

Navigating Conflict of Interest in Oocyte Donation

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The nature of the relationship between an oocyte donor and physician is difficult to characterize, but it is clearly not a typical doctor-patient relationship. Like Andrea Gurmankin (2001), my colleague and I argue that, because there is a conflict of interest for the physician (and other professionals involved in the process), this relationship ought to be treated more like a research participant-researcher relationship (Kalfoglou and Geller 2000a).

It is valuable to explore whether this conflict of interest influences donor recruitment, informed-consent practices, and quality of care. Designing this type of study is difficult, however. While investigative journalists have long employed the technique of posing as a potential consumer, this type of approach is unlikely to be acceptable to many institutional review boards. Yet a straightforward approach, such as direct observation, may lead to biased findings.

My colleagues and I have approached this issue by retrospectively interviewing 33 oocyte donors (Kalfoglou and Geller 2000b; Kalfoglou and Gittelsohn 2000). We asked the women about the donation experience, including their perceptions of the doctor-donor relationship and their thoughts related to the clinics' recruiting practices and provision of risk information. While this method avoids any type of deceptive practice, it was difficult to recruit participants, because clinics were extremely reluctant to participate.

Former donors reported that, in general, they were satisfied with the experience, and many were willing to repeat it; however, most had complaints about some aspect of the recruiting process, quality of risk information provided, the impact of the financial transaction, or the quality of medical care. Many of the issues they raised are disturbing and warrant further investigation.

Seven women reported that during the recruiting phase they were made promises that were later broken. Four women were promised a specific kind of anesthesia, but then were denied it during the retrieval. A fifth requested and was promised a female physician. On the day of the retrieval, she was informed that a female physician was not available and felt bullied and intimidated by the male physician. Yet another woman was promised free follow-up care. When she experienced postsurgical pain and returned to clinic, she was told that they were no longer responsible for her care. Finally, one woman believed that

she was undergoing oocyte retrieval for her own infertility treatment and traded half of her oocytes for free care. Following the procedure, she learned that the physician had fertilized all of her eggs with sperm from the recipient couple.

In evaluating whether women received all the information they needed to make an informed decision, we listened as the women recalled what they were told about the risks. Even three years later, most of the women could recite a long list of potential physical complications, and others discussed the psychological risks. Most of the women reported that they obtained this information from the clinic or from the lawyer/nurse who was coordinating their donation.

There were two clear cases where the women did not give informed consent. Two women reported that, in spite of asking repeatedly, they were never informed about the physical risks. One was told there were no risks. The second was repeatedly promised that she would receive written information, but it never arrived. In spite of the fact that she refused to sign the consent form, the clinic proceeded with the donation.

Other examples call into question whether the information provided was complete. Some women reported that their drugs were either lacking the package insert or that the insert was in a foreign language. Others reported they were not given sufficient time with a physician to ask questions. Additionally, many participants were troubled by the lack of information available on long-term physical risks, such as the potential increased risk of ovarian cancer and the effect on future infertility. Some of the women attributed this lack of information to the fact that clinics have little incentive to conduct follow-up research.

Most of the women felt the financial compensation was appropriate because it covered expenses, lost wages, and their time and effort, but it had a number of other effects. Some of the women reported that they felt like and were treated like a commodity. They used terms like "prostitute" and "livestock" to describe how they felt, and they described the medical care as cold and impersonal. Specific actions such as being referred to by a number or pseudonym rather than their names, being segregated into a separate waiting room, and being instructed not to speak to other patients contributed to this feeling.

A number of women reported that the payment was set up so that they would have an incentive to stay compliant with the protocol and complete the oocyte retrieval. Others reported that the compensation was set up as a legal

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transaction—if the woman did not complete the donation process, she could be held legally responsible for all the expenses incurred by the recipient couple. Both of these practices are potentially coercive. As such, the Ethics Committee of the American Society for Reproductive Medicine (ASRM) (2000) advises clinics to avoid them.

An unusually high number of women (27%) experienced side effects significant enough to keep them in bed, prevent them from working, or interfere with their ability to care for their children. All seven of these women donated more than 20 oocytes,² suggesting they were experiencing hyperstimulation syndrome. Because it is in the recipient's and clinic's best interest to maximize the number of oocytes retrieved, we are concerned that there may be undue pressure on physicians to overstimulate donors. One donor recognized this tension during her treatment:

I {wanted to know} how many of these little eggs do they need? Because they were pumping me full of the stronger and stronger drugs and when I first went, I said "well what's a good take?" . . . They {said} "well 10 or 12 is a usual one." And I had something like 25 in one {ovary} and almost 20 in the other, and I was swollen pretty big . . . and they were still putting me on the stronger drugs.

This conflict of interest is exacerbated by the fact that these women do not feel empowered to speak up about

their concern. They believe that because they are being paid (and are not the paying customer), they do not have the right to complain.

The bottom line is that there is growing evidence that the conflict of interest between a donor and physician can lead to many questionable practices. The ASRM has taken the first step to ameliorate some of the problems by developing practice guides, but there is also room for regulations similar to those in place to protect research participants.

References

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2. The remaining women all donated less than 20 oocytes.