FEATURE ARTICLE

First, Do No Harm: Ethical Questions about Ova Donation and Surrogacy

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A recent article in *The New York Times* drew my attention and reflection. Jane E. Brody, personal health columnist for the newspaper, recounted the story of a promising female graduate student who had donated ova to pay for her education.[1] Completing three donations prior to the age of 29, the woman died of metastatic colon cancer at the age of 31. Her case might have been noted simply as a tragic coincidence were it not for the fact that the donor's mother is a physician who began to research and study the link between egg donation and subsequent cancer.

The daughter, an intelligent and capable young woman, had discussed potential risks with a physician at the time of donation and was assured that there were "no known long-term effects" of the hormone injections needed to hyperstimulate her ovaries for ova retrieval.

Catholic health facilities do not in conscience provide in vitro fertilization nor do we facilitate surrogacy. Still, many offer excellent clinical assistance to couples desiring to become pregnant.[2] Furthermore, perinatal and neonatal units in Catholic hospitals care for mothers who have undergone fertility treatments. Reading the article drew me immediately back to the late 1990s and a small hospital in the rural Midwest where I had worked with the ethics committee and offered consultation services. I well recall a meeting with the CEO, chief nursing officer and an ob/gyn physician. The physician had come for a consult, relating that one of his patients (I will call her Jenny), a twenty-year-old state college student, was pregnant and wanted him to

deliver her baby in the hospital in which she was born. She then confided that she was the surrogate mother for a wealthy couple from New York City who would also be present for the baby's birth.

From a farming family, Jenny wanted to supplement her college expenses through payment for surrogacy. She had noticed an ad in her university's newspaper seeking healthy young women willing to travel to New York, undergo assessment and then hormone injections prior to in vitro fertilization and implantation. Jenny's physician noted wryly that coastal fertility centers sought farm-raised, blond-haired, blue-eyed scholar athletes. Jenny fit the bill. She fully enjoyed visiting New York and meeting her baby's parents and considered the injections and procedure a bothersome but necessary step.

The question the physician asked was, "Could a Catholic hospital deliver this child?" If not, his patient would have to travel over 50 miles from home to a physician and hospital with whom she had no comfort or familiarity. The response of the ethics committee was, "We are here to provide care." Additionally, "We don't ask any woman how she got pregnant." Being pro-life means that we care for both mother and baby. Nonetheless the administration was concerned about the possibility of scandal within the community and set forth clear steps to manage what could be a challenging situation for both the mother and the Catholic hospital.[3]

While Catholic hospitals do not offer in vitro fertilization, there is no doubt that many women who have become pregnant through in vitro procedures deliver their babies in Catholic hospitals. The Society for Assisted Reproductive Technology released data in May 2017 indicating that in the 30 years they have kept data, over one million IVF babies have been born in the U.S. They further indicated that these births are at an all-time high with 65,787 babies born in 2015.[4]

Jenny, like the young woman in Brody's article, had been told that there were "no known long-term effects" of the hormone treatment she received. That statement, as it stands, is factual. But the reason for this is that the United States, unlike other medically advanced countries, does not keep an egg donor registry nor a national

inventory of unanticipated consequences of the procedure.[5] Other nations, notably Great Britain, Australia and New Zealand, recognize that reproductive technologies may raise health challenges for donors, and thus regulate the industry and maintain registries of vital information. Records may later provide offspring with essential information for their own health-care choices. The oversight agencies study statistics to investigate the health of both women and children with a focus on obstetric complications, preterm births, cerebral palsy and cancer. However, these oversight agencies note that more research and follow-up studies are needed.[6]

For a variety of reasons, the U.S. treats these technologies more as a business than as health care.[7] A perusal of ethics literature from the mid-1980s to the mid-1990s reflects the ongoing litigation and subsequent debate that followed the famous "Baby M" case. But these and later lawsuits did not change the general laissez faire approach of the U.S. At a minimum, a governmental oversight agency would provide a more comprehensive database listing adverse outcome for mother and child so that the couples who choose to undergo such treatments have solid medical data upon which to ground their decisions. It would also draw attention to the health issues that assisted reproduction raise for mothers and babies.

In the U.S., instead of engaging in the difficult ethical analysis and deliberation necessary to address this divisive issue, legislators essentially punted decisions to the states. Still, a 2015 study by The Pew Charitable Trusts attests to the fact that states drag their feet at any regulation in this high-tech, high-cost, high-profit industry. "The U.S. is the Wild West of the fertility industry," said Marcy Darnovsky, executive director of the Center for Genetics and Society, in the article. The article also quotes ethicist Arthur Caplan who said the business is lightly regulated because "it touches on two 'third-rail' issues…abortion and also the creation of embryos, which politicians run away from because too many people still disagree about the right to use reproductive technologies, particularly who should pay for them and how much."[8] The problem becomes much more serious from a global perspective. Some countries have strict regulations but others – most notably in Africa and Asia - do not, thus often leaving

poorer women vulnerable to the money and treatment offered by these programs.[9]

Jenny's pregnancy was almost 20 years ago. But after reading Brody's article I have wondered about her. Did she have any aftereffects of hyperstimulation of the ovaries? Has she had any other children? Is she aware of the as-yet-unproven conjecture that some egg donors seem to have a higher than average chance of developing cancer? Does she get regular cancer screenings?

Egg donation and surrogacy centers in the U.S. certainly maintain an informed consent process at least from a legal or compliance perspective. However, as Brody's article so clearly notes, the forms simply state that there are "no known long-term effects" of the hormone injections the woman receives. Surrogacy has been practiced in the U.S. since the 1980s and has grown exponentially since then. This cursory type of informed consent is disingenuous at best.

In addition to informed consent, the medical or scientific expert owes the patient or subject truth-telling – defined as veracity, avoidance of lying, deception, misrepresentation and non-disclosure. Granted, because there is no national U.S. registry, and little solid retrospective research exists, fertility centers would presumably maintain that they are not lying nor even hiding information. The long-term information doesn't exist to provide sufficient scientific truth to the egg donor or surrogate.

Another ethical issue must be raised as well, that of exploitation of the donor.[10] While there are some situations in which a woman volunteers to be a surrogate or donor for purely altruistic reasons (for example, carrying a child for a family member or friend), the more common arrangements are made between wealthier individuals and women whose economic circumstances drive them to provide ova for payment. These arrangements can exacerbate already stark divisions between wealthy and poor people, between persons with white privilege and persons of color, between educated and less educated persons. One commentary used the term "alienated labor" observing that the product (the child) is separated from its producer, thus denying the woman the respect and consideration which should be her due.[11] Interestingly, there is little commentary upon the fact that speaking of

the "product" reduces the child to an object rather than a human subject.[12]

Readers of HCEUSA might well ask, "But Catholic facilities do not perform IVF, nor offer surrogacy or egg donation. What can we do about this ongoing situation?" Catholic facilities, with their long commitment to state-of-the-art maternal and child care have a great deal to offer to a national dialogue through physician practice groups and membership in professional organizations. Advocacy for the vulnerable[13] remains an integral part of what it means to be a Catholic institution. Working through long-held existing relationships, health care leaders and their associations can promote national standards and registries so that scientists may glean necessary information to provide robust informed consent to any woman who is considering or has donated ova.

St. John Paul II urged the faithful to engage at the crossroads of present day society, participating in what in Greek culture was called the Areopagus, where contemporary thought leaders respectfully dialogue and debate about culture, science, human life, the economy and politics.[14] Because Catholic facilities do not provide in vitro fertilization and egg donation is not sufficient reason to step aside from the ethical debate and advocacy for vulnerable women and their children who are drawn into the international reproductive technology industry. As Martha Nussbaum says in her column, "What happens to children is my business, and your business, and the business of every citizen. But what happens to the women who bear them is our business, too." [15]

Physicians and scientists commit themselves to "above all, do no harm."[16] Application of this maxim must extend beyond consideration of the immediate harm to patient or subject to the long-term effects of a treatment or procedure. The United States can and must recognize that reproductive technologies are moral, human life issues, not mere business or legal contracts. Those engaged in Catholic health care can and must work to move this process forward toward far greater responsibility and accountability.

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[1] Jane E. Brody, "Are There Long-Term Risks to Egg Donors?" *New York Times*, July 10, 2017.

[2] The rationale for policies in Catholic facilities regarding in vitro is clearly laid out in the USCCB document *The Ethical and Religious Directives for Catholic Health Services* in Part Four "Issues in Care for the Beginning of Life," as well as in the recently published New Charter for Health Care Workers, especially in Part 1, "Procreating". Because of these long-standing commitments, this article does not address these accepted beliefs and practices, but instead looks to further reasons for concern about such practices in the broader medical community.

[3] In this case, of course, we did know the circumstances of the pregnancy; but we still would not have turned a patient away. We did consult with the bishop's health care liaison as Part Six of the ERDs requires (see Directive 67).

[4] "Thirty Years of Assisted Reproductive Technology Data Collection in the USA," Society for Assisted Reproductive Technology, May 1, 2017. Online report.

[5] For a review of surrogacy outcomes (from 1999 to 2013), see: Perkins, Boult, Jamieson and Kissin, "Trends and Outcomes of Gestational Surrogacy in the United States," *Fertility and Sterility*, August 2016. The authors conducted their research from the Centers for Disease Control and Prevention, Atlanta, GA. Their review focused on surrogacy, not on egg donation.

[6] See: P. Doyle. "The UK Human Fertilisation and Embryology Authority. How It Has Contributed to the Evaluation of Assisted Reproduction Technology," *Int J Technol Assess Health Care*, 1999 Winter, 15. Likewise, Australia and New Zealand Assisted Reproduction Database (ANZARD). Neither article directly indicated long-term follow through for women who had undergone hyper-stimulation of the ovaries. Nor was the connection between this stimulation and cancer mentioned as part of these database reviews.

[7] See: L. Frith and E. Blyth. "Assisted Reproductive Technology in the USA: Is More Regulation Needed?" *Reproductive Biomed Online*. October 29, 2014.

[8] Michael Ollove. "States Not Eager to Regulate Fertility Industry," *The Pew Charitable Trusts, Stateline,* March 18, 2015. http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/3/18/states-not-eager-to-regulate-fertility-industry.

[9] See: Peter F. Omonzejele. "The Ethics of Commercial Surrogate Mothering: A Response to Casey Humbyrd," *Human Reproductive and Genetic Ethics*. 17:1 (2011), as well as the editorial in *America*, "Persons, Not Products." October 20, 2016.

[10] Von Hagel and Mansbach. "The Regulation of Exploitation," *International Feminist Journal of Politics*. 18:2 (2015); Jeffrey Kirby. "Transnational Gestational Surrogacy: Does It Have to Be Exploitative?" *The American Journal of Bioethics.* 14:5 (2014).

[11] Anton van Niekerk and Liezl van Zyl. "The Ethics of Surrogacy: Women's Reproductive Labor," *Journal of Medical Ethics,* 1995:346.

[12] Martha Musick Nussbaum expands on this concern in a recent article, "Surrogacy Laws Cruelly Treat Children as Commodities," NCR Online, October 7, 2017, https://www.ncronline.org/news/opinion/surrogacy-laws-cruelly-treat-children-commodities.

[13] USCCB. *The Ethical and Religious Directives for Catholic Health Care Services*. See Part One, Introduction and Directive 3.

[14] John Paul II. *Redemptoris Missio*. December 7, 1990. #37.

[15] Nussbaum, "Surrogacy Laws."

[16] This phrase, while not found in the ancient text of the Hippocratic Oath, has become central to medical education. It is attributed to the 19th century surgeon, Thomas Inman. See: Daniel K. Sokol. "First, Do No Harm Revisited," *British Medical Journal,* 20, September 2014.