THE DANISH COUNCIL OF ETHICS

International trade in human eggs, surrogacy and organs

A report from the Danish Council of Ethics

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Preface

The present report was drawn up by a working party on the Danish Council of Ethics consisting of Thomas Ploug (chairman), Jacob Birkler, Lillian Bondo, Jørgen Carlsen, Mickey Gjerris and Ester Larsen. It was considered and adopted by the Council of Ethics at meetings in September and October 2013.

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Janne Rothmar Herrmann, PhD, associate professor, Faculty of Law at the University of Copenhagen
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November 2013

Jacob Birkler
Chairman of the Danish Council of Ethics

Christa Lundgaard Kjøller
Head of Secretariat

Resumé

Medical tourism is a field that is growing in step with globalization. In this report the Danish Council of Ethics looks at the ethical dilemmas associated with medical tourism, which involves buying and selling human body parts.

In Denmark and the rest of Europe the legislation departs from the fact that we consider it wrong to trade in body parts, but with medical tourism on the increase Danish citizens can choose to purchase such treatments abroad.

The Council has opted to focus on three different types of tourism that involve Danes buying body parts in other countries. These involve the purchase of:

- Unfertilized eggs for the purpose of fertility treatment
- Surrogacy (surrogate motherhood), and
- Kidneys

The three cases have been selected because they differ in respect of some ethically significant parameters, though they all concern the sale of body parts or bodily functions: Buying unfertilized eggs and 'hiring' wombs (surrogacy) do not usually entail what might be called injury, including loss of function, to the person providing them. The situation is different with the sale of kidneys. These sales take place illegally and under conditions in which the donor is very often physically worse off after the sale.

Such differences raise the question of what makes the commercialization of body parts ethically problematic, and whether all forms of body part sales are equally problematic. Should we be prompted to graduate our view of the commercialization of body parts by the differences mentioned? Can these differences in some cases sanction that the commercialization issues are weighed up against the relief the payment, despite everything, affords to people living in abject poverty, who themselves regard such sales as their best option for improving their own situation?

Chapter 1 describes the topic of medical tourism, which has grown in recent decades as Internet advertising and cheap travel opportunities have made travelling for treatments that are cheap or banned in the home country an attractive option. OECD describes the phenomenon as growing but notes that there is a lack of hard research evidence in the field. This report is therefore based on the knowledge available, given that records of such activities are inadequate – particularly that part that takes place illegally or in countries where the authorities lack the resources to collect data or enforce legislation already in effect.

Chapter 2 discusses four ethical topics linked to commercialization of the body, i.e. motivation, exploitation, autonomy and dignity. These are recurring concepts in the debate on medical tourism and commercialization, and the chapter examines different understandings of the concepts in order to posit a joint framework for discussing the ethical problems connected with the three cases.

In Chapter 3 the three cases are examined individually: what knowledge is available about scope and traffic, where do the treatments take place, what does Danish and international legislation on trade in the three types of body parts or bodily functions say, and what ethical problems are associated with them?

Trading in eggs is permitted in a number of countries, including the USA and India. Most Danish couples buying eggs abroad have the treatments performed in other European countries like Spain or the Czech Republic, where actual trading in eggs is not permitted but the size of the compensation payable is enough to induce many, especially poor, women to sell off eggs to fertility clinics.

Surrogacy is permitted in a small handful of countries, including India, Russia and 18 states in the USA. However, there are big price differences between the USA and the other countries, as a result of which India has become a hub for commercial surrogacy. The Indian surrogate mothers are recruited among poor, uneducated women, often from the country, who often describe themselves as being pressured into becoming surrogate mothers by poverty, but having no other alternatives for finding their feet financially and securing an education for their children.

Trading (trafficking) in organs is forbidden in virtually all countries (Iran being the only exception). Globalization and the development of the Internet, however, have made it possible for patients from affluent countries to circumvent the lack of organs available in their home country. On the Net they can find clinics in other countries, where they can pay their way to obtain operations. The countries involved are ones where the ban on selling organs is not enforced, and where there are many poor people who are willing to sell their organs.

Chapter 4 looks at the extent to which Danes travelling abroad to take advantage of fertility treatment with bought eggs, surrogacy and organ trafficking can be punished on their return home to Denmark. Sentencing people in this country for actions undertaken abroad requires such actions, as well as being punishable in Denmark, to be punishable in the relevant country as well (double criminality). That is generally not the case when it comes to trading in eggs and paid surrogacy. An additional condition for punishment is that the Danish penalty provision must have extraterritorial effect, i.e. state that actions undertaken outside Denmark's borders are also punishable under the provision. That condition is not met where organ trafficking is concerned.

Chapter 5 contains the Council's recommendations.

A unanimous Council endorses the overall view that, in principle, the human body and its parts should not be able to be bought or sold. The members attach importance to a number of different reasons in support of this view: People's dignity is violated by treating them as goods or commodities, trading in body parts undermines the altruistic principle on which donation rests in the Danish health system, and trading in eggs in particular leads to a ranking of people.

Finally, trading in body parts involves a considerable element of exploitation of the poorest people on the planet. The donors are not in a position to make a genuinely autonomous choice to sell their body parts; bearing this in mind, the majority of the Council's members therefore consider it right to prevent trading in body parts.

A minority of the members do not consider that sales of body parts differ from other actions which very poor people can be pressured into taking, such as highly dangerous or back-breaking work, which we do not prevent. We therefore have to accept rational people's right to make their own choice between the often meagre possibilities open to them.

Some of these members consider that the best help these people can be given in this sorry situation is to set up certification schemes which ensure that the sale at least takes place with the greatest possible consideration for the donor. The majority of members, however, consider it altogether unlikely that a certification scheme can meet this function and, conversely, fear that such schemes will legalize the trade and thus promote it.

A united Council still considers that donation of human eggs should be done on an altruistic basis. The majority feel that the best solution to the current lack of egg donors in ethical terms would be to boost altruistic egg donation. Some of the members also propose opening the way to donate fertilized eggs left over from fertility treatment. A minority of the members think that until sufficient donors have successfully been obtained by this means, the way should be opened to buy eggs under the auspices of a certification scheme which offers donors protection. A single member is against any form of egg donation.

All the members consider paid surrogacy to be ethically problematic, and a minority are against any form of surrogacy. The majority, however, do not think surrogacy should be forbidden in every situation, and seven members urge the legislators to look into the possibility of facilitating access to altruistic surrogacy in Denmark. Furthermore, a minority consider that the possibility of some form of certified, commercial surrogacy ought to be promoted.

All members of the Council of Ethics regard the trafficking in organs taking place internationally and illegally with the utmost seriousness, but at the same time recognize that the lack of organs for individuals who are severely ill or in

life-threatening situations is a massive social problem which more should be done to solve. A minority recommend that this should include the introduction of presumed consent for donation in Denmark, but a majority consider the issues involved to be so substantial that the scheme should not be introduced. Finally, here again, some members feel that until the organ shortage problem has been resolved, the way should be opened for a degree of certified sales of organs.

As regards the introduction of sanctions against Danish citizens buying body parts or functions abroad, the Council's members recommend that:

In the view of the majority, buying eggs abroad should not be punished in Denmark; instead the authorities should work to prevent citizens choosing this option. Some members do want sanctions for this misdemeanour, however, and a large minority want sanctions against Danish middlemen brokering such trade.

In the view of the majority, purchasing surrogacy should not be punished when the buyers return home either; here again the instrumentality adopted should be information and prevention. A minority wish to see the introduction of sanctions, though insofar as possible these should be formulated so as not to affect the child. Finally, a minority consider that the middlemen should be punishable to a greater degree than at present.

Buying organs abroad is more problematic, yet here again the majority of members also find that the authorities should inform and prevent rather than punish Danes returning home with a 'bought' kidney. Some of the members, however, advocate a custodial sentence for the buyers in all or in particularly serious cases. Finally, some members consider that Danish middlemen should be punishable.

Finally, at an altogether fundamental level, a united Council considers that the Danish health service should guarantee everyone equal access to the necessary treatment, irrespective of the patient having contributed to his or her situation. All Danes, therefore, regardless of whether they have bought eggs, surrogacy or organs in other countries, should be guaranteed relevant medical aftercare in Danish hospitals.

1. The phenomenon of medical tourism and its general extent

Medical tourism is a field growing in step with globalization. It can be a challenge for the national legislators to the extent that their citizens seek out treatments which are illegal in the home country, for example because they are considered ethically problematic. Not least, the challenge consists of the difficulty governments face in monitoring or, where appropriate, punishing their citizens' actions if they take place beyond the country's borders.

An OECD report from 2011[1] states that the phenomenon of medical tourism has taken on mounting importance in recent decades as Internet advertising and cheap travel opportunities have made travelling for treatments that are cheap or banned in the home country an attractive option. The organization also notes, however, that there is a lack of hard research evidence in the field.

This increase in scope is the rationale behind the Danish Council of Ethics having chosen to examine the ethical dilemmas associated with medical tourism that involves the purchase and sale of body parts. It is not the Council's business to take a stance on commercialization in general.

By way of introduction, however, it may be worth noting that there has been a tendency to base the debate around these questions to some extent on an acceptance of the fact that we as a society find ourselves in a "dearth situation". The debate thus makes reference to the lack of organs and eggs. This report primarily hosts a series of deliberations as to which modalities can be taken into service, in an ethically defensible way, to solve the problems of great demand. Part of the debate, however, also includes critical reflection on whether, and to what extent, such problems should always be resolved.

In Denmark the legislation hinges on the fact that we consider it wrong to trade in body parts, but with the increase in medical tourism Danish citizens can choose to buy such treatments abroad.

The Council has opted to focus on three different types of tourism that involve Danes buying body parts in other countries. These involve the purchase of:

- Unfertilized eggs for the purpose of fertility treatment
- Surrogacy (surrogate motherhood) and
- Kidneys

[1] Lunt et al., 2011. *Medical Tourism: Treatments, Market and Health System Implications: A scoping review*. OECD.

Based on its survey of the knowledge available on these phenomena, the Council will present recommendations in relation to the authorities' handling of the issues raised in this field. The Council does this on the basis of a conviction that the trends to globalize the available supply of health services will continue—that we have only seen the start of that development today. While the waiting lists for donating oocytes and kidneys and the number of childless show no sign of diminishing, the possibilities for sourcing commercial providers of eggs, surrogacy and kidneys in other countries are constantly improving.

The Council also wishes to contribute to a public debate on the ethical dilemmas raised by these types of medical tourism: How can we best accommodate society's childless or severely ill individuals while simultaneously ensuring that poor and vulnerable people in other countries are not exploited in the process, and ensure that important values are not sacrificed?

The three cases - sales of eggs, surrogacy and kidneys - have been selected because they differ on some ethically significant parameters, though they all concern the sale of body parts: Buying unfertilized eggs and 'hiring' wombs (surrogacy) do not usually entail what might be called injury, including loss of function, to the person supplying them—eggs exist in such quantity as to make it unlikely that some cannot be dispensed with (though the actual procedure for retrieving them is not without risk and can result in injury in some cases); and undergoing surrogacy does not usually inflict any injury on the woman other than the physical strain that pregnancy can represent. (However, multiple pregnancies and caesareans – a very commonly used method of delivery with about 80% of women in some studies—can increase the woman's risk in the event of future pregnancies, and can result in late-onset damage to her health.)

It is a different story with organ sales. The majority of cases, and the most thoroughly documented ones, pertain to trafficking in kidneys. Here the donor is very often physically worse off after the sale, since the operations generally take place under less than optimal conditions, and corners are cut on the aftercare. Among other things many people experience physical deterioration and impaired working capacity, though also mental ordeals like bouts of depression following the operation.

That raises the question of what makes commercialization of body parts ethically problematic, and whether all forms of body part sales are equally problematic. A distinction needs to be made between sales of whole bodies, body parts and bodily functions. Some take the view that sales of body parts or bodily functions already occur, even in Denmark, such as the sale of hair, or prostitution. There seem to be ethically relevant differences between different body parts, raising the question of how to draw the line when it comes to which body parts or bodily functions it should be possible to sell.

Should the differences mentioned lead to us graduate our view of commercialization of body parts? Can these differences in some cases

sanction that the commercialization issues are weighed up against the relief the payment, despite everything, affords to people living in abject poverty, who themselves regard such sales as their best option for improving their own situation? Will it even be possible to set out criteria as to when the sale of body parts should be permitted, and when not? The Council will look at these questions in this report.

But first a description of medical tourism based on the knowledge available, given that records of such activities are inadequate – particularly that part that takes place illegally or in countries where the authorities lack the resources to collect data or enforce legislation already in effect.

1.1 A phenomenon of mounting global importance

As a broader phenomenon, medical tourism can be seen as part of current years' globalization of the market; outsourcing of production from western countries, especially to countries with low wage costs, has gained impetus since the 1970s. Having initially been unskilled jobs in particular that were outsourced, the trend has now progressed to see more specialized functions also being relocated to low-wage countries, e.g. IT functions.

Many people, however, have viewed medicine as a field that would not feel any major impact from such outsourcing to cheaper countries. Among other things it would require patients to be willing to travel—far, in many cases—to have treatments performed in other countries. Apart from the risk involved in transporting sick people, it also brings with it uncertainties regarding the quality of the treatment and the lack of scope for enforcing liability claims if complications arise. Nevertheless, factors such as the development of cheap transport, the rapid exchange of information and the general globalization in recent years have turned medical services into a commodity that is being traded on the international market, with many countries eager to have their share of the growth industry.[2]

The motive for seeking treatments in other countries can be financial, but it can also be fuelled by the inaccessibility of such treatments in the patient's homeland because there are long waiting lists to receive them—for some patients, fatally long.

One contributory cause of these waiting lists is that most western countries' legislation rests on principles that donation must be altruistic; it is considered morally wrong to commercialize the body and its parts. That principle is found to recur in many international documents. According to the Council of Europe's Convention on Human Rights and Biomedicine (1997)[3] the human body and its

[2] McMahon, D., 2013. Medical Tourism and Cross-border Care. Background paper. *Nuffield Council on Bioethics Forward Look,* 2.

[3] Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine.

parts as such may not be made a source of financial gain (Article 21). Article 3(2) of the EU Charter on Fundamental Rights (2000) states that "In the fields of medicine and biology, the following must be respected in particular: - the prohibition on making the human body and its parts as such a source of financial gain" (letter c). Article 12 of the Directive of the European Parliament and of the Council on setting standards of quality and safety for the donation, procurement, testing, processing, storage, and distribution of human tissues and cells (2004) states that Member States shall endeavour to ensure voluntary and unpaid donations of tissues and cells. WHO adopted a resolution in 2004, urging its Member States to take steps to prevent transplant tourism and the sale of tissues and organs[4], and in 2008 *Guiding Principles on Human Cell, Tissue and Organ Transplantation* was adopted. The following is set out in guiding principle 5: "Cells, tissues and organs should only be donated freely, without any monetary payment or other reward of monetary value. Purchasing, or offering to purchase, cells, tissues or organs for transplantation, or their sale by living persons or by the next of kin for deceased persons, should be banned."

It is not the treatments per se, then, that are regarded as morally wrong, when we speak for example of egg donation, surrogacy (under special circumstances) and organ transplantation. What is regarded as wrong is buying (or hiring) parts of the human body to gain access to the treatments.

Medical tourism has made it possible for affluent patients to circumvent such ethically motivated rules in their homelands and gain access to a market for treatments that involve trading in body parts. These markets are found in countries that either do not have rules dictating against such practices or do not have the capacity to enforce any bans that are in place.

Consequently, there are several factors which are instrumental in promoting medical tourism: partly the wish for cheaper treatments, partly circumvention of domestic waiting lists and partly evasion of domestic bans on treatments involving the sale of body parts. On that basis, three types of medical tourism can be differentiated[5]:

1.1.1 Tourism related to treatments legal in both the patient's homeland and the country of destination

The motives for such travel are often financial, which is especially a factor in countries without public health cover, e.g. the USA. Particularly for the many people without health insurance, being able to save 50-80% of the costs of an operation by having it done abroad is an attractive option. But the American insurance companies too have started to take an interest in sending patients abroad and granting discounts to patients willing to have operations performed

[4] WHO, 2004. *Resolution on human organ and tissue transplantation.* Geneva.
[5] Cohen, G., 2010. Medical Tourism: The View from Ten Thousand Feet. *The Hastings Center Report,* vol. 40, no. 2: 11-12.

in a cheaper country. Typical treatments in this category can be bypass or hip operations.[6] For Danes it may be a case of seeking out treatments which are not covered by national health insurance or which incur a very high user fee, such as dental treatments and cosmetic operations.

1.1.2 Tourism related to treatments illegal in the patient's homeland but legal in the country of destination

Two of the cases selected in this report—assisted reproduction with traded eggs and commercial surrogacy—fall within this category. These treatments are considered morally wrong in Denmark, as many will know—so morally wrong that we have banned them from being carried out by law. But in other countries they are not deemed ethically problematic; in countries like India, in fact, quite considerable efforts are being made by the government to promote them as part of medical tourism, which is viewed as an economic area of commitment for the country.

Morally speaking, therefore, the question arises as to whether Danish legislators should also attempt to enforce Danish rules vis-à-vis Danish nationals located in countries which have different moral standards. By the same token, one might ask whether the Danish police should assist authorities in other countries by apprehending their citizens if they perform actions in Denmark regarded as non-problematic here but prohibited in the home country. Ought sanctions to be introduced for Danish nationals returning home after having bought egg cells or surrogacy abroad and, if so, which sanctions are appropriate? How to avoid such sanctions affecting the child rather than the parents?

1.1.3 Tourism related to treatments banned in both the patient's homeland and the country of destination

Some types of trafficking in body parts are prohibited in practically all countries because they are regarded as ethically unacceptable everywhere. That applies to organ trafficking, which is the last case in this report. International organizations have taken up the subject; thus work is currently in progress under the auspices of the Council of Europe on a *Convention against Trafficking in Human Organs.*[7] As far as is known, Iran is the only country to allow the purchase and sale of human organs. The procedures involved here are far-reaching, as organs are not regenerated and the operation is highly invasive. If it is not performed safely and insufficient aftercare is provided, the donor will sustain permanent injury as a result of undergoing it. For the recipient too the treatment involves risks, and the person in question will need life-long aftercare.

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[6] Pafford, B., 2009. The third wave – medical tourism in the 21st century. *Southern Medical Journal,* vol. 102, no. 8.

[7] See: http://www.coe.int/t/dghl/standardsetting/cdpc/CDPC%20documents-/CDPC%20(2012)%2021%20%20e%20%20Draft%20Convention%20against%20Trafficking-%20in%20Human%20Organs.pdf

Despite these factors there is widespread international trafficking in organs like kidneys, it just takes place illegally or in countries where the authorities lack the facilities to effectively implement a ban on such operations. In many places in the world very poor people are willing to sell their organs, or they are lured into it under false pretences by cynical middlemen. Again, one may well ask whether Danish authorities should introduce sanctions against those citizens who travel abroad to buy kidney transplants, given that their actions also constitute violations of the law in those countries where they are performed. And what sanctions are fitting? Should public hospitals, for example, deny those patients aftertreatment, given that it will involve a great risk of the organ being rejected and pose a serious health risk for the patient?

Medical tourism and trade in human body parts therefore raise a number of ethical dilemmas and legislative difficulties, which are the subject of this report. The following chapters examine the situation for trading in egg cells, surrogacy and kidneys, respectively. The starting point for the ensuing ethical discussion will be that trading human body parts is basically problematic, ethically, but discussion will revolve around whether the gravity of the ethical problems can be said to vary in the three cases, and whether other circumstances—for instance, the donors' lack of alternatives for obtaining the bare necessities of life—advocate treating these areas differently in legislative terms. The last chapter contains the Council's recommendations on the issue.

Generally speaking, it should be noted that it is an area characterized by a lack of precise empirical data, so when working on the present report, one of the premisses was that the Council was forced to base its work on the available data, albeit often inadequate. That applies to the overall assessments of the number of healthcare tourists, as well as patient and donor examinations, and the consequences of various procedures. Studies of such factors are often based on quite small populations, and the results must be read with that reservation in mind.

2. Ethical topics of globalization and commercialization

In the debate on medical tourism and commercialization, particular topics are often foregrounded. One of these topics concerns which integral ethical problems are linked to commercialization. That will be discussed below. Another key topic is exploitation. When well-to-do couples from the West go to India, say, and pay impoverished women to be surrogate mothers, the reaction from many people is that this is unacceptable, because the women are being exploited. Whether that is correct depends, of course, on how exactly the concept of *exploitation* is to be understood. That will also be discussed below, since the intention here is to establish a common platform on which to take a stance on the three cases selected, i.e. surrogacy, organ trafficking and egg donation. In the same way, the meaning of *autonomy* and *dignity* will also require discussion. These are also recurring concepts in the debate on medical tourism and commercialization and, like exploitation, need to be qualified and narrowed down before they can form a starting point for adopting a position on the various types of agreements and transactions.

2.1 Ethical problems linked with commercialization

In Denmark and the other countries that have acceded to the *Council of Europe's Convention on Human Rights and Biomedicine,* it is forbidden to trade in body parts. On the other hand it is permitted to pay compensation for donating bodily material. The likely response is to see this distinction as a reflection of the potential ethical problems associated with commercializing bodily material, whereas these problems can be avoided to a greater or lesser extent by offering compensation only. Some of the problems that may be linked to commercialization will be briefly described below. It should be noted that our highlighting of these problems does not imply any general criticism of commercialization.

The description of the possible problems with commercialization is based on Michael J. Sandel's recently published work *What Money Can't Buy*.[8] Based on the deliberations in that work, the potential pitfalls of commercialization can be divided into three main interrelated groups:

1. Commercialization can change the motives of the people involved, and hence their behaviour.
2. Commercialization can change the understanding or significance of what is being bought and sold.

[8] Sandel, Michael J., 2012. What Money Can't Buy – The Moral Limits of Market. Allen Lane, Penguin Books.

3. Commercialization can be at odds with values we associate with the commercialized object and can be instrumental in undermining these values. Furthermore, commercialization can lead to exploitation.

2.1.1 Commercialization and motivation

One very important point for Sandel is that economic incentives can change the motivation of the players involved, and hence their behaviour, which can have a number of negative consequences, two of which are especially alarming. Sandel illustrates this with a great many examples, two of which will be mentioned here.

The first is an experiment that was conducted by two economists. The economists divided some students who had been assigned to collect money for charity into three groups. The first group was given no money for collecting, whereas the second and third groups received 1% and 10% of the amount collected, respectively. That amount was paid from external funding, so the amount for charity was no less. When the collection had finished, it turned out that the first group had collected 55% more than the group that was paid 1%, whereas the group with 10% was somewhere between these two groups.

Taking the experiment as his basis, Sandel suggests that the result can be explained as follows, as this explanation also chimes with a series of other studies:

> *Most likely, it was because paying students to do a good deed changed the character of the activity. Going door-to-door collecting funds for charity was now less about performing a civic duty and more about earning a commission. The financial incentive transformed a public-spirited activity into a job for pay.*[9]

The fact that commercialization can undermine altruistic and other community-spirited motives or virtues in this way has long been a topic in social philosophy. A key contribution to this debate has been Richard Titmuss's well-known experiments to demonstrate a similar difference in motivation and effectiveness between altruistically based and commercially driven blood donation.[10] For Titmuss, however, it was relevant not only that altruistically driven blood donation appeared to produce a greater quantity and a better quality of donation;[11] it was also essential that altruistic and commercially driven donation practice did not appear to be capable of functioning in parallel, because in the process the commercial logic apparently ended up infiltrating the practice of altruistic donation and resulted in a substantial fall in the number of altruistically minded donors.

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[9] Ibid., p.118.

[10] See Titmuss, Richard, 1970. *The Gift Relationship: From Human Blood to Social Policy*.

[11] The latter is because altruistically minded donors have no interest in donating blood that may pose a risk of infection, while this does not necessarily apply to commercial donors.

A third, altogether central point for Titmuss, however, was also that an altruistically based donation practice, together with other similar practices, is a necessary means of creating a sense of cohesion in society. According to Titmuss such practices help to create and support the motives and virtues necessary to make society as a whole work. The claim that altruistic donation practices can contribute to creating cohesion in society can be difficult to substantiate. But it could also be pointed out that exercising altruism is a benefit in its own right, which can be worth promoting. Presumably, most people find it more appealing to live in a society with altruistic donation than one where donation is done in return for payment.

It is worth mentioning that according to Sandel the recipient of money is not the only one whose motivation and behaviour can change as a result of commercialization. That is also true of the payer. Sandel gives a curious example of this. At a child-care centre a fine was introduced for parents who picked their children up after closing time. But quite contrary to expectation, these fines did not lead to fewer parents collecting their children late. On the contrary, what happened over time was that far more children were collected later—and this effect lingered on even after the penalty system had been abolished. A possible explanation, according to Sandel, might be that the parents perceived the fine as a payment they were willing to pay, so that it also gave them the right to pick up the children later, thereby suspending normal standards of accountability vis-à-vis the staff and the children to such an extent that it was not immediately possible to reinstate them by no longer imposing fines.

The first example involving the collection of money for charity demonstrates that there is no guarantee you will get more donors in a country like Denmark by introducing substantial compensation or increasing the size of already existing compensation in connection with e.g. donation of organs or eggs. The other example, by contrast, highlights the fact that commercializing the donation relationship can also have a bearing on the recipient's perception of the exchange. If a larger sum is paid for e.g. eggs or organs, the material can be understood from a market-economic logic and regarded to a greater extent perhaps as a commodity one has paid for and therefore can make demands of—also bearing in mind that the price of eggs in the USA depends on the donor's educational background etc.

2.1.2 Commercialization can change our understanding of the commercialized object

It is an old and familiar truth that money cannot buy everything. It cannot buy love, for example, for that kind of relationship presupposes the creation of some mutual feelings and expectations, which cannot be created with the aid of payment. A less well-known truth, which is logically connected to the first one in reality, is that there are many things that certainly can be bought, though not without changing their significance. One example of that is citizenship. If

Denmark starts selling Danish citizenship to very high-paying people—as the USA is on the brink of doing—then we are gradually dissolving the understanding of citizenship which has hitherto served us and served partly as a basis for citizenship, which to some extent is about the degree of affiliation with the country, not just about a person's financial status.
It is the same with some of the rights and duties we have as citizens in society. If we allow the individual citizen to sell his chance to vote to others or pay someone else to serve his compulsory military service, we are also well in the throes of altering our understanding of citizenship and the exchange between the individual and society as a whole. That is not to say that this type of change is necessarily for the worse, but it is important to be sensitive to whether such changes are actually desired—and why they come about.

2.1.3 Commercialization and underlying values

In the work on commercialization already referred to, Michael J. Sandel offers his take on when commercialization can change our understanding of goods or activities in a way that can be said to have a corrupting effect:

> *We corrupt a good, an activity, or a social practice whenever we treat it according to a lower norm than is appropriate to it. So, to take an extreme example, having babies in order to sell them for profit is a corruption of parenthood, because it treats children as things to be used rather than beings to be loved.*[12]

The example is apposite because it highlights the point clearly: in some instances our understanding of goods or activities is patently associated with values and norms which are completely and utterly incompatible with commercialization.

The difficult cases lie midway between these extremes. Here a sort of value-related excavation work needs to be performed in order to figure out what kind of values and norms can possibly be corrupted. Sandel gives a highly germane example of the nature of that excavation work:

> *In order to determine whether a woman's reproductive capacity should be subject to a market transaction, we have to ask what kind of good it is: Should we regard our bodies as possessions that we own and can use and dispose of as we please, or do some uses of our bodies amount to self-degradation? This is a large and controversial question that also arises in debates about prostitution, surrogate motherhood, and the buying and selling of eggs and sperm. Before we can decide whether market relations are appropriate to such domains, we have to*

[12] Michael J. Sandel 2012, p. 46.

figure out what norms should govern our sexual and procreative lives.[13]

The extreme controversiality of answering the question posed can be illustrated by the discussion of the concept of dignity included in the *Council of Europe's Convention for the protection of human rights and dignity of the human being with regard to the application of biology and medicine* from 1997. This convention states that the signatories to it must protect all people's dignity and identity. But in the discussions on egg donation there is disagreement as to whether it is incompatible with human dignity to commercialize eggs.

Some people feel that such incompatibility exists because trading in body parts is treating human beings as a means, not as an end in themselves. Others, by contrast, take the opposite approach, based on the view that the person's dignity is not regarded as being linked to the use of individual body parts.[14]

The fact that such disagreements actually exist creates complications in terms of how to regulate a particular field in purely legislative terms. Do disagreements about surrogacy and egg donation, say, constitute an argument for making liberal legislation and entrusting the decision to the relevant players themselves? Or, on the contrary, do we as a society have to determine which values we wish this type of transaction to be based on, and then cast our legislation around that decision?

2.1.4 Different types of incentives

Carrying on from the discussion above of the possible corrupting effect of commercialization, it would be only natural to wonder whether incentives can possibly be created for donating or acting as a surrogate, say, which are not of a financial nature. The Nuffield Council on Bioethics discusses that question in its report *Human bodies: donation for medicine and research* (2011), distinguishing between different ways of motivating potential donors to donate.

One type of initiative is those that focus on, and attempt to support, the altruistic motivation already possessed by the potential donor. Such initiatives can consist, for example, of:

1. Informing people about the need to donate bodily material for others' treatment or medical research.
2. Showing recognition of, and gratitude for, altruistic donation through whatever methods are appropriate to the form of donation and the donor concerned.
3. Removing some of the barriers and disincentives to donation experienced by those disposed to donate.

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[13] Ibid., p. 47.

[14] For more detailed discussion see e.g. Ch. 4 in the Nuffield Council on Bioethics. 2011. *Human bodies: donation for medicine and research.*

4. Initiatives that give people already disposed to donate an extra prompt or encouragement.[15]

According to the Nuffield Council the four initiatives listed are relatively uncontroversial, because they strengthen pre-existing altruistic motivation and therefore play no part in eliminating it. For example, according to the Nuffield Council, there is no problem preserving altruistic motivation, even though the donor is compensated for transport costs and actual loss of earnings etc. if the person is not actually rendered financially better off than he or she would have been without the donation.

The converse is true of the following two initiatives, which according to the Nuffield Council are "non-altruist-focused"; on the contrary, these interventions can be instrumental in undermining the altruistic motivation a potential donor already possesses. For that very reason, these initiatives are problematic and must always be subject to careful scrutiny:

5. Initiatives offering associated benefits in kind to encourage those who would not otherwise have contemplated donating to consider doing so.
6. Financial incentives that leave the donor in a better financial position as a result of donating.[16]

As an example of initiative 5 the Nuffield Council cites egg sharing, in which a woman who is herself childless and contemplating a course of IVF is given the chance to have a child, because she receives free or reduced-cost treatment in return for passing on surplus, unfertilized eggs to other women.

Based on the list of types of initiative compiled, the Nuffield Council expresses several views that are relevant to the discussion of medical tourism and commercialization:

- Type 5 initiatives are less problematic than type 6 initiatives because they are harder to view as actual body part sales.
- Less problematic initiatives should be tried out before setting in train more problematic ones, i.e. initiatives 1-4 before initiatives 5-6 and also, as mentioned, initiative 5 before initiative 6.
- If use is made of initiative 6, the nature of the transaction must be such that payment is viewed as a reward for the person donating—and not as payment for the material donated. E.g. payment to an egg donor must not depend on the number of eggs or their quality.

[15] Ibid, p. 7.
[16] Ibid.

2.2 What is dignity?

The concept of 'dignity' plays a central part in the present-day debate on the use of various biotechnologies.[17] At the same time, it plays a very complex part. On the one hand it has a prominent role in various conventions and declarations, where it is used to establish a position on specific applications of particular biotechnologies. In practice, then, there is some degree of consensus as to both the essential nature of the concept and the assessments of the technologies it brings with it. Yet on the other hand it is difficult to give even a vaguely precise definition of the concept, which seems to have a number of different and often opposing meanings. In as far as consensus can be reached on the use of the concept in a particular context, that consensus will often be intuitive in nature: It may be possible to agree on the considered opinion that something is undignified, but it is a rather more difficult task to agree on and explain more precisely how the concept of dignity can justify an ethical ruling.

Below, examples will first be given of the part which the concept of dignity plays in conventions and treaties. Some of the key definitions will then be presented in brief. To start with, though, two examples of ethical assessments will be given which take the concept of dignity as their point of departure, and which many people will no doubt be able to endorse. The first is taken from the Danish Council of Ethics' report "Conditions for Psychiatric Patients" from 1997, which states:

> *In different societies and at different times there will be differences as to what is regarded as undignified or humiliating, and hence also as to what a concept of human dignity involves. In a European context forcible immobilization comprises an infringement of a person's dignity, albeit in some cases the only possible way of calming a disturbed patient. Why? Because in European culture a notion exists that the person is independent and free, and immobilization appears to be the absolute denial of independence and freedom.*

So, as shown, what is regarded as undignified is considered culturally conditioned, which may help explain the difficulties of finding a common definition. Nonetheless, many westerners can probably endorse without further thought the statement in the quotation that forcible immobilization comprises an infringement of the patient's dignity—without saying in the same breath that immobilization is wrong in all cases. Other values may be involved, such as the patient's safety, which must be ascribed greater importance in a particular situation.

[17] See e.g. Caulfield, Timothy, and Roger Brownsword. January 2006. Human dignity: a guide to policy making in the biotechnology era? *Nature Reviews Genetics* 7: 72-76.

The second example is taken from the book *Principles of Biomedical Ethics*[18]*,* which mentions that it can be undignified for care home residents to go around naked, despite having taken their clothes off themselves and not feeling violated or embarrassed by their nakedness. That example too demonstrates an interesting aspect of the dignity concept, that assessments of dignity are not necessarily closely bound up with the individual's own view of his or her situation. In other words, a person may well be in a situation which is undignified for him or her without realizing it or agreeing with it themselves.

2.2.1 Dignity in treaties and conventions

As mentioned, the dignity concept is central to a number of conventions and treaties. It is incorporated, for instance, as part of the actual basis for the human rights enshrined in the UN's Universal Declaration of Human Rights from 1948. Among other things, this is apparent from the two mentions of the concept in the introduction, i.e. the preamble presented by way of reasoning for the specific rights in the subsequent articles. In addition, the concept is included in the first article of the declaration:

> ***PREAMBLE***
> *Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world, (…)*
>
> *Whereas the peoples of the United Nations have in the Charter reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women and have determined to promote social progress and better standards of life in larger freedom, (…)*
>
> *Article 1*
> *All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.*

The dignity concept is also central to the *Bioethics Convention*, being included in the description of the overall purpose of the convention:

> *Article 1 – Purpose and object*
> *Parties to this Convention shall protect the dignity and identity of all human beings and guarantee everyone, without discrimination, respect for their integrity and other rights and fundamental freedoms with regard to the application of biology and medicine.*

[18] Beauchamp, Tom L., and James F. Childress, 1994. *Principles of Biomedical Ethics*, 4th ed., Oxford University Press.

As set out in the preamble to the convention, this description of purpose is bound up with the recognition that misuse of biology and medicine may lead to acts that endanger human dignity.

Finally, it should be mentioned that the concept of dignity is also incorporated in *UNESCO's Declaration on the Human Genome and Human Rights,* e.g. in Articles 2 and 11:

> *Article 2*
> *a) Everyone has a right to respect for their dignity and for their rights regardless of their genetic characteristics.*
> *b) That dignity makes it imperative not to reduce individuals to their genetic characteristics and to respect their uniqueness and diversity (...)*
>
> *Article 11*
> *Practices which are contrary to human dignity, such as reproductive cloning of human beings, shall not be permitted. States and competent international organizations are invited to cooperate in identifying such practices and in taking, at national or international level, the measures necessary to ensure that the principles set out in this Declaration are respected.*

Some critics, however, aver that clauses such as the one in Article 11 are all but impossible to comply with as long as the concept of dignity has not been defined in more detail. According to Audrey R. Chapman, that is particularly applicable to the Declaration on the Human Genome and Human Rights, since nowhere in the convention does it say anything about how to identify practices contrary to human dignity.[19]

2.2.2 Definitions of the dignity concept

As already outlined, the dignity concept is integral to several key declarations and conventions, and has at least in that respect has had an influence on western culture. As mentioned, however, it is not obvious how the concept is to be understood, so some very short definitions of the concept will be given below—or rather a description of the traditions and schools of thought with which the concept has been interlinked. Therefore they are only to a very limited extent precise, clear-cut definitions.

2.2.2.1 Dignity as excellence and the good life

According to the *Great Danish Encyclopaedia* the word 'dignity' was used in the Middle Ages of the dignity (Lat. *dignitas*) of people as God's creatures and, from

[19] See Chapman, Audrey R., 2011. Human Dignity, Bioethics, and Human Rights. *Health Care, Bioethics and the Law*, *Amsterdam Law Forum,* Vol. 3:1.

the Renaissance, of a human being's personal value or worth, whereas nowadays it tends to be used of a person's charisma and as a characteristic ability to endure great adversity in life.

In one reading of the concept, dignity means something along the lines of excellence, honour, esteem or virtue. In this reading the concept can be construed such that dignified life is life that expresses some of the fundamental values and virtues that are part and parcel of a good and valued human life.

These fundamental values and virtues can be understood as ethical, in the narrow sense that they concern the regard we should have for one another and the attitude we should adopt towards other people in order to show adequate care and respect. So based on this understanding, for example, two people living together can be said to be undignified if the relationship is devoid of virtually any form of consideration or empathy. Primarily, therefore, the point is not that it is wrong to treat another human being in such a way, but rather that a relationship is undignified for both people if for some reason they are incapable of treating the other decently and are therefore unable to display one of the most fundamental virtues that forms part of a good human life.

In a slightly broader interpretation, the relevant values and virtues concern the individual's self-realization on a more general level and thus refer also to whether the individual's activities generally match up to the perceived notions we have of a valued human life. Based on this construction, many and varied types of activities or states qualify for consideration as undignified for the particular person. It can quite rightly be asserted that to exercise suppression is to violate dignity; that a person's dignity is violated by that person being made a slave; that it is undignified to appear naked or dirty in the public space or not to be able to provide for oneself and one's family etc. Conversely, as pointed out, the tenor of these possible assessments is that living a life with some degree of self-determination, maintaining a suitable standard of hygiene, at least towards the outside world, and so on is dignified and part of a valued human life.

Invoking this view of dignity, there will invariably be disagreements between different people as well as between different cultures as to when a state or an activity should be labelled dignified/undignified. That has to do with the variation in what is viewed as a good human life. For instance, some cultures accept polygamy, whereas in other cultures it will definitely be thought undignified for a woman to be married to a man with more than one wife.

A possible objection to the view of dignity described might be that the concept of dignity is not directly coterminous with the concept of good human life. Only special states or activities render assertions of dignity or unworthiness reasonable; it does not apply to all those states and activities that have to do with the good life. This criticism is presumably justified, but it should be mentioned that attempts have been made to counter it in modern literature on the subject. Thus the philosopher M.C. Nussbaum has linked the dignity

concept with her own view of 'capabilities', i.e. what genuine functional possibilities and scope for action a particular person has. The point now is that, according to Nussbaum, it is possible to formulate a list of the human capabilities that are central framework conditions for living a dignified human life. These capabilities include e.g. "*bodily health*: being able to have good health, including reproductive health, to be adequately nourished, and to have adequate shelter" and "*bodily integrity*: being able to move freely from place to place; to be secure against assault, including sexual assault and domestic violence; having opportunities for sexual satisfaction and for reproductive choice".[20] Nussbaum's list does not unlock the key to making assessments regarding dignity with unerring certainty, but at least it does single out those areas where such judgements can be apposite.

2.2.2.2 Dignity and Christianity

Historically, the concept of dignity also has a clear correlation with the biblical account of creation, in which mankind is described as having been created in God's image. If mankind was created in God's image, then on the basis of some readings, that can immediately be taken as supporting evidence for at least two factors. Firstly, mankind as a whole has a different status and value from the rest of creation, i.e. greater dignity. It is precisely this greater dignity, one might argue, that rightfully entitles mankind to rule over the rest of nature, as indeed he is entitled to do, according to the creation account; not necessarily by exploiting nature for his own gain, but rather as a kind of agent for God perhaps.

Secondly, the individual also has dignity precisely because he or she was created in God's image. It is debatable what exactly can be inferred from this, but the line of thought has often been used to justify the notion that human life is inviolable to some extent. That can be understood such that human life must not be taken or destroyed, or it can be construed such that there are limits to how much (ref. UNESCO's Declaration on the Human Genome and Human Rights) human life may be manipulated. Both readings make it necessary to decide when, more precisely, human life is involved. Does human life already start, for example, at the point of fertilization or not until some later juncture? It is also necessary to figure out what it means to treat human life in a dignified manner. E.g. is it undignified to create a new individual with the aid of reproductive cloning, and if so why?

It must be mentioned that many secular—i.e. non-religious—constructions of human dignity also take as their basis the view that mankind is something special, both as a species and as an individual. One example of a definition of dignity based on such a view is to be found in an article by the influential American doctor William P. Cheshire:

[20] Nussbaum, M.C., 2000. *Women and Human Development: The Capabilities Approach,* Cambridge and New York: Cambridge University Press, cited here from Chapman, 2011.

> *A suggested definition of human dignity is as follows: The exalted moral status which every being of human origin uniquely possesses. Human dignity is a given reality, intrinsic to the human substance, and not contingent upon any functional capacities which vary in degree. Evidence of this status may be found in such faculties as abstract reasoning, language, conscience, and free will, which human beings have the capacity to develop and exercise unless limited by disease, coercion, or the will. The possession of human dignity carries certain immutable moral obligations.*[21]

As explained, the individual's dignity is not locked into its own specific attributes. Dignity, by contrast, is imparted by virtue of traits associated with mankind and humanity as such. From this it also follows that it is perfectly possible to argue that each individual's dignity can be violated, even if that individual itself has no perception of being violated, since disregard for its humanity is independent of what it perceives or chooses itself. For example, enslavement is arguably undignified, even if a person has chosen it himself and feels quite comfortable being enslaved. At any rate, it involves a debasement of one's humanity.

2.2.2.3 Dignity and Kant

In the philosophy of Immanuel Kant (1724-1804) the concept of dignity is interconnected with an acknowledgement of the special capacities that people possess for autonomy and moral acting. Put in slightly simplified terms, therefore, it can be maintained that Kant's concept of dignity can reasonably be replaced by the principle of respect for other people's autonomy, as described above. This thought process will not be pursued any further here, therefore. However, it should be mentioned that a principle formulated by Kant has had independent significance for the discussion of dignity, namely Kant's categorical imperative, in its second formulation. The principle reads as follows: *Act in such a way that you treat humanity, whether in your own person or in the person of any other, never merely as a means to an end, but always at the same time as an end.*

Treating other people purely as a means to an end is thus synonymous with treating them in an undignified manner, because it fails to acknowledge their intrinsic value. Another, related formulation is that such treatment objectifies or commodifies others; they are viewed as objects and not as subjects with an independent perspective on life which must be taken seriously and respected in its own right.

Note that Kant's categorical imperative in its second formulation is not altogether easy to apply, since the principle does not say that one may *not* treat others as a means to an end *at all*. What it does say, though, is that others must not be treated *only* as a means to an end. In practice, therefore, whether it is

[21] Cheshire, William P., summer 2002. Toward a common language of human dignity. *Ethics & Medicine,* vol. 18, no. 2: 7-10, p. 10.

legitimate to apply Kant's imperative in any given situation depends on when the limit to the degree of acceptability of using others as a means to an end is exceeded. In many contexts that will probably be determined by a number of relatively specific attributes linked to the particular situation. For example, ordinary paid work is not normally regarded as being inconsistent with the principle unless the employee has altogether unreasonably poor working conditions.

2.2.3 Gathering the strands of the dignity discussion

To recap, it should be mentioned that the constructions of the dignity concept outlined can perhaps contribute to explaining why the concept is difficult to deal with. For in part it is intertwined with several different modes of thought that have nothing to do with one another on the face of it; and in part the modes of thought to which the concept is pegged give no precise definition of the concept in isolation either. Rather, it is a case of singling out the problem fields upon which the concept impinges. Accordingly, it may be left up to the individual's intuition to decide when it is legitimate to use the concept. However, opinions are divided as to whether these woolly points make the concept unusable in practice. Some think that is the case, whereas others maintain that similar ambiguities attach to a great many of the other concepts fundamental to bioethics.

2.3 What is exploitation?

In terms of definitions, there is broad consensus that exploitation presupposes, as a minimum, that a person A (the exploiter) benefits from a situation that involves B (the exploitee) in an inappropriate or unreasonable way, made possible among other things by A in some sense being the superior party in the situation.[22] That can be due to e.g. A having greater power, wealth or knowledge than B. The definition does not necessarily imply that A is aware of exploiting B, or of himself having created the situation that makes the exploitation possible. But of necessity A must derive benefit from the situation to such an extent as to warrant it being regarded as unjustified, precisely because it has been achieved by unreasonable means.

The essential point is that exploitation does not imply that the exploitee is necessarily worse off or harmed directly as a result of the transaction with the exploiter. On the contrary, it is consistent with the concept of exploitation that the exploited party is also afforded some advantage(s) by the transaction as compared with the original situation. It is precisely that aspect of exploitation which makes the concept interesting at a theoretical level, for if the exploitee is also afforded some advantage(s) by the transaction, how can it be wrong? After all, the very concept of exploitation implies that the proceedings involved are ethically objectionable.

[22] See Wertheimer, Alan, 2008. Exploitation. In: *Stanford Encyclopedia of Philosophy* (http://plato.stanford.edu/entries/exploitation/) and Goodin, Robert E., 1995. *Protecting the Vulnerable.* Chicago and London: University of Chicago Press.

A distinction can be made between exploitation harmful to the exploitee and exploitation beneficial to the exploitee. The latter form of exploitation, of course, is the one which is difficult to relate to. On the face of it, then, it would seem reasonable to intervene in the first form and attempt to avoid it. Similarly, a distinction can be made between exploitation for which the exploitee has not given voluntary and informed consent, e.g. because the exploitee has not been adequately informed or has been manipulated, and exploitation for which the exploitee has given voluntary and informed consent. In that case, too, the second form of exploitation is obviously more difficult to relate to than the first.

The distinctions mentioned offer a very usable basis for an ethical discussion of e.g. surrogacies and organ trafficking because they allow one to focus on the type of transactions that include primarily ethical problems or dilemmas. If a surrogate mother, for example, does not give voluntary and informed consent for the transaction, then purely on those grounds the agreement is wrong and should be prevented. People may think the same is true if the agreement is undoubtedly going to harm the surrogate mother—even if she has actually given voluntary and informed consent to go through with it. Conversely, it is not obvious what stance to take on agreements which are mutually advantageous and for which the surrogate mother has given her voluntary and informed consent.

The fact that exploitation can be mutually advantageous and involve the consent of the exploitee can be illustrated by an example. An infirm motorist runs out of petrol in the middle of the desert in the baking heat with no water and no phone. His petrol tank has sprung a leak. Another motorist happens to come along. He has plenty of petrol in his spare jerry-can and offers to sell some of it for £100 a litre. The infirm motorist buys 5 litres, enough to get him out of the desert. He is more than happy to pay £500 for it. Nonetheless, one can argue that he has been exploited, as he was only willing to pay so much because he found himself in a highly vulnerable situation. At most the other motorist ought to have charged him the same amount for the petrol as he himself paid for it.

As stated, one of the pivotal elements of our understanding of exploitation is that the exploiter achieves some benefit from the transaction in an unreasonable manner. So it would be an advantage if it were possible to word something about how to describe the specific aspect of exploitation that makes it unreasonable, but that does not seem to be possible. For instance, the philosopher Robert E. Goodin[23] maintains that “There is nothing about acts that make them intrinsically exploitative. It all depends on the context in which they are performed—on the nature of the game that people think they are playing.”[24]

[23] This and the following references to Goodin, Robert E., 1988. *Reasons for Welfare.* Princeton, New Jersey: Princeton University Press.
[24] Goodin (1988), p. 143.

According to Goodin, then, exploitation is tightly bound up with a lack of "fair play". Exploitation involves not complying with the formal or informal rules associated with the ethos of the game ("unfair play"), but instead pursuing an advantage in a situation where it is inappropriate to do so. Goodin gives several examples of what can make the pursuit of an advantage inappropriate and therefore justify a claim of exploitation. This applies e.g. in the following situations:

- When dealing with people who are not themselves in pursuit of achieving advantages. One example here can be trying to benefit from the fact that another person is in love with one.
- When dealing with people who are themselves incapable of adhering to the rules of the game to pursue advantages. That might be the case if, say, cheating a blind person by short-changing them. That is not just cheating, it is also exploitation.
- When dealing with people who are clearly inferior. An example might be financial agreements between children and adults.
- When securing the advantage due to the sorry plight or misfortune of others. That might be the case, say, if selling an ineffectual treatment to a very ill person.

The list is by no means exhaustive, but in Goodin's opinion exploitation can generally be said to involve violating an established principle of not exploiting vulnerable people. In that respect, exploitation is always linked to the relation between the exploiter and the exploitee not being equal in some sense. This inequality may or may not be entirely situational, as is the case for example with the motorist charging an extortionate price for the petrol from his spare jerry-can.

The above description of the concept of exploitation does not necessarily imply that economic transactions between those who are well off and those who are very badly off should be avoided at any cost. Conversely, one may claim, it is not appropriate to leave payment (if any) to the disadvantaged party to the outcome of a 'free' negotiation process between the parties. In that case the "distribution" of the advantages would almost inevitably end up being asymmetrical—precisely because of the disadvantaged person's exposed or vulnerable situation. If such transactions are to be conducted, the disadvantaged person must therefore be offered a fair or reasonable price. How such a price can be set is difficult to answer, however. Some have suggested that it must be set in a hypothetical market situation with relatively perfect market conditions. But one problem with such a model is that there may be some transactions that no one would accept under perfect market terms, e.g. the sale of kidneys. In such instances, therefore, the model provides no answer.

Importantly, exploitation is not inconsistent with the exploitee making a choice which, apart from being informed and free, is also rational, given the exploitee's actual situation. That may sometimes be thought to be the case in connection

with e.g. organ trafficking and egg cell trading as well as surrogacy agreements. If these transactions actually are the best option open to the exploitee to improve his or her own life situation and that of any relatives, and involve no risk that is not commensurate with the earnings potential, it may be rational to enter into the transaction, seen from the exploitee's own perspective. As mentioned, however, that does not imply that the transaction should be regarded as unproblematic from an ethical point of view.

Finally, it should be mentioned that, it can be argued that the possibilities for exploiting individual citizens must be regarded as worse in a welfare society like the Danish one than in societies with sizable groups of very poorly-off people—at any rate where the forms of exploitation concerned have to do with financial agreements or transactions. According to Goodin, that consideration can even be said to constitute one of the very reasons for creating a welfare state:

> *By guaranteeing that everyone's basic needs will be met through the impersonal and nondiscretionary agency of the state, we render otherwise dependent people substantially less dependent upon (and hence less vulnerable to) the actions and choices of particular others, who might otherwise have taken unfair advantage of those dependencies and vulnerabilities to exploit them.*[25]

If that is correct, and all other things being equal, agreements on e.g. surrogacy or organ trafficking must be said to entail a lesser risk of exploitation if implemented in Denmark rather than countries like India or Pakistan.

2.4 What are paternalism and autonomy?

A recurrent argument in favour of restricting the options available to potential surrogate mothers, organ donors or egg donors is that they cannot give free or informed consent to an agreement and are therefore incapable of safeguarding their own interests themselves. Such reasoning is paternalistic and used several times in this report. The discussion below will therefore be devoted to what paternalism is—and when the exercise of paternalism can be said to be justified.

Constraints on a person's self-determination for the person's own sake are termed paternalism and can be defined as "the intentional overriding of one person's known preferences or actions by another person, where the person who overrides justifies the action by the goal of benefiting or avoiding harm to the person whose preferences or actions are overridden".[26]

In other words, when a person acts paternalistically, that person overrides another person's right to self-determination or autonomy with the aim of

[25] Goodin, 1988, p. 125.
[26] Beauchamp, Tom L., and James F. Childress, 1994. *Principles of Biomedical Ethics.* 4th ed. Oxford University Press, p. 274.

benefiting the person or preventing that person from coming to harm. Paternalistic actions are usually perceived as problematic in a society like the Danish one, where the emphasis in many settings is on people's right to make up their own minds. That applies within the health sector too. For example, Section 2 of the Danish Health Act states that "The Act stipulates the requirements imposed on the Danish health services with a view to ensuring respect for the individual, their integrity and self-determination". And this declaration of purpose has left its mark on many of the provisions in the Act.

2.4.1 Different forms of paternalism

In the debate on paternalism a distinction is made between different forms of paternalism. The distinction between hard and soft paternalism is an important one. The hard paternalist overrides another person's self-determination or autonomy, despite regarding the other person as altogether legally competent. The soft paternalist, on the other hand, intervenes to prevent the other person from carrying out actions which, for some reason, must be characterized as involuntary or non-autonomous. The soft paternalist therefore considers the other person to be either momentarily or permanently incompetent to make decisions, which is part of the reason for intervening.

2.4.1.1 Hard paternalism

In the discussion on paternalism a recurring topic has been whether it is ever apposite to exercise paternalism vis-à-vis individuals who are fully qualified to make decisions. A common view is that this is not the case. A person who is fully qualified to make decisions will also be the best person to judge what course of action or level of exposure is best or most proper for them. Among other things, that has to do with knowing one's own values and interests better than others. For that very reason a person is also better at deciding what risk they are willing to take to achieve a particular benefit.

A person's choosing to disregard their own welfare in order to safeguard others' is not an expression per se of the person being disqualified to make decisions. On the contrary, it can be the only right thing to do on the basis of the values that person holds. The fact that commercial donors primarily perform donation in order to improve their family's standard of living does not, therefore, immediately warrant restricting their freedom on paternalistic grounds. Thus an essential point in the discussion on self-determination is that human self-expression is value-based and can reflect many different types of values. How these values are to be interpreted and weighed up in relation to one another can be difficult to gauge for anyone other than the person themselves. That consideration is precisely one of the reasons for hard paternalism seldom being considered acceptable.

2.4.1.2 Soft paternalism

Whereas hard paternalism is generally regarded as unacceptable, by contrast there is broad-based agreement that soft paternalism is defensible in many cases. So the salient point is not whether exercising soft paternalism can

sometimes be justified; rather, the salient point is which instances, more precisely, it is apt to exercise soft paternalism in.

2.4.1.3 Conditions for exercising soft paternalism

The literature on paternalism includes a multitude of attempts to posit and qualify the criteria governing when the exercise of soft paternalism is justified. One of the altogether fundamental criteria is that the person is not capable of make decisions and is therefore not competent of giving valid informed consent or a valid informed refusal to the offer presented. Whether that is the case has to be determined partly on the basis of the following parameters:

1. The person's ability to understand that he or she has different options.
2. The person's understanding of his or her own situation.
3. The person's ability to reason and adopt a rational position.
4. The person's ability to relate to his or her situation and scope for action on the basis of the values and interests (normally) endorsed by that person.

One view that consistently runs through the literature on paternalism is that the greater the risk a person runs, and the greater the risk of irreversible consequences a person exposes themselves to, the greater the demands one can be permitted to make of the patient's skills under points 1-4 when it comes to deciding whether soft paternalistic intervention is warranted.

The extremely extensive literature on the criteria for exercising soft paternalism will not be discussed further. Suffice it to say that the individual criteria rarely take the form of being either realized or non-realized—rather, they are realized to a greater or lesser extent. More often than not, therefore, the degree of decision-making competence a person must possess in order to be qualified to make a particular decision is a considered judgement, as the person can perfectly well be deemed capable of making some decisions, but not others.

Arguments in favour of prohibiting surrogacy, trading in kidneys or egg donation often take the nature of soft paternalism. That applies e.g. to the following argument, adduced by Simon Rippon:

> *I will argue that having the option to sell an organ may result, in circumstances which are predictably common among those in poverty, in individuals being held to account by others for taking and, more importantly, for failing to take the available option. I will also argue that people in poverty would be significantly harmed by being held to account in these predictable ways, with respect to the sale of their organs.*[27]

[27] Rippon, S. Published online, 28 June 2012. Imposing options on people in poverty: the harm of a live donor organ market. *Journal of Medical Ethics*, p. 4.

In one interpretation the argument can be viewed as an instance of soft paternalism.[28] If a person has an opportunity to sell their organs and chooses to do so, it must be regarded as a reflection of pressure from the surroundings. There is no free choice involved, therefore. For that reason, preventing the person from having the opportunity may be an acceptable option. Conversely, not selling their organs can also have negative consequences for the person. In that case the world around may reproach the person for failing to sell. All things considered, therefore, the best thing is for the option of selling one's organs not to exist at all.

[28] This interpretation is not entirely faithful to the text.

3. Types of medical tourism – three examples: trading in egg cells, surrogacy and organs

3.1 Trading in human eggs

3.1.1 Egg donation and eggs as a commodity

A substantial proportion of medical tourism concerns fertility treatment, with assisted reproduction using donor eggs making up a major share of that category.

Since the 1970s it has been possible to harvest mature eggs from a woman's ovaries, enabling eggs to be donated to other women with a faulty ovarian function or women who are not producing eggs. The most frequent causes of this are Turner's syndrome or premature menopause.

Egg retrieval uses a hypodermic needle guided through the top of the vagina or skin of the abdomen into the ovary, thereby making a hole in the egg sac (follicle) and allowing the egg to be aspirated. By stimulating the woman hormonally, it has become possible to develop multiple follicles with mature eggs in the ovaries simultaneously, thereby creating the possibility of harvesting several mature eggs during the procedure.

Unfertilized eggs can be kept alive for a long time in the right fluid or frozen, which is another prerequisite for being able to donate the eggs to other women. Since 1997 an option open to women in Denmark and regulated by law has been to donate eggs anonymously and without financial compensation other than to cover the costs of their donation. Danish legislation contains an explicit ban on selling, brokering the sale of, or in any other way contributing to the sale of unfertilized or fertilized human eggs (Danish Act on Medically Assisted Reproduction, Section 12).[29]

There are few women today, however, who wish to undergo the not altogether risk-free procedure associated with egg donation.

[29] However, it is permitted to pay the donor a fee for her costs associated with egg donation, giving rise to the question of what constitutes reasonable compensation without actual payment being involved. Different amounts of compensation are paid out at e.g. Danish and Swedish hospitals, and in Lund (Sweden) a trial in which egg donors are paid SEK 11,000 has eliminated the shortage of eggs (Dahlgaard, M., and U.G. Hansen, 2013. *Svenske æg til danske kvinder* [Swedish eggs for Danish women]. *Berlingske Tidende,* 15 June 2013). See discussion of this and the Council's recommendations for the size of compensation in its January 2013 statement at: http://www.etiskraad.dk/EtiskRaad/Hoeringssvar/~/media/bibliotek/udtalelser/2013/DER-Udtalelse-om-kompensation-for-aegdonation.pdf

Egg retrieval is often painful and can result in bleeding and inflammation. Hormone treatment can cause discomfort, pain and other complications, and hyperstimulation can produce severe shifts in the salt and fluid balance. That is presumably one of the contributory causes of there being very few egg donors and hence a not unsubstantial waiting list for the treatment in Denmark. In that situation a number of Danish women and couples are seeking treatment in countries where the size of the compensation given to donors means there is no lack of egg donors.

3.1.1.1 The global situation

Since the European countries do not record data about their own citizens' fertility trips, there are no official statistics detailing the scope of this traffic. The market involved is partly illegal, for which reason the data about its scope are inadequate. However, a number of surveys and journalistic reports from recent years do indicate it is a growth market. The authors of an extensive study of patients at 46 fertility centres in six European countries that receive patients from other countries estimate that 11,000–14,000 patients in Europe have fertility treatments performed in other European countries annually. Among the couples involved in the study, 22.8% received donor eggs and 3.4% embryo donations (both eggs and sperm).[30] The latter is prohibited in Denmark, where assisted reproduction may only be carried out if either the father or mother-to-be supplies germ cells and thus becomes a genetic parent to the child.

In studies the women sourcing the treatments cite a number of reasons for seeking them abroad. The most frequent ones include waiting lists for donor eggs in the home country, but lower prices for treatment abroad also exert a pull. In addition, many people cite ethically based restrictions on such treatments in the home country as a reason.[31] In Denmark these restrictions consist of payment for eggs being banned and, as mentioned, simultaneous egg and sperm donation not being allowed. There is also an age limit of 45 for women wishing to receive eggs.

In principle the ban on paying egg donors applies throughout Europe, since most European countries have acceded to *the Council of Europe's Convention on Human Rights and Biomedicine*[32]*,* which prohibits making the human body and its constituent parts a source of financial gain. In the process they have also undertaken to combat trading of human eggs. But there is a grey zone, in that most countries allow the donors some financial compensation, and the level of compensation varies, both from one country to another and between clinics in those countries. In some countries, e.g. in southern Europe, the size of such compensation indicates that the women are not donating for altruistic reasons

[30] Shenfield et al., 2010. Cross-border reproductive care in six European countries. *Human reproduction,* published 26 March.
[31] Hudson et al., 2011. Cross-border reproductive care: a review of the literature. *Reproductive Biomedicine Online 22,* p. 680.
[32] See also the European Parliament resolution on the trade in human egg cells, P6_TA(*2005*)0074.

but effectively selling their eggs. In these countries there is no waiting time for donor eggs at private clinics.

In a number of countries outside Europe trading in eggs is not banned. This applies to e.g. the USA, where neither egg donation nor fertility treatment in general is regulated to any particular extent. Compensation for egg donation is left to self-regulation guided by a set of guidelines from *the Ethics Committee of the American Society for Reproductive Medicine*. American fertility clinics report that they treat 1,399 women annually from other countries (making up 4% of their treatments). The largest group of patients comes from Latin America (39%) and Europe (25%). At the same time, it is estimated that 217 American women seek treatment abroad every year.[33]

In India trading in eggs is not merely not banned, it is encouraged by the Indian government, which views medical tourism, including fertility tourism, as a promising financial area of commitment. At the moment the area is unregulated, but a bill on assisted reproduction, which has been under consideration in parliament for several years now but not passed, proposes official legalization. Its Section 26(6) says that: "An ART bank may advertise for gamete donors and surrogates, who may be compensated financially by the bank."[34]

3.1.1.2 Examples of provider countries

As mentioned, the compensation fees for egg donors in several southern European countries are of such magnitude as to be effectively tantamount to trading in eggs. Spain and the Czech Republic were the most sought-after European countries for those women travelling to receive egg donation in the study above. Other European countries that often play host to fertility travellers are Greece and Cyprus.

In Spain the standard compensation comprises 900 euro for egg donors (approx. DKK 6,800) whereas in the Czech Republic it is typically 800 euro (DKK 6,000).[35] However, it is important to take the relative price level in different countries into account here. Thus 800 euro in the Czech Republic represents far more than a month's pay for a factory worker. It is also important to take account of the country's level of prosperity and the donating women's possibility of finding work. In some cases, for example, women from Ukraine are willing to fly to Cyprus to donate eggs for approx. USD 500 (DKK 3,000).[36] The phenomenon of flying in donors is due to some northern European women wishing for donors with the same ethnicity as themselves. They are therefore willing to pay higher prices to obtain a donor with Caucasian features.

[33] Hudson et al., 2011.
[34] Draft: The assisted reproductive technologies (regulation) bill – 2010.
[35] Bergman, S., 2011. Reproductive agency and projects: Germans searching for egg donation in Spain and the Czech Republic. *Reproductive Biomedicine online* 23, p. 601ff.
[36] Caney, S., 2010. Unpacking the global human egg trade. See: www.fastcompany.com/1676895/-unpacking-global-human-egg-trade

Even cheaper eggs can be bought in actual developing countries. Thus the British daily *The Guardian* reports women in Indian villages selling their eggs for approx. DKK 650—the equivalent there of twice a man's monthly wage.[37]
In the USA the financial compensation for egg donation is left, as mentioned, to self-regulation guided by a set of guidelines from *the Ethics Committee of the American Society for Reproductive Medicine*. That society recommends that the fertility clinics pay between USD 5,000 (DKK 29,000) and USD 10,000 (approx. DKK 58,000) for donor eggs, though the guidelines are not binding. According to a study conducted in 2006 of 105 advertisements inserted in 63 student papers, 50% of the ads offered to pay USD 5,000 or less for an egg, 27% offered USD 5-10,000 and 23% offered more; a single ad offered USD 50,000 (DKK 290,000) for an egg from the right donor. Prices depend on the donor's appearance, ethnicity and intelligence (top grades at prestigious schools).[38]

Despite the higher prices, some Europeans looking for egg donation do travel to the USA. Thus American data show that 45% of the women travelling to the USA every year to receive egg donation come from Europe. At the same time, some American couples do travel to countries where the prices of donor eggs and treatment packages are lower than the USA.[39]

Just as the prices of eggs vary greatly between different countries, the prices of a course of treatment with donated eggs do so too: the journalist Scott Caney states e.g. that a course of treatment in the USA costs an average of USD 40,000 (DKK 230,000), whereas in Cyprus it is available for USD 8,000 (approx. DKK 44,000).[40]

3.1.1.3 A global market

Truly, there is a global and diversified market for trade in human eggs, and the marketization means that the egg donors are subject to ranking. At the top end some prospective parents are trying to "buy their way" to a child with certain, specific characteristics by paying high prices for eggs from beautiful American elite students.

At the bottom end the poorest donors are in such a weak position that they risk being exploited and exposed to unsafe treatment in connection with donation. Donating eggs involves a risk of the woman being hyperstimulated with the follicle-stimulating hormone, which is intended to ensure that she matures eggs for extraction—preferably slightly more than normal. If too many eggs are matured, it can lead to ovarian hyperstimulation syndrome (OHSS), which is a potentially life-threatening condition with, among other things, enlarged ovaries

[37] Prasad, R., 2008. The fertility tourist. *The Guardian.* Wednesday 30 July.
[38] Levine, A., 2010. Self-Regulation, Compensation, and the Ethical Recruitment of Oocyte Donors. *Hastings Center Report* 40, no. 2: 25-36.
[39] Here from Hudson et al., 2011. Cross-border reproductive care: a review of the literature. *Reproductive Biomedicine Online* 22, pp. 673-685.
[40] Caney, 2010.

and build-up of fluid.[41] Reports from India state that some doctors are giving doses of follicle-stimulating hormone far exceeding the recommended dosage in order to increase the number of eggs that can be harvested in one cycle (and thus boosting the recipient woman's chances of pregnancy). Information is often withheld from poor and underresourced donors about the risks entailed, and for financial reasons they do not receive the necessary treatment if they are hyperstimulated.[42]

Although conditions are presumably not as crude everywhere as at these Indian clinics, as a purchaser of donor eggs in another country it can be difficult to know whether the egg donor has been through a process of informed consent, given safe doses of medication and paid a price that can be considered reasonable for her eggs.

So although poor donors often run a risk of very low payment, some women themselves view selling their eggs as their best option for coping with financial expenditure on basic things like food and their children's education. *The Guardian* quotes egg donor Pushpa from a village in the state of Gujarat, who sold an egg for approx. DKK 650 (GBP 70) (twice her husband's monthly wages, saying:

> *I don't feel exploited; here, in the villages, every aspect of life is exploitative - where you can work, what you can eat, when you have sex. This is the best option available to me. I wanted to send my children to a good school. They will have a better future.* [43]

In the vast majority of cases the egg donor sells her eggs to the fertility clinics, and in many cases there are also middlemen involved; these are the stages that profit most from the procedure.

3.1.1.4 The situation for Danes paid for donating eggs abroad

There are no restrictions on Danes—often assisted by Danish fertility clinics—travelling abroad to buy fertility treatment involving donor eggs. And presumably in practice, too, it will be particularly difficult to document that a woman returning home pregnant from a holiday has fallen pregnant as a result of commercial egg donation.

3.1.2 Ethical discussion of trade in eggs

At a fundamental level, trade in eggs outside of Denmark entails a number of the same ethical issues as commercial surrogacy and organ trafficking. Firstly, there is a risk that the woman selling her eggs is being exploited, which is made

[41] Ingerslev, J. et al., 2012. Udvikling og udfordringer i fertilitetsbehandling i Danmark. *Ugeskrift for læger,* 174/41.
[42] Prasad, Raekha, 2008. The fertility tourists. *The Guardian*, 30 July, and Tanderup Kristensen, Malene, 2012. Cross-border Reproductive Care - Surrogacy in India. Aarhus University Hospital.
[43] Ibid.

possible by her vulnerable plight of poverty, low level of education and so on. That exploitation is possible partly owing to her being hyperstimulated with hormones to obtain multiple saleable eggs, or to the woman's payment not being reasonable in relation to the risk and effort involved in extracting the eggs. Nor, oftentimes, does the payment match the payment received by the intermediaries or health professionals involved, just as the woman does not necessarily receive adequate medical aftercare if problems arise in connection with harvesting the eggs.

Another issue is that the woman's consent to the agreement can be difficult to describe as autonomous in many cases. That may tie in with the information about the risk from hormone stimulation and egg retrieval quite simply being withheld from her; or it can be due to her situation being so desperate that she has no other real options, and in that sense must be said to be pressured or compelled by her plight to agree to sell her eggs.

A third problem is whether it is undignified for the woman to sell her eggs, because she is overlooking her own reproductive freedom – her right to dispose over her eggs for the purpose of her own reproduction – and commodifying parts of her own body by treating it as a means of making money.

Finally, trading in eggs embraces a problem also linked to surrogacy, i.e. such commercialization may conceivably have a bearing on our understanding of parenthood. As mentioned in the paragraph above, in many cases the price of the eggs is particularly dependent on the woman's conditions, credentials and attributes, in that well-educated women, for example, can get more money for their eggs than uneducated ones. There is no ruling out that this aspect of commercialization can contribute to changing the understanding and expectations of the child-to-be on the part of the woman or couple receiving an egg. If a lot of money has been paid for an egg from an elite donor, the expectation may also be that it will be reflected in the attributes the future child will have.

The issues outlined have been detailed elsewhere in this report and will not be described in detail here, therefore. How it can be attempted to counter such problems has also been described, e.g. by creating certification schemes which lay down specific minimum requirements regarding the terms governing the conclusion and implementation of the agreement. But of course, it is debatable whether the problems of trading in eggs are just as serious as those connected with surrogacy and organ trafficking. In some respects that does not seem to be the case. For instance, intervening in the woman's reproductive freedom can scarcely be described as being as radical when trading in eggs as in connection with surrogacy—much like the health-related discomforts associated with harvesting eggs, which will usually be less than those involved in removing a kidney.

3.1.2.1 The government's tasks and duties

For some years now the unfertilized eggs available in Denmark have been smaller in number than the women wishing to receive them. In an attempt to provide more eggs, more liberal legislation has been introduced in recent years, among other things permitting women who are not themselves undergoing fertility treatment to donate eggs, as well as both donation from a known donor and cross-donation. In cross-donation a woman obtains an egg from a known donor, typically a female friend or relative, which is "swapped" via a pool for an egg from a donor unknown to the woman; the woman then has this egg fertilized and implanted in the womb. This ensures that the egg donor's anonymity is preserved. The woman does not become pregnant with eggs from her friend or relative, and the friend or relative may have a heightened incentive to donate, precisely because the woman is given an opportunity to get pregnant without complications arising as a result of the friend or relative being the biological mother of the child resulting from the set-up.

In spite of these initiatives, however, there is still a great deficiency of eggs for donation in Denmark, which is the reason some women or couples go abroad to obtain an egg in return for payment. Viewed from the government's perspective, the lack of eggs is not expedient or desirable in a number of respects. For one thing it means that some women or couples do not get the child they wish for. For another it leads, as has been said, to some women or couples going abroad and obtaining an egg in return for payment, receiving treatment that (at least in some cases) is not medically equivalent to the treatment they could have received if it had been carried out in Denmark. What is more, in the process Danish citizens are more or less forced to participate in an arrangement that cannot necessarily be justified, since it entails exploiting poor women and in some instances is also contrary to the Bioethics Convention. As mentioned, actual trade in eggs is not permitted under this convention. Some Danish fertility clinics also take part in the traffic, offering through their websites to facilitate contact with clinics in countries including Spain and Greece, which can offer fertility treatment with donor eggs in return for payment. The Danish clinics also offer to convey the man's sperm to the clinic with a view to fertilizing the donor egg, and to take charge of hormone treatment for the Danish women so that they can receive the fertilized egg.[44]

To what extent it is the public sector's task to get involved in ensuring that the need for donated eggs is met, thereby also obviating the adverse consequences of an egg shortage, is open to discussion. In terms of a society like the Danish one, that can perfectly well be argued to be the case, because the public sector has assumed the task of meeting its citizens' health-related needs in other contexts too. That view is shared by the Nuffield Council:

[44] See e.g. http://www.lundstrom.dk/Aegdonation_i_udlandet.htm and http://www.copenhagenfertilitycenter.com/behandlingen/gdonation.htm

> *We return here to the idea of the state as the "steward" of good health, and reiterate the stance that the underpinning concept of the state as steward of public health is equally applicable to the responsibilities of states with respect to the donation of bodily materials. In our view, this stewardship role is as applicable to the donation of reproductive material as it is to other forms of bodily material, notwithstanding the view (very firmly expressed by some) that fertility is essentially a private concern.*[45]

Even adopting that view, of course, it is not acceptable to procure either bodily or reproductive material at any cost. There can be other considerations pointing in the opposite direction. Thus, in the context of egg donation, for example, some of the opposing considerations that seem to call most obviously to be taken into account are regard for the donor, regard for preserving community values by supporting altruistically based donations and regard for the child-to-be. Under any circumstances, however, a key question is whether it is possible to obtain more eggs for donation in Denmark by ethically acceptable means.

3.1.2.2 Compensation and trade

As mentioned, owing to the Bioethics Convention, trading in eggs is not permitted in Denmark, but it is permitted to pay compensation for the donation. An interesting question is whether more eggs for donation can be procured by raising the amount of compensation and, by extension, how great the amount of compensation can be before it is actually a case of payment.

One of the purposes of offering compensation instead of making a payment can be to ensure that the donor undertakes the donation on the basis of altruistic motives.[46] That is not to say that the donor may not have motives for donating other than altruism, but there may be a risk of altruistic and financial motives making odd bedfellows. The possibility of such motives coexisting must be assumed to depend on a number of things.

Firstly, it must be assumed that the possibility of altruistic and financial motives coexisting depends on the size of the compensation. That this is so can be illustrated by the following quote from a Danish egg donor, Stinne Fruelund, who had previously donated eggs a couple of times for the sum of about DKK 1,900 a time. Of this, DKK 500 was for the actual donation, whereas the other money was payment for transport costs. According to Stinne Fruelund, it might change her understanding of the donation to raise the compensation to e.g. DKK 5,000:

[45] Nuffield Council on Bioethics, 2011. Human bodies: donation for medicine and *research*, pp. 15-16.

[46] See the section on commercialization in the text "Ethical topics concerning globalization and commercialization".

> *Well, I chose to become a donor before I knew I would be getting anything for it financially. So for my own part I know that I would still do it because I would like to help others. But 5,000 kroner is a whole lot of money for a single mum like me. So somewhere along the line I might well consider donating eggs as a possible solution if I was strapped for cash. At any rate, I think it's a dangerous dilemma*.[47]

The quote demonstrates that it can be difficult to cling to an altruistic motive for donating if the compensation is sufficiently high. Stinne Fruelund's assumption, then, is that if the compensation was DKK 5,000 instead of DKK 500, she would presumably only be able to think of her donation as altruistic because she had previously donated at a considerably lower price. If the compensation had been DKK 5,000 from the outset, it would have been harder for her to think of it as an altruistically motivated act.

It should be mentioned that if in the process the panel of egg donors ended up consisting almost exclusively of financially motivated donors, the general perception of egg donation might easily change, so that both the players involved, the actual transaction and the donated eggs came to be understood in market-economic terms. But if such a shift in perspective did take place, that could have a number of consequences for this practice. E.g. it might result in there being fewer rather than more eggs for donation in Denmark, since in principle it would be irrational for a Danish egg donor to make her donation in Denmark if she could obtain a higher price abroad. Hypothetically, therefore, an increase in the compensation for egg donation in Denmark might lead to a shortage of eggs in the long term, as donors would have a purely financial outlook and would therefore head wherever the price was highest. That will not necessarily happen if donors see themselves as participants in a partially altruistically minded practice. Nor, moreover, is there any guarantee that the financial motivation for donating eggs is necessarily more powerful for Danish citizens than the altruistic one.

It is not definite, therefore, that the problem with waiting lists for eggs for donation in Denmark can be remedied by raising the size of the compensation. However, one alternative might be to regard the compensation as made up of financial compensation for transport and lost earnings potential as well as a symbolic recognition of the donor's efforts. It may conceivably be thought that the compensation given to an egg donor should consist not only of money, but of a paid stay of recuperation instead, for example, which could be used after the donation procedure. If such a stay were sufficiently lucrative, it might constitute an incentive to donate that would not undermine the altruistic motivation.

[47] Berlingske, 11 December 2012, 1st section, p. 6: "Ægdonor: Penge skaber et farligt dilemma".

3.2 International surrogacy

3.2.1. Different forms of surrogacy

Surrogacy refers to an arrangement in which a woman consents to become pregnant for the purpose of giving birth to a child which she will hand over to someone else at the time of the birth. With technological developments in fertility treatment, there are now two forms of surrogacy biologically:

- Traditional surrogacy: The surrogate mother is the child's genetic mother, either by the natural method or by being inseminated with the planned father's semen (the semen can also originate from a sperm donor, of course),

- Gestational surrogacy: The surrogate mother does not provide the egg; it can come either from the planned mother (if she is producing eggs but does not have a functional uterus) or from an egg donor. Again, the semen can come from either the woman's partner or a sperm donor. The fertilization takes place in vitro, and the fertilized egg is transferred to the surrogate mother. The first case described was in 1984.[48]

The phenomenon only started to take on importance when surrogacy brought about with the aid of insemination began to emerge as a commercial phenomenon in the USA in the late 1970s and early 1980s. Here, of course, it was the surrogate mother who provided the egg and became the child's genetic mother.

In the past ten years the other type of surrogacy has gained ground, and today it is used in 95% of cases in the USA, whereas in India it is practically the only method in use.[49] For many surrogate mothers it matters greatly that they are not the genetic mother of the child and that fertilization takes place in vitro, as infidelity, in India for example, carries a particular social stigma.[50]

Surrogacy is currently desired by women who, for medical reasons, cannot see a pregnancy through because their wombs are malformed or damaged, e.g. as a result of being treated for cancer. Some women are born with functional ovaries but without a functional uterus, and can thus supply eggs that can be fertilized and implanted in a surrogate mother. Also, some male homosexual couples and singles wish to have children by surrogacy. The wish can be reinforced by the fact that it is becoming increasingly difficult to adopt foreign children, while the supply of Danish children up for adoption is very small.

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[48] Jadva et al., 2003. Surrogacy: The experiences of surrogate mothers. *Human Reproduction*, vol. 18, no. 10: 2196-2204.
[49] Smerdon, U.R. 2009. Crossing Bodies, Crossing Borders: International Surrogacy between the United States and India.
[50] Pande, 2009, p. 147.

3.2.1.1 Social and psychological aspects of surrogacy

During a pregnancy, bonds both psychological, biological and epigenetic form between the pregnant woman and the fetus.[51] On the basis of the existing studies it is difficult to conclude anything definite about the importance of being a surrogate child for children's wellbeing and bond with their parents. Only few studies with small numbers of participants have been conducted into wellbeing in children born by surrogacy. A British study carried out over 10 years compares 32 children born by surrogacy with 32 born by egg donation and 54 born by traditional fertilization. Here it was found that the relation between parents and surrogate children of pre-school age was more positive than in those families where the children were born by traditional fertilization. That changed when school started, when the mother-child relationship was less positive in the surrogate families than in those where the children were born by traditional fertilization. At the same time, the surrogate children displayed greater adjustment problems at age 7 than children born by egg donation. The findings were not significant, however, as the surrogate children functioned well in their early school years.[52],[53]

By way of comparison, several studies show that adopted children are at significantly increased risk of different types of mental health problems.[54] The fact that both adopted and (less so) surrogate children experience greater adjustment problems at age 7 than children born by egg donation could indicate that a gestational relationship between mother and child is more important than genetic kinship. Interestingly, the problems decreased for both surrogate and adopted children later on as they were growing up.

In terms of consequences for the surrogate mother, a British study from 2003 showed that the women in general did not experience greater problems handing over the baby to the planned parents. Some experienced emotional problems during the weeks after the birth, but these lessened with time.[55]

3.2.1.1 The global situation

Surrogacy is currently banned in most countries, including Finland, France, Germany, Italy, Mexico, Sweden[56], Switzerland and some American states.[57]

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[51] See e.g. Brudal, L. 2000. *Psykiske reaksjoner ved svangerskap, fødsel og barseltid.* Bergen, Norway: Vigmostad & Bjørke A/S.

[52] Golombok et al. 2011. Families created through surrogacy: Mother-child relationships and children's psychological adjustment at age 7. *Dev Psychol*. 47(6): 1579–1588.

[53] Golombok et al. 2013. Children born through reproductive donation: a longitudinal study of psychological adjustment. *Journal of Child Psychology and Psychiatry,* vol. 54, no. 6, pp. 653–660.

[54] Ljungdal et al. 2007. Adoption och psykiska hälsoproblem - en systematisk litteraturöversikt. Swedish National Institute of Public Health.

[55] Jadva et al. 2003. Surrogacy: the experiences of surrogate mothers. *Human Reproduction,* vol. 18, no. 10, pp. 2196-2204.

[56] However, the Swedish National Council on Medical Ethics has just recommended relaxing the ban on altruistic surrogacy, see SMER 2013.

[57] The Permanent Bureau. 2012. A Preliminary Report on the Issues Arising from International Surrogacy Arrangements. The Hague Conference on Private International Law, p. 9.

Other countries, e.g. Great Britain, permit altruistic surrogacy, whereas still others, including Denmark, do not stop this going ahead in tightly defined situations, i.e. where the surrogate mother herself supplies the egg, the pregnancy is achieved with the aid of privately performed insemination using the husband's sperm and the agreement involved is a non-commercial one.

There is agreement among researchers and in international organizations that recent decades have seen a growth in cross-border surrogacy.[58] However, it is difficult to put figures on the scope of international traffic in commercial surrogate mothering owing to the fact that most countries do not register either their own citizens' use of surrogacy or, in the recipient countries, the number of procedures carried out. The USA, however, does carry out some registration of the IVF clinics' treatments, including their gestational surrogacy treatments.[59] The statistics are patchy and do not include traditional surrogate agreements, but they clearly indicate a tendency towards a large increase in the number of surrogate agreements. Thus, from 2004 to 2008, it doubled, with 738 children being recorded as gestational surrogacy births in 2004 as against almost 1,400 in 2008.[60]

Apart from the legislative factors, this growth is attributed to a convergence of several research developments, demographic and social trends.[61]

In the field of research, as mentioned, the development of assisted reproduction techniques, especially IVF, has enabled the genetic kinship between surrogate mother and child to be discontinued, allowing surrogate mothers to give birth to children to whom one or both the social parents are also genetic parents. The Internet has made it possible for residents of rich countries to easily track down surrogate mothers and clinics in countries with less restrictive legislation. And cheap airfares have made it possible to travel to countries where there are many women willing to undertake the pregnancy in return for payment, owing to impoverishment.

These developments have turned international surrogacy into a phenomenon encompassing every region of the world. Studies done among fertility clinics in the USA, Great Britain and India show that the childless, singles and couples come from around the world to those countries that allow commercial surrogacy.[62] These states are Georgia, India, Russia, Thailand, Uganda, Ukraine and 18 US states, and they have become the centre of the international surrogacy trade. The countries have typically introduced provisions granting the intended parents custody of the child after the birth. However, in most instances

[58] Ibid p. 8.
[59] The statistics are from the US Department of Health and Human Services, *Centers for Disease Control* (CDC) and the *Society for Assisted Reproductive Technology (SART),* respectively.
[60] Council for Responsible Genetics. 2010. *Surrogacy in America.* Accessible online at: http://www.councilforrespons blegenetics.org/pagedocuments/kaevej0a1m.pdf
[61] Ibid p. 6.
[62] According to *The Permanent Bureau* p. 16.

(though not in India, see further below) it is possible for the surrogate mother to change her mind and retain parenthood if she so wishes.

Often, however, the social parents' homeland does not recognize this type of parenthood, and in recent years this has led to a series of court cases in different countries, causing great problems for the social parents—and ultimately for the child. If the planned parents' homeland refuses to acknowledge parenthood and the child's nationality, the child can end up orphaned and without a nationality. In some cases, therefore, it is the very regard for the child that has led to courts of law, e.g. in Belgium and the Netherlands, having recognized parenthood on the grounds that the illegal nature of the surrogate agreement could not be assigned greater importance than the child's basic interest in having a family and a nationality.[63]

Apart from the legislation, the cost of the surrogacy pathway also plays a part for many couples. There are big price differences between the USA and the other countries that allow commercial surrogate transactions, as a result of which American couples often resort to India too. The same applies to Britons, because although only altruistic surrogacy is permitted in Great Britain, paying the surrogate mother's costs of up to GBP 15,000 (DKK 90,000) is permitted. The table below shows the approximate price differences between Great Britain, the USA and India, the costs in India equalling those in Great Britain; on the other hand, the legislation in India is sympathetic towards surrogacy, and the planned parents are offered assurances that the surrogate mother will not choose to keep the child.

	Great Britain	**USA**	**India**
Payment/compensation to the surrogate mother (DKK)	90,000	100-140,000	28-40,000
Total costs of the surrogacy (DKK)	140,000	285,000-1.4m	140,000
Handover of the child can be enforced	No	Yes (in states where legal)	Yes

Source: Shetty, Priya. 2012. India's unregulated surrogacy industry. The Lancet, vol. 380, 10 November.

Another relevant difference is that the proportion of the payment due to the surrogate mother differs greatly between the three countries. In Great Britain 64% of the DKK 140,000 goes to the surrogate mother, whereas in India she receives only 20-28% of the total cost for the intended parents of DKK 140,000. But although the Indian clinics and middlemen pocket the bulk of the amount

[63] Ibid p. 21.

paid by the intended parents, the remuneration of DKK 28-40,000 received by the surrogate mother[64] nevertheless contrasts with the monthly income for Indian families, which is often around DKK 500-1,300.[65]

3.2.1.2 Example: The situation in India

As mentioned, India is perhaps the largest provider of commercial surrogacy in the world. This is down to factors such as the country having a combination of many English-speaking, well-trained doctors coupled with a large, poor section of the population from which women can be recruited as surrogate mothers. Added to this, however, the Indian government is officially banking on medical tourism as a growth area. As part of that, commercial surrogacy was legalized in 2002, and the *Confederation of Indian Industry* estimates that the traffic now generates DKK 13bn in annual turnover. Subject to the uncertainties involved in computing the figure, because there are no published surveys of Indian fertility clinics, it is estimated that 25,000 children are born to Indian surrogate mothers, including half for western clients.[66]

Despite this commitment India's medical tourism industry is completely unregulated, however, discounting some short guidelines from the *Indian Council of Medical Research* (ICMR). The government has a draft bill in the pipeline: *the ART regulation draft bill 2010;* but it has not yet been tabled in the parliament. Among other things its intent is to draw up binding rules for surrogate agreements, to look after the interests of both the planned parents and the surrogate mothers. The bill lays down limits on the age of the surrogate mother and the number of pregnancies she can complete. A national authority is to be set up to regulate the fertility clinics and to receive and handle complaints about them. Payment for surrogacy will be permitted, and the contract must include a life assurance policy for the woman. The bill also specifies that the intended parents must be given as legal parents on the birth certificate, and at the same time they must undertake to take in the child irrespective of any disabilities or other circumstances (e.g. divorce between the parents during the pregnancy). Finally, the bill contains a proposal to set up 'banks' of potential surrogate mothers so that clients can deal with them directly in order to avoid clinics and middlemen monopolizing the contact and taking the lion's share of the payment.[67]

As stated, the bill has not yet been tabled, so the area remains unregulated until further notice. However, under pressure from the EU in the autumn of 2012, the Indian authorities have impressed on their embassies that homosexual couples, singles, unmarried couples and couples from countries where surrogacy is illegal cannot obtain a visa to enter the country with a view to obtaining

[64] Shetty, Priya. 2013. India's unregulated surrogacy industry. *The Lancet,* vol. 380, 10 November.
[65] Malene Tanderup, interview survey from Delhi.
[66] Ibid.
[67] Saxena et al. 2012. Surrogacy: Ethical and Legal Issues. *Indian Journal of Community Medicine*, vol. 37, no. 4: pp. 211-13.

surrogacy treatments in India.[68] That said, there are parallel examples of the legislation in India not being enforced in the case of the fertility clinics. For example, Indian legislation does not under any circumstances allow the use of gender (sexing) tests with a view to aborting fetuses of unwanted gender.[69] Yet the scale of both sex-selective abortion and killing of girls is so great that in 2007 there was a shortfall of 42.7 million women in India.[70] The figure was arrived at by working out how many Indian girls and women there were supposed to be if the country had the normal distribution of sexes, which for neonates is 101 boys per 100 girls. By way of comparison, in 2011 it was 110.5 boys per 100 girls in India, and in some regions the skewed ratio was greater; thus, in Punjab it was 120.3 boys per 100 girls.[71] These statistics show that sex-selective abortions are taking place on a massive scale, made possible by the use of fetal diagnostics. So enforcement of the legislation is far from being consistent in this field.

Indian surrogate mothers are recruited from among poor, uneducated women, often from the country. It is often their husbands and middlemen who talk them into entering into the agreements, and they are often left uninformed about the risks they run, e.g. in the event of multiple pregnancies.[72] Many clinics implant 5 or 6 embryos at a time without involving the women in the decision about the number, just as they do not involve the women in decisions concerning any subsequent fetal reduction required. That leads to many multiple pregnancies and caesareans.[73] The women are often installed by their commercial agent in hostels, where they have to live together with other surrogate mothers, either throughout the pregnancy or from the time they start to show. Here the women's diet, exercise and contact with the outside world are all monitored. In the event that the pregnancy goes wrong, the women are often not paid, and they do not receive post-natal medical and psychological treatment.[74]

An ethnographic study from the town of Anand in the Indian state of Gujarat (which has become a centre for international commercial surrogate treatment), which includes 42 surrogate mothers, shows that 34 of the women came from

[68] Peter Dalberg, head of Section, Danish Ministry of Foreign Affairs' Citizens' Service Centre, and Jette Samuel Jeppesen, Chief Adviser at the Danish Ministry of Foreign Affairs, personal communication. See also Nilanjana Bhowmick, 2012. Why People Are Angry about India's New Surrogacy Rules. *Time World*, 15 February.

[69] Source: L brary of Congress (http://www.loc.gov/law/help/sex-selection/india.php) which refers to the Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, No. 57, of 1994, and the Pre-natal Diagnostic Technologies (Regulation and Prevention of Misuse) Amendment Act, No. 2002, No. 14 of 2003.

[70] United Nations Development Programme. 2010. Power, Voice and Rights - A Turning Point for Gender Equality in Asia and the Pacific, p. 42, and the United Nations Population Fund. 2007. Characteristics of sex-ratio imbalance in India and future scenarios.

[71] UNFPA. 2012. *Sex imbalances at birth, current trends, consequences and policy implications,* p. 20.

[72] Saxena et al. 2012; see also Shetty, 2012.

[73] Tanderup, Malene. 2012. *Cross-border Reproductive Care - Surrogacy in India.* Research Year Report. Aarhus University Hospital.

[74] Saxena et al. 2012; Shetty, 2012.

families with incomes on or below the poverty line. The remuneration for the surrogacy was equal to almost 5 years' income for the women's families. The women's level of education varied, but the majority had completed their schooling at the start of middle school.[75]

Surrogacy is extremely stigmatized in India, many people equating it with prostitution, partly because they are ignorant about the procedures applyed. In many instances the woman herself does not make the decision to undertake the surrogacy, it is taken by her husband or the extended family, who see it as an obligation for the family.

In an ethnographic PhD dissertation Amrita Pande has conducted field work among surrogate mothers in Gujarat. According to her a composite picture is emerging, in which some of the women choose to take on the surrogacy, but many are pressured by financial desperation.[76] The women interviewed give regard for their family, repayment of debts and investment in their children's future as the reason for taking on the surrogacy. Several of them further point to the lack of alternatives as their reasoning, for example surrogate mother Salma says:

> *Where we are now, it can't possibly get any worse. In our village we don't have a hut to live in or crops in our farm. This work is not ethical – it's just something we* have *to do to survive. When we heard of this surrogacy business, we didn't have any clothes to wear after the rains – just one pair that used to get wet – and our house had fallen down. What were we to do?* (Pande, 2009, p. 160)

And Anjali says:

> *I am doing this basically for my daughters. Both will be old enough to be sent to school next year. I want them to be educated, maybe become teachers or air hostesses? I don't want them to grow up and be like me – illiterate and desperate. I don't think there is anything wrong with surrogacy. But of course people talk. They don't understand that we are doing this because we are compelled to do so. People who get enough to eat interpret everything in the wrong way.* (Pande, 2009, p. 161)

3.2.1.3 The situation for Danes bringing home "surrogate children"

In Denmark surrogacy is permitted if altruistic, but not commercial. Danish legislation thus contains no blanket ban on surrogacy, but provisions in different laws exclude some forms of surrogacy and assistance in concluding and implementing an agreement.

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[75] Pande, 2009.

[76] E-mail correspondence, professor of sociology at the University of Cape Town, South Africa.

According to Sections 33 and 34 of the Danish Adoption (Consolidation) Act, granting or receiving assistance "for the purpose of establishing contact between a woman and a person or persons wishing that woman to bear a child for them" is a punishable crime. The provision also covers advertising to arrange contact between a couple and a surrogate. Furthermore, Section 13 of the Act on Assisted Reproduction states that assisted reproduction must not take place "when there is an agreement between the woman in whom it is being attempted to establish the pregnancy and another person stating that the woman is to give birth to a child for the former". Infraction of the provision is punishable with a fine or imprisonment for up to four months. Section 31 of the Children's Act should also be mentioned, under which an agreement to the effect that a woman giving birth to a child must hand over the child to another person after the birth is invalid.

Commercial surrogacies created in Denmark are not legally enforceable. It is clear from the explanatory notes to the bill on the Danish Adoption (Consolidation) Act and the Nationality Act[77] that "the woman who is going to give birth to the child must not be able to gain any profit or in any other way have her standard of living raised" by being a surrogate. Therefore, agreements on surrogacies may only "involve defraying specific, reasonable expenses related to the woman's pregnancy and the birth". Thus the public administration authorities may not approve agreements to transfer custody or grant permission for adoption if the surrogate mother is paid a fee.

Every year a number of Danish couples are known to opt to avail themselves of surrogate mothers abroad, but no statistics on this are kept, so the precise figure is not known. In 2012 the National Social Appeals Board's Division of Family Affairs knows of 3-4 cases of children who have been brought into Denmark in this way, but estimates that this is not all the children who have been brought in.[78] An article from the Danish daily newspaper Politiken from April 2012 states that "Politiken knows of more couples who have obtained a child through a surrogate mother in India than the Danish embassy in India does. Tyge Trier, a lawyer, knows of cases where parents have successfully entered Denmark with a surrogate child without the authorities' knowledge."[79] It seems likely, therefore, that there is a "dark figure" for cases that go unrecorded.[80] This is due not least to the fact that there are many different authorities and fields of law involved in the area, making it difficult to gain an

[77] L 64, FT 1985-86.
[78] Rikke Koefoed Nielsen, Deputy Head of Division, Family Affairs, National Social Appeals Board, Danish Ministry of Social Affairs and Integration, personal communication.
[79] Junker, Maj Susanne. 2012. Par med rugebørn strander i udlandet. *Politiken,* 6 April.
[80] By way of comparison the Norwegian newspaper *Aftenposten* quotes the country's Directorate for Children, Youth and Family Affairs as evidence that in 2012 there were 37 stepchild adoptions in Norway; see article by Tine Donnerud from 3 April 2013 at http://www.aftenposten.no/helse/37-barn-av-surrogatmor-stebarnsadoptert-i-Norge-i-2012-7163700.html

overview of the scale on which children are being brought into Denmark after coming into the world with the aid of a surrogate mother.

In adoption guidelines from 2013[81], it states that, against the backdrop of a number of specific cases, the Family Affairs Division of the National Social Appeals Board has tried to clarify whether Section 33 of the Danish Adoption (Consolidation) Act applies in cases where a foreign organization provides assistance in mediating contact between a Danish married couple and a foreign surrogate. It concludes – on the basis of the wording in Section 33 – that if such assistance can be deemed to have been received in Denmark, i.e. material from the foreign organization to a Danish married couple has been received in Denmark, and mediation of the contact between the foreign surrogate and the Danish married couple has taken place in Denmark—the Danish couple can be punished for infringing Section 33 of the Adoption (Consolidation) Act. Where such assistance may be deemed to have been received abroad, on the other hand, the couple can only be punished if the act of receiving such assistance is also punishable in the country concerned (principle of double criminality). Where illegal brokering of surrogacy is suspected, the adoption case must be presented to the Family Affairs Division of the Social Appeals Board.

Some countries, e.g. India, recognize commercial surrogacy, as mentioned, and attribute parenthood to the intended parents. However, the Danish authorities do not recognize such birth certificates and hence do not regard the child as Danish. Conversely, India does not regard the child as Indian, and in reality that can lead to the child in reality becoming stateless. Furthermore, not everything can be covered by a contract—who, for example, will assume parenthood if the parents die before the child is born. In that case the child will be left without legal parents.

When a couple has used a surrogate in another country and wishes to return home to Denmark with the child, as the first step they have to get in touch with the Danish embassy in the relevant country in order to get the child out of that country and into Denmark.

Before the embassy can issue the necessary documents, the request must be dealt with by a number of Danish authorities, and it can take anything from a few weeks to a year for a parenting couple to obtain permission to bring the child into Denmark.

Current practice does not preclude a child born to a surrogate abroad from being able to establish a legal family affiliation with the couple who have returned home with the child. The focus is on the father, in particular, who will have the option of being recognized as the legal father under Danish rules. Under Danish law the woman giving birth to the child is the legal mother. The

[81] Guideline no. 9328 of 28 June 2013.

woman here, who after all has not given birth to the child, must therefore adopt it as a stepchild in order to achieve the status of legal mother. This does not require approval as an adopter; there are more lenient rules. According to the Social Appeals Board, there is no discrimination in relation to the rules, regardless of whether it is a case of surrogacy – either negatively or positively. An application for stepchild adoption must be submitted to the administrative authorities.

Whether permission is granted for stepchild adoption is contingent on certain factors:

- The couple must be married/registered partners.
- There must be consent from the man (the legal father) and the surrogate mother. She will be asked for a declaration via the embassy.
- There must be evidence of a stable living arrangement with the child, implying inter alia that the child and the couple must have been living together for at least 2½ years (according to practice).
- The stepchild adoption must be in the child's interest, above all. The focus is on regard for the good of the child.

As will be seen, using a surrogate abroad is a very long-winded and uncertain affair. Typically, it takes up to three years before both the woman and the man become the child's legal parents. And there are no guarantees that the couple will achieve the desired results. Particularly for the woman, there is uncertainty. She is completely dependent on the man's wish to cohabit and consent to stepchild adoption.

A raft of dilemmas arise for the authorities when dealing with cases involving Danes wishing to bring children born to commercial surrogate mothers home to Denmark. Sanctions in the form of denying acknowledgement of parenthood will have the unintended consequence of affecting the child harder than the parents, because the child risks being left without legal parents and nationality. Conversely, failure to sanction can be said to constitute acceptance of commercial surrogacy in some sense. Discussion of the ethical and legislative dilemmas will be resumed in the following sections.

3.2.2 Ethical questions concerning commercial surrogacy

Surrogacy has always been a controversial and hotly debated practice, whether altruistic or commercial, and whether the surrogate mother is from the future parents' homeland or from another country. Some of the key arguments in the debate will be described in brief below. First each individual argument will be presented in very general terms. Then its particular implications for commercial surrogacy, using a surrogate mother from abroad, will be discussed.

It should be mentioned straight away that the discussion about the use of surrogate mothers in Denmark cannot necessarily be "transferred" to the use of foreign surrogate mothers outside of Denmark. In some cases context is

crucially important to the implications of the argument. This is particularly because living conditions for foreign surrogate mothers are basically so much worse than conditions for Danish women that it is questionable whether there is any point in stipulating the same sort of requirements for agreements concluded abroad as for agreements concluded in Denmark or other western countries.

3.2.2.1 Exploitation

A consistent topic in the debate on surrogacy is that surrogate mothers agree to enter into the surrogacy agreement only because they are fundamentally in an exposed or vulnerable situation.[82] The argument can be deployed for commercial and altruistic agreements alike.

In connection with altruistic agreements, for example, the line of thought may be that the future surrogate finds it difficult to say no to a friend or relative who asks her to do her a favour. If it is the friend's or relative's only and last realistic chance to have a child, the woman may feel pressured into taking part in the arrangement, even though she would rather not and maybe even thinks she should actually opt out altogether.

The exploitation argument can also be used in conjunction with commercial agreements, where it is usually the future surrogate mother's economic plight that constitutes grounds for invoking exploitation. The argument, then, is that the woman only accepts the agreement or the conditions governing the agreement because she is badly off. Had she been better off, she would either have refrained from being a surrogate altogether or demanded higher payment.

Marshalling a response to this version of the exploitation argument opposed to commercial agreements is no simple matter in practice. One possibility is to cite it as support for the need to avoid commercial surrogacies altogether because they virtually always contain an element of exploitation. This view can be backed up with other considerations perhaps, for example that being a surrogate mother is also undignified and risky, or it locks the woman into a particular form of self-suppression in which she assumes the role of a "birthing machine" and hence helps maintain an erroneous and suppressive image of women as individuals whose value, by contrast with men's, is primarily associated with their sexuality and reproductive capabilities. For some branches of feminism, the latter view has been one of the key arguments against surrogacies of both a commercial and an altruistic nature.

Paradoxically, however, the greater the degree of exploitation, the more difficult it can seem to argue wholeheartedly against commercial surrogacy agreements. If, for instance, a Danish woman is prevented from being a commercial surrogate because it is considered exploitative, the consequences of missing out on the money will presumably be a manageable prospect for the

[82] Compare the discussion on the concept of exploitation in the text *Ethical topics concerning globalization and commercialization.*

woman herself. All things being equal, her most basic needs can be presumed to be satisfied, whatever happens, since she lives in an affluent welfare society geared towards solidarity.

For a poor woman from India or Guatemala, on the other hand, going through with a commercial surrogacy agreement may be the only or the best chance to secure her own or her children's survival and education. With that in mind, it may seem unreasonable to allude to the fact that this kind of agreement ought to be avoided altogether, because it is undignified and risky for the woman or traps her in a particular form of self-suppression. All things being equal, the alternative seems to be worse in many contexts, partly because her alternative work options involve exploitation too, and possibly even greater risks than those connected with being a surrogate.

As stated on a more general level, the line of argument above makes an issue of how the context – understood here as the foreign women's life situation and other opportunities – should be incorporated in any ethical evaluation of commercial surrogacy agreements. Ought anyone opposed to commercial surrogacies being carried out in Denmark because they involve exploiting the surrogate mother also be against Danish women or couples going abroad and using a surrogate, because it involves exploitation? And if so, is this because exploitation of women by using them as surrogate mothers involves exceptional problems? Or are we also obligated to try and prevent all *other types* of transactions where foreign people are being exploited on account of their desperate situation? That can presumably be said to be true in a great many cases, e.g. in the manufacture of very common products like clothing and food in developing countries. Or should one, instead, face the fact that living conditions for people in other parts of the world are basically completely different from ours and for that reason content ourselves with endeavouring at the very least not to offer them worse conditions of employment than those they would be offered in other contexts? That would imply, for example, that the correlation between risk and payment would have to be no less favourable for the surrogate mother than for other comparable jobs in her own homeland.

Recent years have seen the emergence of an altogether different approach to discussing how to relate to the issue of exploitation, and in part it has also been attempted to apply it in India.[83] The idea is to accept surrogacy agreements and at the same time try to ensure that the surrogate mother is guaranteed reasonable conditions for her participation in the arrangement so that the other players do not capitalize on her poverty.[84] This counters the exploitation

[83] As is clear from the text "International surrogacy", India has developed guidelines for surrogacy agreements which it intends to introduce into the legislation.

[84] Compare the deliberations on exploitation in the text "Ethical topics concerning globalization and commercialization": Even if the surrogate mother herself accepts an agreement and benefits from it as well, it is not necessarily reasonable, because others obtain far greater benefits. For example, most people will probably find it patently unreasonable that the middlemen make far more money out of the arrangement than the surrogate mother herself.

problem while at the same time not depriving the surrogate mother of the chance to improve her life opportunities and those of any family she may have. The challenge in relation to this option, of course, is to figure out precisely what terms it is reasonable to posit for the agreement.

A relevant criterion may be to demand that the surrogate mother be assured reasonable payment, which in part is independent of whether the procedure leads to the birth of a healthy child. The remuneration must be linked to the time and effort spent on the project, not the outcome.[85]

Moreover, a criterion might be to require that the surrogate mother be guaranteed safe and adequate medical treatment throughout the procedure and after the birth, also in connection with hormone stimulation and implantation of eggs. Carrying on from this, it might be a condition that the surrogate mother must not be able to be ordered to have a caesarean, fetal reduction or induced abortion performed unless well founded on purely medical or professional health grounds. In addition there must be a limit to the number of fertilized eggs the surrogate mother can have implanted in the womb.

Furthermore, it seems only reasonable that any constraints on the surrogate mother's personal freedom during the course of the pregnancy must be described in her contract, and they must be in reasonable proportion to the desire to avoid injury to the fetus during the pregnancy.

Finally, it might be a condition that the surrogate mother not be able to get into a situation where she ends up being responsible for the child unless she herself wishes to assume that responsibility.

It must be mentioned that a boilerplate argument in the debate on surrogacy and exploitation is that trying to prevent surrogacy agreements with foreign women is only appropriate if it goes hand in hand with attempting to improve the women's living conditions in other ways; failing that, they are merely robbed of an opportunity to improve their existence without putting anything in its stead.

In one interpretation the argument is based on an assertion that it is hypocritical to oppose surrogacy agreements without putting something in their stead, because the western countries already have an independent obligation to help people in such great distress as the women we typically use as surrogate mothers usually are. Conceding that such an obligation does exist, surrogacy agreements take on the nature of what some have called "omissive coercion"[86], i.e. coercion made possible by our own acts of omission. The concept demonstrates how, not surprisingly, the issue of exploitation and commercial

[85] This also remedies the problem, in that being a surrogate can be said to be undignified—see under 'dignity'.
[86] Wi kinson, Stephen. 2003. The exploitation argument against commercial surrogacy. *Bioethics*, vol. 17, no. 2: 169-187.

surrogacies is interconnected with a far broader issue of the western world's duties to those in other parts of the world who are highly disadvantaged.

3.2.2.2 Dignity

As set out in the section "Ethical topics concerning globalization and commercialization", the dignity concept is difficult to define precisely. In addition some of the central definitions are relatively elastic. That can make it difficult to respond to whether commercial surrogacy in particular is undignified for the surrogate mother.

Kant's concept of dignity is often presented in such a way that other people must never be treated as a means to an end. The correct representation, however, is that others may never *only* be treated as a means to an end, but must always also be treated as an end in their own right. Whether others are treated in an undignified manner is thus a question not of either-or, but rather of degree. In some cases, then, it may be obvious to most people that a commercial surrogate mother is being treated in an undignified manner, because she is very largely being treated as a means of producing a child. In other cases, by contrast, the evaluations will be more mixed.

The same applies to the interpretation in which a person's dignity is linked to whether that person commands the functions and scope for action we generally associate with a good human life. For instance, this can be possible functions and actions linked to physical health and bodily integrity, including reproductive choices and scope for avoiding risky or injurious actions. Thus, as in the Kantian reading, dignity again becomes a question not of either-or, but of degree. A commercial surrogate mother, for example, can have her bodily integrity violated to a greater or lesser degree, and that applies equally to her personal freedom. But at the same time, the individual parameters for dignity can be linked in complex ways. It may be, for instance, that the violation of dignity which for a particular woman is associated with being a commercial surrogate mother is 'outweighed' by the enhancement she subsequently experiences in her dignity, because she has become self-sufficient and can give her children an education.

Since the dignity concept is thus a relatively imprecise and 'graduated' concept, no more discussion will be devoted here to how undignified it is to be a commercial surrogate mother. Let it merely be noted that commercial surrogacy agreements can incontrovertibly contain elements which the surrogate mother finds it undignified to accept. That does not mean that it is irrational of her to accept the agreement under any circumstances whatsoever, or that doing so cannot improve her life situation on balance. It merely means that the implementation of the agreement is associated with a loss of dignity, even if that loss is outweighed by other benefits.

Different parameters for possible ways of countering exploitation of commercial surrogate mothers are set out above. Interestingly, all of these parameters can

be brought into play in relation to the dignity discussion as well. The point about payment, for example, thus includes recognition of the fact that the woman should not be thought of exclusively as a means of producing a child. It must be acknowledged that, from the woman's own perspective, the surrogacy takes the form of a job that will subsequently give her the opportunity to make a better life for herself. By the same token, the other requirements and conditions for entering into surrogacy agreements tie in with central conditions and scope for action which most of us regard as fundamental prerequisites for a good and successful human life: physical health and integrity as well as personal and reproductive freedom. This convergence is hardly coincidental. Presumably, it is due to the fact that the surrogacy issue implies some problematic points of such a fundamental nature that they are unavoidably 'subsumed' by many different theories and conceptual systems.

3.2.2.3 The child's welfare and our perception of children

One of the Danish Council of Ethics' core concerns is assisted reproduction. The Council has often outlined its views on the area, therefore, and has presented views and submitted recommendations on the use of a great many different techniques. One consideration has been central to this stance, namely the regard for the child that emerges from using various techniques. There has been broad-based consensus that the regard for the child calls for particular attention, and that this regard cannot be overridden because other considerations, e.g. regard for the parent or parents-to-be, are given higher priority. On the other hand there has often been disagreement on other points. One point of contention concerned the way different types of arrangements actually affect the child-to-be's life chances and quality of life. That is an empirical question, in principle, yet it is so difficult to 'measure' that the answer easily ends up being at least partially attitudinal. Another question is how good a child's life opportunities have to be in order to be considered acceptable. Must they be ideal, ordinary or perhaps simply so good that the child will foreseeably not be forcibly removed from its parents at some point after its birth?

The last two questions are also relevant to commercial surrogacy agreements, of course, but in this context again it is difficult to give a clear answer to how the arrangement affects the child-to-be's life chances and quality of life more precisely. As set out in the text on international surrogacy, then, different studies have been done into the importance of the bond established between mother and child following the birth, and of the well-being of children born by surrogacy. But none of these studies seems to yield pronounced results that speak either for or against surrogacy agreements with any crucial weight.

With regard to the question of how good a child's life chances have to be in order to be considered acceptable, it should merely be mentioned here that during the Council's history, and in the literature on the subject, many different

criteria have been suggested as a basis on which to answer the question.[87] In practice these criteria lead to widely divergent evaluations.

At one end of the scale it has been suggested that, for the sake of the child, it can only be wrong to bring it into the world if the alternative – i.e. that it will not even come into existence – is more attractive. In practice that criterion leads to the regard for the child playing virtually no role prior to conception, since it is more or less impossible to argue that the child will have a life that is any worse than not existing.

The other end of the scale can indicate that the child must have ideal living conditions; but conversely, that criterion is so demanding as to be virtually impossible to fulfil by definition. In between these extremes, as mentioned, a number of other criteria can be highlighted, e.g. the child must have normal living conditions at the very least, and the parents must be in a position to provide for it themselves, or one can try to draw parallels with the criteria for forcible removal or the criteria for adoption.

However, it is one thing to look at the individual child's foreseeable life chances, but quite another to take a position on whether using a commercial surrogate can be instrumental in causing a negative shift in the perception of children and having children due to the market logic commercialization brings with it. As mentioned in Chapter 2, one of the philosopher Michael J. Sandel's points is precisely that commercialization can have a corrupting effect, because it changes the understanding of the commercialized object and can help to undermine the values we associate with the object.

As previously stated, Sandel gives an illustrative idea of when that can be said to be the case:

> *We corrupt a good, an activity, or a social practice whenever we treat it according to a lower norm than is appropriate to it. So, to take an extreme example, having babies in order to sell them for profit is a corruption of parenthood, because it treats children as things to be used rather than beings to be loved.*[88]

The example is aptly chosen, because it foregrounds the point clearly: In some cases our understanding of goods or activities is clearly associated with values and norms that are completely and utterly inconsistent with commercialization. But essentially, such goods and activities are an extreme point on a spectrum

[87] These complicated questions have been dealt with in several of the Council's publications, see e.g. Danish Council of Ethics, 2003: *Ethical Problems concerning Assisted Reproduction, 1st part, Right to children? = Right to help having children*? And Council of Ethics, 2005: *Letter of 4 April 2005. Reply to enquiry from the Danish Ministry of the Interior and Health: Possible amendments to the Assisted Reproduction Act*. The publications also contain proposals as to how to justify the various criteria.

[88] Michael J. Sandel, 2012, p. 46.

whose opposite end has objects or activities whose commercialization appears to be a straightforward affair.

The difficult cases lie midway between these extremes. Here a sort of value-related excavation work needs to be performed in order to figure out what kind of values and norms can possibly be corrupted. As previously mentioned, Sandel gives a highly germane example of the nature of that excavation work:

> *In order to determine whether a woman's reproductive capacity should be subject to a market transaction, we have to ask what kind of good it is: Should we regard our bodies as possessions that we own and can use and dispose of as we please, or do some uses of our bodies amount to self-degradation? This is a large and controversial question that also arises in debates about prostitution, surrogate motherhood, and the buying and selling of eggs and sperm. Before we can decide whether market relations are appropriate to such domains, we have to figure out what norms should govern our sexual and procreative lives.*[89]

One key question, by extension, is what importance the understanding of commercial surrogacy agreements can presumably assume for our understanding of children. This problem was altogether crucial to the Council's adoption of a position on commercial surrogacy agreements in 2008, which amongst other things states that:

> *The Council of Ethics is against commercial surrogacy agreements because, in the Council members' view, they can be conducive to an adverse change in basic notions of parenthood and human reproduction. One of the pivotal elements of these notions is that the fetus and the newborn child have dignity and value in their own right. As a basic premiss, therefore, the parents are expected to receive the child and give it love and care, regardless of its characteristics and attributes. But acceptance of commercial surrogacy agreements can, in the members' opinion, be instrumental in undermining these notions. Thus experience from the USA, among other places, shows that there are a number of examples of the couple who had ordered a child not wanting it after the birth—in some cases because it failed to live up to their expectations.*
>
> *It is debatable whether commercial surrogacy agreements can be described as "trading in children" or compared with prostitution. However, that type of comparison is not necessary to justify the Council's critical attitude towards commercial surrogacy agreements. It is quite adequate to note that, at any rate, such commercial logic*

[89] Ibid, p. 47.

results in an altered perspective, because it creates a series of implied expectations, for example "getting value for money", "getting paid for one's work", or that "the quality of the work is expected to be up to standard".

In that sense both the surrogate mother and the fetus unavoidably form part of a commodified and mercenary outlook which is not compatible with society's standards of dignity and good parenting. Nor, as set out in the recommendations, can the Council accept commercialization of surrogacies if foreign surrogate mothers are used. The Council does not feel that such commodification of the child is made any less problematic by conducting the surrogacy abroad[90]*.*

As with the deliberations on the welfare of the child, here again it is a case of problems of an empirical nature, which in principle can be confirmed or refuted by investigative means. In practice, however, such investigations can be difficult to conduct. Yet some of the things that are actually taking place in India and Guatemala would seem to indicate that they are not purely speculative deliberations. Thus, as described elsewhere for example, it is not an unknown phenomenon for foreign couples to engage up to three surrogate mothers at a time and demand that they abort if more than one of them becomes pregnant. Similarly, fetal reductions are not uncommon, which has to do with the fact that a number of fertilized eggs are often implanted in the surrogate mother's womb in order to ensure that at least one child results from the process. From a Danish perspective both practices are unacceptable.

Some observers think they see a link between surrogacy and the sale of children:

In the global environment of assistive technology and the demand for babies, we contend that Guatemalan women are at risk of human sales of their offspring in global surrogacy schemes.[91]

The observation is supported by the development that has taken place in Honduras:

In Honduras, they have paid teenage girls to get pregnant; the merchants then follow the young throughout their pregnancy to make sure they eat well and receive some kind of prenatal care. Once a baby is born, and if the baby is healthy, the mother is paid $50.00 for the product. This practice is not very different from what we call

[90] Danish Council of Ethics. 2008. The Council of Ethics' statement on surrogate mothers, 21 May 2008 [Danish only].

[91] See Rotabi, K. Schmidt, and Nicole Footen Bromfield. 2012. The Decline in Intercountry Adoptions and New Practices of Global Surrogacy: Global Exploitation and Human Rights Concerns. *Affilia: Journal of Women and Social Work,* vol. 27, no. 2: 129-141, p. 134.

"surrogate motherhood" in the U.S.; however, it is substantially cheaper.[92]

The quotations illustrate the scare scenarios such a development might imaginably go on to bring in its wake; but whether this will actually happen—and, if so, how it will affect attitudes towards children in the countries involved more generally—is difficult to say.

3.2.2.4 A non-ideal world

In the real world a number of surrogacy agreements are transacted and completed which are so patently unreasonable that it does not take any great ethical fact-finding work to form a view on them. This may be connected e.g. to the fact that the surrogate mother cannot read and is not informed about all aspects involved in the agreement she signs. But ethically, whatever happens, the conclusion and completion of surrogacy agreements must be conditional on the woman being capable of giving informed consent for the agreement and therefore being able to study and familiarize herself sufficiently with its terms and decide what it will mean for her in both the shorter and the longer term.

The surrogate mother's autonomy or self-determination can also be undermined in other ways. Among other things, it can be argued that in some cases she is in such an exposed and vulnerable situation due to her poverty, that she can be said to have been forced to accept the agreement and is not, in the true sense, capable of relating to it realistically or critically.[93] In other ways too, the conditions attaching to the surrogacy can be such as to unhesitatingly warrant being labelled unacceptable. It is thus plain from the section on international surrogacy that Indian surrogate mothers can have 5 or 6 embryos at a time implanted without being involved in the decision, just as they are not involved in any decision to perform fetal reduction. Similarly, it often happens that the women are not paid if anything goes wrong during the birth, nor do they receive medical and psychological treatment after the birth.

3.2.2.5 Weighing up values

There is scarce likelihood of the problems described above disappearing purely as a result of legalizing surrogacy and simultaneously introducing a certification scheme, or even a global scheme. For example, a well developed black market with low prices would probably still exist in developing countries like India. That may be a case in point for the need to give some pragmatic thought to how to relate to and, if necessary, regulate surrogacy in our less than ideal world. If a certification scheme is not going to solve the problems anyway, it is not certain that it is the right path to follow, based on pragmatic deliberation.[94]

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[92] Ibid.

[93] For a more developed discussion of this issue, see the section "Ethical questions about organ trading".

[94] See also the deliberations on pragmatic reasons for regulation in the section "Ethical questions about organ trading".

But even assuming all players are interested in doing the ethically correct thing, it is still not without its problems to say what this actually is in the context of commercial surrogacy agreements. That is due to several different values and deliberations being involved, which point in different directions. These values and deliberations therefore need to be weighed against one another—and there is no telling whether the outcome of such considerations will be the same for different people. A further complication is that the individual regards or values do not speak unequivocally for or against commercial surrogacy in all cases. For some people, for instance, regard for the child dictates against it, because from the outset the child is not given optimal opportunities, partly because it is taken away from the woman who has been carrying it during the pregnancy and may also be its biological mother. For others, though, deliberations about the child's welfare cannot be used as an argument to gainsay such agreements—the contrary, rather—since unlike so many other children the child can normally be expected to grow up in a family that wants it and is ready to take care of it.

3.3 Trade in organs

3.3.1 Organ donation and trade in kidneys

People's experimentation on transferring organs from one person to another dates back a long way in history, but until the mid-1900s such experiments were unsuccessful. The early 1900s onwards began to see an appreciation that the poor results were due to the body's immunological reaction and rejection of foreign (i.e. exogenous) organs. The first successful transplants, therefore, were kidney transfers between monozygotic (and therefore genetically identical) twin brothers in 1954 and between twin sisters in 1956. Effective immunosuppressants were not developed until the early 1980s, and these drugs meant that total tissue compatibility was not necessary when transplanting most major organs. That changed kidney transplantation from a clinical experiment to a clinical treatment option.[95]

To start with, most donors were alive because there was no way of preserving organs from dead people. In the 1960s, however, better technologies were developed for short-term organ preservation, and organs from dead people started to be used. With the improved possibility of transplantation the need for organs from dead people in the 1980s and 1990s grew faster than the supply of organs and a constant dearth arose in all countries. The lack of deceased donors led to growth in the number of live kidney donors in the 1980s and 1990s, and since 2000 these have made up approx. 50% of all transplants. Nonetheless, all countries—except for Iran, to which we shall return—still suffer from a constant lack of organs; all countries have long waiting lists, and every year there are sick people who die waiting for organs.

[95] Linden, P. 2009. History of solid organ transplantation and organ donation. *Critical Care Clinics*, vol. 25, issue 1, p. 167 ff.

Kidney patients' survival has improved considerably since dialysis was developed in the USA in the 1960s, when it transformed terminal kidney failure (or end-stage renal disease (ESRD)) from a fatal diagnosis into a chronic disease. However, dialysis requires the patient to be hooked up to the dialysis machine for many hours a week, reducing the possibility of living a normal life and the patient's mobility substantially.

There are a number of drawbacks with dialysis rather than transplantation; among other things transplantees have an almost normal kidney function, whereas dialysis patients have 10% of the function at most. In addition dialysis patients have both greater morbidity and greater mortality than transplantees. However, owing to the immune-suppressive medicine that transplantees have to take to avoid rejecting the transplanted organ, the risk of developing tumours in this group is more than double that of the standard population.[96]

With globalization and the development of the Internet it has become possible for desperate patients from affluent countries to get around the lack of available organs in their home country. On the Net they can find clinics in other countries, where they can pay to get operations. These are countries where the ban on the sale of organs is not enforced, and where there are many poor people willing to sell their organs.

The trade that takes place is illegal, as the sale of organs is prohibited in practically all countries (Iran being the only exception), with several international organizations having adopted declarations and conventions opposed to organ trafficking. In 2002 the Council of Europe's Convention on Human Rights and Biomedicine (the Bioethics Convention) was given an additional protocol concerning transplantation[97], acknowledging the need to "protect individual rights and freedoms and to prevent the commercialization of parts of the human body involved in organ and tissue procurement, exchange and allocation activities". Article 3 of the EU Charter on Fundamental Rights (2000) and Article 12 of the Directive of the European Parliament and of the Council on setting standards of quality and safety for the donation, procurement, testing, processing, storage, and distribution of human tissues and cells (2004) are worth highlighting.

In 2004 WHO adopted a resolution urging its Member States to take steps to prevent transplant tourism and the sale of tissues and organs[98], and in 2008 its Guiding Principles on Human Cell, Tissue and Organ Transplantation were adopted. The following is set out in principle 5: "Cells, tissues and organs should only be donated freely, without any monetary payment or other reward of

[96] Dr Claus Bistrup, Consultant, Odense University Hospital, presentation for the Danish Council of Ethics, 24 June 2013.
[97] Additional Protocol to the Convention on Human Rights and Biomedicine concerning Transplantation of Organs and Tissues of Human Origin.
[98] WHO. 2004. Resolution on human organ and tissue transplantation. Geneva.

monetary value. Purchasing, or offering to purchase, cells, tissues or organs for transplantation, or their sale by living persons or by the next of kin for deceased persons, should be banned." As mentioned previously, work is currently in progress on a Convention against Trafficking in Human Organs under the auspices of the Council of Europe.

In 2008 the International Society of Nephrology adopted *The Declaration of Istanbul on Organ Trafficking and Transplant Tourism*, in which it says that commercial organ transplants affecting the vulnerable must be prohibited, and they urged all transplant professionals, individually and through their organizations, to halt these unethical activities.[99]

When the traffic taking place is illegal, it is difficult to obtain data on it, but it is estimated that 5% of all global organ transplants in 2005 were a result of transplant tourism.[100]

The trade centres around kidneys. In the following, therefore, we shall focus on this, though livers, hearts, pancreases, lungs, corneas and human tissue are also traded on a smaller scale.

3.3.1.1 The situation in Denmark

Denmark is no exception when it comes to the permanently large gap between the number of donors—and hence the number of kidney transplants performed on the one hand—and the number of renally impaired people on waiting lists on the other hand. And that is despite the fact that recent years have seen a growth in the number of transplants and a fall in the number of those waiting.

Kidney transplants, Denmark, 2008-2012

	2008	**2009**	**2010**	**2011**	**2012**
Total kidney transplants	196	231	232	235	214
Incl. from live donors	74	90	102	100	77
No. of deceased donors	122	141	130	135	137
Total waiting list	489	455	466	451	465
Dead on waiting list	44	44	20	28	13

Source: Scandiatransplant: http://www.scandiatransplant.org/data

[99] Declaration of Istanbul on Organ Trafficking and Transplant Tourism, see http://www.declarationofistanbul.org/index.php?option=com_content&view=article&id=80&Itemid=84

[100] Shimazono, Y. 2007. The state of the international organ trade: a provisional picture based on integration of available information. *Bulletin of the World Health Organization* 85, p. 959, and Caplan et al., 2009, p. 58.

Organ trading is prohibited under Danish legislation too. Section 268 of the Danish Health Act provides that anyone offering or receiving payment or other financial gain for removal or transfer of tissue and other biological material for treatment by transplantation shall be punished with a fine. The same applies to anyone who, knowing that payment has been made or received, is complicit in the performance of such a procedure. No official inventories are available, therefore, of the number of Danes travelling to other countries to have kidney transplants performed. The Danish Society of Nephrology, however, has done a count for the years 1991-2002 on the basis of the number of patients seeking aftercare at Danish hospitals. It shows that between 1991 and 2002 the figure was 0-4 transplants a year, whereas in 2003-2006 it was 6-7 transplants annually.[101]

3.3.1.2 The global situation

It is estimated that 7% of the world's population suffers from kidney disease and 1.6 million people suffer from *end-stage renal disease* (ESRD).[102] At the same time, the lack of organs from both live and deceased donors is an almost global problem, as mentioned above.

That has led to a flow of traffic, with citizens in affluent countries of Northern Europe, North America and rich Asian countries travelling to poor countries, chiefly in Asia and Eastern Europe, but also South America and Africa, to buy organs from desperately poor people. As mentioned, the countries concerned are ones that have not developed or implemented legislation to prevent organ trafficking.[103] Jeremy Halken has described the situation, saying that buyers and sellers alike are driven by their most basic survival instincts, providing fertile ground for criminal exploitation.[104]

Due to its very nature, there are no good sources for the scale of this trade, but in 2007 Yosuke Shimazono collected the available literature in the field for WHO.[105] His article shows that the trade not merely involves the purchase and sale of organs; a number of middlemen are involved in organizing trips and recruiting donors. This is often transacted through the Internet, where the prices of a transplant package were between DKK 390,000 and 900,000 in 2007. Another source states that the middlemen charge between DKK 550,000 and 1,100,000, of which the donor gets only DKK 5,500– 28,000.[106]

[101] Danish Society of Nephrology. 2006. Landsregister for patienter i aktiv behandling for kronisk nyresvigt. Rapport for Danmark 2006, p. 27.
[102] Harvard Stem Cell Institute: http://www.hsci.harvard.edu/research/kidney-disease-program
[103] Caplan et al. 2009. *Trafficking in organs, tissues and cells, and trafficking in human beings for the purpose of the removal of organs*. Joint Council of Europe/United Nations study. Strasbourg Cedex: Directorate General of Human Rights.
[104] Halken, J. 2011. *Transnational crime in the developing world.* Global financial integrity.
[105] Shimazono, Y. 2007.
[106] Nullis-Kapp, C. 2004. Organ trafficking and transplantation pose new challenges. *Bulletin of the World Health Organization,* vol. 82, no. 9, p. 715.

The donor, then, only receives between 1% and 5% or so of the amount paid by the transplantee (0.5% and 2.5% in the second case). To this must be added another recurrent problem for the donors, i.e. in reality they are paid only 2/3 or so of the amount the middleman had promised them, because he deducts the costs of the operation, hospital stay and transportation from the donor's share of the payment. The transport costs are due to the widespread practice of transporting the donor to wherever the hospital is located, as it is easier to transport the donor than to maintain harvested organs.

Another problem across the board is that the donor does not receive adequate aftercare following the operation, and the person in question is sent home too early. In 2008 a criminal organization that arranged organ deals was uncovered, because a young Turkish man collapsed in Pristina Airport after having been sent home too early following a kidney operation. During subsequent EU legal proceedings it emerged that the financier had been promising poor Turks up to DKK 150,000 or so to fly to Kosovo and donate their kidneys. They were talked into filling out false declarations saying that they were related to the organ recipient and were donating on humanitarian grounds. Many of them subsequently received no compensation at all, and they were sent home without the necessary aftercare.[107]

3.3.1.3 Examples of countries with organ trading

Trade in transplants is known to take place in a number of countries; those often discussed include the following:

India

India was a central organ-exporting country until this practice was officially banned in 1994. A large-scale underground trade still flourishes, however. It is estimated that 2,000 Indians sell a kidney every year.[108] It looks as if, despite everything, the decline in organ trading heralded by the law has prompted more people to go instead to neighbouring countries like Pakistan, Bangladesh and the Philippines to buy organs.

There are some research-based studies into conditions from different regions of India. Thus an interview poll from 2001, which included 305 kidney vendors, showed that the majority made their livning as street traders. On average they had been promised approximately DKK 8,000 for their kidney, but they received an average of just approximately DKK 6,000. 96% of them stated that their motivation for selling their kidney was the need to be able to pay off their debts. At the time of the study, however, 74% were still indebted.

Many of the donors sustained permanent damage after the operation, 86% of them reporting that their health had been somewhat or severely impaired. 50% had persistent pain around the operating scar, and 33% had back pains. Their

[107] Bilefsky, D. 2013. 5 Are Convicted in Kosovo Organ Trafficking. *New York Times*, 29 April.
[108] Shimazono, 2007.

poorer health meant that the donors experienced an average reduction in family income of one third after the sale, causing the number of donors falling below the poverty line to rise from 54% before to 71% after the operation. 79% of the donors stated that they regretted the sale to such an extent that they would advise others against doing the same.[109]

Pakistan
It is estimated that 2,000 kidneys are sold in Pakistan every year, two thirds of which are bought by foreigners.

A study of 239 kidney vendors from 2010 shows that 62% of the vendors earned between DKK 55 and 170 a month before the operation, whereas 32% earned less than that. 90% of them were illiterate, and they had between 2 and 11 people to provide for. They all had large debts.

The donors had been promised an average of just under DKK 10,000 in payment for their kidney, but received an average of just DKK 7,700. The difference was due to the vendors having deducted the costs of the operation, hospital stay and transportation from the donor's share of the payment.

They all indicated that they had enjoyed good health before the operation, whereas only 1.2% reported doing so afterwards. 62% felt physically weaker, so that they could no longer work for such long stints as they could before. 85% experienced no improvement in their financial situation as a result of the sale. 35% stated that they would recommend a family member to sell an organ.[110]

Bangladesh
In Bangladesh the sale of body parts has been illegal since 1999, but despite this it represents a growing phenomenon in a country where 78% of the inhabitants live on less than DKK 11 a day.

An ethnographic study from 2012 of 33 vendors from the capital, Dhaka, showed that most vendors were illiterate and that the fact was exploited to lure them into selling their kidney. They were led to believe that people have a "dormant kidney", which wakes up when the active kidney is excised. Promises of land, a job or a visa for other countries were also used to entice the donor. In reality the donors were smuggled into India and accommodated in unhygienic, overcrowded rooms. A few days after the operation they were sent back to these quarters, then transported to Bangladesh before the wound had healed.

The vendors had been promised an average of DKK 7,800 for their kidney, but 27 of the 33 did not receive the full amount, allegedly because the middleman deducted various costs from their share of the payment.

[109] Cohen, G. 2013. Transplant Tourism: The ethics and regulation of international market for organs. *Global Health and the Law, s*pring 2013, p. 272.
[110] Ibid, p. 270.

78% stated that their financial situation got worse after the operation. They also stated that their health deteriorated, and 79% reported that their scar and the social stigma attached to the sale of a kidney had left them socially isolated.

The ethnologist carrying out the research, Moniruzziman, further claims that many organ recipients from Bangladesh preferred to buy organs from the poor, rather than ask members of their family to donate.[111]

China

The situation in China is exceptional, because 95% of the organs used for the transplants inside the country come from executed prisoners. This is established by reports from the US Department of State, articles in medical journals and reports from NGOs.[112] The number of voluntary donors is very low, so the odds of patients on the waiting list getting a kidney from a voluntary donor are only 0.5% in China, as opposed to 43% in Great Britain.[113]

The Chinese authorities keep the number of executions carried out secret, but Amnesty International states that the country accounts for at least 75% of executions worldwide. The authorities make no bones about the fact that the hospitals use organs from executed prisoners, but state that it is done with the prisoners' consent. There are claims, however, which the authorities deny, that prison guards and executioners force prisoners to sign the consent form, because there is big money to be made from selling the organs.[114]

Some 10,000 transplants a year are performed in China, a figure exceeded only by the number performed in the USA. The majority are performed on the country's own inhabitants, but many well-to-do foreigners buy their way in illegally, jumping the queue to get ahead of those waiting for organs. This is due to Chinese hospitals being under such pressure to generate income, and fewer questions are therefore asked about the source of such income. As a result, companies have sprung up to help patients find the organs and surgeons they need. The Lancet mentions *Yeson Healthcare Services* in Shanghai, which provides liver transplants for approx. DKK 520,000 and kidney transplants for approx. DKK 260,000.[115]

Since organ donors are not paid for their organs in China, there has been discussion as to whether this falls into the category of organ trading.[116] Nevertheless, Chinese transplants are normally included as part of the

[111] Ibid, p. 271.
[112] Biggins et al. 2009. Transplant tourism to China: the impact on domestic patient-care decisions. *Clinical Transplantation* 23: pp. 831-838.
[113] Davidson, N. 2012. In China, criminals fill the kidney donor deficit. *The Guardian,* 27 May.
[114] Watts, J. 2007. China introduces new rules to deter human organ trade. *The Lancet,* vol. 369, June.
[115] Ibid.
[116] However, there are also reports on the purchase of organs from live subjects in China, see e.g. Davidson, 2012.

international trade in organs because paying foreigners are prioritized above the country's own inhabitants, and because there are no clear-cut rules in the field.[117]

However, 2007 saw the introduction of legislation in China aimed at preventing the sale of organs and phasing out the use of organs from executed prisoners.[118] Haibo Wang, director of *The China Organ Transplant Response,* told WHO at the end of 2012 that the new system will be phased in from the start of 2013. Apart from phasing out organs from executees and penalties for receiving payment for transplants, this will entail the Chinese Red Cross setting up an organ donation system based on altruistic donation from deceased people. Among other things, however, that will require both formal and popular acceptance of brain death, and at the moment neither exists. For that reason the supply of organs from deceased subjects is very low.[119]

Legalization of organ trading - Iran

As has been shown, the presence of intermediaries in the organ trade is a massive problem. These middlemen are a mixed bunch, ranging right from poor criminals through sophisticated medical-tourism agencies to religious or charitable trusts, or patient organizations.[120] But what the former groups at any rate have in common is that they are responsible for the contact with the 'client', pocket the money and only pay out a very small proportion to the donor. They dictate conditions and as a rule withhold adequate aftercare from the donor.

Some have claimed that this is the actual problem with existing organ trading. For example, the transplant surgeon Benjamin Hippen argues that selling organs under controlled conditions should be introduced in the USA, because it represents the only way to obtain enough organs to save the lives of those on the waiting list. In his opinion, donation is never without its problems; he thinks, for instance, that even under the present system donors are pressured into donating, not out of altruism, but out of guilt or familial pressure. But these reservations do not count as heavily as the duty to save life, and payment for organs should therefore be permitted, but a system should be set up to have the donor protected by a central register of buyers and donors, and guaranteeing the person in question life-long healthcare cover.[121]

Hippen has studied the set-up in Iran[122], currently the only country to allow trade in organs. The Iranian payment-for-organs set-up can be seen as an attempt to create a system without commercial middlemen and without becoming part of

[117] Shimazono, 2007, p. 957.
[118] Ibid.
[119] Fleck, Fiona. 2012. New era for organ donation and transplant in China. *Bulletin of the World Health Organization* no. 90, pp. 802–803.
[120] Cohen 2013, p. 273.
[121] Hippen, B. 2008. Organ sales and moral travails – Lessons from the living kidney vendor program in Iran. *Cato Policy Analysis.*
[122] Ibid.; the information about the Iranian system comes from Hippen's article.

an international organ trafficking market: the system can only be used by ethnic Iranians; foreigners—including those living in Iran—cannot take part.

Iran permitted fees for donations from unrelated donors in 1988, after which the transplant waiting list slowly dwindled, and by 1999 it had been eliminated. A highly regulated market has been set up, functioning in such a way that when potential recipients of kidneys have been investigated, they are initially encouraged to find a biologically related donor. If that is not successful, they first have to wait six months to see whether a suitable kidney will be donated by a deceased person. If that does not happen, they can obtain a commercial donor.

The donor is selected by the *Dialysis and Transplant Patients Association* (DATPA), which is staffed by volunteers themselves suffering from kidney failure, and the organization receives no compensation for matching kidney donors to recipients. People interested in selling a kidney approach DATPA themselves and are then referred to transplantation centres for typing and examination according to the same criteria as apply to donors who do not receive financial compensation. DATPA will then find a matching patient at no charge.

The payment to the donor comes partly from the state, which contributes approx. DKK 8,000 and one year's health insurance. In some cases the organ recipients must themselves contribute DKK 13,000–25,000, but if the person in question is poor, the amount can be donated by various charitable organizations. DATPA is in charge of coordinating payment.

However, there are hitches with bureaucracy and slow procedures, which have opened the door for unofficial, direct negotiations between the parties. The streets near Teheran's major hospitals are hung with notes written by poor people wishing to sell their kidneys, so that the Iranian system has been described as a market for kidneys.[123]

Hippen highlights some issues with the Iranian system:

- A disproportionately large share of the donors, 70% according to studies done, are poor based on any definition of the concept.

- It is a view widely held—despite the lack of any inventories detailing the personal and health-related implications for donors—that selling their organs will eventually have adverse health costs.

[123] Dehghan, S.K. 2012. Kidneys for sale: poor Iranians compete to sell their organs. *The Guardian,* 27 May.

- It has been claimed that the possibility of trading in organs undermines altruistic donation of e.g. kidneys. On the face of it, however, this is not corroborated by the Iranian experience, since biologically related donation has been constant at 12-13% of donations

- There is a slight tendency towards poorer results for the recipients of purchased organs as compared with recipients of altruistically donated organs. A possible explanation can be that when vendors are generally poor, they are exposed to environmental factors, especially infections and malnutrition, which can weaken their kidneys

3.3.1.4 The situation for Danes returning home for aftercare

Trade in organs, as already mentioned, is illegal in Denmark, but when Danes nevertheless return home from abroad after having bought an organ and an operation in another country, the Danish health services is put in a dilemma. Such patients will need life-long aftercare in order not to reject the transplanted organ, and omitting to provide that aftercare will assume serious, possibly fatal consequences for the transplantee. Such patients are not dismissed out of hand, therefore, but offered the same aftercare as other transplantees who are Danish nationals.

This is where a dilemma arises, because it may be felt that the Danish health services are thus being forced to shoulder a form of complicity in relation to the organ trading the patient has been involved in. Conversely, declining to treat the patient would be unprecedented in terms of the Hippocratic Oath and the health services' principle of treating all sick people, regardless of the reasons for their illness. For example, all skiers and other practitioners of sports are entitled to treatment for any injuries they sustain after all, and we know of no examples from other areas of severely ill people being denied treatment in the Danish health services. Treatment is free of charge for patients resident in Denmark. The Danish Health Act makes no provision for charging for treatment in the public hospital service which the patient can receive free.

One alternative to denying the transplantees aftercare might be to legislate to introduce sanctions against Danes who have facilitated organ trading by purchasing organ transplants abroad. The question in that case will then be which sanctions are expedient, taking into account both the donor's and the recipient's situation.

3.3.2 Ethical questions concerning organ trading

The vast majority of organ trading taking place from live donors involves kidneys. The vendor is typically very badly off and enters into the transaction purely in an attempt to pay off bottomless debt or improve his family's living conditions. In the vast majority of cases, however, selling the organ does not solve the donor's problems in the long run. On the contrary, many donors end up in an even more hopeless situation and regret the sale for that same reason. The sorry outcome to the transaction that ensues for many people is due in most cases to the donor being more or less duped into entering into the agreement by intermediaries, receiving insufficient aftercare and therefore losing some of his capacity for work, as well as being cheated out of a good deal of the money he or she has been looking forward to.[124]

In the vast majority of cases, therefore, the organ trading that takes place in the real world is difficult to defend or justify. It is the middlemen and the organ recipients who profit from the situation, whereas the vendor is very largely exploited and treated altogether unacceptably. However, this section will not be devoted solely to organ trading as such; the question is also what ethical issues would be linked to organ trading even if it did not involve the totally egregious forms of exploitation usually involved in current practice.

This will be elucidated below by discussing what is objectionable about an argument whose gist is that organ trading is acceptable insofar as the following provisos are met with regard to the transaction[125]:

1. Prior to the procedure the possible donor is given comprehensive information about the possible risks of donating and about the precise tenor of the agreement. A condition for implementing the agreement is that the donor is able to grant informed consent and has therefore to a reasonable extent understood and accepted both the contents of the agreement and the possible risks.

2. The procedure is performed under medically safe conditions. The agreement gives the donor the right to adequate aftercare and includes health and life insurance, protecting the donor and/or his/her family in the event of permanent injury or death. The agreement must make it clear that none of the expenses connected with the donation are incumbent on the donor, including travel and accommodation costs.

3. The agreement guarantees the donor 'reasonable' payment. What constitutes reasonable payment can be difficult to clarify. Allowance

[124] See e.g. the section *Facts about organ trading* or Carney, Scott, 2011: *The Red Market,* William Morrow, Ch. 3: Kidney Prospecting, for documentation of these conditions.

[125] The provisos set out are roughly equivalent to the rule sets proposed as a condition for legalizing trade in organs from live donors, see e.g. Working Group on Incentives for Living Organ Donation, 2012, Incentives for Organ Donation: Proposed Standards for an Internationally Acceptable System. *American Journal of Transplantation,* vol. 12, no. 2: pp. 306-312.

may sometimes have to be made for the value of the organ to the recipient, not just the minimum the donor will accept by way of payment. This can avert the donor's dire economic plight from being exploited. The transaction must give the donor real-term opportunities to improve his or her existence, also in the longer term.

3.3.2.1 Can the donor grant informed consent for the trade?

In the western world the discussion about patients' self-determination has revolved primarily around which abilities and skills the individual patient has to possess in order to be able to grant informed consent, e.g. skills like rationality, understanding of the situation and the ability to make decisions. In the debate on organ trading, however, it has been contended that this individualistic angle of approach to the understanding of informed consent is far too narrow. One of the criticisms is that a society's social structures per se can be included as prerequisites capable of undergirding or undermining the possibility of giving informed consent. More specifically, extreme poverty is mentioned as a possible form of coercion, rendering impossible any notion of a free choice in connection with organ trading:

> *For the poorest and most vulnerable members of the world community effectively have no or little choice but to participate in this market as vendors.... the economic incentives which third-party brokers in the black market offer to poor potential vendors function as a form of coercion, precisely because the desperate persons to whom such incentives are offered are not realistically in a position to exercise their options to refuse the offer.*[126]

In other words, predicated on this criticism, it is the absence of genuine alternatives that undermines the possibility of making a real-term, informed choice. It might perhaps be formulated thus: that the future donor's impoverished plight here and now makes it unreasonably hard for him or her to stipulate requirements and make up his mind about the transaction over a longer-term future perspective.

A related issue is that in many cases it is better for a potential donor to have no possibility whatsoever of selling an organ than to have this possibility.[127] In one interpretation of the argument this is because, if the possibility of selling an organ actually exists, a potential donor can feel pressured to donate by his or her situation and relatives, since he or she—assuming the possibility exists—may be reproached and held responsible for not donating. That would not be feasible, of course, if the possibility of selling organs were entirely non-existent.

[126] Jaycox, Michael P. 2012. Coercion, autonomy, and the preferential option for the poor in the ethics of organ transplantation. *Developing World Bioethics,* vol. 12, no. 3: 135-147, pp. 140 & 141.
[127] For a more in-depth presentation of the following arguments see Rippon, Simon, 2012.

It should be mentioned that the above deliberations on the possibilities for consent are primarily addressed at the organ trafficking that involves abjectly poor donors. More affluent people do not have the same acute need of funds and are thus not exposed to the same degree of pressure. By extension, one may ask perhaps whether it is actually the potential donors' possibility of granting informed consent that is the problem. An alternative reading might be that in some cases the donor understands his situation perfectly well and makes a decision which, viewed from his perspective, is actually rational. The fact that it has to be characterized as rational, however, is due exclusively to the donor's situation. If the situation were less desperate, selling an organ would not be an option at all.

If this interpretation of the argument is correct, the problem of informed consent cannot in itself be used as an argument against organized organ trafficking in which the donor is assured of decent conditions (compare points two and three above). The argument suggests, instead, that the donors' poverty is fundamentally to blame.

3.3.2.2 Commercialization and dignity

However, in a more far-reaching interpretation of the argument above concerning pressure from e.g. relatives, the point is also that the existence of a free and legal organ trading market can eventually alter the social framework conditions around such trades, because organs will be perceived as products to a greater extent than at present and will thus be covered by the general logic of commercialization:

> *I will argue that having the option to sell an organ may result in circumstances which are predictably common among those in poverty, in individuals being held to account by others for taking and, more importantly, for failing to take the available option. I will also argue that people in poverty would be significantly harmed by being held to account in these predictable ways, with respect to the sale of their organs.*[128]

So organs would be perceived as articles of value and be used in financial transactions and settlements on a par with other articles of economic value, e.g. as collateral for the purpose of borrowing etc.

It is scarcely pure speculation that the sale of organs can be enrolled in a more extensive commercialization logic. Thus at one point in Israel, HMOs – the country's leading provider of health insurance – was involved in organ trading by refunding expenses for a transplant abroad. It also says in Chapter 3 of The Red Market (2011) that at one point American insurance companies were considering putting organ transplants out to tender in hospitals in India,

[128] Rippon, Simon, 2012, p. 4/6.

Pakistan and Egypt, because donations from live donors would be a cheaper solution for the companies than e.g. ongoing dialysis treatment or transplantation in the USA. However, the book does not reveal how these deliberations ended.

If the sale of organs in the sense outlined were to be included as part of a more extensive, legalized and institutionalized social practice, then on the basis of several of the definitions described in the section "Ethical topics concerning globalization and commercialization" it could be argued that such a practice would constitute an essential violation of man's dignity. For instance, one could enlist a Kantian interpretation and claim that mankind was too largely being treated as an object or a means, not as an end in his own right. By the same token, it might be said that viewing the other person as a supplier of organs is not compatible with the virtues we normally deem to be valuable and fundamental to our social intercourse with one another. Since the dignity concept as described in the section mentioned is difficult to manage in practice, this line of argument will not be expounded on here, however.

To a greater extent than the argument about informed consent, the arguments about commercialization and dignity are independent of who the organ vendors are. That has to do with the fact that the former arguments concern the view of humanity involved at a more general level, whereas the latter arguments specifically refer to the commercial donors' actual situation. The former arguments can therefore be used against all forms of organ trading, whereas the latter can primarily be used in relation to organ trafficking that involves exploitation.[129]

3.3.2.3 Prohibition or regulation

As previously mentioned, it can be hard to justify the illegal trade in organs currently taking place around the world. The question is, however, how to deal with this situation legislatively. One possibility is to regulate the area, another is to ban such transactions altogether.

A common argument in the debate on organ trading is that, at least at a fundamental level, it is difficult to justify an actual ban on organ trading based on regard for the donor if the ban actually deprives the donor of the chance to improve his or her situation.[130] At the same time, the fact that trade in organs rarely results in such improvement in practice does not initially warrant a ban. Instead one must decide whether it is possible to regulate the field so that the donor can actually be expected to achieve some benefit from the trade. One way of doing that is to arrange for the donor to receive adequate information. The information must not merely concern the actual procedure and the possible aftereffects and risks; the donor must also be given knowledge of other donors'

[129] See the section "Ethical topics concerning globalization and commercialization" for a discussion of the term exploitation.
[130] See e.g. Cohen 2013.

experiences—particularly the fact that donation is rarely a more permanent solution to the donor's problems—so that he or she can form realistic expectations about the future following donation, should it go ahead. In addition the donor must be examined prior to the operation and have sufficient aftercare as well as being guaranteed reasonable payment in connection with the trade etc.

A pivotal question, however, is whether it would be possible in practice to ensure that regulatory initiatives would guarantee the donor sufficient benefits as a result of the donation. In an article from spring 2013 Glenn Cohen discusses this problematic point, referring in this connection to the experiences from Iran, where they have attempted to set up a regulated and commercialized market.[131] A study from Iran shows that out of 300 commercial donors, 85% would definitely not sell a kidney again, given the option, whereas 76% would encourage other potential vendors not to donate in the strongest terms.[132] In Cohen's opinion this demonstrates the potential difficulty of ensuring that the donor actually achieves benefits from the transaction.[133] For that very reason, preventing organ trafficking by regulatory means can be relevant on purely pragmatic grounds according to Cohen. But in that case such regulation must take place in the recipient's homeland since—with the exception of Iran—bans on organ trading already exist in those places where such trafficking occurs. These bans have proved not to be effective.

It is very largely debatable which regulatory initiatives it would be appropriate to introduce in the recipient's homeland. In a Danish context, for example, it seems anything but obvious to refrain from giving home-coming organ recipients free aftercare (which is one of Cohen's proposals), as that runs counter to a basic principle of the Danish health services: that patients are treated irrespective of whether their condition is their own fault or not. But experience from e.g. Israel demonstrates that regulatory initiatives in the home country can actually reduce the volume of traffic abroad in some cases.

> *The Israeli law indeed curbed outgoing transplant tourism. Under threat of criminal sanctions, the HMOs stopped funding overseas transplantations when the altruistic motivation of the donor could not be verified – these were, in fact, the majority of cases. Consequently, the number of Israeli transplant tourists dropped precipitously: from at least 155 in 2006, prior to the 2008 transplant law, to 35 in 2011.*[134]

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[131] Cohen, Glenn, 2013.

[132] According to Zargooshi, J. 2000. Quality of Life of Iranian Kidney Donors. *Journal of Urology,* vol. 165, no. 2: 386-392; quoted here from Cohen, Glenn, 2013.

[133] Cohen gives a number of additional reasons for this, e.g. that selling one's organs is highly taboo in most countries, making it particularly difficult to provide information about actual conditions for the donor after the donation. For supplementary arguments, see also Jaycox, Michael P., 2012.

[134] See Erfat, A. 2012. The Politics of Combating the Organ Trade: Lessons from the Israeli and Pakistani Experience. *American Journal of Transplantation,* vol. 13, iss. 7: 1650-1654, p. 1,652.

The above discussion demonstrates that the question of whether and, if so, how to legislate on organ trading depends on both ethical deliberations and actual conditions. The discussion also demonstrates the importance of bearing in mind whether organ trading is being discussed at a fundamental or a practical level. One may well be opposed to organ trafficking on fundamental grounds, for example, based on an ideal that no one should be so poor as to be compelled to sell their organs – yet still be against a ban on such trade in the real world, because the sale of organs is regarded as being beneficial to the vendor—in which case one merely has to be prepared to revise one's views if the latter turns out not to be the case.

3.3.2.4 Regard for the recipient of the organ

Finally, it should very briefly be mentioned that it is debatable what role the organ recipient should play in evaluating transnational organ trading. On the face of it, perhaps, one may be prone to regard the recipient as the strong party in the transaction, because the recipient, unlike the donor, typically comes from an affluent country and is relatively affluent himself. On the other hand there is no ignoring the fact that the organ recipient is normally caught up in an exposed state of organ failure, which may be life threatening. He or she will often have been on an organ waiting list for a long time and will have had a highly impaired quality of life e.g. on account of permanent dialysis treatment, lack of mobility and so on. In that sense, then, both the recipient and the vendor of the organ find themselves in an exposed and vulnerable situation – and in a sense the organ recipient is out to achieve the same end as the donor, i.e. improve his future quality of life and future possibilities. All things being equal, that would advocate making organ trading possible, without saying that the end justifies the means in the same breath. If the trade in organs per se is ethically indefensible, it can perfectly well be argued that regard for the organ recipient should play a secondary role or not be taken into consideration at all.

To what extent people are willing to pay heed to the recipient of the organ naturally depends also on the view they basically hold on organ transplantation as a whole. For some it is a medical treatment option on a par with so many others. But many different views exist on transplantation. For example, in his book *The Red Market,* Scott Carney describes the view that donation and transplantation must be deemed to be one of the most striking expressions of "medical hubris", since in many instances people go to extremes to guarantee ageing people a few years' extra life of doubtful quality instead of accepting death as a condition of human life.[135] So, of course, anyone taking this view, will be less positively disposed towards organ trading than someone with the former view.

[135] For amplification of this line of argument, see Carney, Scott. 2011.

4. Medical tourism – deliberations on criminality

The preceding chapters describe the extent to which Denmark permits treatment with assisted reproduction using traded eggs, to make use of commercial surrogacy or to trade in human organs. The question then raised is to what extent Danes travelling abroad to avail themselves of such services can be punished in Denmark on their return home. Thus this chapter deals solely with the criminal-law aspect of medical tourism[136].

Section 4.1 discusses punishable actions committed in Denmark.

If the action was undertaken abroad, imposition of a punishment in Denmark requires the action, as well as being punishable in Denmark, to be punishable in the relevant country (double criminality). An additional condition for punishment is that the Danish penalty provision must have extraterritorial effect, i.e. state that actions undertaken outside Denmark's borders are also punishable under the provision. The issues concerning Danish courts' authority (jurisdiction) and punishment are discussed in section 4.2.

Questions of complicity can impinge when a punishable action has been aided and abetted in Denmark and either intentionally or adventitiously performed or consummated abroad. That question is discussed in section 4.3.

Section 4.4 contains a recapitulation of the chapter relating to the subject of the report.

4.1 Actions performed in Denmark

The jurisdictional provisions of the Danish Penal Code regulate the question of cases in which Danish courts are competent to make a ruling in a concrete criminal case. Sections 6-9 of the Penal Code[137] qualify which criminal cases can be adjudicated by Danish courts. Above all, the possibility of bringing in a punishable action under Danish jurisdiction depends on whether the action was committed (or is operative) *within* the Kingdom of Denmark (Sections 6 and 9), or committed *outside* the Kingdom of Denmark (Sections 7 and 8).

Danish jurisdiction covers all actions *committed in the Kingdom of Denmark*, cf. Section 6, item 1, of the Penal Code, on the *territorial principle.* That applies regardless of whether the perpetrator has any affiliation with Denmark in the form of nationality or residence etc. Even if it was not performed in Denmark,

[136] This chapter is based primarily on the Danish Ministry of Justice's White Paper No. 1488 on Danish jurisdiction, 2007, to which reference can be made.
[137] Danish Consolidation Act No. 1028 of 22 August 2013.

the action can still be subject to Danish jurisdiction if the punishability of the action depends on or is affected by an intentional or adventitious consequence and this effect happened to or was intended to supervene here in Denmark, cf. Section 9 of the Danish Penal Code on the *principle of effect.*

Danish courts thus deal primarily with Danish conditions.

Punishment can only be meted out when the law makes express provision to do so. That basic principle is set out in Section 1 of the Danish Penal Code.

As shown in the preceding chapters, trade in kidneys (Section 268, subs. 2, of the Danish Health Act[138]) and human eggs (Section 12 of the Act on Assisted Reproduction[139], cf. Section 29) and commercial use of surrogate mothers (Section 33 of the Adoption (Consolidation) Act[140], cf. Section 34) is not permitted in Denmark. If any of these actions is carried out in Denmark, Danish courts can give directions for punishment.

4.2 Actions performed abroad

If a Danish citizen goes to another country and performs these actions, under the jurisdictional provisions of the Penal Code, as mentioned above, it must be decided whether Danish courts have the option of ruling on punishment when the person concerned returns home to Denmark.[141]

If an offence bears no connection as such with Danish territory, either in terms of action or effect, there may be Danish jurisdiction instead under Section 7, subs. 1, of the Penal Code on actions performed outside the Kingdom of Denmark by persons having some affiliation to Denmark in the form of nationality or residence, ref. *the active personality principle*. The connection with Denmark is thus based not on the territory, but on the perpetrator.

4.2.1 The principle of double criminality

Under Section 7 of the Danish Penal Code, actions performed abroad by a Danish citizen come under Danish jurisdiction as and where such an action is also punishable under the legislation in force (the double criminality requirement). Section 7 of the Penal Code is based on a white paper produced by the Danish Criminal Code Commission of 1917:

> *When the question becomes to what extent there are grounds for the State to punish its citizens for offences committed by them abroad, it is not deemed sufficient to refer solely to the fact that the State is entitled to demand allegiance of its citizens to the State's court usher,*

[138] Danish Consolidation Act No. 913 of 13 July 2010.
[139] Danish Consolidation Act No. 923 of 4 September 2006.
[140] Danish Consolidation Act No. 392 of 22 April 2013.
[141] The chapter should not be read as an exhaustive examination of the rules of Danish jurisdiction, as the focus is on the problems discussed in this report.

even when those citizens are abroad. The purpose of the punishment is not to engender formal obedience towards the court ushers but to protect public interests, and the question must therefore be to what extent the State's interests call for its citizens' obedience towards the court ushers when those citizens are abroad. Paramount here is the fact that the State does not generally engage in surrendering its own subjects and therefore, for the sake of the foreign state and for its own sake, it must undertake to mete out punishment for certain actions committed by such persons abroad. These considerations, however, can go only so far as to apply punishment where such action is also punishable in accordance with the legislation of the land where it has been committed; and insofar as it involves a state territory recognized under international law, it is therefore deemed that some limitation ought to be imposed on the ambit of such jurisdiction in accordance herewith.

It should further be stated that the double criminality requirement incorporates a basic point of view that a person should generally be able to expect that he cannot later be prosecuted if his action is in keeping with the legislation in force in the country where that action was undertaken. As a visitor to a foreign country, then, one ought to be able to behave like the country's own citizens, even when they enjoy liberties not available to the visitor in his home country.

On a more practical note, it is worth mentioning that if an action is legal in the relevant country, there may also be difficulties in getting the relevant country's police to assist with investigation and conservation of evidence. The same will apply in Denmark, too, where the Danish police do not normally assist in investigating actions that are legal in this country.

The principle of double criminality holds good in most countries. If a country does not have that principle, the country's citizens would possibly be punishable, e.g. on returning home after a stay in Denmark, for actions they have practised completely legally in Denmark. Most countries thus have an interest in upholding the principle and only make exemptions for actions in situations where extraordinary regard has to be taken. Based on such deliberations, any departure from the double criminality requirement calls for there to be special circumstances, or for a particular need for protection to otherwise be deemed to exist. This may include whether the action relates to serious violations of the individual, whether there is an obvious risk of circumvention, with the illegal activities being moved abroad, and the extent to which such a departure is rooted in consideration for the effective legal enforcement of norms that enjoy broad-based support among the international community.

In Danish law the double criminality requirement in Section 7 of the Danish Penal Code has been rescinded in relation to female circumcision, for sexual exploitation of children and human trafficking. While rescindment of the principle

in relation to female circumcision is aimed at protecting citizens here in Denmark, the protection associated with the sexual exploitation of children and human trafficking is broader, covering citizens in other countries as well.

Sections 6 and 7 of the Danish Penal Code are supplemented by Section 8, paras 1-6, of the Penal Code, according to which there is Danish jurisdiction for a number of actions undertaken abroad, regardless of whether the perpetrator has any affiliation with Denmark. Thus actions undertaken outside the Kingdom of Denmark fall under Danish jurisdiction when the action is covered by an international provision under which Denmark is obliged to have jurisdiction (Section 8, para 5). To the extent that international agreement can be reached on adopting a convention or some other covenant obligating the participating states to have jurisdiction, there will thus be Danish jurisdiction in accordance with this provision.

4.2.2 According to which country's legislation?

The jurisdictional provisions of the Danish Penal Code do not stipulate which country's (substantive) legislation a criminal case has to be determined by.

Instead, Section 10, subs. 1, of the Penal Code provides that the ruling on punishment must be made in accordance with Danish law if a case comes under Danish jurisdiction. The paramount chief rule, therefore, is that a Danish court vested with jurisdiction in pursuance of the jurisdictional provisions of the Penal Code must decide the case *applying Danish legislation*. In certain instances, however, foreign legislation can have a bearing when a case is *sub judice* at a Danish court, as the sentence imposed cannot be more severe than provided for under the country in which the crime was committed.

4.2.3 When can a person be punished?

The jurisdictional provisions also do not regulate the question of whether it is possible to punish a particular action in accordance with the (substantive) legislation of the convicting country (or 'venue')—here Denmark.

If the case involves an action committed outside Danish territory, the Danish penalty provision per se is not sufficient to allow sentencing under Danish law. It will also be necessary to assess whether the provision extends beyond the country's borders. Prosecution at Danish courts and under Danish rules thus presupposes that the penalty provision in question has a validating effect that is not restricted to Danish territory (extraterritorial validity).

Whether the rule has extraterritorial validity must be determined on the basis of a description and understanding of the punishable action in the relevant provision. As a general rule the provisions of the Danish Penal Code on e.g. homicide, violence, aggravated theft etc. are assumed to be valid beyond national borders. As far as special legislation is concerned, i.e. the Danish Health Act, the Act on Assisted Reproduction etc., the point of departure is different, to wit that penalty provisions in these laws apply solely to actions

undertaken here in Denmark. In other words, such acts aim to set out guidelines for Danish conditions. When interpreted, however, the relevant provision in an ad hoc act can result in a penalty provision in such special legislation also having to be presumed to include actions undertaken abroad.

So if a law cannot be deemed to have extraterritorial validity, there will be *no* possibility of a Danish court meting out punishment for actions performed abroad.

As mentioned above, collecting and presenting the relevant evidence in cases where the action has taken place abroad can involve considerable difficulties. Even in cases where the double criminality requirement has been met and there is basically a possibility of assistance from local authorities, therefore, prosecution in Denmark can be difficult if in practice the type of offence concerned is not prosecuted in the "offending" country. In that case, local authorities will presumably not go to any great lengths to assist with prosecution in other countries either.

4.3 About complicity in particular

A person or persons complicit in a crime can also be punished in certain situations. Section 23 of the Danish Penal Code provides that "the specific penalty provision for an offence shall include anyone who has aided, abetted, counselled or procured the act. The punishment can be reduced for anyone whose only intention has been to provide assistance of minor importance or to strengthen an already resolved intent and if the offence has not been consummated or intentional complicity has not been successful".

One question that may be asked, therefore, is whether a person performing an action in Denmark who aids and abets the subsequent performance of the offence abroad is punishable under the complicity provision?

Section 9 of the Danish Penal Code provides that complicit actions are deemed to have been undertaken in the Kingdom of Denmark if the perpetrator's whereabouts were somewhere in the country at the time of such action, regardless of whether the offence was consummated outside the Kingdom of Denmark. When part of an offence has been committed in the Kingdom of Denmark, the offence in its entirety is deemed to have been committed in Denmark.

There is no requirement to have double criminality, but as is the case above, imposing punishment here in Denmark presupposes that the matter involved must be a punishable offence covered by a Danish substantive penalty provision with extraterritorial validity. Failing that, the complicit action does not concern an action executed abroad that is punishable under Danish law.

4.4 Recapitulation, actions performed abroad

As set out above, imposing punishment in Denmark for actions perpetrated abroad requires such actions, in addition to being punishable in Denmark, to be punishable in the relevant country as well (double criminality). An additional condition of punishment is that the Danish penalty provision must have extraterritorial effect, i.e. state that actions performed outside of Denmark's borders can also be punished under the provision.

For two of the cases selected in the report the double criminality requirement will often fail to have been met. These are trade in eggs and commercial surrogacy, which can be conducted legally in some countries. Hence Danish courts cannot impose punishment in Denmark for the purchase of eggs and commercial surrogacy carried out in the countries in question.

Trade in organs, by contrast, is prohibited in virtually all countries, with odd exceptions. Regardless of whether the double criminality requirement has been met for the purchase of organs abroad, then, Danes returning home from abroad after a kidney transplant can only be prosecuted and punished in this country if, subject to interpretation, Section 268 of the Health Act can be assumed to have extraterritorial effect. According to the Danish Ministry of Health and Prevention the provision does not cover actions performed abroad.

Punishment for aiding and abetting trade in eggs, commercial surrogacy and organ trafficking also requires the relevant penalty provisions (the Act on Assisted Reproduction, the Adoption (Consolidation) Act and the Health Act) to have extraterritorial effect, which cannot be presumed to be the case (see above, on the Health Act).

Middlemen's activities conducted in Denmark can be punished independently, as and when the specific action is covered by a penalty provision. According to the Danish Act on Assisted Reproduction there is a ban on "brokering or in any other way facilitating the sale" of unfertilized or fertilized human eggs. Under the Adoption (Consolidation) Act it is a punishable offence to "grant or receive assistance" to make contact with a surrogate. Under the Health Act there is scope for punishing "anyone who, knowing that payment has been made or received as mentioned in paragraph 1, is complicit in the performance of such a procedure".

5. Recommendations

5.1 Selling human body parts and bodily functions

All the Council's members endorse the general view that, as a matter of principle, the human body and its parts should not be able to be bought or sold. The members attach importance to a number of different reasons for this point of view, with all members not necessarily endorsing every argument below:

One important reason is that turning the human body and its parts into goods that can be traded on a market fails to respect the special value or **dignity** vested in mankind. The concept of dignity, as mentioned in the background text (Ch. 2.4), has many interpretations, but at an overarching level supporting a market for trade in the human body can be seen as treating the human being as a thing and thus violating its dignity.

The members consider there to be a continuum from trading in whole individuals, which represents the most serious violation of dignity, through trade in vital body parts to surrogacy and trade in egg cells. The members agree, though, that all the types of body parts or bodily functions included in this report are so high up on the scale as to make it problematic to turn them into commodities.

There are other weighty reasons why the human body should not be turned into a commodity and why we should adhere to the **altruistic principle** for donation in the Danish health services. For some members it is the motives underlying our actions that are ethically significant. The altruistic principle emphasizes regard for the other person who needs an organ to survive, or who views having a child as an existential requirement. But receiving payment for one's help shifts the focus from regard for the other person (in human relations) to a costing exercise centred around personal gain.

Apart from being ethically problematic, as previously mentioned (see Ch. 2.1), there is even some empirical precedent for asserting that such a changeover from altruistic to commercial motives for donating body parts actually detracts from the effectiveness of the donor system.

Most members find that what makes the cases of donation described morally problematic is the aspect of commercialization, and that altruistic donation of body parts and bodily functions on the other hand is positive in most cases and should be promoted.

Finally, quite a few members stress that the marketization of body parts and bodily functions leads to a **ranking of people**, particularly in the reproductive domain. On the global market for human eggs those eggs originating from Caucasian women with particular attributes and qualities represent a much

higher financial value than eggs taken from women from a different ethnic and social background. If the way were opened on a larger scale for human parts to be saleable on a commercial market, with a resultant attachment of market value to different types, in the Council's opinion it would only serve to reinforce the tendency already in existence to rank people according to ethically arbitrary criteria such as ethnicity, social status and particular characteristics currently regarded as desirable or sought-after.

The Council's members further consider that when people who are privileged from a global perspective buy vulnerable, poor people's body parts, it invariably entails an element of **exploitation**, making the action wrong as a basic point of departure. There are presumably not that many people who would be willing to donate their eggs, be surrogate mothers or give up their kidneys to unknown people from another country unless they were forced into it by adversity. The situation is highly complex, however, as it will often be a case of donors viewing their selling of a body part as their opportunity to meet basic food and housing needs and a chance to take care of their children.

Autonomy and paternalism

The general vulnerability of the donors poses another challenge in relation to the requirements we normally make in terms of making **autonomous choices**. A number of problems are borne out here.

For one thing there is a problem with observing the rules of informed consent, which have been laid down to ensure the donor's autonomy. These rules presuppose that the donor makes his or her choice on the basis of adequate information about the procedure and its risks. There is a fair indication that commercial donors are not sufficiently informed about these risks, often signing agreements they cannot read and have not understood.

Another obstacle that is manifest, particularly perhaps in relation to egg donations and surrogacy by women, can be that the traditional structures in many countries mean it is actually not the woman herself who makes the choice but her husband or possibly the extended family.

Finally, it is open to discussion whether the individual donor's social conditions mean that the person does not actually make a free choice to sell a body part. A possible objection is that the proviso for being able to make a free choice is, as it were, not "having a gun pointed at one's head", and thus in real terms being forced by circumstances to make a particular choice.

The majority of the Council's members (Jacob Birkler, Lillian Bondo, Kirsten Halsnæs, Søren Peter Hansen, Lotte Hvas, Lene Kattrup, Ester Larsen, Anne-Marie May, Edith Mark, Jørgen E. Olesen, Thomas Ploug and Christian Borrisholt Steen) find that these characteristics of the situations describing the sale of egg cells, surrogacy or organs mean that the vendors have no way of making a genuinely autonomous choice. The members acknowledge that

preventing people who make approaches themselves and express a desire to sell their body parts from doing so does represent a form of paternalism, yet still think it is appropriate to do so; for in so doing, these people are prevented from being pressured into a choice that will harm them in the long term, and which will simultaneously contribute to undermining key social values such as the altruistic donor system.

Other members (Jørgen Carlsen, Mickey Gjerris, Gorm Greisen, Steen Vallentin and Christina Wilson) recognize that although there is no such thing as entirely free choice in a situation where the donor is pressured by extreme poverty, it is a condition that applies equally to many other choices poor people have to make.[142] If paternalism is justified in terms of preventing trade in body parts and bodily functions on these grounds, then poor people should be prevented from being pressured in the same way into making other choices that will eventually harm them, such as taking on dangerous or back-breaking work. We must therefore accept that only these people themselves can choose between the often meagre possibilities they have unless we can give them a better option.

However, some of these members (Gorm Greisen and Christina Wilson) consider that although there is a sense in which permitting trade in body parts can be said to be in the interest of those involved, it should not be legalized. Legalization can shift society's goalposts for the extent to which it is allowed to exploit others' weakness and it can undermine the altruistic principle on which the Danish health services rest. The members therefore feel that the ban on selling body parts and bodily functions must remain in place.

Trade and certification schemes

The Council has discussed the viability of introducing a certification scheme in which an organization would undertake to ensure that the sale of body parts or bodily functions took place under circumstances that safeguard the donor as best possible. The scheme would have to be conducive to sales being transacted without the use of paid middlemen, an informed consent process taking place, and the donor receiving proper medical treatment and aftercare. Finally, it would have to guarantee that the donor received a price more reflective of the value of such body parts for the recipient and high enough to be able to make a genuine difference in terms of improving the donor's situation.

The majority of the Council's members (Jacob Birkler, Lillian Bondo, Gorm Greisen, Søren Peter Hansen, Lotte Hvas, Kirsten Halsnæs, Lene Kattrup, Ester Larsen, Anne-Marie May, Edith Mark, Jørgen E. Olesen, Thomas Ploug, Christian Borrisholt Steen and Christian Wilson) oppose this solution. Here they emphasize that although the idea of wanting to safeguard the donors involved is

[142] It is true of much of the work currently being outsourced by western countries to countries where labour is cheap that it is only low-cost because people in poor countries often have to work under dangerous or very physically arduous conditions, and they only take on this work because they are forced into it by extreme poverty.

appealing, introducing certification schemes could give rise to some serious problems, in addition to which it would be very difficult or impossible to realize the idea in practice.

These members consider that such schemes will probably bolster the market for organs and surrogate mothers, it will be easier for providers to market their 'products', and buyers will also enjoy easier conditions and greater transparency on the market, and a better conscience too perhaps. It is therefore considered that certification schemes might prove highly damaging, as more vulnerable poor people in developing countries would end up participating in such commercialization projects. Moreover, these members find it highly unrealistic to expect legal systems and governance in poor developing countries to be able to ensure that contracts or other agreements on organ donation or surrogacy are complied with in a way that avoids violating human dignity and risks for the parties involved. Finally, these members would like to point out that certification schemes do not solve the problem of assuring the voluntary nature of the choice to be a surrogate mother or organ donor. In both instances there will still be a risk of that choice being made by others or being due in some other way to unreasonable pressure from circumstances.

In the opinion of these members it will be harmful on balance to turn essential parts of the human being into commodities. More particularly, the existence of a market will undermine the altruistic principle on which the Danish donation system hinges. In all likelihood the incentive to donate organs altruistically will diminish if there is a possibility of procuring body parts via the market. Despite the good intention, these members fear that such a certification scheme will become just a way of buying into a good conscience, which does not solve the actual problems in practice.

The members listed are all opponents of certification schemes, both as regards trade in eggs and organs, and in connection with surrogacy.

Other members (Jørgen Carlsen and Steen Vallentin) consider that if the sale of a body part or bodily functions actually noticeably improves the plight of very poor people without inflicting serious harm or damage on them, that will advocate the acceptance of certification schemes in certain, limited situations. Although the members endorse the view that selling body parts is wrong, for the reasons previously set out, it can nevertheless be viewed as a solution of last resort that can improve an otherwise hopeless situation for the vendor, and one which realistically the person can only improve in this way.

The members view the creation of a certification scheme as the least problematic solution to an ethical dilemma, because it would respect donor autonomy**.** The members find that it would be unacceptably paternalistic to try to prevent donors from exercising their own right to make a rational and informed choice as to what course of action to take to improve their lot when we have no way of offering a better alternative.

These members do not, however, think such choices should be respected or accepted from the inhabitants of those countries that have developed welfare system that guarantee that their basic needs are met. When, in the members' opinion, the sale of body parts is only acceptable for people who have no other way of providing for their basic needs, it is because those members, as mentioned, find the sale of body parts per se ethically problematic and therefore consider that, all things being equal, it should be prohibited, and only permitted in emergencies.

One member (Mickey Gjerris) supports the view that there are conceivably situations in which the ethical problems of commercializing body parts or bodily functions might be disregarded for even more essential considerations. This member particularly highlights the regard for the severely ill and the childless, for whom having to abandon the prospect of having children poses an existential problem. The member stresses the importance of mounting campaigns to recruit donors, more effective efforts by hospitals or the introduction of a principle of presumed consent for donation from deceased people.

However, if such a redoubling of efforts failed to solve the problem, this member thinks there might be no choice but to permit the sale of body parts or bodily functions in narrowly specified situations. Here again, though, a prerequisite for even being able to accept this would be the need to safeguard the donor as much as possible with a functional certification scheme, as described above. It would be particularly difficult to guarantee this if the transaction took place in countries with supervisory bodies that worked less well. Rather, then, the member finds that trade in Denmark should be permitted, under the auspices of the Danish health services, where all things being equal the possibilities of effectively protecting the donor would be better.

All the members endorsing organ trading in certain non-ideal situations are aware that even such limited schemes run the risk of legitimizing organ sales in other situations too. They therefore deem it important to introduce such schemes for delimited periods of time, stipulating strict criteria regarding compliance with conditions and at the same time providing information about the problematic aspects of trade in the relevant body parts or bodily functions.

Attitudes towards setting up certification schemes would vary in different situations, in the view of their supporters, for which reason their positions will be briefly elaborated under the stance on individual techniques.

5.1.1 Trade in eggs for fertility treatment

The members agree that the problem of buying egg cells is smaller than in the case of the other two examples because egg cells are constantly being matured, and because hormone treatment and egg harvesting do not generally have to have serious side-effects for the donor if carried out under safe medical

conditions. Thus they do not feel that egg cells make up such important parts of the body as to make their sale a violation of dignity. Nonetheless, it is essential not to undermine the principle that body parts and bodily functions must only be donatable altruistically—the principle on which Danish and European legislation is based.

Rather than undermining altruistic egg donation, some members (Jacob Birkler, Lillian Bondo, Gorm Greisen, Kirsten Halsnæs, Søren Peter Hansen, Lotte Hvas, Ester Larsen, Anne-Marie May, Edith Mark, Jørgen E. Olesen, Thomas Ploug, Christian Borrisholt Steen and Christina Wilson) feel that the best solution in ethical terms to the present lack of egg donors would be to encourage altruistic egg donation. This could be done by providing a proper framework for donating eggs and informing people about the way donation helps childless couples. Some members also flag up the solution of promoting the possibility of so-called cross-donation. In the view of some members (Mickey Gjerris, Gorm Greisen, Jørgen E. Olesen and Thomas Ploug) it can also be done by opening the way for donation of fertilized eggs left over from fertility treatment. That is currently prohibited in Denmark, where either the mother or the father must be genetically related to the child, but it is known from other countries like the USA and several European countries.

Other members (Jørgen Carlsen and Steen Vallentin) share the wish to promote altruistic egg donation but consider that until the lack of eggs has successfully been remedied, the problem should be addressed by setting up a certification scheme. Here women in countries with no social security, living under conditions in which their basic needs are not provided for, must be able to sell egg cells under reassuring conditions. This will allow the risk of hyperstimulation with hormones, inflammatory conditions and so on to be minimized, making sure that the women are informed about the risks associated with the procedure and consent to it, not least allowing a minimum price to be guaranteed and paid directly to the woman, thereby avoiding exploitation by middlemen.

One member (Mickey Gjerris) also stresses the importance of being able to help childless women, stressing that in a situation where people have been informed about the lack of donor eggs on a massive scale and other methods of obtaining more altruistically donated eggs (like those mentioned above) have been exhausted, there might be a need to open the way for some, certified trade in eggs. In this member's view, however, such trade should take place in Denmark, where there are better facilities for inspecting that treatment is being given under safe and secure conditions than exist in more remote countries, all things considered.

One member (Lene Kattrup) considers that egg donation or the sale of eggs should not be permitted. Every child should be guaranteed the right to be able to rely on the woman to whom that child was born also being its biological mother. At any rate the government should not be party to a failure to

accommodate this right, and the certainty and sense of security which for many people means having the sure knowledge of their origins and thus a feeling of identity and 'belonging'. This member, moreover, points out that adoption should be promoted as an alternative, partly because the world has a large surplus of unwanted/orphaned or distressed children, who could be guaranteed a good childhood growing up in Denmark. Viewed from a societal perspective, we have no shortage of children in Denmark, as there has been an excess of births every year for the past thirty years, and the population is growing rapidly. As of 1 January 2013 the population in Denmark numbered 5,602,628. According to Statistics Denmark, there will be 6 million Danes by 2037. The member feels that we will soon be too many in number. Finally, the member points out that much more research should be done into the actual causes of infertility in both sexes in order to try and find predisposing environmental factors etc., thereby enabling us perhaps to achieve improved natural fertility—instead of relying chiefly, as now, on more technical fertility assistance for couples suffering from childlessness.

5.1.2 Commercial surrogacy

The Danish Council of Ethics recognizes the problems connected with childlessness due to dysfunctions/disorders/absence of the womb, both for the childless couples and for those involved in transboundary commercial surrogacy.

The actual term 'surrogacy' calls for an acknowledgement that to bear a child is to do something in lieu of the intended mother. The Council opts to use the term in the light of its widespread application. Some members, however, wish to stress that they view the child borne by a woman as the woman's legal child, and conversely the woman is the child's legal mother. Therefore, it is important to realize that the 'surrogacy' tag is instrumental in fostering a prior acknowledgement that the fetus/child does not belong to the woman bearing the child.

All the members consider paid surrogacy ethically problematic for one or more of the following reasons: it constitutes a violation of dignity, it can alter the view of pregnancy and parenthood, it risks undermining the altruistic principles on which the Danish health system is based, and it has elements of exploitation.

Some of the Council's members (Jacob Birkler, Lillian Bondo, Søren Peter Hansen, Lotte Hvas, Lene Kattrup, Edith Mark and Christian Borrisholt Steen) also consider there to be heightened reasons for opposing surrogacy, commercial as well as altruistic, because surrogacy reduces the female body to a cocoon for the production of an individual.

Some of the Council's members (Jacob Birkler, Lillian Bondo, Lotte Hvas, Lene Kattrup, Ester Larsen, Edith Mark and Christian Borrisholt Steen) think that surrogacy entails a violation of the child produced. This attitude is based on a view that the bond between fetus and mother during pregnancy is essential to

the child's ongoing development, and a surrogacy agreement represents a planned removal of the child from the only mother it knows. That can result in the child's scope for harmonious growth and development being impaired.

Other members (Jørgen Carlsen, Mickey Gjerris, Gorm Greisen, Kirsten Halsnæs, Anne-Marie May, Jørgen E. Olesen, Thomas Ploug, Steen Vallentin and Christina Wilson) do not consider that surrogacy as such should be banned in every situation, although the practice can be claimed to be ethically problematic for some or all of the reasons adduced. In terms of the bond between mother and child during pregnancy, they acknowledge that this is important and that, all things being equal, breaking off that contact on birth should be avoided. However, these members do not consider this per se justification for banning surrogacy entirely. Only very few people are the result of an entirely optimal pregnancy or entirely optimal conditions during childhood and adolescence. There is insufficient evidence to show that a stressful pregnancy or removing the child from the mother after birth represents an insurmountable obstacle per se to the child being able to have a good life.

These members think the legislators should look into the possibility of relaxing access to altruistic surrogacy in Denmark, for the sake of those couples who are childless. These members recommend that the provisions of the Danish Adoption (Consolidation) Act making it punishable to provide or receive assistance "for the purpose of establishing contact between a woman and a person or persons wishing that woman to bear a child for them" should be relaxed so as to make only the commercial operation side punishable under the provision. Most members, accordingly, feel it should still be an explicit condition for the woman to undertake the surrogacy without payment.
And the surrogate mother should be guaranteed the right to keep the child, if during the course of the pregnancy she bonds with it to such an extent that she cannot part with it.

In addition some of these members (Jørgen Carlsen, Steen Vallentin) find that the woman's right to make the decision as to whether she wants to be a paid surrogate mother should be respected if she has no other way of ensuring the provision of her basic needs. As previously outlined, a certification scheme should be used to safeguard her right to informed consent in relation to the number of eggs she wishes to have implanted, and the right to oppose selective termination and unnecessary, planned caesareans. During and for a period following the pregnancy the woman should also be guaranteed insurance against disablement and death, and the right to decline to be detained in hostels during the pregnancy. Furthermore, she should be guaranteed the right to choose to keep the child if she bonds with it as she goes through the pregnancy. Finally, the woman must be guaranteed payment that will give her a real-term opportunity to improve her life situation.

Another of these members (Mickey Gjerris) thinks the care for childless couples dictates that more should be done to promote altruistic surrogacy in Denmark; it should possibly even be permissible to advertise for surrogate mothers. If, despite such increased efforts, the problem of the lack of surrogate mothers cannot be solved and the illegal traffic continues, this member finds that the way should be opened to permit Danish couples – as a last resort – to have a child by means of certified, commercial surrogacy. The member stresses here that seeing a pregnancy to term is normally not seriously harmful to a woman, if monitored, and if the birth takes place under safe, reassuring conditions, but it is important to ensure that conditions are safe. In that case, therefore, it should be a condition that the surrogacy takes place here in Denmark so as to allow compliance with certification conditions to be monitored.

5.1.3 Trade in organs

All members of the Council of Ethics regard the trade in organs taking place internationally and illegally with the utmost seriousness. Selling an organ is a particularly invasive act and can assume grave consequences, especially when not done under safe medical conditions. Furthermore, the operation is irreversible; organs never regenerate. Moreover, there are widespread reports of cynical middlemen and criminals enticing donors with information about the procedure and payment that is downright wrong, stealing a large part of the already modest proportion of payment promised to the donor. The members therefore find that organ trading is particularly problematic, ethically, for one or more of the above-mentioned reasons: it constitutes a violation of dignity, it can lead to an altered and more selfish relationship between buyer and seller, and the existing practice has a very appreciable element of exploitation.

The members acknowledge that the lack of organs for people who are severely or life-threateningly ill is a very big social problem, which more should be done to solve. Therefore, more ought to be done to promote altruistic donation. Some of the members (Jacob Birkler and Mickey Gjerris) feel that other methods should be taken into service to promote altruistic donations; it might be in the form of, say, setting up a memorial grove for organ donors. It might be a place where we as a society mark the life-giving connotations of organ donation, where next-of-kin and relatives as well as transplantees could be commemorated. It must be assumed that more people would volunteer as organ donors, because in this way they would realize the life-giving aspect of being a donor.

The Council's members note that the work on a *Convention against trafficking in human organs* on the Council of Europe focuses, among other things, on initiatives to counter the shortage of organs, which is one of the principal causes of organ trafficking. The convention process mentions a proposal that the countries introduce the principle of presumed consent into their legislation.

In that case some of the Council's members (Jørgen Carlsen, Mickey Gjerris, Gorm Greisen, Jørgen E. Olesen and Christina Wilson) advise following such a

recommendation and introducing presumed consent. Among other things the members refer to one or both of the following arguments. The first is that the idea of presumed consent is positive, because it weights the community's obligation to help fellow citizens who are severely ill. The second is that there are admittedly problems with overriding the citizen's freedom to basically dispose over his or her own body, but the large-scale problems associated with the lack of organs and with the international trade in organs weigh more heavily. These members, therefore, all endorse the view that we should introduce presumed consent for organ donation if it leads to more severely ill people being able to receive organs.

Other Council members (Jacob Birkler, Lillian Bondo, Søren Peter Hansen, Kirsten Halsnæs, Lotte Hvas, Lene Kattrup, Ester Larsen, Anne Marie May, Edith Mark, Thomas Ploug, Christian Borrisholt Steen and Steen Vallentin) regard the problems of introducing presumed consent as so key that it should not be introduced. The members consider it important to nurture respect for citizens' philosophy of life and right to self-determination,[143] but think, as mentioned, that a major boost should be given to endeavours to source organs through altruistic donation.

One member (Jørgen Carlsen), however, thinks that as long as the problem with the lack of organs for the severely ill persists, it is necessary to take on board that some people will choose to travel abroad out of desperation. This member feels that the problems of organ trafficking have intensified *precisely because* it is a practice almost universally carried out illegally, relegating it to an illegal activity among criminal networks. The donors are poorly resourced, and they are utterly at the mercy of criminal middlemen, making their exploitation far more serious. The member therefore finds that here too a certification scheme could be put into service. If the transplants could be 'corralled' into a safe medical arena, and if the donor was fully informed about the concomitant risks and guaranteed proper, life-long aftercare – and particularly if the person received payment that could genuinely help him out of his desperate poverty— the situation would be less serious. Realistically speaking, however, the member acknowledges that this solution presumably cannot be realized on account of all countries having banned organ trading; so from a legal point of view certified trade in organs could not be conducted in some countries. However, that does not change that, in the member's opinion, this is what we ought to do.

Another member (Mickey Gjerris) shares the view that sympathy for patients with life-threatening renal disorders should result in efforts to procure organs by altruistic means being redoubled many times over. This possibility should be

[143] For a discussion of informed versus presumed consent, see the Council of Ethics' statement *Organ donation – Ethical deliberations and recommendations* from 2008 at: http://www.etiskraad.dk/Udgivelser/BookPage.aspx?bookID={43292FF4-2184-40FF-9012-F7F799E2017F}

pursued, including by introducing the principle of presumed consent, as mentioned. But if, after intense work on this, the does not solve the problem and the illegal traffic continues, some degree of payment for organs should be contemplated in the Danish health system, where the possibility of superintending the conditions under which it takes place are present. That would be an unfortunate solution, however, and should therefore only be a solution of last resort, all other channels having been exhausted.

5.2 Should legislative sanctions be introduced for Danes buying the three types of body parts and bodily functions?

The Council's members agree as to the ethically problematic nature of Danes opting to buy body parts or bodily functions abroad and thus bypassing Danish legislation and the ground rules of democracy. The question is, however, what stance society should take in relation to penalizing or introducing sanctions against those citizens who nevertheless choose to buy egg cells, surrogacy or organs abroad. Different practical considerations come into play here, making it difficult to find suitable sanctions. A large part of the members therefore feel that these actions rank as morally questionable, but are not suited to formal sanctions.

A smallish proportion of the members consider that, in principle, some form of sanctions should be introduced vis-à-vis those citizens circumventing the law in this way. Some focus on the fact that these citizens are offending against the very values we have chosen to base our legislation on, and that a lack of sanctions can be taken as acceptance of this. Others wish for sanctions to discourage more people from taking the same actions. Still others wish to signal by penal means that the individual cannot break the shared ground rules at his discretion whenever they simply fail to serve his interests, then enjoy the benefit of the advantages provided by the community unchallenged.

Different conditions apply, however, making it difficult to introduce sanctions in the different cases:

5.2.1 Trade in egg cells for fertility treatment

As mentioned, the Council of Ethics' members find that trading in egg cells is less serious than is the case in the other two examples. Furthermore, as regards introducing sanctions against those women who buy egg cells abroad, there is the added complication in practice that it will be particularly difficult to prove that a woman returning home pregnant from abroad has been undergoing fertility treatment with purchased eggs.

The majority (Jacob Birkler, Lillian Bondo, Jørgen Carlsen, Gorm Greisen, Søren Peter Hansen, Kirsten Hastrup, Lotte Hvas, Ester Larsen, Anne-Marie May, Edith Mark, Jørgen E. Olesen, Thomas Ploug, Christian Borrisholt Steen, Steen Vallentin and Christina Wilson) find that the measures needed to stem the traffic to seek out treatment using eggs purchased abroad should lie prior to such actions being undertaken. The authorities should inform and spur on

public debate about the conditions in those places where women sell their eggs out of hardship, about the inadequate medical conditions, the risk of hyperstimulation and other complications, and about the exploitation by middlemen etc., but not introduce actual sanctions.

Furthermore, other members (Lene Kattrup and Mickey Gjerris) consider that, in principle, sanctions should be introduced for women who in spite of this go abroad and buy eggs. The sanctions must be brought in to deter Danes from travelling abroad to buy eggs. They can take the form of, say, a large fine or community service.

Finally, some members (Mickey Gjerris, Gorm Greisen, Kirsten Halsnæs, Lotte Hvas, Lene Kattrup, Edith Mark, Jørgen E. Olesen and Steen Vallentin) consider that middlemen, including Danish fertility clinics, involved in sending Danes abroad and even, according to their website, preparing the women with hormone treatment etc. prior to their departure, should be punishable for these actions.

5.2.2 Purchasing surrogacy

Special circumstances prevail when it comes to imposing sanctions on Danes seeking out surrogacy abroad. This is due to the fact that the majority of possible sanctions risk having the undesirable effect of penalizing the parents who have performed the problematic action to a lesser degree, and penalizing the child to a greater degree. This applies to failure or difficulty in allowing the child to be brought into Denmark, imprisonment of the parents, and indirectly also large penalty fines for the parents.

Another complication is that commercial surrogacy is permitted in a number of countries, including India and the USA. Introducing sanctions against Danes seeking out treatments in countries where they are legal would be at odds with the principle of double criminality, which in most cases the Council acknowledges to be a suitable form of reciprocal protection of countries' right to enforce their own legislation within their own borders.

The majority (Jacob Birkler, Lillian Bondo, Jørgen Carlsen, Søren Peter Hansen, Kirsten Hastrup, Lotte Hvas, Ester Larsen, Anne-Marie May, Edith Mark, Jørgen E. Olesen, Christian Borrisholt Steen, Steen Vallentin and Christina Wilson) do not consider that sanctions should be introduced against those couples seeking out surrogacy abroad. Measures taken by the authorities should be preventive instead, consisting among other things of promoting information and debate about general conditions relating to surrogacy and the ethical problems associated with the commercialization of body parts or bodily functions.

Other members (Mickey Gjerris, Gorm Greisen, Lene Kattrup and Thomas Ploug) consider that the ethically problematic aspects of commercial surrogacy dictate that, in addition to prevention, sanctions should be introduced to prevent

Danish citizens from entering into such agreements. Wherever possible, such sanctions should be formulated so as not to penalize the child, but the parents.

Finally, some members (Gorm Greisen, Lotte Hvas, Lene Kattrup, Edith Mark and Christian Borrisholt Steen) find that middlemen brokering contact with surrogate mothers abroad should be punishable for these actions to a greater extent than is the case at present.

5.2.3 Purchasing organs

All the Council's members view the trade in organs taking place internationally and illegally with great seriousness; ethically, such traffic is highly dubious. But the question of punishment is complex, because people returning home after a kidney operation, which may even have been performed under less than ideal conditions, can be debilitated and they will need life-long aftercare. Being put behind bars can assume serious consequences for them.

The majority (Jacob Birkler, Lillian Bondo, Jørgen Carlsen, Søren Peter Hansen, Lotte Hvas, Ester Larsen, Anne-Marie May, Edith Mark, Jørgen E. Olesen, Thomas Ploug, Christian Borrisholt Steen, Steen Vallentin and Christina Wilson) find that here too the authorities' efforts – apart from attempting to increase the number of altruistic donations – should consist of providing information about the ethical problems associated with organ trading and with commercialization of the body as a whole. Prevention and debate should be the instrumentalities used to prevent international organ trafficking, but beyond that actual sanctions must not be introduced against those Danes who buy kidneys abroad.

Conversely, some members (Gorm Greisen and Lene Kattrup) consider that a custodial sentence should be introduced for Danes buying organs in countries where it is banned. Another (Mickey Gjerris) feels that instead of a custodial sentence, community service should be introduced for purchasing organs. Finally, some members (Jørgen E. Olesen, Thomas Ploug, Christian Borrisholt Steen and Steen Vallentin) think a custodial sentence should be considered in particularly blatant cases where regard for the donor's welfare and wellbeing has been completely flouted.

In addition some members (Mickey Gjerris, Lotte Hvas, Lene Kattrup and Edith Mark) find that middlemen brokering contact with organ donation clinics abroad should be punishable for these actions.

5.3 Is there an ethical obligation for Danish society and its health system to help Danes who have bought body parts abroad?

The Council's members agree that, at an altogether fundamental level, the Danish health services should build on the Samaritan principle, whereby everyone has equal access to necessary treatment irrespective of their own culpability or other non-medical factors. That means that all Danes, whether they have bought eggs, surrogacy or organs in other countries, and regardless

of the fact that organ trafficking is illegal the world over, should be guaranteed relevant medical aftercare in Danish hospitals.

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