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Collaboration and Commodification in Assisted Procreation: Reflections on an Open Market and Anonymous Donation in Human Sperm and Eggs

Mary Lyndon Shanley

The practices through which American society regulates the transfer of human gametes (eggs and sperm) reflects and shapes our understanding of our relationship to our genetic materials. The ways in which we think about and justify these practices engages important themes of liberal political theory and law: the understanding of individuals as autonomous or defined (at least in part) by relationships that entail dependence and care; the meaning of reproductive freedom and procreative collaboration; and the extent to which a free market may protect or undercut individual liberty. Two ethical and policy questions reflect these issues: should persons created with third-party gametes be able to learn the identity of the donor(s), and should the sale of eggs and sperm be prohibited, regulated, or left to the open market? This article contends that society should prohibit both anonymous transfer of and payment for human gametes themselves. Abolition of both anonymity and payment in the practice of gamete transfer is necessary to reflect properly the collaborative nature of assisted procreation. Although political reality may lead society to permit payment of a strictly capped "inconvenience allowance" for undergoing the procedures involved in transferring one's gametes, such payment (while preferable to payment for gametes themselves) inappropriately conceptualizes use of one's body as a commodity.

During the academic year 1999–2000 an ad appeared for a few weeks in the newspaper of the college where I teach: "Special Egg Donor Needed—\$25000," said the headline (*Miscellany News* [newspaper of Vassar College], 3 Dec. 1999, p. 22). The text continued, "We are a loving, infertile couple hoping to find a compassionate woman to help us have a baby. We're looking for a healthy, intelligent college student or college graduate, age 21–33, with blue eyes and blonde or light brown hair. Compensation \$25,000 plus expenses. Your gift of life would bring great joy. Please contact us through our representative" (an 800 phone

I want to thank the anonymous reviewers of this article for excellent criticisms that helped me clarify my argument. I benefited from the opportunity to present portions of this work at UCLA, Columbia University, the University of Michigan, Trinity College (Hartford), and Washington University. Address correspondence to Mary Lyndon Shanley, Department of Political Science, Vassar College, Maildrop 455, 124 Raymond Avenue, Poughkeepsie, NY 12604–0455 (e-mail: shanley@vassar.edu).

number followed).¹ An ad placed in some other college newspapers offered \$50,000 for the eggs of an athletic, 5-foot-10-inch woman, who had scored at least 1,400 on the Scholastic Aptitude Test (*New York Times* [Metropolitan Edition], 3 Mar. 1999, p. A10). Another ad, placed by an agency, that ran almost every week in my campus newspaper stated, “Being an Egg Donor Is an Awesome Gift” and offered \$5,000 plus expenses to any donor who was “healthy, age 21–30, a non-smoker, and average weight” (*Micellany News*, 24 Mar. 2000, p. 5). Such offers are attractive to some of my students, both those who want altruistically to help others, and those who are concerned about the financial debt they have incurred from student loans. More than personal considerations, however, should arise in thinking about whether or how to respond to such ads; conceiving children through the use of third-party genetic material raises complex ethical, social, and legal issues.

The practices through which we regulate the transfer of human gametes (eggs and sperm) reflects and shapes our understanding of our relationship to our genetic material, the extent to which family bonds are created by nature and by human will, and the role the market should play in forming families. The ways in which we think about and justify these practices engages important themes of liberal political theory: the understanding of individuals as autonomous or defined (at least in part) by relationships that entail dependence, interdependence, and care; the meaning of reproductive freedom; and the extent to which a free market may protect or undercut individual liberty. Here, I approach these theoretical issues by focusing on two ethical and policy questions that arise when people form families with gametes supplied by other persons. First, should persons created with third-party gametes be able to learn the identity of the donor(s)? Second, should the sale of eggs and sperm be prohibited, regulated, or left to the open market?

At the outset, one must decide what to call the practice under discussion. In “gamete transfer,” a person uses sperm or eggs from someone else who is not his or her spouse or life partner and has no intention of being a legal or social parent to the child created from this genetic material. (A gamete can be *either* an egg or a sperm; a gamete is a cell that contains half the genetic material needed for human procreation.) This practice is usually called gamete “donation,” a term that suggests that a gift is being made. Only rarely, however, do people transfer gametes without receiving money for them. (Instances of transferring gametes to another as a gift are almost always between family members.) Since one of the ethical issues I want to examine is the buying

¹ The same ad appeared in *The Michigan Daily* on 12 Oct. 1998, p. 5A, and undoubtedly in other college newspapers.

and selling of eggs and sperm, I will speak of gamete “transfer” rather than “donation.” I will refer to the person who is the source of the gametes as the “provider,” not the “donor,” reflecting the fact that he or she is paid. I do not discuss directly the fertility clinic or sperm bank that acts as an intermediary between provider and recipient, although such vendors (often intent on maximizing profits) shape current practices of gamete transfer.²

Gamete transfer has received relatively little attention from courts and legislatures in the United States. Courts have dealt on occasion with what to do with frozen embryos of married couples when they divorce or when they are deceased, but transferring sperm or eggs for someone else to use to conceive a child has been largely unregulated.³ Some state legislatures have passed laws making the husband of a woman who is inseminated with someone else’s sperm by a doctor the legal father of a child so conceived. But there has been little attention to the questions that concern me here: whether someone conceived through the use of third-party gametes has a right, when an adult, to learn the provider’s identity, and whether human gametes to be used for procreation should be bought and sold or the gamete provider compensated for the act of transferring sperm or eggs.

Thinking about adoption offers some guidance in thinking about gamete transfer. Gamete transfer can, like adoption, create a family in which the child is not genetically related to at least one parent, and ads soliciting eggs in some ways resemble those placed in newspapers by couples seeking to adopt children: “A happily married loving white couple wishes to share their warmth, laughter and hearts with a newborn. Will provide endless love and security, with close family ties. Expenses paid” (*Poughkeepsie Journal*, 23 Sept. 2000, p. 8D). In important ways, however, gamete transfer is different from adoption. Only genetic material, not an actual child, is transferred between adults, and a child conceived through gamete transfer usually has a genetic relationship with *one* parent (this is true in both heterosexual and same-sex couples and for single mothers). That genetic relation and the fact that one parent bears and gives birth to the child may make the child seem more the parents’ “own” than an adopted child would be.

The implications of the fact that the child is one’s own, and yet was created with the genetic material of a third party, have not been adequately examined. Instead, practices surrounding gamete transfer developed incrementally as the technology developed and demand increased, and the way gamete transfer

² “In most cases of sperm ‘donation’ and some cases of egg ‘donation,’ the term ‘vendor’ more accurately describes the gamete provider” (Mahowald 2000).

³ Good discussions of gamete donation, frozen embryos, and relevant court cases are found in Christine Overall (1987 and 1993).

takes place bears the marks of the original procedures and social context in which they developed.

Initially, only sperm could be transferred, a relatively simple procedure that doctors began recommending in the 1940s, and one that could easily be done secretly as well as anonymously. Heterosexual couples used insemination to have children that closely resembled both parents. When egg transfer became possible after the first successful *in vitro* fertilization (IVF) in 1978, sperm transfer was the model, though the far more complicated procedure and scarcity of providers led to pressure to pay egg providers more (Kolata 1998).⁴

In the 1970s, the debates over how to think about gamete donation were complicated by social change and medical developments. The women's movement enabled single women to think about creating families without husbands (Ludtke 1997).⁵ And greater openness about same-sex relationships led some lesbian couples to use gamete transfer to have children. By the end of the 20th century, therefore, gamete transfer was used to create both traditional-looking heterosexual families and less-conventional-looking lesbian (and with the development of "surrogacy" or contract pregnancy, gay men's) families.

But major issues raised by this widening practice remain in political, legal, and moral limbo.⁶ Should we, and if so how should we, now think about and regulate secrecy, anonymity, and openness in gamete transfer? Should regulations be the same for heterosexual and homosexual couples, and for single persons and couples? Whose interests should be considered in setting such policies? And what restrictions, if any, should be imposed on the buying and selling of human genetic material? What practical and ethical considerations need to be weighed in arriving at any policy?⁷ Before taking up those arguments, I briefly review the medical procedures involved in gamete transfer.

⁴ Kolata (1998) reports that in contrast to the ready availability of sperm, eggs are in short supply and recipients must sometimes wait up to a year for third-party eggs. To increase the number of eggs available, one infertility clinic now pays \$5,000 for one month's "harvest" of eggs, twenty times the amount paid ten years before when the practice began.

⁵ See Ludtke (1997), for a discussion of unmarried motherhood since 1945, whether resulting from divorce, unintentional out-of-wedlock birth, or intentional (either through sexual intercourse or sperm donation) single motherhood.

⁶ A thorough review of the legal issues involved in gamete transfer is found in Hollinger (1985).

⁷ When biomedical technology made it possible to fertilize an egg outside of the human body, "a potentially new legal and social entity had come into the world in the form of the human embryo in the very early stages of development, alive but outside the parental body. How to think it [the nature of the embryo outside the body], that is, imagine it and make it real, became a matter for debate" (Strathern 1992).

How Gamete Transfer Is Done

Prior to the 1940s, couples who wanted to raise a child but found they could not conceive might occasionally raise a relative's child, or might formally adopt a child. Gradually, some doctors began offering patients the possibility of artificial insemination when the difficulty appeared to be with the husband. Artificial insemination (more recently called "alternative" insemination since some people considered "artificial" to be misleading and disparaging) by donor (AID or DI for "donor insemination") was used in cases of sterility or low sperm count, or if the husband were the carrier of an inheritable disease. In alternative insemination by husband (AIH), several ejaculates from the husband were combined to offset low sperm count or motility. Alternative insemination was a simple procedure performed in a doctor's office. At the most propitious time in the woman's ovulatory cycle, the doctor collected ejaculate from the husband or provider (often waiting in a room down the hall from the examining room), placed it in a syringe, and injected the sperm in the woman's vagina as close to the cervix as possible. It enabled many patients to become pregnant.

Since a couple's use of alternative insemination was not generally known, creation of a family using this procedure required less social effort and explanation than adoption. The insemination procedure could be done during a seemingly routine visit to the doctor. Apart from the physician, only those the couple chose to tell would know a couple was engaged in infertility treatment. Often, not even family members and friends knew that the pregnancy had resulted from someone else's sperm. Occasionally, even the husband did not know his wife was undergoing alternative insemination. When a heterosexual couple used DI, there was no need for a home study and evaluation of their fitness to be parents; there were no worries that the child might have suffered unknown physical or psychological difficulties prior to placement; and there was some physical resemblance between parents and child.⁸

Studies of the use of transferred gametes to overcome infertility began appearing in medical journals in the United States in the early 1940s.⁹ The doctors selected the providers, who were usually medical students, other university students, or hospital personnel. Virtually all doctors paid providers for their semen;

⁸ When same-sex couples use DI, if the nonbiological parent wants to secure parental rights through second-parent adoption, a home study must be done.

⁹ Seymour & Koerner (1941) reported that at least 9,500 pregnancies had been achieved by alternative insemination, two-thirds of them using the husband's sperm. This figure was sharply criticized as unsubstantiated and probably far too high by Claire E. Folsome (1943). Curie-Cohen, Luttrell, & Shapiro (1979) review early literature and describe the practices surrounding use of third-party sperm.

usually \$25 per ejaculate in the mid-1970s, with a low of \$20 and a high of \$100, rising to approximately \$170 by the late 1990s. Doctors might use the same provider repeatedly; a research team at the University of Wisconsin reported that, in response to a survey conducted in 1977, many doctors said they used a provider for no more than six pregnancies, although 5.7% had used a provider for 15 or more. About 50% of the doctors kept records on the women they inseminated, but many fewer kept medical records on sperm providers or on children born after DI (Curie-Cohen et al. 1979). Until the 1980s, little screening beyond self-reporting of medical history was done. After transmission of Acquired Immune Deficiency Syndrome (AIDS) became a risk, semen was tested for the Human Immunodeficiency Virus (HIV) and frozen for future injection.

The fact that early providers were largely medical school and university students, and that recipients were private patients of doctors affiliated with teaching hospitals, suggests that whites would have been the majority of those taking part in alternative insemination as either providers or recipients. Both early and more recent reports of the incidence of DI indicate that race-matching is the norm, that is, recipients use sperm from providers with the same racial identity as their partner. I have not been able to find any information on the relative number of members of various racial groups who use DI. My guess is that recipients are disproportionately white, since there is a much larger pool of children of color available for adoption than of white children, and less emphasis on the genetic tie in constituting families in many black communities (Roberts 1995).

A variety of concerns made anonymity and secrecy seem appropriate when married heterosexual couples had a child using DI. The association of manliness with potency, and the stigma attached to the inability to sire children, made many couples anxious to keep their use of DI secret. Some legal and religious authorities suggested that sperm transfer might constitute an act of adultery.¹⁰ Lawyers were unsure about whether the provider had any parental rights or responsibilities with respect to the child.¹¹ Parents rarely told their children that they were conceived with donated sperm; many psychologists counseled parents to protect themselves and their child from the possibility that the child might feel resentment if she learned that she was “different” from other children.¹²

¹⁰ In 1948, the Report of a Commission Appointed by His Grace the Archbishop of Canterbury recommended that donor insemination should be considered a criminal offense, and courts in the United States were uncertain about whether AID constituted adultery. See Daniels & Taylor (1993).

¹¹ See the articles and cases cited in *In re Adoption of Anonymous* in Areen (1985).

¹² See both Douglas J. Cusine and Christine Manuel (in David & Price 1980).

The goal of DI was to create an “as if” family, one in which the children to all appearances were the biological offspring of the husband and wife. Both the practice of “matching” the provider and the recipient’s husband in physical appearance, and anonymity, supported this goal. The 1977 survey by the University of Wisconsin researchers found that doctors tried to match hair color, skin color, eye color, height, religious or ethnic background, ABO blood type, and educational level (Curie-Cohen et al. 1979). Doctors took great care to make sure that the identities of neither providers nor recipients would be known, and many gynecologists who delivered babies conceived by DI never knew that their patients had undergone alternative insemination.

The practices that grew up around DI carried with them complicated messages about what mattered in creating children with third-party gametes. On one hand, the way DI was carried out suggested that what really made a man a father could be social, not invariably genetic, parenting. As the practice of DI grew, many state legislatures and courts declared that any child conceived within a marriage by donated sperm was to be considered the legal child of the husband and wife.¹³ The fact that providers were paid a token amount, were not counseled about any possible psychological effects of their act, and were permitted or encouraged to sell sperm multiple times all suggested that the sperm were without particular significance to the man or the possible future child. (This casual attitude toward sperm donation contrasted markedly with some people’s insistence that an unwed father who had never seen his child had a right to veto a mother’s decision to place the child for adoption.¹⁴) On the other hand, practices involving the receiving family suggested that the fact that they were conceiving through use of transferred genetic material *was* significant. In several countries (although not in the United States) couples received extensive counseling before insemination. Doctors tried to match physical traits, took great care to keep provider and recipient from seeing one another, and kept all records confidential. When the technology to freeze sperm (called cryopreservation) developed, recipients could choose from among a far greater number of providers and match characteristics more precisely than they could when fresh semen was needed. Cryopreservation made both matching and anonymity easier to achieve.

With the development of in vitro fertilization, it became possible to acquire eggs as well as sperm from a third party, though initially IVF was used by married women who produced healthy

¹³ See, e.g., *In re Adoption of Anonymous* and the editor’s “Notes” in Areen (1985).

¹⁴ See Shanley (1995). The difference may stem from the fact that the unwed father pitted his will against an unwed mother, while the sperm provider transferred his sperm to a married couple, which involved another man. Many people are hostile to women who procreate without legal ties to a man.

eggs but could not conceive because their fallopian tubes were blocked. The first birth from this procedure took place in 1978. In 1984 a woman gave birth for the first time to a child to whom she bore no genetic relationship after a provider's eggs were fertilized in a petri dish and successfully implanted in her womb. Thereafter doctors began using IVF to join the husband's sperm with transferred eggs to enable couples in which the wife did not produce healthy eggs to create a child. By 1999 about 5,000 egg transfers a year took place in the United States (Mead 1999).

Egg transfer involves a far more complicated procedure than sperm transfer does. Where AIH and DI require only a syringe for introducing the sperm, both providers and recipients in egg transfer undergo significant medical treatment. A woman who is to donate eggs receives hormone injections to stimulate ovulation. For three weeks, a provider injects herself with Lupron, which shuts down the ovaries so that no eggs ripen or are released. Taking this drug often produces menopause-like symptoms: hot flashes, difficulty with short-term memory, and insomnia. The provider then switches medication, injecting herself for a week with the follicle-stimulating hormones Pergonal and Metrodin. These injections hyperstimulate the ovary and cause the release of an abundance of eggs, often a dozen or more. Finally, the provider receives an injection of human chorionic gonadotropin (hCG). About 34 to 36 hours after hCG administration, eggs are retrieved either by laparoscopy or ultrasound.¹⁵

In its early years, egg transfer was done using laparoscopy; now ultrasound is the preferred method. For laparoscopy, the woman is placed under anesthesia, and doctors insert a needle into her abdomen just below the navel. Carbon dioxide gas is released into the abdominal cavity, moving the abdominal wall away from the organs. Then the doctor inserts the laparoscope, a small fiberoptic instrument about a half-inch in diameter, into the abdominal cavity in order to view the ovaries and fallopian tubes. When the laparoscope provides a good view of an ovary, the doctor punctures the egg follicle with a needle inserted through another small incision, applies suction, and collects the contents of the follicle in a tube or trap. The ultrasound procedure requires only local or very light anesthesia. The ultrasound reveals an image of the egg follicles by sound waves sent through the bladder. The doctor can then insert a needle through the vaginal wall to reach the ovarian follicles using suction to capture the eggs. Once the eggs are extracted, technicians place them in culture dishes with sperm. About 24 hours later, the eggs are observed for signs of fertilization, and those that appear fertilized are placed in an incubator for another 24 hours. By this time,

¹⁵ The description in this paragraph (and the next) is drawn from M. McShane in Baruch et al. (1988) and from Mead (1999).

successfully fertilized eggs will have divided into two, four, or even eight cells. Usually about two to four of these pre-embryos are then placed into the uterus by means of a small catheter.

The recipient, for her part, must also undergo hormonal treatment to synchronize her menstrual cycle with that of the provider, although of course she does not experience hyperstimulation of her ovaries. The recipient often needs additional hormonal injections for a short period after egg transfer to facilitate the egg's implantation in the uterine wall.

The difficulty of the medical procedure, the scarcity of egg providers, and the use of advertising and high payment to induce women to part with their eggs raised ethical questions that had not arisen with sperm transfer. Initially, the practices surrounding egg transfer by-and-large followed the model of sperm transfer: recipients selected providers with characteristics they desired for their children; the identity of providers was kept secret; fertility centers and doctors served as intermediaries; and providers were paid a fee. By the 1990s, however, ethicists discussed limiting the numbers of transfers that anyone could make because of the unknown long-term effects of the hormone injections and restricting the amount that could be paid to a provider. In addition, the movement toward open adoption in the 1980s and 1990s led some professionals to advise that children of a suitable age be told that they were conceived through DI but not given any information concerning the identity of the provider (Curie-Cohen et al. 1979).

How we regulate the formation, maintenance, and dissolution of families both reflects and shapes our understanding of both intimate and larger social relationships and bonds. At present, in the United States, the tale told by policies and practices surrounding gamete transfer is one of individuals who are free to commodify their genetic traits, consulting only their own immediate interests and values.¹⁶ However, this is not the only way to conceptualize gamete transfer. Attention to the child's psychological experience and to the multiple relationships that create

¹⁶ It is interesting to speculate whether, had egg transfer developed before sperm transfer, different images or analogies concerning what was involved in transferring gametes might have developed. Sperm is easily removed from the body, ejaculation is pleasurable, and the act can be repeated without difficulty or harm to the body. Egg transfer, by contrast, cannot be done alone and unobserved and requires hormonal injections and surgery, both of which cause discomfort or pain. The need to coordinate the menstrual cycles of provider and recipient suggests a cooperative relationship between provider and recipient even when they do not know one another. Egg transfer should not be repeated frequently because no one knows the long-term effects of hormonal manipulation or of the ovarian scarring that may occur during extraction. Weighty cultural values associated with "motherhood" also make egg transfer seem more portentous and troubling than sperm transfer: since time immemorial men have impregnated women to whom they are not married and have walked away without a backward glance; women, by contrast, have been expected to love and devote themselves to their children, and those who do not are deemed monstrous. (On cultural attitudes towards mothers who leave their children see Sanger, 1996.)

and sustain any human being (including the variety of family forms that foster human intimacy) would, I believe, generate practices reflecting a less atomistic and a more relational conceptualization of both individuals and society.

An Argument Against Anonymity

Anonymous gamete transfer reflects both the social context in which the practice arose and the individualism that pervades much of American political and legal theory. Even after many states enacted laws stating that a child conceived by alternative insemination was the legal child of the mother and her husband, anonymity remained the norm.¹⁷ While the provider's physiological features, intelligence, ethnic background, and religious identity were important to some recipients, knowing the specific identity of the provider was unimportant, even undesirable. From the perspective of doctors and patients alike, producing a successful pregnancy through alternative insemination was the happy ending of infertility treatment that produced an "as if" family. Typically, doctors told neither provider nor recipients one another's identities.

With anonymity the accepted norm in adoption, it seemed all the more the case that gamete transfer, before a child existed, should be anonymous. Many professionals associated with assisted reproduction argued that anonymity should be the norm, because it freed the provider from any legal responsibility for the child and any apprehension that the child would seek contact with him in the future. Also, the receiving couple and their child would be indistinguishable, or nearly so, from other heterosexual couples with children.

The practice of anonymous transfer was also consonant with those aspects of liberal individualism that embraced equal opportunity and rejected linking legal or political status to accident of birth. National mythology still pictured the United States as a country populated by "self-made men" and people who had cut themselves off from their past and started life anew through immigration or migration to the western frontier. The assumption that the children conceived with donated gametes would become whatever they made of themselves, regardless of the identity of the gamete provider, drew on these images of self-determination.¹⁸

The individualistic understanding of the person reflected in the terms some people used to talk about gamete transfer drew upon legal developments that recognized the individuality of

¹⁷ Hollinger (1985) discusses considerations concerning anonymity in both adoption and gamete donation.

¹⁸ By contrast, for "Harry Potter," genes or lineage determines who he is, despite the fact that he is an orphan.

each family member. Beginning in the 1850s, passage of married women's property acts in many states recognized that a wife, who previously had been subsumed in the legal personality of her husband—who acted for her in legal matters—might hold property and make contracts in her own name. Later in the century, child labor laws and compulsory schooling limited parents' ability to control what their children did. Creation of legal adoption around 1850 allowed the legal bond between biological parent and child to be severed. In the 20th century, the expansion of grounds for divorce suggested that marriage was no longer to be thought of as an indissoluble bond, that under certain circumstances individuals might reclaim their single status. In these various ways, social and political discourse presented the person "as a potentially free-standing and whole entity (an individual subject or agent) contained within an abstract impersonal matrix" (Strathern 1992:135). Bonds between family members which people had once thought of as unchangeable or "given," were now viewed as established by human intention and will. The tension in American political theory and law between the individualistic and relational aspects of each person permeated the ways people talked about gamete transfer.

When doctors developed the practice of sperm transfer, the anonymity that prevailed suggested that there was no intrinsic or essential relationship between provider and sperm, nor between the person to be created and his or her genetic progenitor. "Donation linking a person to a source of genetic endowment does not necessarily link the person to another person. Indeed, twentieth-century people who talk of semen 'donation' treat it as a substance that will fertilize the maternal egg *whether or not* its identity is known" (Strathern 1992:128). Couples using gamete transfer did not think that the genetic tie would make that spouse or partner more of a parent than the genetically unrelated parent. "Nurture" would be every bit as important as "nature" in the child's development, and anyone's claim to be recognized as a parent would rest upon the commitment to the marriage and to rearing the child.

At the same time, however, secrecy and anonymity suggested that the identity of the provider involved in begetting the child *was* important; if the genetic tie had no significance whatsoever, it would not need to be hidden. But what *kind* of significance might the genetic link have? In the past, law had given biology *too much* significance when it gave genetic fathers claims to legal paternity or held that sperm transfer constituted an act of adultery; genetic contribution alone, without the assumption of responsibility for the child, should not give someone a claim to be regarded as a social or a legal parent.

But many people who used third-party sperm or eggs to conceive a child who was genetically related to one parent attributed

a different kind of significance to their genetic link to the child. Having a child genetically related to one member of the couple gave a sense of continuity both to the genetically related parent and to the spouse who would see his or her partner reflected in their child. The genetic tie linked the parents not only to their child but also to the generations that preceded them and, through the possibility that their child would have children, to those following them. The sense of genetic continuity through the generations placed the family in a history that stretched both forward and backward in time. Parents could feel that they were passing on a legacy not only through their words and actions but also through their bodies.

From the perspective of the child, and the person that child will become, knowledge of how and from whom one came to be is now being seen as part of the right to an identity.¹⁹ Upon reaching the age of majority, someone created with transferred genetic material should have the right to learn, although not be compelled to learn, the identity of the provider, not simply medical facts or DNA profile. The reason for this is not that genes “trump” social identity. To the contrary, a genetic relationship should lead to legal parenthood only when the genetic parent assumes responsibility for the child’s welfare.²⁰ The right to learn the identity of one’s genetic forebear stems from some people’s desire to be able to connect themselves to human history concretely as embodied beings, not only abstractly as rational beings or as members of large social (national, ethnic, religious) groups.²¹

Abolishing anonymity would signify that the child—although unambiguously and irrevocably the child of the recipients, the social parents—has come into being not only because of the parents’ desire and choice but also because of the actions of another person. Stipulating that the provider’s name can be disclosed at the request of the grown child precludes imagining the child as the genetic offspring of “nobody” or of “anybody.” It is the person who comes into being that has the right to know the identity of the provider, not the adult recipients of the genetic material. The requirement to make a provider’s identity available upon

¹⁹ The absence of consideration of the child’s perspective in most legal and medical discussions of DI and egg donation is deeply disturbing. A notable exception are the writings of Barbara Bennett Woodhouse, who argues for child-centered analyses of family law issues (1993, 1994).

It is possible that an adult who seeks the identity of the provider may then feel rejected if the provider refuses to meet him or her. But while access to the information seems to me to be a right of the individual created by the transferred gamete, I do not see why that right would extend to a face-to-face meeting or social relationship if the provider objects.

²⁰ I make an extended argument for this principle in *Making Babies, Making Families* (2001).

²¹ Patricia Williams speaks of the significance of transgenerational history in “On Being the Object of Property,” *The Rooster’s Egg* (1995).

the request of the offspring would constitute social recognition of the fact that children come into the world through the actions of specific persons, which can now include both “intentional” parents (those who plan their conception) and genetic providers.

It is important that society as a whole affirm the right to know one’s origins.²² Neil Leighton, a social worker, has argued that children have a right to “the development of a sense of self as a lived narrative blending action and memory [and] to participate in their own histories and their own future.” He worries that “children who have no identifiable origin, no identifiable human beginning to their personal narrative may have a sense of alienation in the world in which they find themselves” (Leighton 1995).²³ While not all children (or the adults they become) may experience such feelings, social policy should place the burden of proof on the person who would seal an adoption record from the adult adoptee or a medical record from the person created with transferred gametes, not on the person seeking information about his or her origins.

Some who agree that people should know that they were created by gamete transfer do not agree that they should be guaranteed access to information concerning the specific identity of the gamete provider. Some assert that guaranteeing access to such information reflects a socially created need that comes from a patriarchal focus on genetic lineage, and others assert that it reflects a kind of genetic essentialism that downplays the importance of experience and social factors in the formation of any person. I reject both patriarchalism and genetic essentialism. It is good, however, when social practices reflect the fact that specific human beings are necessary for any person to come into existence (including, in these instances, both provider and recipients), that individual actions shape the larger social whole, and that cultural development is something individuals participate in rather than something that happens to them. Law and social practice should foster the understanding that what individuals do, even on a small scale, has repercussions beyond themselves and their intimate associates.²⁴

²² Religion, philosophy, and psychoanalysis alike contend that truth is better than either falsehood or obfuscation, and openness is better than secrecy (some form of “the truth shall make you free” is found in each of these fields of thought).

²³ Although I agree with Leighton on the need for a specific narrative of origin, the continuation of this passage uses misleading language about gamete donation: “The pretense that the bioengineered child is the natural child of the pseudo parents presents an experience of family on unsure ground and undermines the essential attributes of intimate human relationships—those of integrity, trust, and openness.” I also urge openness, but would note that the child is not “bioengineered,” that children conceived by means other than heterosexual intercourse are “natural,” and that to call social parents “pseudo” parents is gravely misguided.

²⁴ One of the best contemporary reflections on the relationship between the norms of family life and of political life is Barbara Kingsolver’s *The Poisonwood Bible* (1998).

Arguing that the person created by gamete transfer has a right to learn the progenitor's identity upon reaching age 18 or 21 implies that the gamete provider must be prepared to have his or her identity revealed. The provider would have no legal responsibility to the child/adult beyond that; there is no obligation to meet or to provide financial support.²⁵ Another implication may be that clinics should prohibit multiple donations (say, no more than three).²⁶ Repeated anonymous transfer treats the transfer of genetic material as if it were analogous to giving blood. Yet gamete donation differs in kind and significance from blood donation to provider and recipient alike—a human being may come into existence as a result of the transfer. It seems inappropriate to distance ourselves from our gametes and the procreative potential of our body in the same way we distance ourselves from our blood or organs that can sustain, but not generate a new, life.

My suggestion that we could change the practices surrounding gamete transfer is not ivory tower imagining. Social theorists need to distinguish between genetic and social parenthood, and to give each its proper due. It seems to me that both scholarly discussions, and people's actions, contribute to our collective deliberation. The experiences of some lesbian and gay couples who have chosen to use known providers has suggested that it is possible to do so without generating confusion among family members about who are (or should be) the child's legal parents. In making collaborative procreation visible and validating the significance of specific family histories, these families may provide new modes of thinking and suggest new ways of acting to heterosexual families as well.²⁷

²⁵ The question of whether there might be an obligation of financial support is more complex than I can explore here. Society does not impose any obligations of support on biological parents who relinquish their children for adoption, even if the adoptive parents die or become indigent. Biological fathers of children born to unwed mothers, however, are obligated to pay child support and neither the father nor the mother can waive that obligation by contractual agreement. Permitting a child (or the state on behalf of a child) to seek support from a sperm or egg provider if the child were orphaned or the legal parent became indigent would drastically reduce the number of providers. My approach suggests that the starting point of any analysis of support obligations to children must begin with the child, and ask what support a child is entitled to receive, and who (including the state) bears the responsibility to provide that support.

²⁶ The Sperm Bank of California limits donations to ten pregnancies and encourages providers to permit release of identifying information to an adult conceived with their sperm if the adult requests it. See Seligson (1995).

²⁷ In May 2000, an article in *People* magazine reflected the entry of discussion of reproductive technology and new family forms into mainstream popular culture. The family of Martha Gaines and Margaret Mooney includes their son, conceived with the sperm of a gay friend, and their daughter, conceived with sperm donated by a married friend of the family. A "family photo" in *People* included Martha and Margaret and their children, along with the provider, his wife and their two children (68–75).

An Argument Against Marketing Human Gametes

In the United States, unlike many other countries, the mechanism by which gametes are transferred from one person to another has largely been the market. In market transactions, Marilyn Strathern declares, “an anonymously produced object becomes part of a store on which others draw. Preserving the social anonymity of market goods is . . . fundamental to the supposition that goods are available for all” (Strathern 1992:130). Because gametes are separable from the provider they can appear to have certain characteristics of commodities, objects “produced” by the body that become part of a common store—as the term “sperm bank” suggests. Control over eggs or sperm can be transferred from provider to doctor or fertility clinic, and from these to the recipient. They can be treated as a generalized “resource” that can be traded in the market. Strathern believes that “the market analogy has already done its work: we think so freely of the providing and purchasing of goods and services that transactions in gametes is already a thought-of act of commerce” (Strathern 1992:37). And once people conceptualize gametes as commodities, it becomes very difficult to argue against allowing a market in gametes.²⁸

The fact that it is appropriate for people to regard gametes as the possession of the provider in the sense that no one (including the government and medical research facilities) may commandeer them does not mean, however, that a gamete provider has a right to *sell* that material; the right to exclude others from use does not entail the right to sell. The liberal ideal of “self ownership” does not mean that we can do whatever we like with all our body parts, selling off what we don’t need or want (Scott 1981). The law allows people to sell hair, and sometimes blood, but prohibits the sale of body organs. Even someone willing and able to live with only one kidney or eye may not sell the other, nor may the kidney, eye, heart, or liver from a deceased person be sold. The distinction here is not simply that between renewable and nonrenewable material, or between material necessary and unnecessary to sustain life. It also involves a judgment that some parts of the body should not be for sale either because of the significance of reserving aspects of the human body from

²⁸ As this article was going to press, an anonymous reviewer claimed that I overlook “the logic of Strathern’s argument—set forth in *The Gender of the Gift* (1988) as well as in *Reproducing the Future* (1992)—which is that gametes cannot help but be ‘commodities’ in a commodity economy. . . . We cannot help but construe them as ‘things’ that have a utilitarian value for us.” The reviewer pointed out that in Strathern’s view “it is the separability of the ‘products’ from ‘producers’ and the assumed alienation this involves that marks things as commodities, whether they are given or sold.” The conceptualization and the performance of genuinely collaborative acts, including collaborative procreation, is extremely difficult (the reviewer might say impossible) in a market economy. These comments offer an important and illuminating clarification of Strathern’s work. They do not change my contention that our society should, and can, ban the sale of human gametes.

commodification, or because economic need might lead poor people to sell body parts.²⁹ What kind of “body parts” are gametes, and how should we think about the ways in which they should be transferred from one person to another for purposes of procreation? To what extent should gametes be regarded as personal property, and providers as owners of those gametes?

Buying and selling gametes, whether by differential or uniform pricing, suggests that they are property and that the person in whose body they originate has rights of ownership until he or she transfers the gametes (and the rights of ownership) to someone else. Differential pricing of gametes based on characteristics like the provider’s height, skin and hair color, athletic or academic achievement, and musical ability seems to validate the assumption that persons with such attributes—both providers and as-yet-unborn (indeed, as-yet-unconceived) children—are “worth more” than others. Certain characteristics people are born with are valued more than others: lighter-skinned people encounter less employment discrimination than darker-skinned individuals; men are paid more than women with comparable education. It is bad enough that these and other differences, which are accidents of birth, generate economic inequality in the labor market; it is far worse when these traits lead to differential compensation for the provider’s gametes. When people know that the genetic material that made a particular child’s existence possible was bought for a higher (or lower) price than that of some other child, such knowledge may undermine the proposition that all persons are of equal dignity regardless of their wealth or social status.

Some people believe that paying a flat rate to providers (higher for eggs than sperm donation because egg donation is much more difficult) avoids the affront to human dignity involved in an open market in eggs and sperm and is not improper. They point out that in gamete transfer, unlike adoption, there is no existing child and no social relationship between provider and gamete. Hence the prohibitions on baby-selling do not apply, and the gamete may be sold by the person from whom it is extracted.³⁰ But treating gametes as property that can be sold, even for a uniform price, suggests that individuals “own” their gametes in the same way that they own other transferable property. This is the wrong way to conceptualize human beings’ relationship to their genetic material. Donna Dickenson contends that “the kind of ownership which we can be said to possess in relation to our gametes is conditional: we are not allowed to do

²⁹ Excellent discussions of the issues raised here are found in Margaret Jane Radin (1987) and Christine Overall (1987).

³⁰ Barbara Yngvesson (2000) discusses the ways in which children available for adoption appear as “commodities” even when the processes are legal and respectful to the children as well as the adults.

anything we like with them, because they are not unequivocally ours. They are held in common with past and future generations" (1997:158). A person's relationship to his or her genetic material is better thought of as a kind of stewardship than as ownership.³¹ To shape social practices to avoid conveying the idea that gametes are properly thought of as individually owned property, we must move either to a system of paying for the activities involved in providing gametes (not for gametes themselves), or to pure donation (gift), options I discuss in the next section.

Transforming the Practice of Gamete Transfer

If neither anonymity nor open market buying and selling of gametes is desirable, what are possible policy alternatives and how would each of these shape the "tale told by law and public policy" with respect to gamete transfer? Ideally, knowledge of a provider's identity would be available to the person brought into being through the use of transferred genetic material, and gamete transfer would be a gift relationship with reimbursement only for medical, child-care, transportation, and other necessary expenses. "The gift of life" should be just that, a "gift," if it is to reflect the proper understanding of both provider's and recipient's relationship to this genetic material, and the significance of collaborative procreation to the person who comes into being. I believe it is possible and desirable to devise policies and practices that would recognize the relational as well as the individualistic aspects of human procreation, and would give proper place to the potential child and the adult he or she will become.

Some countries, agencies, and clinics are already moving away from anonymous gamete transfer. After various psychologists, counselors, social workers, and others suggested that the child might have significant psychological needs or other interest in knowing his or her origin, some providers began to allow their names to be given to persons created with their gametes (Annas 1979 and 1998; Roy 1980:499–511).³² Swedish legislation allows

³¹ The notion that we are "stewards" of our genetic material does not mean that society could properly deprive individuals of the ability to make decisions about transferring or not transferring gametes or about using birth control or aborting a fetus. An individual, not society, has the right to decide whether or not to transfer such material, just as an individual has the right to decide whether or not to use birth control or to terminate a pregnancy, but none of these rights rests on a notion that the gamete or fetus is "property" that is "owned" by individuals.

³² Daniels & Taylor (1993) discuss some psychologists' arguments against secrecy and anonymity, and provide a useful bibliography. Robert D. Nachtigall (1993) calls for research to redress the paucity of information we have about how anonymity and secrecy affect members of families formed by gamete donation.

Philosopher James Lindemann Nelson worries that "we frustrate, by our efforts, something [children] have a right to expect" when we knowingly create a child that will not have a social relationship with one of its genetic parents. Anonymity from the outset raises different ethical issues than those that arise when children lose contact with a genetic parent because of divorce, death, or abandonment. (Quoted in Seligson 1995:31.)

the offspring of a provider access to the provider's name once the child is sufficiently mature.³³ Canadian and German reports have recommended that children be given a legal right to know their origins.³⁴ In the United Kingdom, law requires all donor insemination centers to keep identifying information on providers whose gametes are used for conception, and permits their offspring, after reaching age 18, to request information about their genetic origins. Although the intent of the law is to provide nonidentifying information in cases of medical necessity, it does not prohibit the release of identifying information about the provider.³⁵ New Zealand and Australia also have moved toward greater openness and the right of children to information about their origin. In New Zealand, arguments for every child's right to know the identity of his or her genetic forebears have been joined by arguments that indigenous peoples, in particular, have a right to their specific heritage.³⁶ Some of these countries explicitly protect the provider from unwanted contact with the child/adult.

Abolishing anonymity would affect how both providers and others understand the meaning of the practice of gamete transfer. Abolishing anonymity would signify that the child—although unambiguously and irrevocably the child of the recipients, the social parents—has come into being not only because of the parents' desire and choice but also because of the actions of another person. Stipulating that the provider's name can be disclosed at the request of the grown child precludes imagining the child as the genetic offspring of "nobody" or of "anybody," rather than of an individual. Abolishing anonymity not only addresses the iden-

³³ Knoppers & LeBris (1991) contains information on most European countries. See also Daniels & Taylor (1993).

³⁴ Knoppers & Le Bris (1991:349–352). In November, 2001, the report of the Canadian House of Commons Standing Committee on Health, "Assisted Human Reproduction: Building Families," called for only identifiable providers to be accepted in gamete transfer performed in Canada: <http://www.parl.gc.ca/InfoComDoc/37/1/HEAL/Studies/Reports/healrp01-e.htm>. In May 2002, however, the Minister of Health introduced legislation that permitted provider anonymity: <http://www.hc-sc.gc.ca/english/protection/reproduction/index.htm>. At the time of writing the fate of the bill is not known.

³⁵ In December 2001, the government of the United Kingdom published a public consultation paper soliciting comment concerning what information held in the Register of providers of gametes or embryos used in assisted conception should be made available to people conceived with such material. The consultation period ended on 1 July 2002, and the government has said that it will provide a response to the consultation by February 2003. <http://www.doh.gov.uk/gametodonors/> Baroness Warnock, who chaired the Warnock Committee—whose conclusions shaped the Human Fertilisation and Embryology Act, 1990, which recommended provider anonymity—has publicly stated that she now believes donor-conceived individuals should be able to learn their gamete provider's identity.

³⁶ On New Zealand, see Daniels (1998:79–81). While I support every child's right to specific information about her or his origin, I have argued that basing membership in a group *solely* on the basis of blood was unwise (*Making Babies, Making Families*, ch. 1). New Zealand's policy, which responded to the insistence of the Maori for information about genetic heritage, challenges this view, and suggests the need for further discussion.

tity interests of the person who comes into being as a result of gamete transfer but also encourages society to think of human agency and responsibility in collaborative procreation.

If buying and selling eggs and sperm were prohibited, gamete transfer might take place either by payment of an "inconvenience allowance" or by gift. The previous section argued that an unregulated market is an assault on the human dignity of both providers and persons who come into being, and it falsely conflates human freedom with the exercise of market choice. While uniform payment is less objectionable than differential pricing, it still entails the commodification of human gametes. Some people have suggested that payment of an "inconvenience allowance," which would compensate providers for the time and discomfort of transferring gametes, not for the gametes themselves, would avoid the morally unacceptable aspects of gamete transfer.

Donald Evans (1995) argues thoughtfully, but ultimately unpersuasively, for use of an inconvenience allowance to promote gamete transfer. Evans suggests that a person providing his or her gametes for someone else's use is analogous to a healthy person volunteering to participate in a clinical medical trial. Such participants "offer the use of their bodies and body products (such as numerous blood samples) for the purpose of furthering medical knowledge with a view to benefiting others. They stand to gain no medical benefit from their involvement in the procedures in question and are expected to take no more than minimal risk" (Evans 1995: 262). In all these respects gamete providers are like participants in clinical trials.

Without payment, people would not volunteer for clinical trials or to be gamete providers, Evans asserts; and to meet the need for gametes, the latter, like the former, should be paid. Evans is at pains to point out that in clinical trials researchers keep firm control over payments in order "to protect the subjects from undue pressure to engage in activities which are not in their best interests" (Evans 1995: 262). For this reason, payment is not calculated according to risk. Nor is payment linked to "the success or otherwise of the trial. It is based purely on the inconvenience endured by the subject in the course of the research." Payment to participants is calculated according to a standard set of payments, for example, "£2 , , , for each venipuncture, £60 for each twenty-four-hour stay in an observation unit, £15 per visit to the unit plus all expenses, and so on (1995:262)." Having a schedule of payments for each procedure treats all volunteers equally, and a participant who withdraws or is withdrawn from the trial partway through is paid on a *pro rata* basis. Evans suggests that "a similar tariff could be devised for the providers of gametes for use in research or therapeutic services. Payment would be according to numbers of visits made to the unit, numbers of procedures undergone of varying degrees of invasiveness, such as the

taking of super-ovulatory drugs, the extraction under anaesthetic of oocytes and so on” (263).

Payment of an inconvenience allowance that is linked to the actual procedures performed is preferable to payment for gametes themselves because it does not treat gametes as private property, and it directs attention to the provider and the activity or process of transfer rather than to the gamete as a commodity. But portraying gamete transfer as analogous to labor or participation in medical trials brings with it problems of its own. For one thing, an effort to increase the supply of gametes may push up inconvenience allowances to the point where payment becomes an inappropriate inducement to serve as a provider, and where money provides a sufficient reason for donating.

In addition, while an inconvenience allowance avoids treating gametes as property, it treats labor or the use of the body as something that can be bought and sold in a way analogous to remuneration for participating in a clinical trial. Because gamete transfer involves the creation of a new human being it is not analogous to forms of labor or use of the body that do not involve procreation. Bringing a human life into being is an act of tremendous import. If gamete transfer is analogized to other forms of labor or participation in clinical trials, the gamete is viewed as having no particular significance to the provider, it is simply matter that is detachable from the body, not materials that will have psychological and social significance both for the recipient and for the person who may be brought into being. “The social, psychological, and spiritual significance of creating new lives and helping couples to form (or augment existing) families is not reciprocated in the payment of money” (Daniels & Lewis 1996: 1521–36, 1533). (Moreover, the fact that people pay others for their labor and for participation in clinical trials does not mean that these practices themselves are immune to challenge.) A full discussion of the question of whether the notion of “self-ownership” necessarily entails the right to sell body parts, to alienate one’s labor, or to let one’s body be used by others for medical experimentation is beyond the scope of this article.³⁷ I suggest that commodification not only of human gametes but also of certain kinds of labor and uses of the body, including selling the use of one’s body for the purpose of procreation by someone else, should not be regarded as the societal norm. Participation in human procreation is not properly thought of as a market transaction, the essence of which is that the owner can alienate—definitively separate from the self—either procreative material or labor.³⁸

³⁷ On self-ownership and property in the person, see Waldron (1988) and Pateman (2002:20–53).

³⁸ The fact that procreative labor is not alienable is the reason that a surrogacy contract should not be enforced when a gestational mother (surrogate) changes her

How might practices surrounding, and social understandings of, gamete transfer be affected if gametes really were treated as a “gift” from provider to recipient? Ken Daniels and Gillian Lewis (1996) have studied the way the use of “sale” and “gift” affect the way people understand what is involved in semen transfer. They contend that “[h]ow semen provision is constructed in a particular clinical setting directly affects its meaning for the individuals concerned.” Payment can imply to provider and recipient alike that money is reason enough to donate, and that transfer is an impersonal transaction with no enduring implications. In many cases of paid transfer, in everyone’s mind “payment meant that the matter was completed” (1996:1523). By contrast, if the provider is unpaid, the answer to the question “why give my gametes to someone else to help them conceive a child?” cannot simply be “I need or can use the money.” The question of whether or not to donate involves consideration of the consequences of providing others with the means of bringing another human being into existence. Daniels and Lewis observe that if the provider is unpaid, the recipients, for their part, “May find it more difficult to maintain the idea of him as a faceless source of sperm, as his lack of financial motivation could create pause for them to wonder, ‘Why did he donate?’” Staff at clinics may also find it easier to help a provider ascertain and examine his motives when monetary compensation does not provide a ready answer (Daniel & Lewis 1996:1524).

Providing eggs is so much more complicated than providing sperm that people who are concerned to maintain a supply of eggs balk at the suggestion that eggs be transferred only by unpaid gift. Gender equity suggests that since sperm providers are paid, egg providers should also be paid, especially since egg retrieval requires both hormone manipulation and a surgical procedure, both of which entail discomfort and some risk. In England, unlike the United States, egg providers were not traditionally paid, and some feminists denounced a practice that treated women as altruists and men as economic actors. As Donna Dickenson observed, “This assumes either that men own their labour and the products of their bodies in a way that women do not, or that women’s motivation is drastically different from men’s, that it is not rational in the usual sense” (1997a:93), assumptions that are unacceptable. To reflect a commitment to sexual equality, however, one would not have to pay egg providers; one could just as well stop paying sperm providers.

Some people oppose moving to a regime of unpaid gamete transfer because they believe that payment is necessary to get

mind about relinquishment either during pregnancy or immediately after birth. I have argued elsewhere that in such cases a custody hearing is an appropriate procedure that recognizes the claims of both the intentional parents and the gestational mother. Shanley (2001:102–123).

men and women to provide sperm and eggs in sufficient quantity to meet the demand of those wishing to purchase gametes (Baum 2001:107–66; Sauer 1997:7091; see also Kolata 1998). I am not convinced that this is so, or that if it is, that satisfying demand justifies a practice that is in itself improper. Some evidence suggests that unless egg providers receive some payment beyond reimbursement for expenses, the supply of gametes will fall well below the demand. England prohibited remuneration of more than £15 (about U.S. \$24) for egg providers. This amount is inadequate at present to recruit a sufficient number of egg providers; the waiting period to receive eggs is about five years. Some commentators therefore suggest setting a uniform payment between £300 and £400 (about U.S. \$700) as remuneration for the inconvenience and discomfort of transferring eggs (as distinguished from the eggs themselves), while others advocate holding fast to unpaid donation.³⁹ England and Canada have had some success in encouraging “egg sharing,” whereby a woman undergoing IVF using her own eggs donates to someone else any eggs that were harvested but that she did not use.⁴⁰

In France, sperm providers were initially paid, but when it became possible to freeze sperm (and so the providers could come to a fertility center at their convenience) they ceased being paid. The majority of the centers “maintained a policy that the semen donation be simply that, a gift for which no payment is received as is the case for organ donation” (David & Lansac 1980: 15–26, 20). In 1979 doctors reported that “donations have kept pace with semen demands,” although a constant recruitment effort was necessary as demand continually increased.⁴¹ Requests for providers appealed to those who understood the longing for a child, and potential recipients were urged to talk about donor insemination to increase public acceptance and encourage donations.

The United States has never tried a vigorous campaign to try to recruit unpaid sperm and egg providers. Little public discussion about the plight of the infertile and the ability of others to contribute to their effort to procreate has taken place. It is impossible to know how much donations might be increased by a vigorous public education and advertising campaign explaining

³⁹ Craft (1997:1400) argues in favor of an “inconvenience allowance, and Johnson (1997:1401) argues for unpaid donation. See also Dickenson (1997b) for a discussion of the assumptions reflected in England’s laws governing gamete donation.

⁴⁰ Donating extra eggs must not be a condition of receiving treatment, however. No one should be forced to have her genetic material made available for use by another person to procreate.

⁴¹ See David & Lansac (1980). See also LeLannou et al. (1980). Patrick Huerre reported that when donations could not keep up with the increasing demand, causing some recipients to have to wait a year for insemination, the Centers developed a policy of asking potential recipients to recruit providers (whose semen would not be given to them, but to others); see Huerre (1980:461–65).

the help that providers could provide to the infertile. It is known that “when a system incorporates both paying and nonpaying elements, the altruistic element will suffer” (as it tends to do when there is a dual system of payment and donation for blood and bone marrow) (Dickenson 1997a:95). The United States was able to move from a system of payment for blood, combined with a small amount of unpaid donation, to a largely unpaid system through a vigorous public education campaign. Monica Konrad (1998:643) reports that egg providers she interviewed spoke of what they did as “donating means or a way of helping others,” and characterizes their accounts as “narratives of assistance” and of “social efficacy . . . on behalf of others.”⁴² A public education campaign might build upon and foster such attitudes.

Reimagining gamete transfer as something other than a market activity will be an uphill struggle, but is not inevitably doomed to failure.⁴³ It is possible to envision gamete transfer as either a market activity or as a way to collaborate in others’ efforts to conceive a child. Altruistic transfer is preferable to paid transfer because it leads society at large, not only provider and recipient, to reflect on and discuss what participation in human procreation means. Subsuming collaborative procreation into other kinds of buying and selling commodifies either human gametes or the use of the body, or both. Payment suggests that the transfer is a complete and discrete event, that the action of the person providing gametes has no intrinsic relationship to that of the person receiving the gametes. It would be far preferable if the collaborative acts necessary to bring a new life into being were acknowledged rather than obscured in the practices surrounding gamete transfer.

Respect for families—and in particular respect for children and the persons that they will become—requires that gametes not become anonymous commodities and that family formation not be absorbed by the market. Respect for families and for the child (and the person the child will become) sets limits on the

⁴² Konrad sees anonymity as an integral part of these narratives of assistance, although I think anonymity would not be essential to enabling someone else to parent.

⁴³ In a thought-provoking paper, Hawley Fogg-Davis (2000) has suggested that a possible basis for establishing gamete transfer on an ethical foundation would be to regard transfer as a form of work or labor, for which providers could be paid, and then to bring their labor under the jurisdiction of Title VII of the Civil Rights Act of 1964. Because Title VII prohibits discrimination on the basis of race, sex, religion, or national origin, Fogg-Davis believes it could be used to prohibit mention of the provider’s race in any catalogue or other materials relating to the gamete. It is both impracticable and unethical, she argues, to ascribe “race” to gametes, since racial categories correspond not to biological facts but to social constructions, and the law should prohibit sperm and egg banks from listing the race of providers.

While sharing Fogg-Davis’s concern to avoid the perpetuation of white privilege through gamete transfer, I see dangers in treating the act of transferring gametes as a form of work falling under Title VII’s prohibitions on employment discrimination. Bringing gamete transfer under Title VII could result in treating egg donation like any other labor market activity, and treating genetic material as a “product.”

ways in which people can exchange or transfer gametes in efforts to procreate and, in particular, requires that people have access to information about their progenitors and that society abolish payment for human gametes. New reproductive technologies, along with birth control and abortion, encourage voluntaristic models of thinking about family relationships because having children by buying genetic material or gestational services introduces choice and contingency into what was long thought to be inevitable. As Marilyn Strathern notes (1992:34), “However one looks at it, procreation can now be *thought about* as subject to personal preference and choice in a way that has never before been conceivable.”⁴⁴ Discussions of the ethics of gamete transfer have overwhelmingly centered on the choices and interests of recipients, providers, and physicians; only rarely is mention made of the person-to-be. But that person must be central to moral reasoning about procreative practices.

Gamete transfer has not existed long enough for many children and adults created with third-party genetic material to share their perspectives, although these will be very important to future moral reasoning. In the present absence of such first-person testimony, I would suggest that respect for the equal worth of human beings precludes setting different monetary values on genetic material to be used in procreation. And respect for each individual’s right to establish his or her own sense of identity requires that society not withhold from anyone information about his or her origins.⁴⁵ The deep conceptual transformations necessitated by the creation of families from gamete transfer are not encompassed by a false dichotomy suggesting that family bonds are grounded either in “nature” or in “convention.” Rather, these transformations require us to frame an ethic of interpersonal and intergenerational responsibility under conditions of unprecedented choice. They challenge us to alter our conceptual models of human gametes from one of ownership to one of stewardship, and of individual autonomy from bounded separation to self-direction in relationship with others.⁴⁶ It is possible to change both our thinking about and the policies governing the transfer of human gametes to be used in procreation, and we should do so for the sake of all those involved.

⁴⁴ Like Strathern, political theorist Michael Sandel (1982, 1996) and legal theorist Janet Dolgin (1997) have observed this same tension between thinking about family relationships as given “by nature” and family relationships as the result of choice. Both worry that legislatures and courts in the United States have leaned too far in the direction of accepting choice as the basis of family relationships, risking the loss of norms of natural obligation, mutuality or reciprocity, and permanence.

⁴⁵ There might be exceptions to this general rule if revealing information might put someone else’s safety in jeopardy. Some birth mothers fear, with reason, that a father, husband, boyfriend might injure or kill them if the fact of their pregnancy were known.

⁴⁶ See Nedelsky (1989: 7–36; 1990:162–189). For a defense of moral autonomy but with a more bounded view of the self, see Dworkin (1993).

References

- Annas, George A. (1979) "Artificial Insemination: Beyond the Best Interests of the Donor," 4 *The Hastings Center Report* 14–15.
- (1998) "The Shadowlands—Secrets, Lies, and Assisted Reproduction," 339 *The New England J. of Medicine* 935–39.
- Areen, Judith, ed. (1985) *Family Law: Cases and Materials*, 2nd ed. Mineola, NY: The Foundation Press, 878–882.
- Baum, Kenneth (2001) "Golden Eggs: Towards the Rational Regulation of Oocyte Donation," *Brigham Young Univ. Law Rev.* 107–66.
- Canada, House of Commons Standing Committee on Health, "Assisted Human Reproduction: Building Families" 2001. <http://www.parl.gc.ca/InfoComDoc/37/1/HEAL/Studies/Reports/healrp01-e.htm>.
- Craft, Ian (1997) "An 'Inconvenience Allowance' Would Solve the Egg Shortage," 314 *British Medical J.* 1400.
- Curie-Cohen, Martin, Lesleigh Luttrell, & Sander Shapiro (1979) "Current Practice of Artificial Insemination by Donor in the United States," 300 *New England J. of Medicine* 585–90.
- Cuisine, Douglas J. (1980) "Legal Aspects of AID," in Georges David & Wendel S. Price, eds., *Human Artificial Insemination and Semen Preservation*. New York: Plenum Press 485–90.
- Daniels, Ken R. (1998) "Assisted Human Reproduction in New Zealand: The Contribution of Ethics," 8 *Eubios J. of Asian and International Bioethics* 79–81.
- Daniels, Ken & Karen Taylor (1993) "Secrecy and Ownership in Donor Insemination," 12 *Politics and the Life Sciences* 155–70.
- Daniels, Ken & Gillian M. Lewis (1996) "Donor Insemination: The Gifting and Selling of Semen," 42 *Social Science and Medicine* 1521–36.
- David, Georges & Jacques Lansac (1980) "The Organization of the Centers for the Study and Preservation of Semen in France," in Georges David & Wendel S. Price, eds., *Human Artificial Insemination and Semen Preservation*. New York: Plenum Press 15–26.
- Dickenson, Donna L. (1997a) "Procuring Gametes for Research and Therapy: The Argument for Unisex Altruism—a Response to Donald Evans," 23 *J. of Medical Ethics* 93–95.
- (1997b) *Property, Women & Politics: Subjects or Objects?* New Brunswick, N.J.: Rutgers Univ. Press.
- Dolgin, Janet L. (1997) *Defining the Family: Law, Technology, and Reproduction in an Uneasy Age*. New York: New York Univ. Press.
- Dworkin, Ronald (1993) *Life's Dominion: An Argument About Abortion, Euthanasia, and Individual Freedom*. New York: Knopf.
- Evans, Donald (1995) "Procuring Gametes for Research and Therapy," 21 *J. of Medical Ethics* 262–64.
- Fogg-Davis, Hawley (2000) "She Works Hard for the Money?: Addressing Employment Discrimination in Paid Egg Donation." Presented at American Political Science Association annual meeting, Washington, DC.
- Folsome, Claire E. (1943) "The Status of Artificial Insemination," 45 *American J. of Obstetrics and Gynecology* 915–27.
- Hollinger, Joan Heifetz (1985) "From Coitus to Commerce: Legal and Social Consequences of Noncoital Reproduction," 18 *Univ. of Michigan J. of Law Reform* 865–932.
- Huerre, Patrick (1980) "Psychological Aspects of Semen Donation," in Georges David & Wendel S. Price, eds., *Human Artificial Insemination and Semen Preservation*. New York, Plenum Press, 461–65.
- Johnson, Martin H. (1997) "The Culture of Unpaid and Voluntary Egg Donation Should Be Strengthened," 314 *British Medical J.* 1401.
- Kingsolver, Barbara (1998) *The Poisonwood Bible*. New York: HarperCollins.

- Knoppers, Bartha M. & Sonia LeBris (1991) "Recent Advances in Medically Assisted Conception: Legal, Ethical, and Social Issues," 17 *American J. of Law and Medicine* 329–61.
- Kolata, Gina (1998) "Price Soars for Eggs, Setting Off a Debate on a Clinic's Ethics," *New York Times*, 25 February A1.
- Konrad, Monica (1998) "Ova Donation and Symbols of Substance: Some Variations on the Theme of Sex, Gender and the Partible Body," 4 *J. of the Royal Anthropological Institute* 643.
- Leighton, Neil (1995) "The Family: Whose Construct Is It Anyway?" in Carole Ulanowsky, ed. *The Family in the Age of Biotechnology*. Avebury: Ashgate Publishing 91–104.
- Le Lannou, Dominique, Bernard Lobel, & Yves Chambon (1980) "Sperm Banks and Donor Recruitment in France," in Georges David & Wendel S. Price, eds., *Human Artificial Insemination and Semen Preservation*. New York: Plenum Press 89–94.
- Ludtke, Melissa (1997) *On Our Own: Unmarried Motherhood in America*. Berkeley and Los Angeles: Univ. of California Press.
- Mahowald, Mary B. (2000) "Genes, Clones, and Gender Equality," 3 *DePaul J. of Health Care Law* 495–526.
- Manuel, Christine, Marie Chevret, & Jean-Claude Czyba (1980) "Handling of Secrecy by AID Couples," in Georges David & Wendel S. Price, eds., *Human Artificial Insemination and Semen Preservation*. New York: Plenum Press 419–29.
- McShane, Patricia M. (1988) "In Vitro Fertilization, GIFT and Related Technologies—Hope in a Test Tube," in Elaine Hoffman Baruch, Amadeo F. D'Adamo, Jr. & Joni Seager, eds., *Embryos, Ethics, and Women's Rights: Exploring the New Reproductive Technologies*. New York and London: The Haworth Press 31–36.
- Mead, Rebecca (1999) "Eggs for Sale," *The New Yorker* 56–65.
The Miscellany News, vol. 133 (March 24, 2000), 5.
- Nachtigall, Robert D. (1993) "Secrecy: An Unresolved Issue in the Practice of Donor Insemination," 168 *American J. of Obstetrics and Gynecology* 1846–51.
- Nedelsky, Jennifer (1989) "Reconceiving Autonomy: Sources, Thoughts and Possibilities," 1 *Yale J. of Law and Feminism* 7–36.
- (1990) "Law, Boundaries, and the Bounded Self," 30 *Representations* 162–89.
The New York Times, Metropolitan ed. 3 March 1999 A10.
- Overall, Christine (1987) *Ethics and Human Reproduction*. Boston: Allen & Unwin.
- (1993) *Human Reproduction: Principles, Practices, Policies*. Toronto: Oxford Univ. Press.
- Pateman, Carole (2002) "Self-Ownership and Property in the Person: Democratization and a Tale of Two Concepts," 10 *The J. of Political Philosophy* 20–53.
People 53, no. 19 (May 15, 2000), 68–75.
Poughkeepsie Journal, 23 September 2000, 8D.
- Radin, Margaret Jane (1987) "Market Inalienability," 100 *Harvard Law Rev.* 1849–1937.
- Roberts, Dorothy (1995) "The Genetic Tie," 62 *Univ. of Chicago Law R.* 209–73.
- Roy, David J. (1980) "AID: An Overview of Ethical Issues," in Georges David & Wendel S. Price, eds., *Human Artificial Insemination and Semen Preservation*. New York: Plenum Press 499–511.
- Sandel, Michael (1982) *Liberalism and the Limits of Justice*. Cambridge and New York: Cambridge University Press.
- (1996) *Democracy's Discontent*. Cambridge, Mass.: Harvard University Press.
- Sanger, Carol (1996) "Separating from Children," 96 *Columbia Law Rev.* 375–517.

- Sauer, Mark V. (1997) "Exploitation or a Woman's Right? (An Ethical Dilemma: Should Egg Donors Be Paid?)" 314 *British Medical J.* 1403.
- Scott, Russell (1981) *The Body as Property*. New York: Viking Press.
- Seligson, Susan V. (1995) "Seeds of Doubt," 275 *The Atlantic Monthly* 28–31.
- Seymour, Francis I. & Alfred Koerner (1941) "Artificial Insemination: Present Status in the United States as Shown by a Recent Survey," *J. of the American Medical Association* 2747–49.
- Shanley, Mary Lyndon (1995) "Unwed Fathers' Rights, Adoption, and Sex Equality: Gender-neutrality and the Perpetuation of Patriarchy," 95 *Columbia Law Rev.* 201–44.
- (2001) *Making Babies, Making Families: What Matters Most in an Age of Reproductive Technologies, Surrogacy, Adoption, and Same-Sex and Unwed Parents*. Boston: Beacon Press.
- Strathern, Marilyn (1988) *The Gender of the Gift*. Berkeley: University of California Press.
- (1992) *Reproducing the Future: Essays on Anthropology, Kinship and the New Reproductive Technologies*. New York: Routledge.
- Waldron, Jeremy (1988) *The Right to Private Property*. Cambridge: Cambridge University Press.
- Williams, Patricia (1995) *The Rooster's Egg*. Cambridge, Mass.: Harvard University Press.
- Woodhouse, Barbara Bennett (1994) "'Out of Children's Needs, Children's Rights': The Child's Voice in Defining the Family," 8 *Brigham Young Univ. J. of Public Law* 321–41.
- (1993) "Hatching the Egg: A Child-Centered Perspective on Parents' Rights," 14 *Cardozo Law Rev.* 1747–865.
- Yngvesson, Barbara (2000) "Un Niño de Cualquier Color: Race and Nation in Intercountry Adoption," in Jane Jensen & Boaventura de Sousa Santos, eds., *Globalizing Institutions: Case Studies in Regulation and Innovation*. Aldershot: Ashgate Press, 169–204.

Case Cited

- In Re Adoption of Anonymous*, 74 Misc. 2d 99, 345 N.Y.S.2d 430 (Surrogates Court of New York, Kings County, 1973), in *Family Law: Cases and Materials*, 2d ed., ed. Judith Areen (Mineola, N.Y.: The Foundation Press, 1985), 878–82.

Bill Cited

- Canada. House of Commons. Bill C-56, "An Act Respecting Assisted Human Reproduction." 49-50-51 Elizabeth II, 2001–2001. <http://www.hc-sc.gc.ca/english/protection/reproduction/index.htm>.

