increase as well. The higher the payment, arguably the greater the possibility that women will discount risks to themselves or be less forthcoming...
about their medical and social history in order to be accepted as a donor. High payments, particularly for
women with specific characteristics, also convey the idea that oocytes are commodifiable. To the extent that
such high payments may reflect an effort to promote the birth of persons with traits deemed socially
desirable, they may be seen as a form of positive eugenics. Such efforts to enhance offspring are morally
troubling to some insofar as they objectify children rather than assign them intrinsic dignity and worth.
Finally, high payments could make donor oocytes available only to the very wealthy, increasing social and
distributive injustice related to access to fertility treatment (Bayefsky 2016, ASRM EC 2015 - Access to
Fertility Treatment).

**JUSTIFICATIONS FOR PERMITTING REMUNERATION**

Although potential harm must be acknowledged and addressed, financial compensation can be defended
and is justified on ethical grounds. First, the existence of a system of fair recompense within the context of a
professional relationship shows respect for women’s autonomy and honors their capacity to make informed
choices about their bodies and economic lives. Rather than regarding women and their contributions as
commodities, fair compensation for egg donation is aligned with the routine payment for medical services,
including those in connection with reproduction. Second, providing financial incentives increases the
number of oocyte donors, which in turn, allows more infertile persons to have children and provides more
choice of selection of oocyte donors. Third, the provision of financial or in-kind benefits does not necessarily
discourage altruistic motivations; indeed, in surveys of women receiving such benefits, most reported that
helping childless persons remained a significant factor in their decisions to donate (Ahuja 1998, Ahuja 1997,
Klock 2003, Svanberg 2003, Pennings 2014). In a survey of donors who had been compensated up to
$5,000, 88% of subjects reported that the best thing about the donation experience was “being able to help
someone” (Klock 2003).

Fourth, financial compensation may be defended on grounds that it advances the ethical goal of fairness to
donors. There is no doubt that egg donors bear burdens on behalf of recipients and society, and
compensation for bearing those burdens may be justified morally. Because the burdens of donation are
similar regardless of the ultimate use of the oocytes, compensating egg donors for fertility therapy differently
from donors for research cannot be justified. In the United States today, the disparate treatment of egg
donors based on whether their donation is for reproductive versus research purposes endures.

Overwhelmingly, women who donate for reproductive purposes receive compensation while donors who
provide eggs for research do not (Crockin 2010). While there has been some movement at the state level to
permit compensation to research donors, most research entities continue to adhere to a no- (or extremely
limited-) compensation policy such as the one articulated by the National Academy of Sciences with respect
to compensation for oocyte donation for stem-cell research (NAS 2005). In contrast, in 2009 New York
became the first US state to implement a policy permitting researchers to use public funds to reimburse
women who donate oocytes directly and solely to stem-cell research, not only for the woman’s out-of-pocket
expenses, but also for the time, burden, and discomfort associated with the donation process (Roxland
A law enacted in California in 2019 likewise requires individuals who provide human oocytes for research to be compensated for their time, discomfort, and inconvenience in the same manner as other research subjects, lifting a previous prohibition on payments to research donors (Cal Health & Safety Code, AB 922). The Committee favors the New York and California approach for its support of equal treatment of donors regardless of the beneficiary of their efforts.

The failure to provide financial or in-kind benefits to oocyte donors would arguably demean their significant contribution, imposing a system of forced altruism on labor that is uniquely supplied by women. Such an approach also would treat female gamete donors differently from sperm donors, who typically receive a financial benefit (albeit a modest one) for a much less risky and intrusive procedure. Fifth, the emotional pressures created by financial incentives do not necessarily exceed, and may actually be less, than those experienced by women asked to make altruistic donations to relatives or friends. Imposing a broad-based no-compensation policy will not alleviate the need for donor eggs. Forcing infertile women to reluctantly turn to friends and relatives to supply the unique materials needed for their treatment can be demeaning and particularly difficult for patients who already experience high levels of anxiety wrought by infertility. A no-compensation system may leave potential donors more vulnerable to coercion than a system in which appropriate payment can help support the adequate availability of oocytes (Kenney 2014). The absence of compensation for research donation could lead friends and relatives of persons with diseases or disabilities to feel undue pressure to donate to form or maintain an adequate supply of oocytes for research.

Nonpayment may also induce oocyte donation from women with diseases that may benefit from advances in regenerative medicine, even in the face of contraindication for such an undertaking.

Although the physical and psychological risks entailed in oocyte donation are real, they are not so severe as to justify intervention to limit the autonomous decision-making authority of adult women. Programs offering financial incentives should take steps to minimize the possibility of undue influence and exploitation by incorporating certain safeguards into the disclosure and counseling processes. For example, agencies, egg banks, and infertility clinics should be encouraged to provide written information to prospective donors setting out their fee ranges (including minimum fees), any caps on donor age, minimum educational requirements, preferred donor demographic and phenotypic traits as well as medical, psychological and emotional risks associated with ovarian stimulation and oocyte retrieval (Holwell 2014). Programs can also structure the provision of incentives in ways that reduce the likelihood that women will be improperly influenced to donate. Such steps would reflect good ethical practice and reduce the likelihood of later legal action by dissatisfied donors. In the case of donation for research, compensation plans should be reviewed by an institutional review board responsible for ensuring that donors are fairly recruited and adequately informed of risks.

DISCLOSURE AND COUNSELING

Prospective donors should be fully informed about the potential medical and psychological risks of
undergoing oocyte retrieval for donation purposes. This obligation to provide prospective donors with informed consent attaches to any party or program seeking the services of an oocyte donor, including providers assisting intended parents, fertility clinics, egg banks, and agencies involved in recruiting or matching donors and recipients. Those donating oocytes for research should be afforded the additional protection of review by an institutional review board with approval of the informed-consent process and documents.

To encourage informed decisions to donate oocytes, programs should adopt effective information disclosure and counseling policies and procedures. Regardless of how prospective donors are recruited, programs should ensure that they receive accurate and meaningful information on the potential physical, psychological, and legal consequences of oocyte retrieval and donation. The potential negative health and psychological effects should be openly acknowledged. Prospective donors should understand the measures they must take to avoid unwanted pregnancy during a stimulation cycle. They also should understand that they could later develop desires to establish contact with genetically related children, desires that may be difficult or impossible to satisfy because of legal or other barriers. Alternatively, donors should be apprised their desire to remain anonymous to the recipient(s) or resulting offspring may not be possible because of increasingly sophisticated genetic-tracing and social-media technologies.

Donor candidates should be encouraged to explore their possible emotional responses, particularly those that could develop if they experience infertility problems themselves. To reduce the incidence of subsequent psychological problems, it would be prudent to limit donors to women who are 21 or older and who more likely possess the emotional maturity to make such decisions (ASRM PC 2006_Gamete and embryo donation).

To enhance the likelihood that information relevant to donation will be fully explored, programs are encouraged to designate an individual with training and expertise in mental-health care to be available to consult with prospective donors (ASRM PC 2006_Psych assessment). This individual’s primary responsibilities are to ensure that the prospective oocyte donor understands and appreciates the relevant information and that her consent is freely given. She should be told that she may withdraw from the process at any point in time. The prospective donor’s motivation for participating should be explored during the session, with the goal of ascertaining that she appreciates the full consequences of her donation and is properly assessing the risks and that she is not unduly influenced by financial hardships that might compel her to participate.

Empiric data suggest that some egg donors may wish to know whether children are born as a result of their donations. Others may have preferences about how their donated eggs are used (Kalfoglou 2000). For example, donors may not want their eggs to be provided to unmarried persons, same-sex couples, or persons of a different religion or race, or may not want unused embryos produced with their eggs to be...
destroyed or used for research. Program staff should discuss with prospective donors the amount of information they will be given about whether a birth occurs and any control they will have over oocyte disposition. Those donating oocytes specifically for research should be informed about potential uses of their tissues, including the creation of embryos for research.

THE PAYMENT STRUCTURE

Payments to women providing oocytes should be fair and not so substantial that they become undue enticements that will lead prospective donors to discount risks. Monetary compensation should reflect the time, inconvenience, and physical and emotional demands associated with participating in oocyte donation. Thus, a woman who withdraws from donation for medical or other reasons may be paid a portion of the fee proportionate to the time and effort she contributed. To protect the donor’s right to withdraw, oocyte recipients must accept the risk that a donor may change her mind. In no circumstances should payment be conditioned on successful retrieval of oocytes or the number of oocytes retrieved. Likewise, donors should never be required to cover the costs of the interrupted cycle. To avoid putting a price on human gametes or selectively valuing one end-use over another, compensation should not vary according to the planned use of the oocytes (e.g., research or clinical care), or the number or quality of oocytes retrieved (ASRM PC 2006_Guidelines for oocyte donation).

ADDITIONAL ETHICAL CONSIDERATIONS

Once the donation process begins, oocyte donors become patients and are owed the same professional duties present in the ordinary physician–patient relationship. Programs should ensure that every donor has a physician whose primary responsibility is caring for the donor. Oocyte-donor-program staff should recognize that physicians providing services to both donors and recipients could encounter conflicts in promoting the best interests of both parties and should create mechanisms ensuring equitable and fair provision of services.

Programs offering oocyte donation should adopt and disclose policies regarding whether coverage exists of an oocyte donor’s medical costs should she experience health complications from the procedure (ASRM PC 2006_Guidelines for oocyte donation). Ideally, programs should ensure that donors are covered for any health-care costs incurred as a result of participating. Limits and terms of coverage need to be explained and accepted by the donor. Programs should also offer referral for psychological services to oocyte donors who experience subsequent distress related to the procedure, including the experience of being excluded from a potential donation (Zweifel 2009).

All programs offering financial incentives should ensure that advertisements for donors are accurate and responsible (CA Health & Safety Code). If financial or other benefits are noted in advertisements, the existence of risks and burdens also should be acknowledged therein. Donors independently recruited by prospective oocyte recipients, agencies, or egg banks should undergo the same disclosure and counseling.
processes as donors recruited by fertility practices. If donors have been independently recruited, programs should ascertain whether excessive or improper incentives were offered. Programs should refuse to participate if prospective oocyte recipients or recruiting agencies have offered excessive gifts or payments that compromise the donor’s free choice or have engaged in other ethically inappropriate conduct. Programs should adopt procedures and standards for determining when independent recruitment arrangements involve payment that is unduly coercive and thus has a negative impact on a patient’s autonomous decision-making. Programs should not assume that known donors, such as family or friends, are not being financially compensated. In a recent study of recipients using known and anonymous donors, all but one of the known donors had been compensated, and there were no differences in amounts provided to known or anonymous donors (Greenfeld 2004).

To reduce the potential health risks of repeated donation and to lessen the risk of inadvertent consanguinity among offspring, programs may wish to limit the number of times a woman may undergo retrieval procedures purely to provide oocytes to others (ASRM PC 2006_Guidelines for oocyte donation, ASRM PC 2019_Repetitive oocyte donation). A good-faith effort should be made to avoid accepting women who have already made a high number of donations elsewhere. The ASRM Practice Committee recommends that the number of stimulated cycles for a given oocyte donor be limited to 6 (ASRM PC 2019_Repetitive oocyte donation). Finally, all ART programs offering oocyte donation should engage in further study of the medical and psychological effects of oocyte donation on donors. Findings from such research promises to improve understanding of risks and benefits and allow programs to provide more accurate information to prospective donors.

CONCLUSION

The use of donor oocytes for reproductive and research purposes is well established, resulting in family formation for couples and individuals who lack viable oocytes as well as supporting potential advances in medical discoveries, treatments, and therapies. In the United States, it is commonplace for women who provide oocytes to others for reproductive use to receive financial compensation. This remuneration compensates donors for the time, inconvenience, and discomfort associated with the oocyte retrieval process and is ethically justified. Conversely, most women who donate oocytes for research purposes do not receive financial compensation based on existing laws and policies. The Committee believes the disparate treatment of reproductive versus research donors is not ethically justified, and changes should be made to equalize the treatment of all oocyte donors. Concerns over the commodification of human gametes and its impact on human dignity are acknowledged; but, on balance, the need to respect women’s autonomy, capacity to make informed choices, and desire to avoid forced altruism compel support for a system of financial compensation for oocyte donors. Compensation should not vary according to the planned use of the oocytes (fertility therapy or research), or the number or quality of oocytes retrieved. The amount of compensation should be fair and not so excessive as to become an undue enticement that negatively impacts a donor’s ability to make an informed decision about the donation process.
ACKNOWLEDGMENTS

This report was developed by the Ethics Committee of the American Society for Reproductive Medicine as a service to its members and other practicing clinicians. While this document reflects the views of members of that Committee, it is not intended to be the only approved standard of practice or to dictate an exclusive course of treatment in all cases. This report was approved by the Ethics Committee of the American Society for Reproductive Medicine and the Board of Directors of the American Society for Reproductive Medicine.

This document was reviewed by ASRM members and their input was considered in the preparation of the final document. The following members of the ASRM Ethics Committee participated in the development of this document. All Committee members disclosed commercial and financial relationships with manufacturers or distributors of goods or services used to treat patients. Members of the Committee who were found to have conflicts of interest based on the relationships disclosed did not participate in the discussion or development of this document.

Judith Daar, JD; Lee Collins, JD; Christos Coutifaris, MD, PhD, Joseph Davis, DO; Leslie Francis, PhD, JD; Ruth Farrell, MD; Elena Gates, MD; Elizabeth Ginsburg, MD; Susan Gitlin, PhD; William Hurd, MD, MPH; Mandy Katz-Jaffe, PhD; Sigal Klipstein, MD; Richard Paulson, MD; Richard Reindollar, MD; Ginny Ryan, MD; Mary Samplaski, MD; Mark Sauer, MD, MS; Sean Tipton, MA; Lynn Westphal, MD; Julianne Zweifel, PhD

REFERENCES

29. Paolo Emanuele Levi-Setti, M.D Appraisal of clinical complications after 23,827 oocyte retrievals in a large assisted reproductive technology program. Fertility and Sterility® Vol. 109, No. 6, June 2018 0015-0282