

# Navigating Conflict of Interest in Oocyte Donation: An Analysis of Donors' Experiences

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**Abstract** The relationships oocyte donors have with lawyers, psychologists, and health care providers are explored and recommendations to address conflicts of interest are suggested.

**T**he practice of oocyte donation raises numerous ethical challenges. One of these challenges arises out of the perceived conflict of interest that exists for lawyers, psychologists, and health care providers with whom an oocyte donor must interact. In a typical professional relationship, a woman seeks out the advice of these professionals for her own needs, and she is responsible for the professional's fee. In all three professional relationships mentioned above, the relationship creates special duties on the part of the professional. For instance, the professional must keep information confidential and must act in the best interest of the client or patient. This is unlike an employer/employee relationship where there is not the same type of obligation.

The relationship the donor has with these professionals is unusual for a number of reasons. First, the donor is not motivated to engage the services of these professionals for her own legal or medical need. Instead, she is typically motivated to participate based on financial compensation, compassion for the infertile, or a combination of both.<sup>1</sup> Ethicists question whether these incentives to donate are exploitive because they convince the donor to engage in a risky activity that she otherwise would not be engaged in.<sup>2-3</sup> In addition, the fact that the donor is getting paid can cloud the relationship. It is possible for the professional to perceive the donor as something closer to an employee rather than a client or patient.

Next, the donor is not the consumer because someone else is ultimately

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responsible for the professional's fee. The professional has an incentive to act in a way that keeps the consumer happy. This may be in direct conflict with what is in the best interest of the donor. In addition, the donor often does not get to choose the professional. If she is not satisfied for some reason, she does not have the option to change.

Third, the professional has a vested interest in recruiting or at least not dissuading the donor. For the health care provider, this is obvious. If the donor does not participate, there can be no in vitro fertilization (IVF) process for the infertile woman who lacks ovarian function. This conflict has the potential to affect the informed consent process if the health care provider minimizes the risks involved in order not to dissuade the donor. This incentive is subtler for lawyers and psychologists who work with donors. They get paid their fee regardless of whether the donation is completed; however, they may be dependent on the health care provider for future referrals. If too many of the potential donors they counsel withdraw or are rejected, they may lose future business.

Finally, there is an added conflict for health care providers because they are focused on helping the recipient woman become pregnant. There is an incentive not only to keep the consumer happy, but also to produce high success rates because these rates are used in marketing the clinic. There is a great deal of pressure on the health care provider to stimulate the donor to produce the maximum number of eggs possible so that the recipient has multiple chances at pregnancy. There is always the threat that health care providers will be so focused on the ultimate goal of making the recipient pregnant that they will be willing to overlook what is in the best interest of the donor.

Simply stating that a conflict of interest exists does not mean that it negatively affects the advice or care received by the donor. As Edmund L. Erde points out, there is a difference between potential intemperance and intemperate behavior.<sup>4</sup> These professionals are familiar with conflicts of interest and have found ways of addressing them. Whether the professional follows medical or business ethics, typically, the first step is to recognize the conflict of interest. Next, it must be disclosed to the client or patient. Finally, there may be institutional safeguards set up to protect the client or patient. For instance, if a large law firm is representing two sides of a dispute, there are communication barriers set up to ensure that neither party's case is compromised. In the health care setting, a well-recognized conflict of interest exists when a physician tries to recruit his patients into one of his own research studies. Institutional safeguards intended to protect research subjects include institutional review of the research protocol, guidelines that the protocol must minimize any harm or potential harm to the subject, informed consent, stipulations that the participant can withdraw at any time, and certain restrictions on advertising and financial incentives. Additionally, the physician who is overseeing the participant's care may not be the person to obtain the informed consent.

Recognizing this conflict of interest within oocyte donation, we decided to investigate it from the donor's point of view. How would former donors define the relationships they had with these professionals? Would they describe their relationship with the health care provider as a typical doctor-patient relationship or as something else? How would donors assess the quality of the interactions they had with these professionals? If they sensed any unusualness in the relationships, to what would they attribute this? We were also interested in discovering factors that either contributed to or mitigated the effects of this conflict of interest.

To investigate these questions, we conducted 33 in-depth interviews with former oocyte donors and six interviews with women in the process of donating. Qualitative interviews with former donors were used to explore

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*The first step (for the professional) is to recognize the conflict of interest. Next, it must be disclosed to the client*

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these questions because we wanted to give the participants the opportunity to focus on what they felt was most relevant about their experiences. Others have pointed out that qualitative methods are particularly well suited to discovering and understanding women's experiences.<sup>5</sup> These women were drawn from multiple clinics and agencies that recruit oocyte donors as well as from an Internet oocyte donor discussion group. Women were selected to participate if they were compensated for the donation and did not have a preexisting relationship with clinic staff and, therefore, were not the medical consumer. Both known and anonymous donors were included. Participants gave their informed consent before participating. Interviews followed an interview guide. Interviews were taped, transcribed, and edited to remove personal identifiers. Study methods are described in greater detail elsewhere.<sup>6</sup>

## DONOR'S EXPERIENCES WITH PSYCHOLOGISTS

All but one former donor reported some sort of meeting with a psychologist, counselor, or social worker prior to being accepted as a donor. Former donors almost universally recognized that there was a strangeness in the relationship they had with the psychologist. The most common cause for this was the donor's understanding that information she provided the psychologist might be used to exclude her as a donor. There was no expectation of confidentiality. At least three women reported that they felt like they were at a job interview. While some donors mentioned that the psychologist disclosed that part of the purpose of the visit was to screen them, not a single donor mentioned that the psychologist openly acknowledged this conflict. Claire\* commented on this without any prompting,

I was sort of curious to see how she handled her position in terms of disclosure and that sort of thing—about what her purpose was. And I expected her to say, 'I am being paid by the recipient couple. I am not your advocate.' Nothing. She didn't even have me sign a release, which I thought was a little tacky.

Former donors said that they believed the primary purpose of the screening was to screen out potential donors who might cause a problem for either the couple or the clinic. The next most commonly understood purpose was to make sure that the donor could emotionally handle the donation experience and was adequately informed. This purpose supports the best interest of the donor, so it does not contribute to the conflict of interest. Amy's response was typical. She thought the purpose of the visit was,

... to make sure I knew what I was getting into—that this was something that I wanted to do—to make sure I think also that I was not somebody who was solely motivated by the financial compensation.

Other potential purposes mentioned by former donors included: 1) to ensure they would be compliant with the protocol; 2) to make sure they were free of mental illness or diminished intelligence because these traits could be genetically inherited by the potential offspring; 3) to make sure that, in cases where the recipient and donor were friends, they were in agreement over issues that could later cause tension in the relationship; 4) to discover hidden motivations; 5) and to make sure the donor's partner was supportive of her decision.

Because donors did not have the reassurance that information they provided would not be used to exclude them or be kept confidential, and because they did not always understand the purpose for some of the questions, there was information that donors felt they had to conceal from the psychologists. For instance, a number of women mentioned that they downplayed their financial motivation to donating because they thought it would look bad.

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*Donors did not have reassurance that the information they provided would not be used to exclude them*

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\*Names of all participants have been changed.

In addition, donors and recipients who knew each other often concealed that they met over the Internet for the express purpose of forming an oocyte donation relationship. Melanie reported that she knew what she was doing would create a baby, but she intentionally talked about it in abstract terms because she thought that was what the counselor wanted to hear.

They asked, 'well how do you feel about this and do you think of this as a baby' type of thing, and I went with it more scientific. Well I donate blood, and a lot of blood is pumping around in other people's bodies and everything like that. But I knew all along that what I was participating with was making a child somewhere . . . but I didn't get into it with the counselor because I didn't want her to think that I was going to be some fruitcake trying to track these people down.

Three former donors concealed the fact that their primary motivation to donate was to compensate for a previous abortion because they were afraid this motivation would exclude them from participating. Another woman, Cassie, reported that she concealed a rape and subsequent abortion that took place in her teens not because it was related to her motive to donate, but out of fear she would be judged. She said, "I felt like they would think I was a whore."

Often times clinics ask questions about reproductive history to assess a woman's fertility. In other words, a prior abortion or pregnancy that ended in adoption proves the woman is fertile. In addition, psychologists may ask about these issues because they know there is an association between women who are interested in oocyte donation and a history of sexual trauma and reproductive losses.<sup>1</sup> Their goal may be to give women the chance to work through these issues with a trained professional, but the opportunity is lost because potential donors expect that these questions are for normative social judgment rather than to assess fertility or ability to cope with the oocyte donation.

## DONORS' EXPERIENCE WITH LAWYERS AND LEGAL ISSUES

Of all the women interviewed, the women most likely to have had independent legal representation worked with matching agencies. This may be because at least one of the owners of the matching agency was a lawyer herself and wanted to make sure the donors had independent legal representation. Donors who worked with this agency were able to choose their own legal representation. A few of these lawyers actually disclosed to the donors that there was a conflict of interest because someone else paid their fee. In these cases, the disclosure was followed by reassurance that they would act in the best interest of the donor even though someone else paid the bill. There were a couple of occasions where the donor and recipient shared the same lawyer. Reflecting back on this, Danielle now believes this was a mistake. She said, "I had an attorney, they had an attorney, and it was the same attorney, which was my mistake—but I didn't lose out on anything." When asked why this was a mistake, she responded, "Because I look back and think that when you have—when you are sharing the same attorney, you're not really being represented."

Even though recent guidelines published by the American Society of Reproductive Medicine (ASRM) recommend that oocyte donors "should be encouraged to seek legal advice" and "execute documents that define or limit their rights and duties with regard to any offspring," women who donated directly through a clinic were the least likely to have legal representation.<sup>7</sup> Many women recalled signing papers that appeared to be legal, but when there was no lawyer involved, there was a great deal of confusion over what was a consent form or "hospital papers" and what was a legal contract.

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*Women who donated through a clinic were least likely to have legal representation*

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It is unclear why women recruited directly by clinics were less likely to have legal representation. Perhaps clinics were not as familiar with the legal aspects of oocyte donation, or the ASRM recommendations have not had time to be implemented. A more disturbing explanation is that clinics are not recommending or requiring legal representation for the donor because it would increase the financial burden on the recipient couple.

A number of women who were donating to women they knew or women they met over the Internet reported drafting their own contracts without legal assistance. Some reported using a contract they obtained from a prior donation or using a contract they obtained from other donors over the Internet. These women often had more bargaining power over what was ultimately in the contract. Women working with matching agencies often felt constrained by the contract because they were not permitted to negotiate the details. Though some of the details caused donors concern or seemed unfair, they reported that they trusted the agency coordinator, thought the risks were minimal, and decided to just hope for the best.

One legal issue that concerned donors was that quite often the donor was expected to assume the financial burden of any medical costs associated with side effects or complications of the donation. This was especially true for women who worked through particular agencies or clinics. Women who have had multiple donation experiences learned to negotiate insurance coverage or expenses related to complications into the agreement with the recipient couple. In other cases, donors were told by the clinic that the clinic, not the recipient couple, would be financially responsible for any medical complications. Other donors explained that the agency or clinic told them that their personal health insurance would cover the cost of any unanticipated medical complications because oocyte donation was just like any other high-risk activity. Most women accepted this explanation because they believed it to be true and were convinced that the risk of significant complications was minimal. Some women agreed that this expectation was reasonable, but others were not always pleased. Melanie said,

All the donors had to have some kind of medical insurance because they would not be responsible at all . . . I felt boy you're asking me to take all these risks. They're paying you for it, but at the same time, if anything goes wrong, I'm just cut loose. That didn't seem to be the way it should be, but it's a business type of thing.

A number of women mentioned that all of their follow-up care was provided free of charge; however, two women got stuck with medical bills from follow-up care and medical complications even though both were promised that the clinic would cover these costs. One woman was promised follow-up care prior to donating, but after the donation, that care was denied. She sought out her own personal physician for a sonogram and had to pay hundreds of dollars out of pocket because she was uninsured at the time. Another woman, Tina, fainted at work while she was taking the hormonal injections.

I'm trying to sort it out cause I don't know where to put the blame, or if there is anyone to blame. People pass out all the time. But once I passed out, I had to stay over night in the hospital . . . I had muscle spasms and I started to convulse.

The clinic denied that the condition was related to the donation and refused to pay for her hospitalization. She is currently fighting with her own health insurance and workman's compensation over the \$3500 bill.

Many women believed that the contract protects donors. Some women who experienced problems blamed themselves for not getting every detail spelled out in writing. Daphne had an unusual situation. She was infertile

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*The donor was often expected to assume . . . any costs associated with complications*

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herself and had gone through IVF a number of times where she donated half of her eggs in return for free infertility care. She always had a contract with the primary clinic she used. She decided to do one cycle of IVF with a different clinic and did not have a contract for this cycle. She reported that the clinic gave all of her eggs to the recipient woman and then refused to compensate her for them. She was devastated and threatened to sue, but stopped pursuing it because it was too emotionally draining. When asked why she didn't have a written contract she responded,

I didn't know any better. I just did not know. I was used to my doctor who took care of me . . . so it never dawned on me that somebody would be out to screw you.

She stated that she had switched doctors and was willing to trust the new doctor because she was so desperate to have a baby. She thinks now that the only way donors will be protected is through education and contracts that protect the donor's interests.

There was often ambiguity about what was a legal issue and what was a medical issue, and at what point it was appropriate for donors to negotiate over these issues. This confusion was partially influenced by who the two contracting parties were. Some donors reported that the contract was between them and the recipient couple, whereas others thought it was between themselves and the clinic. For instance, women who worked with the matching agency were required to sign the contract before they met with a physician. Chris thought this was the appropriate time to negotiate over medical issues.

. . . one of my concerns was for the retrieval—the anesthesia—whether it was going to be general—and I said, can you put it in [the contract] that it's going to be general anesthesia? I do not want to be awake. And she came back with no, we can't do that because that's between—that's dealing with the clinic, and this is just the contract between these people [the recipient couple], and they have no control over it.

In other instances, medical issues did show up in the legal contract. For instance, one woman was asked to sign a legal contract that would permit the physician to use laparoscopic surgery if he was unable to reach her ovaries through transvaginal aspiration. At other times, women were still not protected even if their terms were spelled out in writing. Barbara requested a female physician. The egg donor coordinator promised her that she could have a female health care provider; however, on the day of the retrieval she was informed that a female was not available. She expected the clinic to live up to their agreement because she had a contract, but eventually she gave in when she learned her only options were to have the retrieval with a male physician or carry the eggs around for another 3 weeks while in significant discomfort.

While a contract may appear to protect the donor's interests, certain legal stipulations contained in the contract can actually undermine the doctor-donor relationship. Approximately one-half of the women, including all of the women who worked with one particular matching agency, reported that they signed a legal contract that held them financially responsible if they back out of the process. This meant that if the woman did not complete the donation process and was not excused from the process by a physician for medical reasons, not only would she not receive compensation for her time, but she would have to repay thousands of dollars that were invested in screening and medication costs. Most of the women who signed these contracts thought this stipulation was fair, but most of them also believed this was only a light threat because they believed the agency and the recipient couple would not sue them if they had a "reasonable excuse."

This legal stipulation was coercive in ways that may not be readily apparent. In many of the donors' minds, at the point at which they signed the

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*One half of the women signed a contract that held them financially responsible if they back(ed) out of the process*

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contract they believed the donation was a “done deal.” A number of donors expressed that they felt they had lost their one bargaining chip to have any measure of control over the process. Donors could no longer use the threat of withholding their eggs to get their way. Katie ran into a situation where she had a family emergency on the day of the retrieval. She tried to negotiate a different retrieval date, but she reports,

... he was just like, ‘no, you signed a contract, and this is the day the retrieval is going to be and that’s just the way it is.’ Quite frankly, I thought that was bull shit because he could have easily have kept me on [the medication].

When she was asked what she thought would have happened if she had a negative reaction to the medications such as migraine headaches, she responded,

I don’t think they really cared about that, at least I didn’t feel they would have cared about that. There wasn’t a lot of ‘how are you feeling? Are you doing okay with all of this?’ ... So I don’t really know what could have gotten me out of it if I had changed my mind.

This was contrasted with Allison’s experience. She did not have this stipulation as part of her contract and had no difficulty negotiating the date of her retrieval.

For another woman, Chris, this stipulation in the contract affected the informed consent process. She was told that after signing the contract, she had one opportunity to void it. If, after meeting with a physician, she learned something that made her too uncomfortable to proceed, that would be her only opportunity to back out. She discussed her interaction with the physician during that visit.

I felt like it was gonna be more of a discussion with him besides just the exam, and I guess I had some questions and stuff. That was supposed to be kind of a forum for you to talk to the doctor and have the opportunity to ask questions ... and excuse me, the doctor never even—I mean it was like the exam and that’s it. He never even asked me. And so when I called [the lawyer] and had some concerns that I talked to her about, and I said, ‘you know this doctor never even—I thought I was going to be able to discuss some things with him, you know, discuss a few things. He never even gave me the time of day.’ And she must have said something because the next time I went in, he was like ‘did you have questions?’ or something like that, and I was like, ‘no, never mind.’ At that point, I was kind of like, it’s a done deal.

It was clear that women who didn’t have this legal threat as part of their agreement felt more freedom. Melissa reports,

I could stop at anytime if I wanted to ... the compensation would vary based on when I stopped, but I was always at liberty to stop ... I think they were fairly up front about the fact that they didn’t want me to stop, but I never felt like I couldn’t.

## DONORS’ EXPERIENCES WITH HEALTH CARE PROVIDERS

About half of former donors stated that the fact that they were receiving treatment for the benefit of another patient, and that they were being paid had no perceivable impact on the care or information they received. They felt that the doctor–donor relationship was just like a doctor–patient relationship. In fact, at least two women thought they got special attention because they were donors. Janet described her experience.

A lot of [the nurses] didn’t know [that I was a donor], but their reaction when they did know, and definitely the reaction of [the doctor] was ‘oh, you’re this

big hero,' and 'this is so great.' 'You're such a wonderful person.' . . . It was probably beyond what a patient would have gotten, so it was great.

A few women recognized the potential for a conflict of interest and were initially concerned that they wouldn't be treated like a patient but were pleasantly surprised with the information and care they received. Nancy reported,

I was curious before I went in there if that would have any affect on it, but I feel like it didn't at all. I felt like they were as much concerned about me as they would be about the recipient. And I didn't feel like they were treating me any less professional than they would any other patient or answering any less questions than they would . . . Another concern I had was if they would be honest about the risks because they benefited from me doing all this . . . but I felt like they were honest. They gave me information and [name of women] sent me articles about the studies. So I felt like they were being very honest and sincere.

A number of women stated that they didn't expect the same kind of care they would receive from their own private physician. For instance, Barbara stated that oocyte donation is clearly a business arrangement not health care, but this was okay with her so long as the donor understands this from the beginning. Cassie experienced some emotional pressure to make sure that she did not disappoint the recipients, but she thinks this is to be expected. Tonya mentioned that the donor should have no expectation of confidentiality from health care providers because the information could be very important to the recipient couple, the donor's health, or the ultimate success of the procedure. Danielle described her expectations this way.

. . . [the physician] doesn't have to treat me great. I'm not paying him. The other people are paying him. And I mean if you think about it, his job is to get my eggs . . . His job is not to be nice to me. His job is not to hold my hand. His job is to put me to sleep and take my eggs.

Allison reported that she thinks a bit of skepticism on the part of the donor is to the donor's advantage.

Allison: I don't think [the clinic staff] have my best interest at heart, but I don't expect them to. I think a lot of people think that all doctors have their best interest in mind, and I don't think that way about doctors, so . . .

Interviewer: Do you think donors should feel that way?

Allison: Should think that clinics have their best interest in mind?

Interviewer: Well, because they are doctors?

Allison: No, I think that it's actually against their interest to think that way. If they go in with a skeptic's eye, then they can really see, 'oh, maybe there's some other way of doing this.'

While many donors expressed some skepticism about assuming that health care providers were acting in their best interest, others pointed out that people are socialized to trust health care providers. Hanna stated, "We do trust our doctors because they look professional, they are educated, they speak well, and they wear white."

Whereas half of the former donors thought the conflict of interest issues had no impact on the relationship, another half perceived a difference in the relationship that affected their care. The most common reaction was that the clinic staff appeared to be more concerned about getting the donor's eggs than about her emotional or physical well-being. Katie said,

. . . I think that this doctor specifically just saw me as an egg producer. 'Well I need her eggs to continue, so I have to meet her on certain requirements, but I don't have to be there. Once she's done, once I have what I need, I'm on to my next step. I'm on to the next egg donor and the next family.' . . . It really did make you feel like a commodity, and that's hard for anybody. There's

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*The most common donor reaction was [that] staff . . . was more concerned about getting the . . . eggs than about her . . . well being*

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probably a really good reason why they don't let people sell their kidneys—sell their lungs.

Former donors said they felt neglected when health care providers failed to ask how they were doing, did not answer questions directly, dismissed donors' concerns about their health or physical symptoms, and failed to provide follow-up care. A couple of former donors also pointed out that there is a lack of long-term research on how the donation process affects donors. Both women believed that this lack of research is because no one really wants to know if oocyte donation is harmful to the donor because it would only dissuade donation.

A small number of women described being treated with outright disrespect. Chris reported,

... you're not really part of the game there . . . and I think both of those things negatively affect the quality of care. It was horrible, I mean the likes of which I have never experienced going to any doctors . . . and people have different opinions on it, and they think that everyone in there is doing it for money—like you're some kind of prostitute. Like you're doing this for money and that's the only reason you're there and so you deserve no respect.

She described a number of situations that made her feel very uncomfortable. For instance, after she had disrobed, someone decided she belonged in a different room and made her walk in front of a waiting room full of people in nothing but a sheet. Later she described her encounter with the anesthesiologist.

So I called him up, and I'm like this is Chris—I gave my own name. And he screamed at me, "Don't use your real name. I don't want to know your name. I don't care what your name is." . . . and to have him, the anesthesiologist, bitching at me because I used my real name. Oh like I'm not his patient?

Christine also felt she was treated with disrespect. First, she had warned the anesthesiologist that she had a strong tolerance to a particular type of anesthesia. She believes he ignored her because she woke up during the procedure and was in a great deal of discomfort. She was conscious enough to talk with the health care providers in the operating room, but they did nothing to alleviate her discomfort. Next, she had been promised follow-up care if she needed it, but when she arrived at the clinic in pain a week after the operation, she was told that any follow-up care was her own responsibility. She was unable to pay for private care because she was uninsured at the time. Finally, when she asked for her medical records and information about what had been done to her, she was told to leave the clinic. When she requested her medical records in writing, the clinic responded by sending her a check for \$500 and a letter that told her not to contact them again. To this day, she has a great deal of anxiety about the long-term impact of the donation on her body, and she distrusts health care providers.

Some women described feeling disempowered by the donation arrangement. For instance, Brenda stated that she couldn't make any demands because she wasn't the consumer. A number of other donors felt limited in the questions they could ask because they said some of them seemed inappropriate. For instance, they didn't feel comfortable asking how much discomfort to expect. Others mentioned that they did not feel they had the right to complain about anything because they were getting paid.

Three women reported concern that their physical health may have been compromised in order to maximize the number of eggs the health care provider was able to retrieve, but they were afraid to discuss this with the physician. In two cases, the women were informed that somewhere between 10 and 15 eggs was a typical harvest, but both of these women had over 45 eggs retrieved.

Many of the steps clinics took to maintain confidentiality made donors feel like objects, commodities, or second-class citizens. For instance some clinics insisted that donors use a pseudonym or number instead of their names. Other donors were told not to speak to anyone in the waiting room, and one woman was specifically segregated in a separate tiny waiting room without any magazines, TV, or "something to drink."

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*Steps to maintain confidentiality made donors feel like . . . commodities*

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## DISCUSSION AND RECOMMENDATIONS

While this study focused on the experiences of oocyte donors, additional research is needed to explore how health care providers and lawyers interpret and react to the conflict of interest inherent in the relationship with oocyte donors. It will be important to compare the perceptions of these professionals with the perceptions of donors to further understanding between donors and the professionals and to negotiate policy that all parties can agree upon. With these limitations in mind, we discuss the different factors that contribute to the conflict of interest between oocyte donors and the professionals involved in the process, and we make recommendations for ways to mitigate their effects.

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*Research is needed to explore how health providers react to the inherent conflict of interest*

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As we have seen, some donors were reluctant to be completely honest with psychologists because they had no assurance that information they provided would remain confidential. In fact, the information could have been used to exclude them. In these instances, the donor missed out on an opportunity to discuss these issues with a trained professional. Members of the National Advisory Board on Ethics in Reproduction (NABER) recognized this conflict of interest and recommended that the psychological screening process be separate from the psychological counseling process.<sup>8</sup> This could mean that donors have one visit with a psychologist that is clearly for screening purposes and a separate visit to address the donor's needs. During the second counseling visit, donors should be told that all information provided will remain confidential unless it would have a harmful effect on the recipient couple or potential child. This second visit could actually be with a different psychologist to provide greater assurance of confidentiality.

Donors might be less reluctant to discuss certain issues if they understood the exclusion criteria. If it was clear that a prior abortion, history of sexual abuse, or a financial motivation to donate was not going to exclude them from participating, donors might be more willing to discuss these issues with the psychologist. NABER members have recommended that an intercenter task force of providers and consumers be convened to establish universal exclusion criteria and that these criteria be publicly available to potential donors.<sup>9</sup> The ASRM has taken the first step in making recommendations for appropriate physical and mental health screening criteria for potential donors,<sup>10</sup> but they are only recommendations and are unenforceable.

In order to limit the pressure on psychologists and lawyers to encourage and approve every potential donor, there should be some distance between the professional and the infertility clinic. The mental health group of the ASRM has already begun discussion about the pressure on psychologists to approve every potential donor.<sup>11</sup> A more thorough examination of this issue is needed with formal screening guidelines that psychologists can use to justify exclusions. As a starting point, one clinic has reported that their screening criteria are very accurate in predicting donors who will successfully complete the donation process.<sup>12</sup>

According to former donors, problems exist within the legal process that can affect clinical care. The most pronounced problem is the stipulation that the donor will be held financially responsible if she backs out. With this stipulation, the transaction is no longer a "donation" but a performance agreement.

There is a good chance that such a contract would not stand up in court, but it works because donors fear that it could be enforced. Not only is the agreement coercive, but it also impacts clinical care. The donor loses her one bargaining chip she has to control the donation experience—she can not threaten to walk away if she is unhappy with decisions that are made about her clinical care. Donors may also overlook their right to be fully informed if they believe that the agreement is a “done deal.” The only way to mitigate the effects of this stipulation is to eliminate it. A performance agreement with the threat of a lawsuit for a person volunteering for clinical research would be considered completely unethical. An oocyte donor should be told that she can walk away at any time and still receive compensation for the time she has invested. This policy recommendation is supported by NABER<sup>13</sup> but is overlooked in the ASRM guidelines.<sup>14</sup>

If clinics and agencies were not permitted to place the financial risk on the donor, the financial risk would automatically fall on the recipient couple. Likewise, the recipient couple accepts the financial risk if the donor fails to produce eggs. Clinics could alleviate this financial risk to both donors and recipients if they set up a financial buffer that covered failures and dropouts. Reducing the financial risk might mean that more infertile couples and potential oocyte donors were willing to participate in the process. It would also alleviate the coercive pressure on the donor because donors feel a tremendous obligation to the infertile couple they are helping even if they have never met them. Knowing that the recipient couple would not be financially harmed if they withdrew from the donation process would reduce some of that pressure on donors.

Similarly, many contracts make the donor financially responsible for complications that result from the donation. Unfortunately, this is similar to current practice in the U.S. where research participants are financially responsible for complications resulting from participation in a study. Because of this policy, a “donor” could wind up with large medical bills related to the donation. Some have suggested that financial pools be set up to compensate injured research participants.<sup>15</sup> A similar pool, set up by each clinic or all infertility clinics collectively, would be an appropriate way of ensuring that donors are not financially harmed as a result of participating in a “donation.” Alternatively, the donor could be protected if the clinic or recipient couple financed a short-term health insurance policy and agreed, in writing, to pay for all deductibles and copayments. NABER supports this recommendation.<sup>16</sup>

Donors expressed confusion over the documents they sign and at what point it was appropriate to negotiate over medical and legal issues. Health care providers and legal representatives have an obligation to clarify the information that is in documents that potential donors are asked to sign, who the agreement is between, and the implications of the agreement. They also must help women understand both the legal and medical implications before the donor makes any commitments. For instance, the donor should be able to negotiate over clinical issues such as the type of anesthesia that will be used, prior to signing either a consent form or legal contract. Clinics and matching agencies have an obligation to look out for the donor’s legal rights by providing her with free, independent legal representation.

Former donors’ most frequent complaint about their interaction with health care providers was that they were not treated with respect and sometimes felt neglected. Some donors stated that this could simply be the result of the health care provider’s personality, but more often they attributed the way they were treated to the fact that they were a donor. Not a single donor reported that the conflict of interest faced by the health care provider was disclosed or discussed. It may be that health care providers are not consciously aware of it; therefore, the first step that must be taken to mitigate the effects of

this conflict of interest is an open discussion within the assisted reproductive technology community.

Health care providers must understand that women are socialized to trust them. Whereas some women recognized this was an unusual relationship and were skeptical that the health care provider would look out for their best interest, others were willing to trust simply because the “provider was a doctor” (Hanna), “the hospital had a good reputation” (Justine), or “the office looked nice” (Daphne). Health care providers have an obligation to avoid taking advantage of this trust. Oocyte donors may at times feel like employees, but they are not. They are more like participants in nontherapeutic human research. As such, the health care provider has an obligation to look out for their best interest. Institutional protections similar to those used to protect research subjects may mitigate the effects of this conflict of interest. For instance, institutional review boards could review egg donor protocols and consent forms. A small fee paid for by the recipient couple could subsidize the cost of the review. Fees to cover regulatory costs of assisted reproductive technology are standard in other countries such as the United Kingdom.

There are additional steps the profession can take to mitigate the conflict of interest beyond recognizing and then disclosing the conflict of interest to donors. First, health care providers need to be educated about how their behavior affects the oocyte donor. Donors who are treated with respect and appreciation leave feeling very good about the donation experience. Donors who are treated with indifference or disrespect describe feeling like a commodity or a prostitute. It is unethical to treat a donor badly, but it also damages the clinic’s reputation, affects whether the woman will be willing to repeat the experience, and, if the donor shares her experience, shapes the expectations of other women who are considering or will later consider becoming a donor. Health care providers must also understand that they have additional obligations to donors above and beyond their obligations to their patients because the donor is putting herself at risk but derives no medical benefit. For instance, health care providers must take steps to ensure that the donor has given fully informed consent. They must remain available throughout the process to answer any questions that arise. They must be sensitive to potentially coercive influences that are affecting the donor. Finally, they must be attentive and responsive to the donor’s medical complaints both during and after the donation.

There are institutional changes that health care professionals can make to address the conflict of interest. For instance, as a part of the ASRM practice guidelines, providers should develop a universal informed consent document for oocyte donation and should mandate follow-up medical care and make follow-up psychological care available for all oocyte donors.

There is tremendous pressure on health care providers to stimulate the donor to produce the maximum number of oocytes because it is in the recipient’s best interest to have multiple attempts at implantation. Unfortunately, this incentive to hyperstimulate the donor is not in the donor’s best interest. Hyperstimulation syndrome is the most dangerous complication that can result from oocyte donation. Although its occurrence is rare, in severe cases it can lead to hospitalization and can be life-threatening.<sup>17</sup> With traditional IVF, the infertile woman is stimulated with hormones to produce eggs, but there is a disadvantage to overstimulating the woman because it may affect the lining of the uterus and decrease the chance of implantation of the embryo. In oocyte donation, this disadvantage to overstimulating the donor does not exist.

There is no perfect solution to change this incentive to hyperstimulate the donor, but there are a number of policy changes that could reduce the incentive. First, the ASRM needs to include a strong statement in its clinical practice guidelines that overstimulation of donors is to be avoided and that the

best interest of the donor is to take priority. Next, health care providers need to keep up with and use the latest techniques to reduce hyperstimulation syndrome and identify women at high risk. An appropriate monitoring schedule should be written into the clinical practice guidelines. In addition, donors and recipients need to be fully educated about the risks of hyperstimulation syndrome. Finally, the recommendation above that clinics take on the financial responsibility for medical complications would provide a disincentive to risk hyperstimulating the donor.

Ultimately, the best way to address the conflict of interest with health care providers is for donors to be empowered. Health care providers can facilitate this process by suggesting to women that they seek a second medical opinion; by insisting that recipient couples finance independent legal representation for the donor; by providing medical literature on oocyte donation to the donor as well as preparing written information in simple language; by allowing the donor to have a copy of all consent and legal documents in advance to review with her lawyer or additional health care provider before she signs them; and by conducting follow-up research on the long-term medical and psychological effects of oocyte donation on donors.

Networking is one of the more powerful tools to empower oocyte donors. This does not take place naturally because oocyte donation is not something these women discuss with casual acquaintances; however, the Internet provides an opportunity for these women to discuss their concerns with women they know will not judge them. It is a safe environment because donors can use anonymous E-mail addresses and the chat group is closed to nondonors. Information is also available online. Providers can contribute to this information sharing by posting information on donation on their web sites and by referring potential donors to the listserv discussion group.

Because commercial oocyte donation is going to continue to be practiced in the United States, professionals have an obligation to continue to examine conflict of interest issues and work on finding ways to mitigate their effects.

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*Allow the donor to have a copy of all consent and legal documents in advance*

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