Distributive Justice in the Allocation of Donor Oocytes

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Due to the shortage of oocyte donors, the waiting lists are lengthening. This raises the ethical question of how the available oocytes should be distributed among candidate recipients. The paper clarifies the ethical structure of the allocation process to find a set of rules that generates decisions that are acceptable for all people involved. The selection includes two steps: admission to the waiting list and ranking of those on the list. The following criteria can be used to decide about the admission of candidates: success rate, health risks, age, parental competence, nationality, primary versus secondary infertility, and capacity to pay. Four criteria may function to rank recipients who should have first priority for receiving oocytes: waiting time, medical urgency, phenotypic matching, and synchronization. The introduction of a point system is defended because it allows balancing of the different ethical principles involved and because it installs an objective system of operating rules which avoid favoritism and personal biases.

KEY WORDS: Allocation; distributive justice; ethics; oocyte donation; recipient selection.

INTRODUCTION

Oocyte donation has grown rapidly since it was first offered in 1984. It gives women without ovarian function the possibility to bear children genetically related to their partners. However, a constant feature of this new treatment option is the severe shortage of donors. As a consequence of the discrepancy between supply and demand, the waiting lists are lengthening. More and more, the overall situation for oocyte donation becomes comparable to the situation for organ donation. A remarkable difference is that whereas the selection of recipients for organ donation has received a

great deal of attention in the literature, very little can be found about the selection of oocyte recipients. To date, there are no published reports on the way fertility centers determine who will receive the oocytes that become available at a certain moment.

How should the available oocytes be distributed to the candidate recipients? The main question is to decide which allocation criteria are ethically relevant. For organ donation, medical practitioners as well as ethicists agree that admission to the waiting list should be based solely on medical criteria. It is, however, quite complicated to distinguish medical and nonmedical criteria. Age, which is an important indication for oocyte donation, contains both medical and nonmedical aspects. Undoubtedly, there is a tendency to rationalize nonmedical criteria in medical terms because medical criteria carry the connotation of objectivity and scientific validity and are used to strengthen the impression of impartiality on the part of the selectors (1). Moreover, in some cases the medical data are ambiguous, which allows each side in the debate to select the findings which fit their opinion. The discussion on the influence of uterine aging and oocyte quality on success rates illustrates this point.

The goal of the present article is to clarify the ethical structure of the allocation process to find a set of rules that generates allocation decisions that are acceptable to all people involved. The ethical system has to provide reasons for choosing between different potential recipients. These reasons successfully justify the allocation "when those who are at a disadvantage cannot reasonably complain that their interests were not given sufficient weight" (2).

DETERMINING THE RELEVANT CRITERIA

Three selective steps or stages can be distinguished: referral for the treatment, admission to the waiting list, and selection from the waiting list (3). Very little

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is known about the first stage. The crucial player at this point is the general practitioner whose knowledge of fertility techniques and whose evaluation of the patient as a potential recipient will be decisive. Personal values, religious convictions, and prejudices about social class and parental competence may all influence the decision to refer a patient for oocyte donation. For obvious reasons, it is impossible to estimate how many people do not get past this first gate.

We will concentrate on the criteria for the second and third stages of the selection: criteria that decide about the admission to the waiting list and criteria that determine the ranking of the potential recipients on the list. These questions have to be treated in chronological order. However, some characteristics that can be used to regulate admission to the list can also be used to rank individual candidate recipients who are already admitted. The main factors to choose among possible uses of a criterion are the certainty attributed to the criterion and the flexibility one wants to impute in the allocation process. Admission is an all-or-nothing decision: one is accepted or not. The more criteria are used for exclusion from the list, the simpler the allocation. A candidate who does not possess the requested characteristic is not admitted. However, using a criterion for ranking rather than for exclusion or admission has a "mitigating" effect which is better adapted to the uncertainty most practitioners and ethicists feel concerning the decision. The candidate who does not possess the requested characteristic is not categorically denied access, she is given lower priority. This option demands the introduction of a point system. The candidate receives fewer credit points than her competitors or she gets penalty points. The sincerity of this procedure is determined by two factors: the scarcity of the oocytes and the points accorded to certain features. If the shortage is permanent and serious, any setback amounts in practice to the exclusion from treatment. It is also easy to fix the amount of penalty points in such a way that lacking the feature implies denial of access.

A point system which gives credit points to the morally relevant features of the prospective recipients has several advantages. First, it allows us to take into account more than one relevant factor simultaneously in the allocation procedure and it enables us to balance the different ethical principles. Second, if the system is considered fair and equitable, physicians and others will be less tempted to request an "exception" or privilege for specific patients. Such favoritism is based largely on subjective weightings by the physician, his/her idiosyncratic values and personal prin-

ciples. Interference by individual physicians in the allocation process can be avoided by installing an "objective" system of automatically operating rules on which a general consensus has been reached. In general, it will help us to achieve a fairer and more equitable distribution of the reproductive material.

CRITERIA FOR ADMISSION ON THE WAITING LIST

Success Rate

Success rate is probably the most widely used method of prioritising patients (4). This criterion is based on utilitarian theory. Utility in the context of fertility treatment is measured by the "take-home baby" rate. This is a gross reduction of the notion of utility in infertility treatment but it is nevertheless considered as the ultimate criterion for the quality of the treatment both by patients and by fertility centers. If we accept this criterion, the waiting list should be composed in such a way that the expected number of pregnancies from a given number of oocytes is maximized. The oocytes should be given to the woman with the highest chance of pregnancy. A system that does not take account of the medical efficacy would only "promote an abstract and sterile notion of equality" (5).

It has been argued that, for efficiency reasons, donor oocytes should preferably be donated to younger women who have a greater chance of becoming pregnant (6). This presupposes that older women have a lower success rate than younger women when donor oocytes are used. The debate on this question is still going on, with great fierceness. According to some studies, the better results of women younger than 40 years of age are due to the effect of uterine age, which makes the uterus less receptive to implantation (7). Other studies claim that there is no adverse effect of recipient's age on pregnancy outcome after oocyte donation and that the success rate is determined by the quality of the oocytes (8). Whatever the final conclusion of this debate, if we accept the success rate as an important factor in the ranking of candidate recipients, other determinants should be included that also have a detrimental effect on the pregnancy rate, such as smoking, drinking, and obesity. Also, more individual factors, such as a history of miscarriages and thus a higher likelihood of losing the pregnancy, should be considered when we have to decide whether to allow women access to scarce oocytes (9).

Oocytes are a rare and valuable resource that should not be wasted. The selection of recipients according to chances of success can be interpreted as an obligation following from the gift. This obligation has been termed "the obligation of grateful use" (10). Since the donor considers her oocytes as precious and charged with a special symbolic meaning, it would be wrong to use this gift in a treatment that has almost no chance of success.

The present problem is a conflict between the principle of justice and the principle of utility. If the oocytes should be donated to those who have the highest success rate (thus maximizing utility), some women will never have the chance to be treated. If each individual is entitled to an equal opportunity to benefit from the health care system, then each woman has the right to receive oocytes, even with a very slim chance of becoming pregnant (11). A trade-off between the medical efficacy and utility and the equality of opportunity can be found in a threshold principle. This principle consists of two rules: a minimum level of success is fixed for admission, and above that line, no interpersonal comparisons of chances of success are made. On the one hand, the maximization, which is implied by utilitarianism, is abandoned as being incompatible with the principle of equality of opportunity. If Mary has a 90% chance of success and Magdalene 10%, then this difference does not constitute a reason to give priority to Mary. The 10% chance of Magdalene still constitutes a fair chance that she can reasonably take. On the other hand, we are not forced to donate the oocytes to women whose chance of success are so low that treatment is medically futile. The threshold principle implies that success rate is not a relevant factor for choosing between individuals on the waiting list. It determines only whether someone will be eligible for placement on the waiting list.

There are borderline cases where society will have to decide which prognosis is sufficiently high to admit certain patients to the waiting list. When the chances of success of a particular patient or group of patients are estimated to be 3%, should they be offered IVF with or without donor oocytes? The chance of success as an objective measure does not impose a conclusion by itself. The decision (whether or not to treat or to offer donor oocytes) depends on several value judgments such as the justifiability of making society pay for a treatment which almost certainly will be unsuccessful, the degree of paternalism of the physician or the extent to which he/she thinks that the ultimate decision should be left to the patient, the extent of the shortage of oocytes, etc.

Health Risks

Most practitioners will refuse to proceed if the pregnancy will seriously jeopardize the health of the woman. Like success rate, medical urgency and health risks are medical criteria which need to be evaluated and interpreted by means of an ethical framework. How high is too high? Again, the degree of paternalism demonstrated by the physician will be crucial in the final conclusion. Nevertheless, especially in view of the obligation of the physician not to cause harm, there is a level of risk for the life or health of the women which justifies a refusal of the request (12). The physician should ascertain the woman's ability safely to tolerate pregnancy, labor, and delivery (13). Health risk is thus also structured as a threshold principle.

Age

A criterion becomes really problematic when it has a social and/or moral meaning. The use of the criterion in the allocation can then come across as discriminatory. The debate about postmenopausal women illustrates this point. The editors of *Lancet* argued that one of the factors to be considered in the distribution of oocytes was "the use of scarce and expensive health resources that might deprive infertile younger women of similar benefit" (14). They further claimed that "justice demands that young infertile women should take precedence over those who are postmenopausal." In the same vein, Baird (15) stated that "prioritization based on appropriate use of scarce resources suggests that donor-egg IVF should not be available to postmenopausal women until the needs of women in the normally fertile age group have been addressed." She based this position on the utilitarian principle that "because younger women have a greater chance of bearing a child, they are more likely to benefit from treatment" (16). Still the choice of terms shows that background theories concerning the "normal reproductive period" and the "unnaturalness" of the medical intervention influence this normative position. This attitude coincides almost completely with the opinion of the Royal Commission on New Reproductive Technologies from Canada except that the latter recommended that postmenopausal women "should not be candidates to receive eggs or zygotes" (17). The Royal Commission goes a step further and denies these women admission to the waiting list. Against this position it has been argued that the formal principle of justice demands their treatment since these patients are relevantly similar

to other classes of patients who also receive assistance in reproduction (18).

Parental Competence and Well-Being of the Child

The content of the notions of fairness and equity is determined by the concrete context in which the decisions are made. Fertility treatment needs a special framework because of the specificity of the consequences of the treatment, i.e., the birth of a child. Within this framework, the worthiness of the patients for parenthood can be introduced as morally relevant. The recipients would be placed on a scale according to the degree to which they are considered fit for parenthood. The most difficult issue confronted when trying to introduce such ranking is the fact that no one has been able to indicate characteristics that reliably predict who will be a good parent (19). Some countries consider all family constellations that deviate from the heterosexual married couple as detrimental to the psychosocial development of the child and thus as a reason to exclude those candidate recipients from access to treatment. The attempt to select on the basis of parental competence could be seen as a maximization of utility in terms of the well-being of the child. The oocytes should be given to those women who will raise the happiest child. Although everyone immediately sees the difficulty of performing such an estimation, this argument has been used to exclude older, single, and lesbian women.

Nationality

Another critical element in the distribution is the presence of foreign recipients on the waiting list. More accurately, the reference is not nationality but membership, defined as "contributing and residing persons." Of course, since most health care systems are restricted to national boundaries, both terms will overlap to a large extent. This is a very delicate matter since any mention of nationality inevitably carries a connotation of nationalism and extreme right-wing ideology. The "my people first" idea is used nowadays to justify all kinds of xenophobic reactions. Nevertheless, there is a problem if a clinic serves large numbers of foreign patients.

Due to the absence of a law regulating assisted reproduction, countries such as Belgium are confronted with this question because the neighboring countries have a legislation that restricts the categories of patients by imposing more restrictive age limits (such as The Netherlands) or by forbidding the application of oocyte donation as such (such as Germany). Treat-

ment itself is not a scarce resource in Belgium and does not constitute a reason for selection. If foreign recipients bring their own personal donors, they do not draw from the general donor pool and there is no reason why they should not be treated. However, if bringing along a personal donor is a condition for treatment, patients from abroad will not be put on the list for anonymous donation. At present a very substantial portion of the candidates (up to 50%) on the waiting list for anonymous donation in Belgian fertility centers is foreign residents (20).

In the context of organ transplantation, it has been argued that donated organs should be considered as assets of the community. This conception is based on the idea that the organs were given by members of the community to help other members and because transplantation is part of the public health care sector and is funded and organized by the community (21). Although the idea of mankind as one big family and the idea of the universal moral community may serve as an ideal, it does not imply that we have to share everything with everyone. The starting point should be the question who is responsible for the shortage of oocytes or for the prohibition of oocyte donation in the country from which the candidates come. By focusing on this question, we find that the first cause is located in the political structure. The parliament or the government of countries such as Germany is responsible primarily to their citizens (22). Foreign centers should not be blamed for a situation and a frustration that is caused by the government of those who seek help. Still, although restrictions are morally justifiable, a society shows its moral worth by behaving altruistically toward nonmembers. An intermediate solution taken from the organ donation practice is the installation of a quorum for nonresidential foreigners. The National Task Force in the United States accepted the rule that only a small portion of available organs (between 5 and 10%) should go to nonresident foreigners (23). It is ultimately for society to decide to what extent it will share oocytes.

Primary Versus Secondary Infertility

Several arguments could be advanced to justify according priority to primary infertile women. People should have equal opportunity to realize certain goals in life. Women who have a child have already experienced the feelings and sensations to which oocyte donation gives them a chance, e.g., "to experience pregnancy and birth, a genetic connection to the child, control over prenatal process, and a sense of hope and

opportunity to create a family" (24). It is possible to defend this prioritizing based on an equal distribution of benefit and chance and on the goal of health care in general. A just society might rationally prefer to allocate oocytes to childless people rather than to those who already have children. If a basic principle of the allocation system is to give people an equal chance to create a family, then it is better to give priority to those who have no family at all. It could also be argued that if people do not know which position they have in the situation (they do not know whether they have a child or not), they would rationally prefer to give the oocytes to the primary infertile. If no such restriction is imposed, some women will have more than one child, while others have none. The shortage of oocytes combined with the argument of the equality of opportunity results in the conclusion that secondary infertile couples should not be admitted to the waiting list.

Capacity to Pay

A problem which attracted a lot of attention and debate is the ever-increasing amount paid to candidate donors (25). Payment, in cash or in kind, is for some the only solution to overcome the present shortage of eggs and to shorten the waiting period for the patients (26). This fact leads indirectly to a violation of the principle of justice and of the principle of equal access to health care. The most direct effect of the application of the rules of the market on the side of the collection of oocytes is the modification of the transaction from a gift to a sale. Childress already pointed out in the context of organ donation that "there are important moral connections between organ procurement and organ distribution" (27). Recruiting donors by means of the rule of supply and demand will inevitably lead to the introduction of a similar allocation rule on the distribution side. The additional cost of donor compensation is passed directly through to the recipients. When exorbitant amounts are paid to the donors, the price of an IVF cycle will become even steeper than it already is, which will finally lead to the exclusion of the poor. The treatment costs, including the money paid to the donor, may constitute an insuperable obstacle for a considerable number of potential patients. When we are talking of a basic need, selective access for the rich is one of the most vexing and reprehensible forms of discrimination. The prevention of this injustice should be considered within the context of the development of a general public health care system.

CRITERIA FOR RANKING PATIENTS ON THE WAITING LIST

The third stage in the selection concerns the ranking of patients who are already admitted to the waiting list. These criteria should determine who should have priority when a donor presents herself.

Waiting Time

Most people understand the importance of justice in the procedure when they consider the conflicts between waiting time and utilitarian elements such as urgency and efficacy. The "first come, first served" rule has an intuitive appeal because we represent the waiting list as a queue. The queuing principle is generally considered as a neutral principle because it requires no background information on the recipients. The only relevant consideration is when a person gets in line (28). An example can easily show that it cannot be the sole consideration for an equitable distribution. When I am waiting for the doctor and someone is brought in who is clearly in a critical condition (while I am not), I will accept that the doctor treats him first. We generally accept that urgency and seriousness give a person the right to move up on the list. Simultaneously, we will not accept that a person who has been on the waiting list for several years is constantly passed by newcomers with urgent needs. Urgency and waiting time should be balanced.

Waiting time is one factor beside others to which points should be accorded. This element carries a lot of weight because of the psychological effects of being put on a list. Beside the feeling of powerlessness, there is the uncertainty about finding a suitable donor in time and the stress of waiting. In this sense, waiting time expresses the psychological burden. The queuing principle can be seen as a means to spread the disadvantages and costs of the scarcity and simultaneously as a way equally to distribute the opportunity of trying.

Medical Urgency

This factor intervenes when one can predict that the medical condition of the patient will deteriorate to such an extent that a pregnancy will no longer be acceptable or possible in the (near-) future. Two possibilities come to mind: the necessity of interventions which would destroy a woman's capacity to bear children (like a hysterectomy) and an increase in pregnancy complications due to illness or age. The closer

a woman comes to this critical threshold, the more urgent her request for treatment. On the basis of justice considerations, the limited supply should be allocated to those with the most urgent need. While a younger woman can wait a little longer, the older one should get priority. This type of selective allocation is called "peacetime triage" (29). The main negative consequence of this policy is that younger patients remain on the list longer. Even if we accept that there is no significant decrease in success with older age, the mean age of the women will be higher at the moment that they receive treatment when this criterion is accepted. Consequently, they will have a higher risk of medical complications and, if the fears of some authors prove to be true, they will have more problems raising their children. The main advantages of such a system are that everyone has the opportunity to try for a child and that relatively few women will reach the upper age limit without having been offered treatment.

The alternative is an allocation policy that is typically applied on the battlefield: the efforts of the physician are directed at those who are most likely to benefit while the critically injured are left to die. The obvious problem is how to decide who falls into the last category, i.e., who should not receive fertility treatment with donor oocytes. The present age limit for treatment adopted at most fertility centers demarcates that category. The criterion "medical urgency" is for practical purposes replaced by "age." An age limit, however, considers all patients of a certain age as equally fit. It could be argued that the medical urgency of the older patients should be assessed on an individual basis, taking into account the medical condition of the mother and her ability to meet the needs of the child (30).

Phenotypic Matching

This element would be one of the most limiting factors if rigorously applied. Matching donor and recipient on phenotypic traits and blood groups disturbs the sequence on the waiting list. The policy between centers and countries on this issue differs considerably. Given the scarcity of donor oocytes, no matching is done in Belgium except for race and ethnicity (31). In France, on the contrary, the donor for a given recipient is selected according to phenotypic characteristics and blood group (32). The main motive for the choice of these characteristics is the possibility of secrecy. The physical resemblance of mother and child and the matching of blood groups

gives the parents the option of keeping the donation a secret for the social environment and for the child itself (33). The match on phenotypic traits to select a potential recipient does not exclude the necessity to choose among those who fit these traits. A perfect match is relatively rare and most candidates fall in a middle range. In addition, some parents prefer a sperm donor who does not match on some points to a further delay of their treatment (34). Given the scarcity of oocyte donors, this consideration will become even more important for recipients of oocytes. Finally, even when matching is performed, there is no reason to use it as the primary and/or exclusionary criterion for the selection of recipients. Recipients can be given credit points according to the extent of the match but the number of points should be such that it does not override all other factors.

Synchronization

The menstrual cycle of the donor and of the prospective recipient have to be synchronized. The more the cycles are synchronized, the faster the donor can start donating. Since candidate donors already passed through a few months of initial investigations, blood tests and screening, some of them want to get it over with. Frequently, and this is especially true for egg sharers, they have plans of their own, for instance, about when to have their next child. By taking into account synchronization, the procedure tries to accommodate the wishes of the donor and attempts to minimize her discomfort and burden. This adaptation is not possible for known donors since the cycle of their recipient needs to be brought into sync with their own. However, known donors are usually prepared to accept the additional waiting time.

Since the main advantage depends on the wishes of the donor, the criterion could be used selectively for those donors who would abandon their intention to donate or who would be seriously bothered by the delay. If the donor's plans are not thwarted by the postponement, synchronization should be given low weight. It can be used as a tie breaker among patients whose conditions are otherwise similar. As such, it is a flexible criterion that is ethically neutral since synchronization itself is purely coincidental.

CONCLUSION

When we have decided which criteria are relevant in the allocation process, we still have to weigh the

different factors. The assignment of relative weights to the various factors expresses our moral judgments concerning the allocation. We can "test" the algorithms by imagining a large number of hypothetical microallocation situations. The weights can then be adjusted to obtain allocation decisions that correspond with our moral intuitions and that do not strike us as morally unacceptable. As an example, we need to find an algorithm which balances medical urgency and the burden of waiting. If we attach many points to waiting time (say 20 points per year), patients who were put on the waiting list for premature ovarian failure at the age of 29 will have a total sum that is largely sufficient to give them priority on women put on the list for age-related infertility at the age of 40. Alternatively, we could attribute a large number of points to medical urgency starting with an exponential increase in credit points at the age of 45 (supposing 50 is the upper age limit). We could add 20 points at the age of 46, 40 points at the age of 47, and so on. In such a distribution, almost all women would have the possibility to receive treatment before the age of 50. More complex systems can be proposed to value each factor on its moral value.

There is no theoretical reason why there would be one and only one solution to the allocation problem. Given the number of criteria involved and the variation in practical organization of the oocyte donation programs, it would already be a great step forward if we could find a satisfying solution. To obtain such a system, we do not need consensus on the exact weight each of the criteria should have, but we should at least reach agreement on which factors are morally relevant in the allocation decision. Moral pluralism in modern society will make this a more difficult project than it may look at first sight. However, the only way to address such value conflicts is through a sustained and open dialogue among all the parties involved. Since the waiting lists for oocyte donation will continue to grow in the following years, the debate should start without further delay.

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