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Exploitation in the Global Medical Enterprise: Bioethics & Social Injustice

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BIOETHICS AND SOCIAL INJUSTICE likely seems an odd couple given the other topics covered in this book. On the surface anyone remotely informed about bioethics would make connections between the abortion and stem cell controversies and the injustices affected against the human embryo through his or her commodification and destruction. At the other end of the lifecycle the dismissal of human dignity through euthanasia and physician-assisted suicide seems obvious. Yet, this neglect goes hand-in-hand with a loss of respect for the special value and dignity of human life in its various embodiments throughout the lifespan. Less obvious to those both inside and outside the bioethical conversation is the profound connection of bioethics to issues of social justice, particularly through the interplay of discrimination and exploitation throughout the global medical enterprise. This essay seeks to traverse some of that terrain to raise awareness of these issues of justice within the realm of medical research, women's health, reproductive medicine, global healthcare, organ transplantation, and bioethics as a whole. Each of these topics is worthy of its own devoted essay. Our aim in this essay is modest: to introduce some of the more scandalous facets of bioethics and social injustice; to assist in bringing together two conversations that are often kept apart. Throughout we will point the interested reader to additional literature to explore these topics at greater depth.

In this edition of the essay we are highlighting four key areas of exploitation in the global medical enterprise. We begin with a brief explanation of our shared assumptions regarding the application of discrimination and exploitation within the context of the global medicine. We then turn to a topical discussion where Michael reviews medical research and patient protections. Next Paige examines concerns over the exploitation of the female body through issues raised by assisted reproductive technologies. Michael then examines the "red market" and the global dilemma of black market organ trafficking. Finally, we conclude this essay with a case study on the emerging practice of medical tourism, demonstrating the moral complexity of social justice in a global context.

Discrimination & Exploitation within the Context of the Global Medical Enterprise

At the risk of being overly simplistic one way to organize the disparate issues that coalesce around bioethics and social injustice is to draw an initial distinction between issues which can be categorized as *discrimination* and those which can be categorized as *exploitation*. While this distinction is

problematic inasmuch as many issues of exploitation are at their core issues of discrimination, it is useful for our purposes to express the degree of severity to which social injustice is manifested in a given bioethical arena. In this way they serve more as a continuum than as exclusive categories. For instance, one issue of discriminatory medical practices, whether intentional or not, surrounds the frequent lack of availability of basic prenatal and perinatal care within the context of maternal health. The primary issue here is the availability of or access to maternal care leading up to and surrounding childbirth. In some cases the absence of basic maternal health services is quite simply a result of gender discrimination within a given culture. Here discrimination manifests itself through the denial of access (whether this is active or passive discrimination is irrelevant).

Exploitation, as we use it in this essay, is more aggressive in its manifestation. The exploited individual is often a target of market driven forces. Here the human being that is exploited is effectively commodified, treated as a natural resource, or at the very least a source from which resources can be deployed or harvested. This perception of the human being in question as a commodity may be either implicit or, in its most extreme manifestations, explicit. Examples of human exploitation include the renting of wombs, the purchase of organs from live donors, buying human eggs, and unethical forms of medical research. Ultimately, discrimination and exploitation are similar, despite the varying contexts of bioethics, because they both entail the instrumentalization of human beings. Here at its core is a violation of a basic Christian insight into the nature of human beings. Created in the image of God, human beings are unique within the created order. By virtue of being created in the image of God, human beings have a unique value and dignity. Christians, therefore, should be committed to the value and dignity of human beings at every life stage from conception to death regardless of gender, race, ethnicity, class, or capability.

Patient Protections & Human Subjects Research

Medical research by nature should pursue the goal of improving human health. In late 2010 a shocking series of headlines hit the cable news outlets and newspaper covers.^[1] The inflammatory revelation? In the 1940s U.S. government researchers with the permission of the Guatemalan government intentionally infected hundreds of male prisoners and poor women with syphilis and then treated them with penicillin to study the effectiveness of the then relatively new treatment.^[2] When the news broke, the National Institutes of Health and U.S. government officials quickly moved to condemn this serious breach of human rights from the nation's past. Sadly this was not the first time U.S. researchers had violated human rights in medical experimentation. One of the lead investigators of the Guatemalan study already had gained infamy through his later participation in the notorious Tuskegee Syphilis Study.^[3] Additional archival research performed by the Associated Press in the wake of the Guatemalan revelation further uncovered that U.S. medical research practices during the first half of the 20th century raised numerous human rights abuses.^[4]

After the lessons from the flagrant dehumanization of human life perpetrated by the Nazi regime in Germany, the once-revered medical profession was scrutinized under the international human rights microscope. In the wake of the experience of Nazi prisoners, the international community established the Nuremberg Code of Medical Ethics in 1947.^[5] The Nuremberg Code prohibited non-therapeutic, non-consensual experimentation and led to further reflections on the responsibility of medical professionals to their patients, greater attention given to patient autonomy and rights, and the importance of informed consent in medical practice. Furthermore, special concern was given to the protection of patients in medical experimentation, which evolved into the contemporary concern for human subject research ethics.

Although the bitter harvest was reaped by the Third Reich, the poisonous seeds were sown in the U.S. Egregious violations of informed consent and the classic medical maxim to "first do no harm" were made public in the U.S. through the Tuskegee Syphilis Study. Initiated before World War II and thus exempt from at least the formal codification of directives for medical research in its early years, the study nonetheless continued without a correction in method until 1972. When the study had run its course hundreds of African-American men previously infected with syphilis had not been accurately informed of their condition nor had they been treated. Despite clearly violating several directives of the Nuremberg Code after its formal codification regarding informed consent and intentionally

exposing the subjects to known harm, the study was not halted even when penicillin became recognized as the standard of care for syphilis.^[6] Tuskegee and Guatemala stand as stark reminders illustrating the danger and shame of allowing medical research to get ahead of moral reflection, but they also point to a danger of the instrumental use of human beings through medical discrimination and exploitation.

In response to the staggering revelations of the Tuskegee study, the U.S. federal government instituted the Belmont Report in 1979 which codified basic protections by enshrining three fundamental ethical principles (respect for persons, beneficence, and justice). These three principles along with the addition of nonmaleficence (in other words, “do no harm”) have become the hallmark of contemporary bioethical reflection.^[7] While flagrant violations of human subjects research protections seem to be well insulated from the general U.S. population, the high pressure stakes which constitute the realities of the global medical enterprise highlight the need for clear guidance and reflection. One area in which this has grown in importance involves drug trials within majority world countries that do not have such robust human subjects protections or regulatory infrastructure.

The 2005 film *The Constant Gardener* depicts a British diplomat investigating the untimely death of his wife. In the process of this investigation the diplomat uncovers a fraudulent drug trail being run in Kenya by a multinational pharmaceutical company. While the plot of *The Constant Gardener* may be adapted from a novel, several instances of alleged wrongdoing in medical and biotechnology research within majority world countries demonstrate that such occurrences are well within the realm of the possible and perhaps even likely. These possibilities point to the need for greater attention to the complex arena of drug trials within the global medical enterprise.^[8] A variety of concerns ranging from negligent trials, to the outsourcing of drug trials to avoid strict regulatory rules, to the “rights” of the indigenous population to benefit from information gleaned from a given study, to their access to drugs tested on them, span the gamut of topics that are raised within the growing discussion of contemporary medical research with particular attention on the pharmaceutical industry.

While the issues raised by medical exploitation in human subjects research are likely distant from the experience of the everyday person in the U.S., there are several key lessons to learn. The first is that the modern medical enterprise exists as the legacy of a noble profession, but has competing interests that must be held accountable to the high standards of protections for human subjects in research. Any time medical research outpaces ethical guidelines, there is potential for major affronts to human dignity. The Tuskegee Syphilis Study, one of the most notorious examples in U.S. history of medical research abuse, created only modest awareness of human subjects research within the general U.S. population.^[9] While a variety of formal mechanisms have been instituted which make such serious violations in medical research unlikely to be repeated in the U.S., this is not necessarily the case internationally.^[10] Individuals advocating international human rights should be aware of the issues presented by human subjects research and the potential for medical exploitation. Furthermore, despite the unlikelihood of such blatant exploitation in U.S. medical practice, a continuing area of concern surrounds the number of health disparities of various socio-economic and ethnic groups, particularly within specific minority populations. Unfortunately, the legacy of such abuses exacerbates perceptions and concerns within minority populations that shape responsiveness to and trust in public health systems, calling for both education and outreach.^[11]

Reproductive Tourism and Medical Exploitation of Women

March 8, 2011 marked the centenary of International Women’s Day. In a global celebration that was both virtual and local, women celebrated economic, political and social achievements of the past 100 years.^[12] Within that broad spectrum, individual nations and organizations are free to choose their own annual theme. One of the most persistent themes is the call to end violence against women and girls. The Millennium Development Goals agreed to by 147 nations in 2000, add specific platforms to the call to end women’s inequality. Goal 3 focuses on education as a means to “empower women and promote equality between women and men.” Goal 5 calls for a 75 percent “reduction in maternal mortality.”^[13]

World leaders, women's organizations, and individual women understand that within the context of social justice issues such as discrimination, abuse, exploitation, poverty, healthcare, and lack of education, women and girls are particularly vulnerable. This vulnerability exposes women to dangers of exploitation simply because they *are* women, with bodies that are viewed as a valuable resource. Nowhere is that more stark than in the exploitation of women's unique reproductive capacities. Women can provide through technology both the eggs and the womb needed for baby-making. Assisted reproductive technologies (ART) have opened up both the possibility and impetus for the instrumentalization of both babies and the third parties who are essential to their creation.

What began as an acknowledgement of marital privacy has now morphed into a culture of babies-on-demand. How did this change in social expectations emerge? A necessarily brief survey of the development of reproductive rights policy in the U.S. is instructive.

Theological Harbingers

The ancestry of reproductive tourism and exploitation begins culturally with the anemic theology of the Protestant church regarding contraception. The most public evolution took place within the Anglican Church. At its 1920 global conference of bishops, they unequivocally condemned birth control: "We utter an emphatic warning against the use of unnatural means for the avoidance of conception, together with the grave dangers—physical, moral and religious—thereby incurred, and against the evils with which the extension of such use threatens the race."^[14] One decade later, the Lambeth conference again reviewed the matter, and reversed its earlier opposition. The bishops resolved that "the conditions of modern life call for a fresh statement from the Christian Church on the subject of sex."^[15] After stating that "the primary purpose for which marriage exists is the procreation of children" in Resolution 13, the bishops approved the use of contraception by married couples if there were a "morally sound reason" that abstinence was not possible, but condemned its use for "motives of selfishness, luxury, or mere convenience."^[16] The bishops went on to record their "abhorrence of the sinful practice of abortion,"^[17] and that extramarital sex "is a grievous sin."^[18]

Within one generation, at the 1958 Lambeth Conference, the bishops addressed family planning in the context of conscience, and linked "responsible parenthood" with "wise stewardship of the resources and abilities of the family as well as a thoughtful consideration of the varying population needs and problems of society and the claims of future generations."^[19] In 1978, the bishops resolved that diocesan programmes should address "the moral issues inherent in clinical abortion and the possible implications of genetic engineering."^[20]

Less than twenty-five years later, in 1982, the Episcopal Church U.S.A. fully embraced artificial contraception "as a means of world population control,"^[21] the use of *in vitro* fertilization by a married couple, and rejected resolutions encouraging consultation with a priest before surrogate maternal or paternal parenthood. Each policy line that was drawn was moved without a clear theological justification other than changing times and cultural needs. This remarkable development within the Anglican/Episcopal Church is symptomatic of the absence of any robust theological rigor and consistency within the broader Protestant community.

Legal Policy Development

The theological pattern repeated itself in the legal arena. In 1965, the Supreme Court struck down a law against the distribution of artificial contraception, or the use by married couples of contraceptive devices. In *Griswold v. Connecticut*, the Court stated that the marital right of privacy protected this area against government intrusion.^[22] A few years later, the Court decided that access to contraception was not about marital privacy after all. In *Eisenstadt v. Baird*, the Court held that "if the right of privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."^[23] These two cases solidified the legal, constitutional right of individuals *not* to procreate.

One year after the *Eisenstadt* case, the Court spoke again. This time, it dealt with the desire to be free from a pregnancy that had already begun. In *Roe v. Wade*, the Court struck down a Texas statute that prohibited abortion except for the purpose of saving the life of the mother.^[24] The Court directed that the case was to be interpreted together with *Doe v. Bolton*, decided the same day as *Roe*.^[25] The two cases struck down the abortion laws of all fifty states, including the most liberal ones. Abortion, previously a crime, became a protected constitutional right, available virtually on demand throughout the entire pregnancy.

Liberal abortion policy opened the door for coercion of women. Widespread availability of abortion removed "the one remaining legitimized reason that women have had for refusing sex besides the headache."^[26] The assumption was that women wanted sex on equal terms with men, at any time, with any person, and without personal risk or consequences. This amplified an era of unprecedented social change.

Women are subject to genuine risks from legal abortion. These include both physical and psychological harm, as well as premature birth in future pregnancies, placenta previa, alcohol and drug abuse, and breast cancer.^[27] Women who have abortions are at higher risk of violence, injury and death, and a higher risk of the termination of their relationship with the baby's father.^[28] Abortion policy excludes the baby's father from any role in preventing the abortion. On the other hand, abortion relieves him of child support obligations, allowing him to walk away from the relationship.

Cultural Connections to Reproductive Technologies

Once the right *not* to procreate was firmly established, it was not a great leap to the right *to* procreate. After all, for the "embarrassingly fertile," we have "sex without children" via contraceptive technology. Now, for the "frustratingly infertile," technology presented us with "children without sex." The right to control the timing and spacing of one's children through contraceptive practices was paralleled by the right to induce children to appear at the desired intervals with assisted reproductive technologies (ART). The right to remove an unwanted pregnancy by abortion, a demand to control the foreseeable consequences of natural processes, was joined to its mirror image: the right to attempt pregnancy by ART, a technological process.

The first ART was relatively simple: artificial insemination by husband, also known as homologous insemination. This led to AID, or artificial insemination with the use of donor sperm. Female infertility could be treated by medicine or surgery, to remove tissue blocking the Fallopian tube, or stimulate oocyte production. In all these ART methods, conception takes place inside the woman's body.

Fertilization outside the body occurs through *in vitro* fertilization, or IVF. After at least eighty unsuccessful pregnancies in other women, the technique was publicly announced with the birth of Louise Brown in 1978. Eggs extracted from her mother were fertilized in a petri dish with sperm donated by her father, then returned to Mrs. Brown's uterus for implantation.

In order to harvest eggs, the woman's ovaries must be chemically induced to ripen and release more eggs than normal. Sometimes more than twenty eggs may be retrieved in one cycle. Egg harvesting carries risks, particularly ovarian hyperstimulation syndrome (OHSS). At least 6 percent of women taking the drugs to ripen multiple eggs are seriously affected by OHSS.^[29] OHSS symptoms range from mild pain and nausea to severe pain, rapid weight gain, and rapid heartbeat.

In the early years of IVF attempts, as many as six or even more eggs would be fertilized and transferred to the uterus for possible implantation. If more than two embryos successfully implanted, "selective reduction" would be recommended, that is, the elimination of the "excess" embryos. Thus, the couple who desperately tried to achieve a pregnancy had to reverse course and terminate the life of one or more embryos.

In the late 1980s cryopreservation techniques were developed to permit freezing in nitrogen of embryos for future use. Thus, only two or three needed to be transferred for a pregnancy attempt.

Even so, a dozen or more embryos might be plunged in liquid nitrogen for an indefinite period. No regulations restrict the number of embryos that may be created or frozen, nor are accurate records required. Today, there may be 500,000 or more frozen embryos in the U.S. [30] After giving birth to one or more children, the couple may then be confronted with making a decision about the rest of their frozen embryos. They may have them thawed and destroyed, donated for research (and their inevitable destruction), or donated to another couple for attempted pregnancy and adoption. Decision-making can be a lengthy, difficult, and emotional process. [31] Similar to the woman with “too many embryos” who is pressured to abort one or more of them, the couple with frozen embryos may be forced to dispose of the costly resources they gave so much to acquire.

IVF: The Largest Unregulated Business in the U.S.

The clinical practice surrounding the treatment of infertility is shaped by at least two powerful factors: the intense desire of couples to have a “child of one’s own,” and the reality that infertility is not a disease but a condition and symptom of the disruption of a normal biological process. Rather than treating the causes of infertility, fertility doctors may urge couples to move directly to ART. The industry is lucrative and relatively independent. Although there are professional guidelines, they are voluntary. Only one in five clinics follows the guidelines of either the Society for Assisted Reproductive Technology or the American Society for Reproductive Medicine, which may limit, for example, the number of embryos transferred. The U.S. has one of the highest rates of multiple births in the world. [32]

The IVF industry is large and powerful. Annual revenues in the U.S. are estimated between \$1.7 and \$5 billion. [33] Proposed regulations, such as those that require informed consent about the risks of egg donation and the genetic risks to the child, are opposed as an interference with privacy and choice. Clinics are subject to general regulations, such as those that apply to laboratories that test semen. They are also directly regulated by federal law which requires them to report their pregnancy success rate, but there is no penalty for non-reporting. The FDA has authority to require clinics to register, set guidelines for screening of gamete donors, and establish “good tissue practices.” [34]

Although some bristle at the use of the term “IVF industry,” it is not unwarranted. Clinics specializing in fertility treatment issue press releases and market their services. One fertility clinic advertised price reductions due to “harsh economic times,” and highlighted their extensive database of egg donors who could meet the needs of couples from countries such as Spain, France, Italy, Germany, Norway, Portugal, South Africa, Brazil, Mexico, Japan and Hong Kong. [35] A quick Internet search would yield dozens of IVF clinic advertisements.

The Temptation for Exploitation: Expansion of ART

The demand for IVF was not limited to producing embryos using a woman’s eggs and her husband’s sperm. Male infertility is a factor in nearly half of all infertile couples. Thus, there was a demand for donor sperm. The first commercial sperm bank opened in 1972. Sperm donors often were medical students, or occasionally a hubristic infertility doctor (reproductive endocrinologist). There has arisen a generation of donor offspring, children whose genetic father is an anonymous sperm donor, who are struggling with identity issues. Elizabeth Marquardt documents their struggles in *My Daddy’s Name Is Donor*. [36]

ART using egg donors was first attempted via artificial insemination in the egg donor’s womb, followed by retrieval of the embryo and transfer to the wife’s womb for continued pregnancy and childbirth. [37] Egg retrieval—rather than embryo retrieval—quickly became the preferred use of egg donors. With the successful use of donor eggs, fertility clinics began soliciting young college women, prime candidates for selling their eggs. Prices as high as \$25,000 or more are advertised for Ivy League women with high SAT scores, athletic skill, mathematic and musical ability, blonde hair, and blue eyes. [38] Few coeds qualify for the promised price, with the average payment nationally around \$4,000. [39] Although the marketing appeal is to donate “the gift of life,” the donor’s motivation is usually to pay off credit card or other debts.

Egg donation comes with risks. As noted earlier the drugs a donor must take to cause one or more dozen eggs to ripen simultaneously carry a 6-10% risk of OHSS, which can be serious, if rarely fatal. There is some evidence of a link with an increased risk of cancers, such as colon, breast, uterine or ovarian cancer. The problem is that these health risks simply have not been studied in detail, or over the long term.[\[40\]](#) These young women cannot give fully informed consent prior to egg donation, as the long-term health risks are unknown, unstudied, and sparsely documented.

The egg donor is not the only woman who risks her health. The subfertile woman who sought egg donation, and is pregnant with the embryo created thereby, faces increased health risks during her pregnancy. A meta-analysis concluded that she is at increased risk of hypertension and placental abnormalities.[\[41\]](#)

Surrogacy: Womb for Rent

For some women, infertility cannot be resolved with egg donation, or the couple prefers not to attempt pregnancy with donor gametes. A woman might not be able to carry a pregnancy to term for a variety of reasons. Her dilemma can be addressed by surrogacy, the use of another woman's womb to gestate the child. Surrogacy has tracked two general paths: altruistic and commercial. Altruistic surrogates are usually known to the couple, often a relative. One well-known case is that of Jaci Dahlenberg, who gave birth to her triplet granddaughters. They do not seek compensation, other than for direct medical costs.

Most surrogacy, although often privately arranged, is conducted along a commercial model. Early surrogates were paid for their time and efforts, and medical costs were covered. Financial transactions were carefully arranged so as not to violate laws against "baby selling." Commercial surrogates may be one of two types: genetic or biological. Genetic surrogates provide the egg, agreeing to be inseminated with donor sperm, usually the contracting intended father. This is also called "traditional" or "straight" surrogacy. These arrangements had a higher incidence of conflict, as some surrogates became attached to the fetus that was also their son or daughter, with half of their DNA coming from the surrogate. The most notorious case was that of Baby M, whose birth mother refused to relinquish her, generating a court battle.[\[42\]](#)

Biological surrogates, also called gestational surrogates or "host" surrogates, do not contribute any genes, but only their womb. This has become the preferred arrangement, particularly when the surrogate is of different ethnicity than the contracting couple. She may be impregnated with an embryo created from the egg and sperm of the contracting couple, the father's sperm and donor egg, the mother's egg and donor sperm, or donor egg and sperm. Thus, the child may have a biological connection to three people.

Baby Battles: The Unintended Consequences of ART

Courts have wrestled with the impact of new reproductive technologies, which may help couples achieve their desired ends, but do not fit within legal categories and established case law. In one case, a girl was declared to have "no legal parent." The contracting couple had acquired an embryo created via anonymous egg and sperm, and contracted with a surrogate to carry the baby. Before birth, the commissioning couple's marriage ended, and both the father and the birth surrogate denied parenthood.

Surrogacy and other ART arrangements raise psychological, social, and legal issues regarding the meaning of family and parent. New labels have been created to describe the various kinds of parent: contracting parent, intended parent, gamete donor, biological parent, gestational surrogate, social parent, and, more recently posthumous parent.[\[43\]](#) Meanwhile, the language used to describe the embryo resembles that of a product, not a person: blast, grade 3, good quality, and high-grade embryo.

International Bargain Hunting: Reproductive Tourism

The ART industry is not confined to U.S. borders. At least three factors have contributed to this expansion. First, there is little diversity in gamete donors and the supply of frozen embryos, so couples have solicited donors outside the traditional “blonde hair/blue-eyes” spectrum. Second, among some ethnic groups, ART is frowned upon, intensifying the desire for privacy, secrecy of using a surrogate, and ethnic matching of donated gametes so that any resulting children will resemble the parents. Third, both IVF attempts and commercial domestic surrogacy are expensive, and surrogacy is not legal in every state. Infertile couples have been presented with a new option: international gamete donors and surrogates. One reporter wrote about the financial devastation of her IVF attempts in the U.S. —\$70,000 to date—and her and her husband’s decision to fly to South Africa to attempt pregnancy with egg donation. They found a sensitive doctor (“how kind he was, compared with American reproductive endocrinologists”), an altruistic egg donor, and a cost of \$9500 vs. \$30,000 in the U.S. [44]

Relatively little is known about global ART, compared with the minute regulation of other aspects of international trade. In some countries, it is virtually unregulated, and in others such as the Ukraine, there is legal support for all aspects of ART, including creating embryos for research. When the UK changed its laws to prohibit anonymity or compensation to gamete donors, the supply decreased significantly. In response, British Caucasian women have turned to countries such as the Ukraine, choosing Slavic women whose appearance matches their own. [45]

These egg donors are vulnerable to exploitation. Many are poor or unemployed, and some donate in extreme secrecy, not telling even their husbands. Although the eggs net the broker or clinic nearly \$5,000, the women may receive as little as \$300. Some donors are flown to Cyprus for egg harvesting, which may be illegal in their country of residence. The egg purchasers live in yet another country, implicating the laws of at least three nations, some of which are often evaded during the transaction. [46] If egg donors are injured during the donation process, they may receive inadequate immediate or follow-up medical care. If they did not produce an abundant harvest of eggs, they have little economic value to the broker. Once they have produced the eggs and if there is permanent injury, there is small incentive for the broker to cover any medical costs. They are, in effect, “damaged goods.”

The wealthy women who use these services are told little about how donors are recruited or treated. Perhaps their ignorance is intentional, or perhaps they are grasping at any straw of hope. One reporter traced the process, and was told a different story by each party involved: the UK doctor, the permanently maimed Romanian donor, the Bucharest and Kiev clinics. Posing as an infertile woman, she encountered pressure to proceed immediately, without any serious medical examination. [47]

Egg donors are somewhat free to travel to self-administer daily injections, travel to the clinic and then leave. Coercion of these women is more often implicit, preying on their poverty-driven vulnerability. However, there is another aspect to reproductive tourism that is more blatantly confining and exploitative: the use of gestational surrogates.

Reproductive Trafficking: Nine Months of Confinement

Couples who desire a gestational surrogate may obtain her services at a much lower cost if they look outside U.S. borders. They may travel to another country for the IVF procedure and transfer to the surrogate’s womb. In countries such as India, commercial surrogacy is “seen as a business opportunity in many locales where public policy is lax and contract pregnancy comes cheap.” [48] Commercial surrogacy in India is estimated to be a \$445 billion industry. Other surrogacy destinations include Guatemala, Argentina, Spain, China, and Thailand. The “tourists” who seek these services may be avoiding laws that prohibit these arrangements in their home country. In response, India has proposed regulating their active, market-driven fertility industry by requiring, among other things, that foreigners must prove that surrogacy is legal in their home country. [49] There have been

situations where couples ran into significant legal obstacles delaying their return home with their commissioned child.

Ironically, the aspects that appeal to the contracting couple represent the greatest potential for exploitation. The intended parents want to ensure that the woman stays healthy during her pregnancy. Victor Hui-Wee commented after their experience with a surrogate in India, "They control everything and that's so important to us. . . . The surrogates live on site in apartments until the baby is born."^[50] Married surrogates are separated from their husbands and children for the entire pregnancy and delivery. The contracting couple is not just relying on the altruistic good will of the surrogate; they are paying for a healthy baby. Whether the surrogate understands what she is being asked to do is less than certain. Some potential birth surrogates sign the contract with a thumbprint, because they cannot read, let alone understand English, the language of the contracts. The socioeconomic and power gap between the intended parents and the surrogate is wide:

Lack of technological understanding among rural Indians also breeds misconceptions about surrogacy. Many, for example, thought that it would be necessary to sleep with another man in order to conceive. Even the pricing structure of surrogacy perpetuates social inequality: Many religious Indian surrogacy clients would prefer for their child to be birthed by an upper-caste *brahmin*, so high-born surrogates can get paid up to double.^[51]

Surrogates are not paid until after the birth if the intended parents decide they do not want the child—as happened with one couple whose marriage dissolved before birth—they may deny parental responsibility, or demand that the surrogate have an abortion. In either case, the surrogate is oppressed: abortion may violate her religious beliefs, and her poverty increases if she must accept the child as her own.

In a recent breakup of a surrogate baby ring in Thailand, it was revealed that Vietnamese women were lured to Thailand, confined against their will under 24-hour security, had their passports confiscated, and may have been raped. The company advertised "eugenics surrogate," which meant that the "consignor" would never have contact with the surrogate. The embryos could be sent by "mail-order." The couple would never have to come face to face with their surrogate.^[52]

The market-driven ethic of using surrogates does not even demand that the contracting couple is infertile. One city in India offers mail-order surrogates. "Busy childless couples and even singles who cannot afford to take extended leaves are now shipping their children-in-the-making to state clinics to be implanted in the wombs of surrogates."^[53] It is a market exchange. The contracting couple has something the surrogate needs: money. The surrogate has something the contracting couple desperately wants: a womb and a guarantee of a controlled pregnancy. Surrogates often say they are doing this to provide a college education for their daughter, to buy a house, to pay off a husband's drinking debts, or because she is a widowed mother.^[54] While commercial surrogacy may help a few women and their families in the short-term, it does not answer the problem of exploitation.

Social Injustice Concerns

It is at this point of injustice that Christians are vulnerable. We cannot hide behind the claim that "we wouldn't do that," or "we're not infertile." The exploitation of women for their eggs and their wombs is possible, in part, because there are few barriers. Legal barriers exist in some countries, but they are skirted or seldom enforced. There are financial barriers, but international reproductive trade has made ART more accessible to Americans, British, and Japanese couples. There are cultural barriers, such as the need for secrecy among some Muslim and Asian communities, but ethnically-matched egg donation or reproductive tourism (where the wife leaves for an extended period and returns home with a baby) negate that barrier.

Can a poor, illiterate Indian woman make an informed choice? Does she have the freedom to resist the promised payment, when faced with no other apparent way out of her poverty? Is this the best we have to offer, to induce women to rent their bodies for nine months for the benefit of strangers? While

reproductive tourism and trafficking may financially help a small group of women, they do not resolve the income disparities and poverty of majority world women. Nor do they protect them from the predatory and exploitative “baby brokers.”

There is yet another aspect to all this, and that is the eugenic aspect of ART. The commissioning couple naturally desires a healthy baby. They may try to control this through PGD—pre-implantation genetic diagnosis—which can reveal genetically-linked diseases. Embryos that do not meet the standard are discarded and destroyed. Or, they may require that as a condition of surrogacy, the surrogate agrees to terminate if something goes wrong. In either case, a much-desired future child is rejected because he or she did not pass quality control standards.

Children are created to serve parental needs and natural desires. Yet, we know that children are a gift, a reward from the Lord to be received with gratitude, not created out of desperation. While technology may be helpful in resolving certain aspects of infertility, it does not prevent exploitation and injury. Instead, global ART may unintentionally enhance their likelihood.

When great goods—whether children or restoration of health, addressed in the next section—are mingled with great harms, our concern for justice must trump our desire for technological restoration. The sacrifice we Christians are called to make may include the denial of what we most deeply long for: a child of our own. But self-denial is not our only option. We are also called to speak out on behalf of those who have no power to speak on their own behalf. Dignity-affirming solutions to poverty and inequality are our task. More families are lifted out of grinding poverty by the education of their daughters than by the selling of female bodies.^[55] A business microloan, for example, may do more to redeem a village than the bounty bestowed on one family who buys a house paid for with the ethically tainted payment for a rented womb.

The Red Market for Human Organ Trafficking

“The Red Market: Inside the Business of Selling Human Body Parts.”^[56]

Not necessarily a headline to be anticipated from a technology and culture magazine like *Wired*. The cultural awareness of a rapidly expanding market for human body parts appears to be on the rise. It has been public knowledge for some time that the demand of individuals in need of organ transplants far outpaces the supply of available donors. Within the U.S. and in similar Western nations, the shortage of donor organs is due to the ethical principles that available organs be supplied voluntarily and in most cases upon the death of the donor.^[57] In lieu of alternatives of for-profit models of organ donation which are limited to only a few countries and come with a variety of concerns,^[58] an illegal industry of black market organ trafficking has developed. This “red market,” as *Wired* magazine labeled it, thrives in contexts where extreme poverty exists such that individuals are either tempted to sell “spare” organs such as kidneys or parts of their livers, or leads to practices where body parts are stolen from the recently dead without consent or taken violently from the living. In some cases individuals reportedly have been killed for their organs.^[59]

Seemingly from the scripts of blockbuster films, tales have emerged of the global red market for organ trafficking.^[60] As if a scene from a horror film, “blood thieves” kept prisoners alive for a few years and retrieved blood from them multiple times per week over the course of their captivity.^[61] In other cases, death row prisoners and political dissidents are executed just as wealthy organ recipients arrive for their matching organ while visiting the country in question. Stories of individuals waking up in alleys missing kidneys, wombs rented, and rendition-like flights where women in poverty are flown to a destination just to harvest eggs, all seem to strain credulity. Yet sadly, truth is indeed sometimes stranger than fiction in the red market world.

Allegations in recent news headlines range from the exploitation of indebted laborers and poverty stricken immigrants to the execution of prisoners (whether military prisoners or political dissidents) for organs.^[62] The details of the cases change depending on the marginalized group exploited for their organs, the geographical locale of the harvesting, and the frequently attendant claims of connections

of these incidents to other crimes against humanity. The continuous thread connecting together these disparate headlines from far flung regions of the globe is the exploitation of humans for organs, whether voluntarily through unfulfilled promises of financial bonuses or through more nefarious involuntary means such as abduction and execution.

While estimates vary given the difficulty of tracking illegal activities, organ trafficking has been reported to range from 5-10% of all transplants worldwide.[63] Clearly selling one's body has taken on new meaning and significance with the rapid expansion of the red market. For those accounts of individuals who "voluntarily" chose to donate a kidney for financial reasons, many do not ultimately find financial relief through their actions.[64] According to one study, in many cases the live donors are left worse off than before, often experiencing regret and hopelessness, as well as permanent impairment, increased risk of long-term health consequences, and inability to return to manual labor.[65]

While less provocative in the headlines, another angle on organ transplantation surrounds the definition of death and the point at which organ procurement becomes permissible. For organs to be viable, they need to be harvested and transplanted within a specific timeframe that varies for each organ. The window for transplantation is relatively small. Recent cases of hospitals utilizing definitions of "cardiac death" and a very minimal passage of time led to charges of premature harvesting.[66] When mixed with discussions of euthanasia and the potential for involuntary euthanasia (meaning the euthanized individual is not a willing participant in their death), this becomes an even more disturbing prospect.

Organ transplantation from its early days included discussion of such issues as the importance of donation as voluntary and the need for proper informed consent. While initially banned, the use of organs from living donors (particularly the donation of a single kidney or a portion of a lung or liver), came to be accepted. Another issue challenging the ethical boundaries of voluntary donation was the commercialization of donation or selling organs. The classic language of organ transplantation as the "gift of life" has undergone a shift toward commodification as growing acceptance of organ trafficking has gained ground (whether or not it has done so entirely within legal frameworks), particularly through the growing practice of transplant tourism. Wealthy organ recipients travel to five-star accommodation medical treatment centers to receive organs procured through often less than noble means. Considerations of this commercialization of organ trafficking has led to questions of who truly benefits from this practice? Clearly, the organ recipient benefits, as do the brokers, hospitals, and doctors who participate. Does the donor generally benefit from this practice? Who ends up making the money? Who carries the greatest risk and burden? Yet the scarcity of organs and the rising demand that comes with an aging population continues to place pressure on the organ transplantation system to find alternative means of supply. Recent moves in countries such as Pakistan and Egypt, which are pursuing legislative means of curbing such abuses, point to positive trends of protecting human rights in these areas.[67] Unfortunately effective enforcement at an international level remains an elusive goal.

Medical Tourism

"Five-star accommodations at a coastal resort in an exotic location to convalesce from a state-of-the-art medical procedure"

Does this statement sound more like a potential advertisement for that long awaited vacation or the possible description of your next hospital visit for a serious medical procedure? In reality it is a little of both. Medical or health tourism is a rising global phenomenon. Cutting across the sectors of medicine and tourism, it is described as "travel with the aim of improving one's health." [68] Spanning the gamut of medical procedures from elective cosmetic surgery and fertility services to advanced treatments such as heart bypass surgery and even organ transplantations, medical tourism is a growing industry in such countries as India, Malaysia, the Philippines, and Thailand. While medical tourism clearly is not an invention of the 21st century, [69] the decreasing cost of international travel, the proliferation of advanced medical technology, and general trends in globalization have led to the exponential increase in foreign patients engaged in and revenue generated by medical tourism.

Alongside the substantial benefits and cost effectiveness^[70] for foreign patients receiving care in which these resort medical destinations thrive are indigenous populations in poverty whose basic healthcare are not being met.^[71]

We close the chapter with a case study to elicit the complexities of dealing with issues of social justice within the global medical enterprise.

Case Study:

Kevin recently began dialysis for kidney failure. His physician has informed him that he is in need of a kidney transplant and has been placed on the organ transplant waiting list. Unfortunately, he has also been notified that this list is long and the transplant may not be for quite some time, including the possibility that it may not be in time to prevent his death. His insurance company has offered for him to receive a kidney transplant in Thailand. The representative suggests that this will allow him to receive his transplant in a timely manner. The insurance company has offered to pay for the transplant and to cover expenses related to the five-star accommodations and care in a Thai facility described in the brochure as a “boutique” resort clinic. The representative seems to imply that a domestic transplant will be rejected for coverage.

Questions for Consideration:

1. Is continued dialysis an option? If not, how does that complicate this decision?
2. Where would the kidney come from? Would it be donated or purchased? Does the procurement process protect the donor from coercion or unnecessary harm? How should we consider the answers to these questions in assessing the decision?
3. Does Kevin have a “right” to a kidney transplant? From the standpoint of his policy coverage? Does he have a moral right to the transplant?
4. What additional factors need to be considered? Are there broader issues of social justice that need to be taken into consideration?
5. As Christians, how should we respond to this dilemma theologically? Practically?

References

[1] Maggie Fox, “U.S. Apologizes for Syphilis Experiment in Guatemala” *Reuters*, Oct 1, 2010, <http://www.reuters.com/article/2010/10/01/us-usa-guatemala-experiment-idU.S.TRE6903RZ20101001?pageNumber=2> (accessed January 17, 2011).

[2] Susan Reverby, “‘Normal Exposure’ and Inoculation Syphilis: A PHS ‘Tuskegee’ Doctor in Guatemala, 1946-1948” *The Journal of Policy History* 23(1): 11. For additional information regarding this U.S. Public Health Service research, see <http://www.hhs.gov/1946inoculationstudy/>.

[3] Reverby, 9.

[4] Mike Stobbe, “AP IMPACT: Past Medical Testing on Humans Revealed” *The Washington Post*, February 27, 2011, <http://www.washingtonpost.com/wp-dyn/content/article/2011/02/27/AR2011022700988.html> (accessed March 10, 2011). This investigative review by The Associated Press yielded more than forty studies in the U.S. that involved mental patients, prisoners, children, and chronically ill patients.

[5] “The Nuremberg Code” Office of Human Subjects Research, National Institutes of Health, <http://ohsr.od.nih.gov/guidelines/nuremberg.html> (accessed January 17, 2011).

[6] “The Nuremberg Code.” The directives of the Nuremberg Code especially in question are the first, fifth, and tenth. The first directive requires that subjects must be informed of the “nature, duration, and purpose of the experiment” as well as “the methods and means by which it will be conducted” and

"the effects upon his health or person which may possibly come from his participation in the experiment." The fifth directive states that experiments should not be embarked upon in which "there is an *a priori* reason to believe that death or disabling injury will occur." The tenth directive places the burden of the ongoing continuation of a study upon the investigator's careful judgment to terminate a study at any point if "the continuation of the experiment is likely to result in injury, disability, or death to the experimental subject."

[7] Referred to in shorthand as principlism or also as the Georgetown principles, these four principles have become the standard guidelines of bioethical discourse. The principle of "respect for persons" is often used interchangeably in principlism with the principle of "autonomy." Tom Beauchamp and James Childress, *Principles of Biomedical Ethics* 6th ed (New York: Oxford University Press, 2008).

[8] Gregory Rutecki, "How Much Do We Care When Truth Replaces Fiction? Ethical Conduct and Human Subjects Research in Africa" *The Center for Bioethics & Human Dignity*, October 26, 2007, <http://cbhd.org/content/how-much-do-we-care-when-truth-replaces-fiction-ethical-conduct-and-human-subject-research-a> (accessed January 17, 2011).

[9] Ralph Katz, et al. "Identifying the Tuskegee Syphilis Study: Implications of Results from Recall and Recognition Questions" *BioMed Central Public Health* December 2009, 9:468. <http://www.biomedcentral.com/1471-2458/9/468> (accessed January 17, 2011). Earlier studies had demonstrated wide disparities in awareness along ethnic/racial lines. Cf. Ralph Katz, et al. "Awareness of the Tuskegee Syphilis Study and the U.S. Presidential Apology and Their Influence on Minority Participation in Biomedical Research" *American Journal of Public Health* 98(6): 1137-1142.

[10] For an international listing with links to key documents in human research protections see the "2011 Edition of the International Compilation of Human Research Protections" produced by the U.S. Health and Human Services Office of Human Research Protections at <http://www.hhs.gov/ohrp/international/intlcompilation/intlcompilation.html> (accessed February 10, 2011).

[11] Heather Cormack, Benjamin Bates, Lynn Harter. "Narrative Constructions of Health Care Issues and Policies: The Case of President Clinton's Apology-by-Proxy for the Tuskegee Syphilis Experiment" *The Journal of Medical Humanities* 2008(29): 89-109.

[12] International Women's Day <http://www.internationalwomensday.com/theme/> (accessed March 30, 2011).

[13] "Empowering Women: The Key to Achieving Millenium Development Goals" *United Nations*, <http://www.un.org/events/women/iwd/2003/background.html> (accessed March 30, 2011).

[14] Resolution 68. Problems of Marriage and Sexual Morality. The Lambeth Conference Resolutions from 1920, <http://www.lambethconference.org/resolutions/1920/1920-68.cfm> (accessed March 8, 2011).

[15] Resolution 9. The Life and Witness of Christian Community—Marriage and Sex. The Lambeth Conference Resolutions from 1930, <http://www.lambethconference.org/resolutions/1930/1930-9.cfm> (accessed March 8, 2011).

[16] Resolution 15. The Life and Witness of Christian Community—Marriage and Sex. The Lambeth Conference Resolutions from 1930, <http://www.lambethconference.org/resolutions/1930/1930-15.cfm> (accessed March 8, 2011). Interestingly, this is the only resolution on marriage with a recorded vote, 193-67.

[17] Resolution 16. The Life and Witness of Christian Community—Marriage and Sex. The Lambeth Conference Resolutions from 1930, <http://www.lambethconference.org/resolutions/1930/1930-16.cfm> (accessed March 8, 2011).

[18] Resolution 18. The Life and Witness of Christian Community—Marriage and Sex. The Lambeth Conference Resolutions from 1930, <http://www.lambethconference.org/resolutions/1930/1930-18.cfm> (accessed March 8, 2011).

[19] Resolution 115. The Family in Contemporary Society—Marriage. The Lambeth Conference Resolutions from 1958, <http://www.lambethconference.org/resolutions/1958/1958-115.cfm> (accessed March 8, 2011).

[20] Resolution 10. Human Relationships and Sexuality. The Lambeth Conference Resolutions from 1978, <http://www.lambethconference.org/resolutions/1978/1978-10.cfm> (accessed March 8, 2011).

[21] Resolution 1982-D016. Reaffirm the Right to the Use of Artificial Conception Control. The Acts of Convention 1976-2006. The Archives of the Episcopal Church, http://www.episcopalarchives.org/cgi-bin/acts/acts_search.pl (accessed March 8, 2011).

[22] *Griswold v. Connecticut*, 381 U.S. 479 (1965).

[23] *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972).

[24] *Roe v. Wade*, 410 U.S. 113 (1973).

[25] *Doe v. Bolton*, 410 U.S. 179 (1973).

[26] Catharine MacKinnon, "Roe v. Wade: A Study in Male Ideology." In Pojman & Beckwith, eds. *The Abortion Controversy: 25 Years After Roe v. Wade*. (Belmont, CA: Wadsworth, 1998), 95-104, 100.

[27] The risk of mental disorders is documented in Natalie Mota, Margaret Burnett and Jitender Sareen, "Associations Between Abortion, Mental Disorders, and Suicidal Behaviour in a Nationally Representative Sample." *The Canadian Journal of Psychiatry* 55(4): 239-247. For the risk of pre-term birth, see, e.g., Calhoun, Shadigian & Rooney, "Cost Consequences of Induced Abortion as an Attributable Risk for Preterm Birth and Impact on Informed Consent" *Journal of Reproductive Medicine* 929 (2007): 52 (listing 59 other studies going back to the 1960s). Placenta previa risk is documented at Thorp, Hartmann & Shadigian, "Long-Term Physical and Psychological Health Consequences of Induced Abortion: Review of the Evidence" *Obstetrical & Gynecological Survey* 67(2003), 58. Substance abuse increases after abortion, according to Coleman, "Induced Abortion and Increased Risk of Substance Abuse: A Review of the Evidence" *Current Women's Health Reviews* 21 (2005), 1. The risk of breast cancer increases both as an independent risk, and due to the loss of the protective effect of a first full-term pregnancy. Thorp, Hartmann & Shadigian, "Long-Term Physical and Psychological Health Consequences of Induced Abortion," 58.

[28] Injury and death associated with abortion is reviewed at EM Shadigian & ST Bauer, "Pregnancy-Associated Death: A Qualitative Systematic Review of Homicide and Suicide" *Obstetrical and Gynecological Survey* 183 (2005): 60.

[29] Helen Pearson, "Health Effects of Egg Donation May Take Decades to Emerge." *Nature* 442 (August 10, 2006): 607-608, <http://www.nature.com/nature/journal/v442/n7103/full/442607a.html?free=2> (accessed March 8, 2011).

[30] Ron Conte Blog, "Frozen Embryos" *CatholicPlanet.Net* August 24, 2009, <http://www.catholicplanet.net/forum/showthread.php?t=3485> (accessed March 8, 2011).

[31] Giuliana Fuscaldo, Sarah Russell, and Lynn Gillam, "How to Facilitate Decisions about Surplus Embryos: Patients' Views," *Human Reproduction* 22 (December 1, 2007): 3129 -3138.

[32] See the longer discussion at Kirsten Riggan, "Regulation (or Lack Thereof) of Assisted Reproductive Technologies in the U.S. and Abroad." *The Center for Bioethics & Human Dignity*, March 5, 2011, <http://cbhd.org/content/regulation-or-lack-thereof-assisted-reproductive-technologies-us-and-abroad> (accessed March 5, 2011).

[33] Alice Gomstyn, "Winning Fertility: Would-Be Parents Win Free IVF" *ABC News Business Unit*, March 18, 2010, <http://abcnews.go.com/Business/WellnessNews/winning-fertility-moms-win-free-ivf/story?id=10118313&page=1> (accessed March 11, 2011).

[34] David Adamson, "Symposium on Assisted Reproductive Technology: Regulation of Assisted Reproductive Technologies in the United States" *ABA Family Law Quarterly* 727 (Fall 2005): 39.

[35] "Extraordinary Conceptions Surrogacy and Egg Donor Agency Announces New Lower Fees" *BigNews.Biz*, March 9, 2011, <http://bignews.biz/?id=979981&pg=1&keys=> (accessed March 9, 2011).

[36] Elizabeth Marquardt, *My Daddy's Name Is Donor: A New Study of Young Adults Conceived through Sperm Donation* (New York: Institute for American Values, 2010).

[37] Sandra Blakeslee, "Infertile Woman Has Baby through Embryo Transfer" *New York Times*, February 4, 1984 <http://query.nytimes.com/gst/fullpage.html?sec=health&res=9404EEDC143BF937A35751C0A962948260> (accessed March 31, 2011).

[38] Kari Karsjens, "Boutique Egg Donations: A New Form of Racism and Patriarchy" *DePaul Journal of Health Care Law* 57 (Fall 2001): 5.

[39] Roni Caryn Rabin, "As Demand for Donor Eggs Soars, High Prices Stir Ethical Concerns," *The New York Times*, May 15, 2007, sec. Health, http://www.nytimes.com/2007/05/15/health/15cons.html?_r=2&bl&ex=1179374400&en=39b5461ce5272679&ei=5087%0A&oref=slogin (accessed March 31, 2011).

[40] Helen Pearson, "Health Effects of Egg Donation May Take Decades to Emerge" *Nature* 442 (August 10, 2006): 607-608, <http://www.nature.com/nature/journal/v442/n7103/full/442607a.html?free=2> (accessed March 8, 2011).

[41] M.L.P. van der Hoorn, E.E.L.O. Lashley, D.W. Bianchi, F.J.H. Claas, C.M.C. Schonkeren, and S.A.Scherjon, "Clinical and Immunologic Aspects of Egg Donation Pregnancies: A Systematic Review" *Human Reproduction Update* 16(6): 704-712

[42] Interestingly, Elizabeth Stern, the wife of the sperm donor, was not infertile. She wished to avoid the health risks of a pregnancy that might aggravate her multiple sclerosis.

[43] Harriet Sherwood, "Israeli Couple Seek Right to Use Dead Son's Sperm" *The Guardian*, February 8, 2011, <http://www.guardian.co.uk/world/2011/feb/08/israeli-parents-dead-son-sperm> (accessed March 8, 2011).

[44] Suz Redfearn, "Pursuing a Baby to the Ends of the Earth" *The Washington Post*, January 14, 2007, <http://www.washingtonpost.com/wp-dyn/content/article/2007/01/10/AR2007011001394.html> (accessed March 8, 2011).

[45] Antony Barnett and Helena Smith, "Cruel Cost of the Human Egg Trade" *The Observer*, April 30, 2006, <http://www.guardian.co.uk/uk/2006/apr/30/health.healthandwellbeing> (accessed March 8, 2011).

[46] Scott Carney, "Importing Egg Donors from Ukraine to Cyprus" *Pulitzer Center on Crisis Reporting*, August 17, 2010, <http://pulitzercenter.org/blog/untold-stories/importing-egg-donors-ukraine-cyprus> (accessed March 8, 2011).

[47] Fran Abrams, "The Misery behind the Baby Trade" *The Daily Mail*, July 17, 2006, <http://www.dailymail.co.uk/femail/article-396220/The-misery-baby-trade.html> (accessed March 8, 2011).

[48] Marcy Darnovsky, "Pregnancy without Borders: Reproductive Tourism's Global Reach" *Biopolitical Times*, September 28, 2010, <http://www.biopoliticaltimes.org/article.php?id=5393> (accessed March 31, 2011).

[49] Doug Pet. "India Moves toward Regulation of Assisted Reproduction and Surrogacy" *Biopolitical Times*, February 10, 2011, <http://www.biopoliticaltimes.org/article.php?id=5591> (accessed February 28, 2011).

[50] Kelle Barr, "Kalamazoo Couples Travels to India for Surrogate Pregnancy" *Kalamazoo Gazette*, July 28, 2010, http://www.mlive.com/living/kalamazoo/index.ssf/2010/07/kalamazoo_couple_travels_to_in.html (accessed March 8, 2011).

[51] Amana Fontanella-Khan, "India, the Rent-a-Womb Capital of the World" *Slate*, August 23, 2010, <http://www.slate.com/id/2263136/> (accessed March 8, 2011).

[52] AFP, "Thai Police Free Women from Surrogate Baby Ring" *Yahoo!7News*, February 24, 2011, <http://au.news.yahoo.com/entertainment/a/-/entertainment/8903363/thai-police-free-women-from-surrogate-baby-ring/> (accessed February 24, 2011).

[53] Radha Sharma, "Busy Couples Now Courier Embryos to Gujarat Clinics" *The Times of India*, August 29, 2010, http://epaper.timesofindia.com/Repository/getFiles.asp?Style=OliveXLib:LowLevelEntityToPrint_TOINew&Type=text/html&Locale=english-skin-custom&Path=TOIM/2010/08/29&ID=Ar01503 (accessed March 8, 2011).

[54] See, for example, the video-journalism report of Linda Blake. "Booming Surrogacy Trade Attracts Couples to Mother India" *VJ Movement*, November 5, 2009, <http://www.vjmovement.com/truth/416?fq=ttype.video&fq=dshow.all&fq=dorder.hot&fq=tab.list> (accessed March 8, 2011).

[55] See, for example, the stories and solutions recounted in Nicholas Kristof and Sheryl WuDunn, *Half the Sky: Turning Oppression into Opportunity for Women Worldwide* (New York: Vintage Books, 2010), and the movement it spawned. <http://www.halftheskymovement.org/get-involved>.

[56] Christian Weber, "The Red Market: Inside the Business of Selling Human Body Parts" *Wired* February 2011, 112-119.

[57] The practice of living donors has grown in recent years and raises a variety of ethical considerations unique from donation upon the death of the donor.

[58] Iran among a few other countries has developed legal for-profit models of organ donation. A variety of concerns have been raised with this approach, but primary concerns center on financial

coercion and the nature of informed consent. Cf. Anne Griffin, "Iranian Organ Donation: Kidneys on Demand" *British Medical Journal* March 10, 2007(334): 502-505.

[59] Separating fact from fiction in the urban myths and rumors of black market organ trafficking proved somewhat more difficult in its early years. In the mid 1980s a story of children being abducted in Northeast Brazil circulated in the international news, raising awareness of this relatively ignored aspect of the ethics of organ transplantation. Similar stories from a variety of other countries began to be circulated in the international news. The Bellagio Task Force in its 1997 report stated that it could find no evidence to support these rumors. D. Rothman, et al. "The Bellagio Task Force Report on Transplantation, Bodily Integrity, and the International Traffic in Organs" *Transplantation Proceedings* 1997(29):2739-45. Cf. Joint council of Europe/United Nations Study "Trafficking in Organs, Tissues, and Cells and Trafficking in Human beings for the Purpose of the Removal of Organs" *Council of Europe*, October 13, 2009, 60-61, http://www.coe.int/t/dghl/monitoring/trafficking/docs/news/OrganTrafficking_study.pdf (accessed March 20, 2011).

[60] Organ trafficking is defined as "the recruitment, transport, transfer, harboring or receipt of living or deceased persons or their organs by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability, or of the giving to, or the receiving by, a third party of payments or benefits to achieve the transfer of control over the potential donor, for the purpose of exploitation by the removal of organs for transplantation." "The Declaration of Istanbul on Organ Trafficking and Transplant Tourism" *Clinical Journal of the American Society of Nephrology* 3(5): 1228, <http://cjasn.asnjournals.org/content/3/5/1227.full.pdf+html> (accessed February 14, 2011).

[61] Weber, 114.

[62] Doreen Carvajal, "Trafficking Investigations Put Surgeon in Spotlight" *The New York Times*, February 10, 2011, <http://www.nytimes.com/2011/02/11/world/europe/11organ.html> (accessed February 11, 2011). Cf. Simon Robinson, "India's Black Market Scandal" *Time*, February 1, 2008, <http://www.time.com/time/world/article/0,8599,1709006,00.html> (accessed February 11, 2011) and Ana Iltis, "Organ Donation and Global Bioethics" *Journal of Medicine and Philosophy* 35(2): 81-85. An alarming set of allegations coming from Kosovo alleged that one clinic was inviting poor immigrants from Eastern Europe to donate kidneys, while also being accused of ties to an organ trafficking ring that harvested organs from Albanian and Serbian prisoners executed in such a manner to facilitate the organ extraction process. Paul Lewis, "Kosovo Physicians Accused of Illegal Organs Removal Racket" *Guardian*, December 14, 2010, <http://www.guardian.co.uk/world/2010/dec/14/illegal-organ-removals-charges-kosovo> (accessed February 14, 2011).

[63] D. A. Budiani-Saberi and F. L. Delmonico, "Organ Trafficking and Transplant Tourism: A Commentary on the Global Realities" *American Journal of Transplantation* 8(5): 925-929.

[64] Fahat Moazam, Riffat Moazam Zaman, and Aamir Jafarey, "Conversations with Kidney Vendors in Pakistan: An Ethnographic Study" *Hastings Center Report* May-June 2009: 33, 39-41. This study reported measurable disparities between the amount promised for the kidney and that which was actually paid. The researchers noted that often the organs were sold to cover significant levels of accumulated debt, with more than half the donors/vendors ending up with persistent or re-accumulated debt after the transaction.

[65] *Ibid.*, 33-35.

[66] Gregory Rutecki, "Where Is the Public Outcry? Infants also Have Human Dignity When They Are Dying and Donating Organs!" *The Center for Bioethics & Human Dignity*, October 24, 2008, <http://cbhd.org/content/where-public-outcry-infants-also-have-human-dignity-when-they-are-dying-and-donating-organs-0> (accessed January 11, 2011). For a discussion of the complexities in the

determination of death, see President's Council on Bioethics, *Controversies on the Determination of Death*, December 2008, <http://bioethics.georgetown.edu/pcbe/reports/death/index.html> (accessed March 31, 2011).

[67] Luc Noël and Dominique Martin, "Progress towards National Self-Sufficiency in Organ Transplants" *Bulletin of the World Health Organization* 2009 (87): 647, <http://www.who.int/bulletin/volumes/87/9/09-068817/en/> (accessed February 14, 2011).

[68] Milica Bookman and Karla Bookman, *Medical Tourism in Developing Countries* (New York: Palgrave Macmillan: 2007), 1.

[69] Harriet Hutson Gray and Susan Cartier Poland, "Medical Tourism: Crossing Borders to Access Health Care" *Kennedy Institute of Ethics Journal* 18(2): 193.

[70] Estimates range from 5-10% on the low end to 50% of the standard costs of medical services in the U.S. *Ibid.*, 50.

[71] *Ibid.*, 7.