Compensation for Egg Donations to Stem Cell Research: Coercion or Choice

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In local newspapers, university publications, private websites, and even on airplane banners, advertisements seeking egg donors abound, each advertisement offering higher compensation than the next.¹ In exchange for giving the “gift of life,” egg donors can receive upwards of $50,000.² Egg donors to In Vitro Fertilization (IVF) clinics may be compensated handsomely without having their altruism questioned. In contrast, women seeking to donate their eggs to stem cell research centers are prohibited from receiving compensation in a few states. Currently, California, Connecticut, and Massachusetts have laws prohibiting compensation beyond direct expenses for women donating their eggs to stem cell research facilities, while not even placing a ceiling on how much IVF clinics can compensate egg donors.³

The stated purpose of these statutes, banning compensation for women seeking to donate eggs to stem cell research, is to protect women from being coerced into undergoing a painful, medically unnecessary procedure.⁴ Accordingly, women can be reimbursed for medical, travel, and miscellaneous expenses, but cannot receive compensation beyond those expenses when donating to stem cell research facilities. This dichotomy in compensation is motivated by the rationale that paying women to donate their eggs to stem cell research facilities is coercive while paying women for donating eggs to IVF clinics is apparently not. This article argues that the opposite is true. Given the “repronormativity of motherhood”⁵ that exists in our society, if women who donate to IVF clinics are considered altruistic, what prevents healthy, young women from being pressured into donating their eggs to help an infertile friend or family member conceive?

What motivates the assumption that when a woman donates to an IVF clinic and gets compensated beyond the expenses she incurred, she acted out of altruism, yet if a woman undergoes that same medical procedure⁶ in order to donate to a stem cell research facility, her donation is deemed the product of coercion or ignorance? Alternatively, is this differential compensation scheme a reflection of the social value placed upon IVF versus stem cell research? The dichotomy in compensation seems to presuppose that egg donors, and society as a whole, should or in fact do believe that the utility of IVF clinics is far greater than that of stem cell research. Accordingly, this article posits that while a woman’s right to receive compensation for the time and inconvenience of egg donation might not be a constitutionally protected privacy right, this differential compensation scheme is nevertheless void under the Equal Protection Clause of the Fourteenth Amendment.

Section II of this article discusses the framework of these various state statutes. Section III examines the social utility of stem cell research, focusing first on the potential benefits that stem cell research could provide for people suffering from genetic diseases ranging from juvenile diabetes to Parkinson’s disease. This article also examines the potential financial benefits of attracting private companies to invest in stem cell research and discuss the fact that everyone involved in stem cell research, with the exception of egg donors themselves, are compensated for their time. Finally, this article contends that in light of the expected social and financial benefits associated with embryonic stem cell research,⁷ egg donors should be compensated for their donations. Since the current ban on federal funding for any stem cell research facility using embryos leftover from IVF treatments limits the availability of embryos available, and given the importance of egg donations for stem cell research, there is no reason that women should not be compensated for their time.⁸

Section IV focuses on the potential drawbacks of IVF of which egg donors, patients, and the public at large may be unaware. This Section analyzes the eugenic underpinnings of IVF clinics since fertility clinics can cherry-pick patients according to criteria such as sexual orientation, marital status, race, and ethnicity, and then use pretext for such discrimination in order to avoid liability.⁹ Moreover, through mechanisms such as pre-implantation genetic diagnosis (PGD) and sex-selection, patients themselves can select character traits of their children-to-be. Section V discusses the actual process involved in donating eggs and the short and long-term side effects of the procedure. Section VI uses a feminist lens to critique this differential compensation scheme, discussing the “repronormativity of motherhood” and the value and definition of motherhood. Lastly, this article examines whether these statutes violate a woman’s right to privacy and whether the statutes violate the Equal Protection Clause of the Fourteenth Amendment.

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II. States’ Statutory Schemes

A. California

California allows egg donors to be reimbursed for direct expenses if women are donating for stem cell research purposes, but does not prohibit compensation for egg donors seeking to donate their eggs to IVF clinics, or even for sperm donors seeking to donate to stem cell research. In addition, Proposition 71 provides $3 billion in funding for stem cell research and creates a state agency, California Institute for Regenerative Medicine (CIRM). Looking at the legislative intent of this statute reveals that state legislators hope to promote embryonic stem cell research while promoting women’s health and ensuring that women are not coerced into donating their eggs for stem cell research purposes. The California statute does not provide criminal sanctions for either institutions or individuals engaging in the selling or purchasing of human eggs.

B. Connecticut

Though Connecticut also prohibits payment to egg donors seeking to donate for stem cell research, unlike California, they similarly prohibit compensation for sperm donors when donating to stem cell research facilities. Moreover, Connecticut has authorized $10 million in funding each year from 2006 to 2015 for grants-in-aid to eligible institutions conducting embryonic or human adult stem cell research.

C. Massachusetts

Massachusetts, like California, includes a preamble explaining its intent to promote regenerative medicine and acknowledging the considerable chance regenerative medicine has of yielding advancements in biological knowledge that could lead to therapies to relieve disease and injury. The statute explicitly states that no such compensation prohibition applies to donors seeking to donate to IVF clinics, and that the legislature does not intend to regulate IVF clinics. Moreover, it carries criminal sanctions that provide for imprisonment for no less than one year, and no more than two years in jail, or imprisonment in state prison for no more than five years, or a fine of not more than $100,000.

III. Potential Benefits of Somatic Cell Nuclear Transfer Research

Somatic Cell Nuclear Transfer (SCNT) is a form of embryonic stem cell research that requires a ready supply of human eggs. In order to understand the implications of these state prohibitions on compensation for egg donation, it is necessary to first explain the potential medical benefits of SCNT. Second, this article will explicate the reason that ova are required in order for SCNT to realize these potential benefits. Third, this article will discuss the anticipated financial gains of SCNT research, examining the disparities of a no-compensation rule for egg donors while virtually all other research participants are compensated for their time.

A. Anticipated Medical Benefits of SCNT

SCNT has great potential to cure genetic and neurodegenerative diseases. Unlike adult stem cells and other cell types, human embryonic stem cells can develop into any type of cell in the human body. In fact, human embryonic stem cells can multiply without differentiating for a significant period of time, allowing scientists to investigate the process by which human beings develop into healthy adults. Because of this special ability to postpone differentiation, human embryonic stem cells provide scientists a unique opportunity to discover the causes of many diseases, including heart disease, juvenile diabetes, Lou Gehrig’s Disease, Parkinson’s disease, and Alzheimer’s disease, to name a few. In addition to finding the causes for many of these diseases, embryonic stem cells could potentially provide their cure. According to the preamble of the Maryland Stem Cell Research Act of 2006, an estimated 128 million Americans currently suffer from these chronic, degenerative diseases. Unlike other types of stem cell research, SCNT allows scientists to target specific diseases to increase knowledge of genetic diseases, develop new treatments, create cell-based therapies, and grow immuno-compatible transplant tissues.

i. SCNT Procedure

In SCNT, two cells are combined in order to grow one cell with particular genetic characteristics. Scientists remove the nuclear DNA from an oocyte, leaving an “ovaplast.” Scientists then extract the nucleus of a specialized somatic cell and insert it into the ovaplast, creating a genetically reconstructed ovum. Instead of creating an embryo, this ovum is programmed to create somatic cells. Once scientists stimulate this ovum, it begins dividing cells, forming a blastocyst. In contrast to blastocysts formed when a sperm fertilizes an egg, a blastocyst created by SCNT is genetically identical to the somatic cell from which nuclear DNA was extracted earlier in the process. Once the ovum has developed into a blastocyst, scientists then interrupt further development in order to use the blastocyst for research.

Because ova are pluripotent, largely capable of self-renewal, and can proliferate extensively, there are currently no adequate substitutes for human egg use in SCNT. While scientists have proposed using eggs from other animals, eggs created by the manipulation of stem cell lines, or using eggs derived from fetal cadavers, each of these alternatives present their own problems. First, eggs from other species would cause an interspecies mixture of DNA which scientists have been unable to resolve. Second, creating human eggs by manipulating human stem cell lines is not yet scientifically feasible. Third, because abortion would constitute at least one source of fetal cadavers, this procedure would likely cause more controversy than the use of human eggs. Since no feasible alternative to human egg donation exists, these compensation prohibitions will greatly impede the progress of SCNT and the promise of treating and curing numerous genetic diseases.

B. Anticipated Financial Benefits of SCNT Research

While indicating that the benefits of embryonic stem cell research are “uncertain,” thus justifying a no compensation rule for egg donations made to stem cell research centers, both California and Connecticut have pledged significant state funding for stem cell research. In 2004, California committed to donating an astounding $3 billion in state funding for embryonic stem cell research. Connecticut has promised to donate $10 million a year from 2006 until 2015, a total contribution of $1 billion. The fact that Connecticut and California have contributed such a considerable sum belies the rhetoric that egg donors should not be compensated because they would be coerced into donating in exchange for uncertain returns.
In addition to expected improvements in regenerative medicine, states also anticipate receiving a share of the prospective profits of embryonic stem cell research. For example, in California, besides authorizing $3 billion in funding, Proposition 71 created the CIRM to, among other things, “make grants and loans for stem cell research, for research facilities, and for other vital research opportunities to realize therapies, protocols, and medical procedures that will result in the cure for, or substantial mitigation of, diseases and injuries.”

Non-profit institutions receiving CIRM funds own any resulting patents. However, for revenue over $500,000 generated from any ensuing patents, California can claim a share of the profits. Moreover, states are interested in placing as few restrictions on stem cell research as possible to attract biotechnology companies to create new jobs and help stagnant economies.

Virtually the only participants that would not have a financial interest in stem cell research would be the egg donors themselves. Besides state governments, researchers, universities, biotechnology companies, the pharmaceutical industry, lawyers, and health care providers all stand to profit from stem cell research and regenerative medicine. “Only the providers of the necessary tissues, without which the research cannot be done and new medical treatments cannot be developed, who are singled out for remuneration prohibitions.”

No vocal opposition seems to exist in regard to anyone else being compensated for their time.

IV. Hidden Pitfalls of In Vitro Fertilization

Because approximately 12 percent of all IVF procedures performed in the United States use donated eggs, it is important to examine the problems inherent in IVF clinic procedures. Although the rhetoric behind in vitro fertilization clinics is that egg donors are helping infertile women create loving and caring families, donors may not know who is actually benefitting from in vitro fertilization. In a survey conducted by Fertility and Sterility, 122 prospective egg donors were given various scenarios. Some of these scenarios include having a donor’s eggs be given to recipients of different ethnic backgrounds, recipients who are HIV positive, and women over 50. Once informed of the various possible destinations of donated eggs, a significant number of prospective donors were ambivalent. Furthermore, six percent of those surveyed were unwilling to proceed altogether.

This section explores the eugenic undertones of IVF clinics, both at the hands of clinics themselves, and at the behest of patients.

A. Discrimination in Access to In Vitro Fertilization

Presently, only seven states mandate that health insurance companies cover IVF treatments. At the average cost of $12,400 per cycle of IVF, and at an average total cost of $100,000, only wealthy, middle class women can afford to undergo IVF treatment. In addition to being prohibitively expensive, fertility clinics are also selective as to whom they sign up as patients based on a variety of criteria that runs the gambit from age and marital status to sexual orientation.

For example, when Guadalupe Benitez and her partner Joanne Clark attempted to obtain in utero insemination from North Coast Women’s Care, located in California, they were rejected because they were lesbians and the director of the clinic thought it morally reprehensible to help lesbians beget children. Ms. Benitez sued the clinic claiming discrimination on the basis of her sexual orientation and won at trial. However, on appeal, the clinic successfully argued that it refused to treat Ms. Benitez on the basis of her marital status, not on the basis of her sexual orientation. Although the clinic was motivated by the fact that Ms. Benitez was a lesbian, it was nevertheless able to avoid liability by providing an alternate justification for refusing to treat her.

In an interview with Dr. Geoffrey Sher, the founder and medical director of the biggest chain of fertility clinics in the world, the Sher Institute of Reproductive Medicine, Dr. Sher was asked the following questions:

“How much selecting is going on?”

“A lot.”

“How much is a lot?”

“A lot.”

During this interview, Dr. Sher admitted that a great deal of screening and selection takes place behind closed doors. A study conducted by Fertility and Sterility showed similar findings. When asked about a doctor’s prerogative to decide who is a fit parent, 56 percent polled responded that they thought doctors had a right to determine who is fit for parenthood.
Both the interview with Dr. Sher and the results of this survey demonstrate the prevalence of impermissible discrimination. So long as fertility clinics can provide legitimate reasons for their illegitimate preferences, these organizations can continue to discriminate against prospective patients freely.52

B. Eugenics-Based Practices of Patients

Selection of character traits of future offspring by patients receiving IVF treatment allows patients to practice “positive eugenics” in addition to the “negative eugenics”53 practiced by some IVF clinics. Because the IVF industry is not federally regulated54 and due to the dearth of statutory and case law regulating egg donation,55 clinics can honor requests by patients to create offspring with specific character traits which can be accomplished by selecting egg donors with a specific eye color, hair color, height, IQ, etcetera. Egg donors can either be recruited directly by the patients, through independent fertility clinics, or by private egg brokerage firms catering to medical centers associated with fertility centers.56 In California and New York, egg brokerage firms have flourished in order to meet the demand for “desirable” donors.57

To illustrate this point further, the profile of a typical woman using IVF is a white, upper-middle class woman in her late 30’s who is college-educated.58 The typical profile of an egg-donor at one of the nation’s leading fertility clinics is that of a young, white woman with some college education.59 This is no coincidence. If women are unable to conceive their own biological children, they at least want to have children who resemble them and have similar phenotypes. However, nothing prevents these women from taking it a step further and attempting to create super babies.

i. Sex-Selection

In in vitro fertilization, three different procedures for sex selection are available in which the sex can be selected or determined before fertilizing the egg, once an embryo is formed, and once the embryo has been successfully implanted in utero and has developed into a fetus.60 Spinning sperm in a centrifuge can separate Y-bearing sperm from X-bearing sperm, allowing patients to choose which sperm to use in fertilizing the egg.61 Moreover, pre-implantation genetic diagnosis (PGD) allows doctors to test an embryo’s chromosomes for sex. Finally, selective reduction allows a woman to terminate a fetus or fetuses on the basis of sex.62

Why do patients choose to engage in sex-selection? Some patients have genetic diseases which are only transmitted to a specific sex.63 Some families want to strike a balance between the number of boys and girls they have.64 Still, others are motivated by cultural perceptions of gender. Dr. Mark Evans, an obstetrician-geneticist shares, “[f]or years...the majority of sex-selection requests came from Asian and Indian parents, who tended to want to keep the boys.”65 Though Dr. Evans refuses to honor such requests motivated by clear gender bias, he will nevertheless honor requests for gay and lesbian couples seeking to have boys and girls, respectively.66

Still, other clinics will honor all requests for sex-selection and even go so far as to advertise sex-selection services in upscale magazines.67 Sex-selection, when used in order to prevent passing on genetic anomalies to offspring, may not seem like a troubling use of sex-
selection, but this too raises serious concerns about creating “designer babies.”

Clearly, in some places around the globe, the preference for male children is so strong that the use of ultrasound and other technologies for sex-selection has strongly skewed the usual ratio of boys to girls. It is not uncommon for American and European specialists in fertility and reproductive technology to point with horror at the declining numbers of girls in China and India. We, the Westerners claim in righteous tones, use the technology for good, medical reasons; they use it for bad, social reasons.

Activists and others concerned about disability rights are less clear about the difference. Do Western parents who are given the option already decide not to have children who would be mildly retarded, need a wheelchair, or be blind? Like being a girl in a culture that values boys, is being disabled a handicap that is best overcome through changes in society?6

Choosing to create or implant an embryo or terminate a fetus solely on the basis of sex in order to avoid creating offspring with genetic anomalies or due to gender perceptions or gender bias raises concerns about creating “desirable” children.

ii. Pre-Implantation Genetic Diagnosis

Pre-implantation genetic diagnosis allows patients receiving IVF treatments to test chromosomes of embryos for potential genetic defects. PGD involves extracting a single cell from the embryo and performing laboratory tests on the nuclear DNA for any genetic anomalies. Despite the risk that PGD might damage the embryo when a cell is extracted, patients nevertheless elect to run these tests to avoid transferring embryos with genetic defects.6 Through the use of PGD, doctors can now detect the following afflictions: “hemophilia; fragile X syndrome; neuro muscular dystrophy; cystic fibrosis; Tays-Sachs; Down syndrome, and hundreds of other genetic disorders, some of them fatal, some of them fatal after months, even years, of suffering.”7

In addition, PGD can also detect embryos carrying diseases that are not apparent until adulthood, such as a predisposition to breast cancer or Alzheimer’s disease.7 While prevention of human suffering is an honorable function of PGD, when a genetic anomaly does not cause suffering or fatality, but instead causes dwarfism, for example, PGD could be used as a tool to create a superior breed where differences are marginalized.

Although there is currently no technique which enables parents to genetically enhance an embryo, advancements in PGD technology could have profound implications for the future. The following quotation from Philosopher Gregory Pence demonstrates the potentially disastrous consequences of allowing market forces, unregulated by government, to create designer babies:

Some day soon, when the opportunities arise, we will see the wisdom of allowing parents maximal choice about their future children. This is not state-controlled eugenics (which attempted to take away such choices from parents) but its opposite. If a child can be given an extra decade of life by an artificial chromosome, or 50 percent more memory through a therapy in utero, then I personally would feel obligated to give my future child such benefits.

What I fail to understand is how other people—or the federal government—could think it just to prevent a parent from benefiting her future children in this way—for example by banning such enhancements. I see no difference between such a ban and a similar ban on parents sending their children to computer camps in the summer: both are intended to better children, both will be done most by people with money.22

Leaving aside the ethical implications of genetic enhancement, the difference between banning genetic enhancement of embryos and sending children to computer camp has its roots in the history of eugenics in this country. If the only people who have this “choice” are upper-middle class families, then the privilege of being a white child would take on a whole new meaning, while births of non-white children would be further marginalized.

V. Procedure Involved in Egg Donation

Women donating eggs to both stem cell research facilities and to IVF clinics must first undergo a screening process in which donors are medically and psychologically evaluated.71 Donors are then subjected to hormone injections for seven to ten days in order to stimulate the ovaries. These hormones typically cause stimulation of five to 15 eggs.74 The progress of donors in both scenarios is monitored by ultrasound.75 Once the eggs have matured, donors receive an injection of human chronic gonadotropin (HCG). Subsequently, these matured eggs are removed during an out-patient procedure in which donors are given anesthesia. Doctors remove the eggs by inserting a needle through the vagina and into the ovaries, where eggs are suctioned in the needle and deposited into test tubes.76
A. Risks and Side Effects
Short-term side effects of egg donation can include mood swings, headache, bloating, nausea, fatigue, breast tenderness, problems sleeping, body aches, problems with vision, and compulsory abstinence. Long-term side effects of egg donation include, among others, the risk of decreased fertility in the future, ovarian cancer, and ovarian hyperstimulation. Women who receive the highest doses of fertility drugs in order to donate eggs are only now reaching an age where cancer becomes more common. Therefore, studies have not found any conclusive evidence regarding the risks of ovarian cancer or decreased fertility.

B. Differences in Procedure between Egg Donation to IVF versus Stem Cell Research
Unlike egg donors to stem cell research facilities, egg donors for IVF are usually phenotypically matched to recipients so that the donor has a “similar look and background as the female recipient of the oocyte.” An additional step involved in the egg donation process that is peculiar to the IVF context is that a donor’s menstrual cycle must be matched with the recipient’s cycle. Accordingly, egg donors to IVF must receive an additional ten days of hormone injections with concentrated drugs such as Lupron in order to suppress the function of the donors’ ovaries. Women donating their eggs to IVF then must go a more arduous and dangerous procedure than women donating their eggs to stem cell research centers.

VI. The Coercion of the Repronormativity of Motherhood and the Constitutional Safeguards of Choice and Equal Protection
Given the drawbacks of IVF and the potential benefits of stem cell research discussed above, and given that the risks involved in egg donation exceeds the risks inherent in donations to stem cell research, the policy rationale behind this differential compensation scheme seems questionable at best. This section examines the underlying presumptions that prompt the no compensation rule. The first presumption is that payment can constitute a form of coercion in and of itself. The second presumption is that women are defined by their fertility and, therefore, donating eggs to an IVF clinic is inherently altruistic, regardless of how sizeable the compensation received. This analysis also evaluates whether these statutes violate a woman’s fundamental right to choose, and concludes that these statutes are likely unconstitutional pursuant to the Equal Protection Clause of the Fourteenth Amendment.

A. Compensation as Coercion
Black’s Law Dictionary defines coercion as “[c]onduct that constitutes the improper use of economic power to compel another to submit to the wishes of one who wields it.” The position of state legislators is that paying women to donate their eggs to stem cell research facilities would be coercive. However, the very compensation schemes California, Connecticut, and Maryland have created coerce women to donate to IVF clinics. Since compensation to women donating eggs to IVF clinics is unregulated, women who otherwise wish to donate to stem cell research centers might be coerced into donating for IVF clinics simply for the financial gain. According to Dr. Mark V. Sauer, the director of the assisted reproduction program at Columbia-Presbyterian Medical Center, his list of prospective egg donors has recently doubled to over 500. Dr. Sauer and other fertility doctors believe the surge in interest is correlated with a recent jump in the amount paid for the services of egg donors. If the aim of state legislators is to decrease coercion in egg donations to stem cell research, then legislators should provide that egg donors to IVF and stem cell research be compensated similarly. Furthermore, to allay concerns of undue influence resulting from exorbitant compensation, legislators could place a ceiling on the amount that egg donors may receive for their time and inconvenience.

B. The “Repronormativity of Motherhood”
In addition to the coercive compensation scheme which favors egg donation to IVF, the repronormativity of motherhood also places pressure on women to donate eggs to IVF centers. By stating that the benefits of embryonic stem cell research are uncertain, whereas the benefits of IVF are clear (helping an infertile woman be able to conceive), state legislators reinforce the notion that a woman’s worth is at least partially connected to her fertility. For example, conceiving biological offspring is seen as a social good whereas adoption is only considered as a last resort. “Reproduction has been so taken for granted that only women who are not parents are regarded as having made a choice—a choice that is construed as nontraditional, nonconventional, and for some, non-natural.” Because motherhood is considered “society-preserving,” altruistic work, to refuse it seems a selfish lifestyle choice. Motherhood is so sacrosanct in our society that legislators seem afraid to regulate in this area, afraid to question the health risks associated with egg donation in IVF, and afraid to consider whether the exorbitant compensation to egg donors in the IVF context is coercive.

C. Compensation as Choice
Having established that payment for egg donations to stem cell research is not coercive per se, the question remains whether these differential compensation schemes violate a woman’s constitutional right to privacy, or right to choice. Roe v. Wade is primarily associated with the holding that the Due Process Clause of the Fourteenth Amendment protects a constitutional right to privacy. More importantly, however, Roe held that fetuses and earlier stages of development up to fertilized eggs are not “persons” within the meaning of the Constitution. Additionally, it held that the state has an important and legitimate interest in protecting potential human life. Because the state has a recognized interest in the development of potential human life, the Supreme Court balanced a woman’s right to privacy against a state’s interests in the potential for life. During the first trimester, a woman’s constitutional right to liberty and privacy are the strongest, and a state’s interests are at their weakest.

In Lawrence v. Texas, the Court confirmed a prior Court holding “that our laws and tradition afford constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing and education.” In this context, privacy rights are primarily understood as respecting a person’s autonomy in their sexual lives. Similarly, in Eisenstadt v. Baird, the Court referred to one’s privacy rights as essential to protect single and married individuals from unwarranted government intrusion into one’s decision whether or not to “bear or beget a child.”
Framed in this manner, the question then becomes whether the doctrine of privacy will apply in the context of new reproductive and scientific technologies, much the same way that courts have asked whether the First Amendment applies to the Internet. The strongest argument in favor of applying the right to privacy in the context of embryonic stem cell research is that by donating eggs to stem cell research facilities, women are contributing to researchers’ understanding of the replication of human cells. The very goal of SCNT is to develop therapeutic cloning in the future. Therapeutic cloning involves replicating fragments of an individual’s DNA in order to replace diseased cells. Since cloning is a form of asexual reproduction similar to the process involved in reproduction of offspring, interpreting an egg donor’s right to privacy depends upon the Court’s rationale for recognizing a right to privacy from unwarranted government intrusion into the decision to have offspring. Like the decision to have genetic offspring, the decision whether or not to donate one’s eggs for any reason (whether motivated by compensation, furthering therapeutic cloning, or a combination of both) involves an individual’s conception of the meaning of life. Accordingly, the Supreme Court should find a woman’s fundamental right to privacy encompasses her right to donate her eggs freely, whether in the context of stem cell research or in vitro fertilization.

D. Equal Protection

If the Court finds that a fundamental right to privacy applies to a woman’s decision to donate her eggs, these state regulations would be unconstitutional unless the state can demonstrate a compelling state interest. Although these states might argue that they have a compelling state interest in regulating egg donations in order to preserve potential life, this argument is flawed for several reasons. The predominant view is that at the earliest, human life begins at conception. Therefore, the state has an interest in protecting an embryo as a potential person. However, in SCNT, no embryos are created. Although SCNT is considered a subcategory of embryonic stem cell research, this is a misnomer because the eggs are not fertilized by sperm. Moreover, if one believes that conception occurs in the womb, then embryos created outside the womb may not be considered potential human beings. States eager to promote embryonic stem cell research would have no incentive to pass legislation that defines conception in any other manner.

Even if states defined human life as beginning with a mature egg or before fertilization of an egg, states would still not be furthering a compelling interest in prohibiting compensation to egg donors of stem cell research while leaving compensation to egg donors of IVF clinics unregulated. The argument that states are protecting human life is tenuous because, in the context of IVF, excess embryos are frequently created and are frozen or discarded. Moreover, because in vitro fertilization is an emerging field, researchers do not yet know how many transferred embryos are implantable in a woman’s uterus. This has led to high order multiple pregnancies which cause complications to both mother and child. Thus, patients often undergo selective reduction in which one or more fetuses is terminated. If one has a fundamental right to privacy in donating eggs, the differential compensation schemes in California, Connecticut, and Massachusetts would be an unconstitutional violation of that right.

Regardless of whether or not the Supreme Court finds a privacy interest in the donation of eggs, California’s regulation is likely an unconstitutional as a means of gender-based classification. Unlike Connecticut and Massachusetts, California allows sperm donors to be compensated for donations made to stem cell research, while prohibiting egg donors from receiving any compensation beyond direct expenses. Since all sperm donors are males and all egg donors are females, the differential scheme necessarily implicates gender. Gender classifications trigger heightened scrutiny of state regulation and will only be upheld if the government provides “an exceedingly persuasive justification.” The purpose of the statute is clear: the process of egg donation is invasive and can cause serious side effects, therefore the prohibition on compensation is meant to protect women. So long as prospective egg donors provide informed consent of the potential health risks involved, they can decide whether the risks of donating outweigh the benefits. By “protecting women,” this statute assumes that women cannot make informed decisions about their own bodies, a view that is paternalistic, patronizing, and unconstitutional.

VII. Conclusion

At first glance, the rationale behind statutes that create differential compensation schemes are concerned with women’s health. By prohibiting compensation, state legislators reason that women will not be coerced into donating their eggs to stem cell research. However, if concern that compensation will coerce women were indeed the rationale behind these statutes, legislators would not leave compensation for egg donations to IVF clinics up to market forces, where women can be compensated upwards of $50,000. A compensation scheme favoring egg donations to IVF clinics is even more coercive in light of the repronormativity of motherhood in this culture. Because motherhood is viewed as altruistic, potential egg donors will more likely be coerced into donating for IVF clinics because
their donation will be viewed as altruistic and they also will be compensated generously for their time.

Depending on how the Supreme Court interprets reproductive privacy rights involving technology and cloning, these statutes, besides being questionable as a policy matter, potentially infringe on the constitutional right to privacy. Because privacy rights are in a state of flux after Gonzalez v. Carhart, it is difficult to know whether the Court will apply reproductive privacy rights in the context of reproductive and biomedical technologies such as therapeutic cloning. Carhart involved a woman’s right to privacy in the third trimester, when a woman’s interests are much weaker in comparison to a state’s interests in regulation. Since egg donation precedes even the first trimester framework, Carhart does not necessarily indicate how the Court would decide privacy rights in egg donation. However, new reproductive technologies challenge the whole trimester framework in Roe and potentially call for an entirely new approach to reproductive privacy rights.

2 See The High Cost of Eggs, supra note 1; Mundy, supra note 1, at 331.
3 Indiana and Maryland also place restrictions upon compensation for egg donations for stem cell research. Indiana allows women to be paid up to $3,000 beyond expenses incurred in the process of donating, but leaves compensation for egg donors to IVF unregulated. Maryland prohibits state funded stem cell research facilities from providing compensation for egg donations. However, the scope of this prohibition appears to be limited to excess eggs harvested for IVF treatment. See Cal. Health & Safety Code §§ 125118, 125119, 125119.3, 125119.5, 125300, 125330-123853 (Deering 2006); Conn. Gen. Stat. § 19a-32d (2006); 105 CMR 960.006; Ind. Code 35-46-5-3; Md. Ann. Code Art. 83A, §§ 5-2b-10, 5-2b-12.
5 See Katherine M. Franke, Theorizing Yes: An Essay on Feminism, Law and Desire, 101 Colum. L. Rev. 181 (2001) (coining the term “repronormativity” and referring to social influences that provide incentives for women to become mothers.)
6 As discussed in Section V, the medical procedure involved in egg donation to stem cell research and IVF clinics is similar. However, egg donations to IVF clinics are more time intensive and carry greater risks than associated with egg donations for research purposes.
7 Throughout the paper, I use the term “embryonic stem cell research” and “somatic cell nuclear transfer” interchangeably since somatic cell nuclear transfer is a subcategory of embryonic stem cell research.
8 See 2002 H.R. 3061 § 510 (a); 45 C.F.R. 46.208 (a)(2); 42 U.S.C.A. § 298g(b) (West 2002).
9 Elizabeth Weil, Breeder Reaction: Does Everybody Have the Right to Have a Baby? And Who Should Pay When Nature Alone Doesn’t Work?, Mother Jones, July/August 2006, at 33
19 NAS Guidelines, supra note 18, at 15 (Differentiation is the “process whereby an unspecialized cell acquires specialized features, such as those of a heart, liver, or muscle cell.”).
22 Ann A. Kiesling, What is an Embryo?, 36 CONN. L. REV. 1051, 1090 (2004) (discussing the term “ovumblast” which indicates that the cell is incapable of developing into an embryo).
23 Angel, supra note 17, at 191. (defining a blastocyst as a “primitive and undifferentiated structure comprising between 100 and 200 cells with no specialized tissues or organs.)
26 Chen et al., Embryonic Stem Cells Generated by Nuclear Transfer of Human Somatic Nuclei into Rabbit Oocytes, 13 CELL. RESEARCH 251 (2003) (embryonic stem cells were produced using SCNT involving human nuclear DNA and ova from rabbits) (During the SCNT procedure, mitochondrial DNA of the egg cell remains even though its nuclear DNA has been extracted. Therefore, this mitochondrial DNA would mix with the human nuclear DNA, potentially causing significant growth and safety risks.).
27 NAS Guidelines, supra note 18, at 38.
28 42 U.S.C. § 289(g) et. seq. (prohibiting modification of abortion procedure to aid fetal donation and requiring that the decision to donate fetal remains be made after the decision to have an abortion).
29 2004 CAL. LEGIS. SERV. PROP. 71 (West).
31 2006 CAL. LEGIS. SERV. CIT. 483 (S.B. 1260) (West).
32 Erika Check, Stem-Cell Researcher’s Move Attracts Funding, 448 NATUR. 398 (July 26, 2007).
33 Id.
34 See 2006 Md. LEGIS. 19 (stating that as the fourth-largest sector for biotechnology, Maryland wants to maintain a “favorable research climate” to draw biotechnology companies).
36 Id.
37 Mundy, supra note 1, at 21.
38 Natalie Adsuar, et. al., Assessment of Wishes Regarding Disposition of Oocytes and Embryo Management Among Orum Donors in an Anonymous Egg Donation Program, 84 FERTILITY AND STERILITY 1513 (2005)
39 Id.
40 Id.
41 Mundy, supra note 1, at 222.
42 Well, supra note 9, at 33.
43 REPROGENETICS 99-100 (Lori P. Knowles & Gregory E. Kaebnick eds., Johns Hopkins Univ. Press 2007)
44 Although in utero insemination is a separate and distinct infertility treatment than IVF, this narrative is meant to demonstrate that fertility clinics generally screen and cherry-pick their patients.
45 Well, supra note 9, at 33.
46 Id. at 35. California does not recognize marital status as a protected class.
47 Id.
48 Id at 34.
49 See id. at 36.
50 Id.
51 See, Weil, supra note 9, at 36.
52 See Weil, supra note 9, at 34 (discussing Kijuana Chamber’s case in which a single blind woman was allegedly turned away from a fertility clinic because she was “prone to emotional outbursts; she had dirty underwear”).
53 See REPROGENETICS, supra note 43, at 3-4. Negative eugenics refers to policies intended to prevent or discourage reproduction by people deemed
socially undesirable. Positive eugenics, by contrast, signifies policies aimed at encouraging “social desirables” to reproduce.

54 Id.
56 Id. at 61-62.
57 Id. at 65.
58 Dorothy E. Roberts, *Race and the New Reproduction*, 47 HASTINGS L.J. 935, 938 (1996) (stating that most couples using IVF are white and that the images IVF clinics use are usually that of a baby with blonde hair and blue eyes, “as if to emphasize her racial purity”).
59 Genetics and IVF Institute, *Summary of Selected Donor Characteristics* (available from 3015 Williams Drive, Fairfax, VA 22031, (703)-698-7355, (800)-552-4363).
60 MUNDY, supra note 1, at 260.
61 Id.
62 Id.
63 Id.
64 Id.
65 MUNDY, supra note 1, at 260.
66 Id.
68 Id.
69 MUNDY, supra note 1, at 229.
70 Id. at 319.
71 Id. at 320.
72 REPROGENETICS, supra note 43, at 8 (emphasis in original).
73 See American Society for Reproductive Medicine, *Guidelines for Oocyte Donation*, 82 FERTILITY & STERILITY S13-15 (Sept. 2004); Natalie Adsuar, Julienne E. Zweifel, et. al., *Assessment of Wishes Regarding Disposition of Oocytes and Embryo Management Among Ovar Donors in an Anonymous Egg Donation Program*, 84 FERTILITY AND STERILITY at 1513-1516 (Nov. 2005) (explaining that the psychological evaluation involved is meant in part to ensure that the donor is not acting under coercion).
76 Id.
77 See generally id. (Since donors receive fertility drugs to stimulate production of mature eggs, sexual activity during this process carries a greater risk than average pregnancy. Also since these fertility drugs trigger the production of multiple mature eggs, there is also an increased risk of multiple pregnancies.).
78 See Jennifer Swift, *Donated Eggs Don’t Come Cheap*, NEW SCIENTIST, Dec. 8, 2007. Ovarian hyperstimulation syndrome occurs when the ovaries swell and retain fluid with symptoms varying from minor abdominal pain to kidney failure and even death. Studies estimate that about six percent of donors may contract ovarian hyperstimulation syndrome.
79 Id.
80 Id. (Studies estimate that about 6 percent of donors may contract ovarian hyperstimulation syndrome.).
83 Id.
84 BLACK’S LAW DICTIONARY (8th ed. 2004).
85 McKinley, supra note 82, at 14.
86 Id. (citing a compensation hike from $2,000 to $5,000 as responsible for the sudden increase in prospective egg donors).
87 See Franke, supra note 5, at 183.
89 Id. at 135-9 (When IVF patients use egg donors, although the recipient’s resulting offspring might not be genetically related to a spouse or partner.).
90 Franke, supra note 5, at 181.
93 Id. at 844.
96 Balkin, supra note 92 at 856.
98 Id. at 847.
100 See Hopkins, supra note 1.
102 Id.
103 Id.