Virtual Mentor
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FROM THE EDITOR
Gifts and Gift Giving
Audiey Kao, MD, PhD

It came without ribbons! It came without tags!
It came without packages, boxes or bags!
And he puzzled three hours, till his puzzler was sore.
Then the Grinch thought of something he hadn't before!
"Maybe Christmas," he thought, "Doesn't come from a store.
Maybe Christmas perhaps means a little bit more!"

In the Dr. Seuss classic, *How the Grinch Stole Christmas*, the Grinch believed that a Christmas without gifts would be no Christmas at all. After fiendishly nabbing all the presents and ornaments in Whoville, he was certain that the Whos would be deprived of their cherished holiday. But to his puzzled surprise, the Whos didn't need their material gifts and presents to celebrate Christmas. In the end, the Grinch realized that the meaningful gifts of Christmas were never those that were purchased in stores and tied with ribbon, but were the warm offerings of peace and happiness that came from the heart.

As we enter this holiday season, many of us will be searching--some of us up to the very last minute--for the perfect gift to give someone special. The ritual of gift giving has a long history and manifests in many ways in different cultures. In ancient Rome, the sacrificial gift was given to the gods with the hope of divine intervention in promoting fertile lands and women. The phrase "do ut des" (I give that you may give) was recited during these sacrificial rites. Each spring, Chinese celebrate the patriotism of a poet martyr by making an offering of rice that is wrapped in bamboo leaves. These offerings were initially made and thrown in the river where the poet died as a gift to the fishes so that they would eat the rice and leave sacred the poet's body.

In the world of medicine, gifts and gift giving also take many forms and come in a variety of packages. All of us who have labored through gross anatomy have benefited from the selfless act of those who gave their bodies to medical education. Many public service announcements promote organ donation by urging individuals to give the "Gift of Life" to potential organ recipients. In many communities, patients show their appreciation to their physicians with home-baked goods and similar gifts.

While these examples appear harmless, if not beneficial, other examples of gift giving in medicine raise concerns. Despite the relationship between medicine and industry in promoting quality patient care and scientific research, the potential for undue influence generated by gifts to physicians from industry is serious and demands attention and redress by the medical profession and others. In this era of genetic and molecular medicine, some consider our growing technical ability to correct fatal or undesirable germline defects in terms of a generational gift that current peoples can give to future generations. On the other hand, there are many others who view the use of these genetic therapies as opening Pandora's Box. Thus, the consequences of gift giving and of framing potential actions as acts of giving are far from benign and unbound; rather, they may have profound effects on medicine and society.

In this theme issue of Virtual Mentor, we explore the various manifestations and consequences of gifts and gift giving in the world of medicine. In some cases, a gift may truly reflect an act of altruism. At other times, a gift is not a free lunch, and the giver may be expecting something in return; giving, like the Romans, "so that you may give." Through our selection of topics and content, I hope that you will gain a better understanding and appreciation of the meaningful implications of gifts and gift giving in your professional career.

Audiey Kao, MD, PhD is editor in chief of *Virtual Mentor*.

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CASE AND COMMENTARY
Ethics of Professional Courtesy
Commentary by Kayhan Parsi, JD, PhD

Case
Dr. Friendly has been practicing pediatrics in a small city for twenty years. He has several colleagues whom he considers good friends. Recently, Dr. Friendly treated the daughter of one of his colleagues. Instead of billing for the procedure, Dr. Friendly waived his normal fee. The patient's mother, Dr. Newcomb, practices internal medicine and feels uneasy about not paying for the procedure through her insurance company. She does not want to hurt Dr. Friendly's feelings, but she thinks that professional courtesy is not required and is ethically questionable. Dr. Friendly sees it differently; he believes that the origins of professional courtesy go back as far as the Hippocratic Oath. In his opinion, professional courtesy helps in a small way to repay the debt he's incurred in learning from teachers and colleagues in medicine. Moreover, he believes that professional courtesy is something that is frequently extended in other fields; why should physicians be excluded?

What do you think?
See what the AMA *Code of Medical Ethics* says about this topic in:

Opinion 6.12 Forgiveness or waiver of insurance co-payments. American Medical Association. *Code of Medical Ethics 1998-1999 Edition*. Chicago, IL: American Medical Association; 1998.

Opinion 6.13 Professional courtesy. American Medical Association. *Code of Medical Ethics 1998-1999 Edition*. Chicago, IL: American Medical Association; 1998.

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The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

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IN THE LITERATURE
Gifts to Physicians from Industry
Keith Bauer, MSW

Wazana A. Physicians and the pharmaceutical industry: is a gift ever just a gift? *JAMA*. 2000;283(20):373-380.

In his study to determine the extent of and attitudes toward the relationship between physicians and the pharmaceutical industry, Dr. Ashley Wazana notes that the pharmaceutical industry spends an estimated $8000 to $13,000 per year on each physician in marketing its products. Promotional campaigns by the pharmaceutical industry often provide physicians with essential information about new drugs and current research.

Not infrequently, however, their marketing activities include gifts to physicians in the form of logo-covered pens and free meals, as well as subsidized travel and support for symposia and continuing medical education programs. Most medical societies do not ban these gifts, but they do have explicit guidelines for regulating the value and type of gift that is appropriate as well as the conditions under which these gifts should be given and received (see, for example, AMA Policy 8.061, Gifts to Physicians from Industry).

Despite these guidelines, many share a concern that gifts may bias physician attitudes and alter prescribing decisions. This study helps to substantiate these concerns. Dr. Wazana suggests educational and policy interventions as partial solutions to counteract the influence of the pharmaceutical industry.

Questions for Discussion

1. Do pharmaceutical industry gifts to physicians have any direct or indirect benefits for patients? What are they?

2. Can patients be harmed by the current gift-accepting practices of medical professionals? How? Do potential benefits exceed potential harms?

3. Should the medical profession curb the pharmaceutical industry's influence on physician attitudes and prescribing choices? If so, how?

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STATE OF THE ART AND SCIENCE

Is Genetic Enhancement a Gift to Future Generations?

Faith Lagay, PhD

The age-old parental desire to "give my kid the best," or "provide my children with advantages I never had" is about to take on a new level of meaning and possibility. If geneticists' predictions are correct, we will one day be able, not only to prevent genetic disorders from disabling our offspring, but also to intervene at the pre-implantation embryo stage to enhance their physical, mental, and even personality traits. Are such enhancements truly gifts? Enhancement choices will, of necessity, reflect parents' judgments regarding which abilities and personality traits they value. Who, then, will be the true recipient and who or what is the gift?

The ability to enhance complex traits lies some distance in the future. Complex physical and mental traits, skills, and talents are mediated by more than one gene, by gene-gene interactions, and by gene-environment interactions. Assuming geneticists nail down these interactions and understand all that goes into producing various traits, they must still perfect technologies for replacing genes and for ratcheting gene expression up and down.

Nevertheless, genetic science pioneers such as LeRoy Walters envision a time when skills and talents can be enhanced and dysfunctional behaviors, such as aggressive, anti-social behavior, can be dampened—either in parental gametes or before an embryo, fertilized *in vitro*, is implanted for gestation.

Determining whether such enhancement constitutes a "gift" or even an ethical practice may be a hurdle as difficult to clear as getting the science right and mastering the technology to make it happen.

Is Gene Therapy a Unqualified Good?

At this point, not everyone agrees that even preventing genetic disease through germline gene therapy is an unqualified good. The ability to insert functioning genes into embryos where their absence would lead to disabling disorders seems, on the face of it, to be a good thing, a benefit, a gift to the child who would otherwise be disabled. But, as ethicists have pointed out, germline gene therapy on embryos does not just prevent genetic disorders, or cure disease, or control symptoms—all valid goals of medicine. Rather, it prevents *an individual* with a given genotype *from coming into being*. Germline gene therapy, some claim, is thus a judgment on what genotypes deserve to exist—what kind of people are wanted and what kind of people are unwanted. Advocates for those with disabilities protest that germline

gene therapy sends a harmful message: people with disabilities are less valued than people without disabilities. Germline gene therapy, these opponents say, is no different from aborting fetuses with inherited disorders and selecting or rejecting embryos on the basis of their genetic make-up. None of the 3 practices is a gift; all are eugenic harms against those with disabilities.

Genetic Enhancement, Even More Controversial

If human germline gene therapy is controversial, germline genetic enhancement (GLGE) is much more so. Putting aside the ethical issue of equitable distribution of genetic services (a concern that applies broadly to all health-associated goods) ethical opposition to GLGE takes 3 major forms. One line of argument claims that God or nature (in the form of evolution) knows best. By manipulating the human genome in any way, we risk grave evolutionary consequences in this world as well as divine or cosmic retribution. For those who hold this opinion, the true gift to our offspring is a genome that has not been tampered with.

A second line of ethical reasoning protests that the desire to tailor kids makes mockery of the concept of parenthood. Parenting's central goal and function, on this view, should be to love, nurture, and, in a way, shepherd the body and spirit of the human being who has come into our care. Parenting in this way becomes a learning, growing, and fulfilling experience. That experience could be lost if parents are able to order custom-built children of the sort they think they could most easily love. Seen either in a spiritual or secular light, this argument insists that the best gift parents could possibly give their children is to practice love and toleration and model those virtues in their children's lives.

The third ethical argument takes a pragmatic stance: what if parents err in judging what would be best for their children? The skills that are needed to succeed in our post-industrial economy change rapidly. Skills that might be advantageous today—a brain attuned to the computer's symbolic, either-or logic, for instance—may not be in as great demand 25 years from now when offspring conceived today arrive on the job market. And what if traits that a couple considers to be deficits—a tin ear, for example, or lack of physical agility—are just the goads that might have spurred the youngster to master musical notation or theoretical math?

Giving A Surprise Gift

Today's parents have little control over the natural abilities and disabilities, personalities, and inclinations with which their kids are born. They may accept credit or blame if the children succeed or fail to become happy, compassionate human beings. But they can take comfort from their inability to know or to choose the child's natural endowment. Imagine the self-recrimination of parents who, using the knowledge of genomics and the awesome power of recombinant DNA technology, design a child whose life comes in some way to tragic consequence.

Can parents really know which set of genes will be the best gift for their children? Is it just possible that some as-yet-undiscovered internal attracting and repelling

mechanism of DNA codons, refined over hundreds of millions of years, might have a better idea? Might geneticists yet observe that natural interaction among base pairs at the molecular level—in *most* cases—encodes for a coherent collection of physical traits, talents, abilities, and even conditions society might call disabilities that, in fact, builds an all-round successful organism? Evolution has been at this task for nearly a billion years. Scientists have been able to recombine DNA for 25 years. One need not believe that evolution has a destiny or a divine intention to think that its most recent product—*homo sapiens*—should take its time in deciding whether the better gift to the future lies in manipulating the genome or letting nature take its course for a while longer while we watch and learn..

Faith Lagay, PhD is managing editor in of *Virtual Mentor*.

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ART OF MEDICINE

Share Your Life, Share Your Decision

Sara Taub, MA

Last year, 21,692 of the more than 72,000 people on the United Network for Organ Sharing (UNOS) national patient waiting list received organs. That same year, 6,125 people were removed from the list due to death--they died before a transplant opportunity arose for them.

These numbers, denoting a supply of available organs less than 1/3 as great as the demand, reflect a crisis for wait-listed individuals. The shortage measures the distance by which technological progress has outstripped society's collective desire to donate. Advances in transplant surgery and in managing illnesses that affect replaceable organs have resulted in longer and longer waiting lists; meanwhile, the number of donors has, unfortunately, not grown proportionally.

Efforts to raise visibility and increase awareness of the need for organ donation have produced such initiatives as this image from August 5, 1998, when the United States Postal Service officially dedicated the Organ & Tissue Donation Stamp as part of the National Transplant Games' opening ceremonies.

Andy Levine's cubist-like design depicts two intertwined figures who share an eye and whose hands reach inside each other's body to touch each other's hearts. The image evokes connectedness, both in the position the figures assume and their reciprocal gestures towards the heart, a symbol of its owner's core.

The caption, "Organ & Tissue Donation--Share Your Life," invites the reader to think now about donation arrangements at the end of life. It departs from the dominant metaphor of organ donation as the "gift of life," which has recently been criticized for creating impossible obligations on the part of the recipient--namely, the overwhelming need to thank or repay the donor for the priceless gift of a second chance.

Together with the words beneath the image, the creation inspires a sense of hope, where there could be sorrow only. With its half-shared features and mutual reaching out, the image suggests an understanding of organ donation as a gratifying exchange: a donor whose heart has been touched, a recipient whose life has been saved.

For a more thorough discussion of the criticisms associated with the "gift of life" metaphor for organ donation, see Laura A. Siminogg and Kata Chillag, "The Fallacy of the 'Gift of Life,' " *Hastings Center Report 29*, no. 6 (1999): 34-41.

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PERSONAL NARRATIVE

"Please Help Me. My Baby Is Sick and Needs Medicine!"

Robert Davidson, MD, MPH

Before coming to Eastern Africa, I was repeatedly warned about "culture shock." We have been fortunate to enjoy a fair amount of international travel and had lived for a time in Central America. I thought I was ready. Most of the transition has gone well. I am even learning a little Swahili. Against the advice of the Regional Security Officer for the US Embassy, we elected to not live in one of the secure compounds of clustered townhomes that house mostly Americans and personnel from other embassies. Instead, we selected a lovely older home on a two-and-a-half-acre plot.

Kenyan Asians and African Kenyans

The neighborhood has very nice homes, many of which are owned and occupied by Kenyan Asians. These folk are third or fourth generation Kenyans who culturally continue to relate to India. They are the descendants from the Indian railroad workers brought into Kenya during the British colonial rule. They have prospered in Kenya financially, and "Asians" own many of the larger Kenyan companies. It seems curious that after three or four generations they still do not identify themselves as Kenyan. We have enjoyed our conversations with our neighbors and have frequently been given advice by them, particularly on how to interact with "Kenyans." It has been more difficult than we thought to relate to "African Kenyans." We have a great relationship with the Kenyan staff at work, both the professional and clerical staff. We have had some wonderful discussions about America. At our Fourth of July party we all toasted our common heritage of rebellion against British rule. However, the rest of the Kenyans with whom we have daily interaction are at such a different income level that it is difficult to be friends or even friendly.

The Most Difficult Cultural Adjustment We Have Faced

The level of poverty and unemployment in Nairobi is so high that we are constantly made aware of the disparity of resources. "Please help me. My baby is sick and needs medicine." This plea came from a woman in rags sitting on the street outside our home with a baby asleep on the dirt. Perhaps the easiest thing to do would be to give her some shillings, which might make me at least feel a little less guilty. However, we are repeatedly warned by other expatriates and our Asian Kenyan neighbors to give nothing to beggars. They will return ten-fold the next day, we are told, if the word gets out that the "daktari" gives money. Perhaps some examples will help portray the dilemma.

We interviewed for a man to help with housework and driving. "Lucas" was selected. He had a pleasant personality and came with good references. However, very soon problems began to arise. Lucas was repeatedly absent for several days at a time due to illness. He came to see me at home on a weekend and asked me to get him some medicine to cure him. I asked if he had seen a doctor. Of course, the answer was that he could not afford it. He then proceeded to take off his shirt to show me a rash that was bothering him. As I gazed at an emaciated body with a typical Herpes Zoster rash, I suspected immediately the problem. This man was in the latter stages of AIDS. In a future segment, I want to talk about the impact of HIV/AIDS in Africa. The physician part of me began to race through options. How could I help? I knew I could not be his physician. I did not even have a Kenyan medical license. He could never afford retro-viral drugs nor even lab tests and preventive therapy such as Sulfamethoxa-zole/trimethoprim. I began to worry that his cough might be more than a simple problem. Could he be spewing mycobacterium on my wife as he drove her around in the car? My mind returned to an incident the previous week when he had presumably fallen asleep while driving and almost went off the road. I of course knew he could no longer work for us. I was not worried about his infectivity, but rather his capacity to do the job. We sat on the porch and talked for a long time. He seemed to understand that he could not work anymore for me but began bargaining for some money so he could go to the doctor, get cured and find another job. I simply could not say no. I gave him one month's salary as terminal pay and some extra money to go see a doctor. We left on good terms.

The next day he was back with his daughter in her school uniform. "Please, I need some money to pay my daughter's school tuition or they will kick her out. She wants to be a doctor like you." As hard as it was, I held the line on what I had already given him and assumed this ended the saga. The next day his wife showed up toting a small baby. "Please daktari, Lucas is very sick and will die if you do not give him some money for medicine." My heart went out to this woman. Was she also HIV+? Was the baby? How could I justify sitting on the porch of this beautiful home saying no to her? On the other hand, where would it stop? This is one of the dilemmas of "giving" in Kenya.

Institutional Need

Recently, I visited a mission hospital outside of Nairobi, staffed by rotating American physicians under the auspices of their church. The chief surgeon, an orthopod from Atlanta, immediately took hold of me and urged, "Come with me. You have to see something." He led me to the bedside of a precious 10-year-old Kenyan girl. She had been brought to the hospital following snakebite. He had operated to remove necrotic tissue from the area of the bite and relieve the tremendous pressure from swelling. However, she was showing increasing systemic manifestations of the venom. In his opinion, if she did not receive anti-toxin within the next 24 hours, she would probably die. Did the Peace Corps have any? How about the US Embassy? Could I help him? My mind began to race. Yes, I knew that *we stocked a shared supply of anti-venom with the US Embassy medical office*. It

was for use on Embassy personnel or dependants or Peace Corps volunteers. The words from my orientation sessions came ringing back. "Under **no** circumstances are you to treat or give medicine to any person other than authorized US personnel." This was the General Counsel for the Peace Corps speaking. My boss, the director of clinical services for Peace Corps and a general surgeon, leaned over and whispered, "You better listen to this as you will be tempted." The speaker went on to outline the dire consequences which could ensue if we "misused" US property. OK! I can handle this, I mused. However, standing in a mission hospital a world away from Washington, looking at a little girl that I could probably help from dying, was not part of the bargain. The US spent millions in aid to Kenya. How could I justify not "giving" to this little girl and this caring and dedicated physician?

The Harambe

The harambe is a long-standing cultural custom in Eastern Africa. It has been explained to me that it comes from the tribal custom of helping other members of the tribe in times of need. During my first week in Nairobi, one of the staff said there was a harambe for one of the secretaries and I was invited. Great, I thought. It is nice to be included. It turned out that it was not a gathering at all. Rather, it was a memo to all participants telling them how much they "owed." I have always been supportive of the graduated income tax, but wow, this was a pretty hefty bill. I paid the money, mainly because I was new in country and did not know what else to do. I did not have a very good feeling about it. Sure enough, the next week I was invited to another harambe. Was this the spirit of giving I wanted? Where would it end? Was I being selfish for wanting a bit more personal involvement and control over my gifts? Would I be culturally insensitive if I did not join in this "long standing Kenyan tradition"?

I could cite more examples, but I think these give a good picture of the dilemmas faced by an American physician in Eastern Africa. I purposely did not say how I decided to respond in these situations. The issues are more important than my responses. I do not view my working here as a "gift" to anyone. I am supported well by the US Government through the Peace Corps, and I am gaining much more than I am able to give through my work as a physician. I do feel a desire to "give" in the face of the huge need I see in this country. We are slowly finding what works for us, but if you are faced with the same situation, expect the decisions to be harder than you think.

Robert Davidson, MD, MPH is professor in the Department of Family and Community Medicine at University of California, Davis, where his interests include both rural health and the organization and financing of health care systems. In the past few years, he has served as both the Director of Rural Health and earlier as the Medical Director of Managed Care for the UC Davis Health System. Out of Africa is an on-line journal of his odyssey in the U.S. Peace Corps as the area Medical Officer in Eastern Africa.

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PERSONAL NARRATIVE
Through the Student's Eyes: "Thoughts on Gross Anatomy"
Audiey Kao, MD, PhD

"The act of human dissection may very well be the one event that distinguishes physicians from nonphysicians in a very real way," says medical student Eric David in his "Thoughts on Gross Anatomy." As the semester-long course in "gross" draws to a close, Virtual Mentor offers Eric David's reflection on the violation and mystery that dissection entails. David also expresses gratitude—his own and that of fellow students—for the "profound gift" of those who granted their bodies for medical student use.

December Patient Story 2
David E. Thoughts on gross anatomy. *Ann Intern Med*. 1999;131(12):974-975.

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PERSONAL NARRATIVE
Through the Student's Eyes: Working in the Shadows
Sara Taub, MA

This month's essay from the patient side of the clinical encounter is not from the patient himself, but through the eyes of his parents. Nicholas Green's father relates the story that Nicholas, the patient, could not tell, a tale of the "simple act" of organ donation.

December Patient Story 1
Green R. A simple act. *JAMA*. 1995;273(22):1732.

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VIEWPOINT

The Twelve Days of Christmas

Audiey Kao, MD, PhD

- On the first day of Christmas, my drug rep gave to me a partridge in a pear tree.
- On the second day of Christmas, my drug rep gave to me 2 ballpoint pens and a partridge in a pear tree.
- On the third day of Christmas, my drug rep gave to me 3 handy penlights, 2 ballpoint pens, and a partridge in a pear tree.
- On the fourth day of Christmas, my drug rep gave to me a 4-volume textbook, 3 handy penlights, 2 ballpoint pens, and a partridge in a pear tree.
- On the fifth day of Christmas, my drug rep gave to me a 5-lb. ham, a 4-volume textbook, 3 handy penlights, 2 ballpoint pens, and a partridge in a pear tree.
- On the sixth day of Christmas, my drug rep gave to me 6 baseball tickets, a 5-lb. ham, a 4-volume textbook, 3 handy penlights, 2 ballpoint pens, and a partridge in a pear tree.
- On the seventh day of Christmas, my drug rep gave to me a 7-course meal, 6 baseball tickets, a 5-lb. ham, a 4-volume textbook, 3 handy penlights, 2 ballpoint pens, and a partridge in a pear tree.
- On the eight day of Christmas, my drug rep gave to me 8 gift certificates, a 7-course meal, 6 baseball tickets, a 5-lb. ham, a 4-volume textbook, 3 handy penlights, 2 ballpoint pens, and a partridge in a pear tree.
- On the ninth day of Christmas, my drug rep gave to me 9 holes of golf, 8 gift certificates, a 7-course meal, 6 baseball tickets, a 5-lb. ham, a 4-volume textbook, 3 handy penlights, 2 ballpoint pens, and a partridge in a pear tree.
- On the tenth day of Christmas, my drug rep gave to me 10 movie tickets, 9 holes of golf, 8 gift certificates, a 7-course meal, 6 baseball tickets, a 5-lb. ham, a 4-volume textbook, 3 handy penlights, 2 ballpoint pens, and a partridge in a pear tree.
- On the eleventh day of Christmas, my drug rep gave to me 11oz. of caviar, 10 movie tickets, 9 holes of golf, 8 gift certificates, a 7-course meal, 6 baseball tickets, a 5-lb. ham, a 4-volume textbook, 3 handy penlights, 2 ballpoint pens, and a partridge in a pear tree.
- On the twelfth day of Christmas, my drug rep gave to me 12 long-stemmed roses, 11oz. of caviar, 10 movie tickets, 9 holes of golf, 8 gift certificates, a 7-course meal, 6 baseball tickets, a 5-lb. ham, a 4-volume textbook, 3 handy penlights, 2 ballpoint pens, and a partridge in a pear tree.

Audiey Kao, MD, PhD is editor in chief of *Virtual Mentor*.

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VIEWPOINT

The Human Egg as "Gift of Life": Its Price Is on the Rise

Sara Taub, MA

"$100,000 for the ova of a Caucasian woman athlete under 30; proven college-level athletic ability preferred."

This offer, which proposed the highest known price for donor eggs, appeared in the classifieds section of the *Stanford Daily* student newspaper this past year. Not just any " Gift of Love and Life" would suffice. A second requirement followed: "Very Special Egg Donor Needed."

It was not the first time that an infertile couple, represented by a recruiting service, offered college women a large sum of money in exchange for eggs of superior quality: ads in campus newspapers and mainstream publications have promised anywhere from $2,000 to $50,000 for them. This ad doubled the "financial compensation" ceiling for the materials of which babies are made. It left unchanged the criteria for ova from young, healthy women with specific physiques and recognized intellectual aptitude.

At one level, calling egg donations to infertile couples "gifts of life," as the ads that solicit them often do, invokes the altruism and generosity implicit in the label. A woman who steps forward in response to the appeal can help a childless couple become a family. Such women are willing to let other people raise beings that are half-made of their genetic material at some medical risk to themselves.

Long-term physical risks are unknown, but women who provide eggs for others run immediate risks that include bleeding, scarring, and pelvic swelling. The donation process requires self-injections of powerful hormones to put the donor's ovulation cycle in sync with the recipient's and to boost egg production. Producing too many eggs can cause hyperstimulation syndrome, which, in rare instances, results in strokes. Such are the physical drawbacks to egg donation.

There are also several ethical ways in which this "gift" is troubling. The large sums of money that couples offer women donors raises one concern: coercion. Offering a student who needs college money or extra cash upward of $2,000 for a resource she has in large supply and the extraction of which places her at moderate risk creates pressure for participation. The money can constitute so great an incentive that the woman fails to consider sufficiently the risks associated with the request. In other words, she runs the risk of giving consent that is inadequately informed.

The other major concern with this "gift" is that recipient couples have extremely specific standards of what constitutes a worthwhile child: "Very Special Egg Donor Needed." Where "special" becomes synonymous with a range of SAT scores, with a certain eye, skin, or hair color, or with a degree of physical and intellectual aptitude, the message is clear: the gift of parental love is reserved for a child who embodies a select set of characteristics that approaches notions of human perfection. This problem is compounded by the fact that the biggest financial incentives are rewards for the would-be embryo's attributes rather than compensation for the woman's inconvenience. The ads are clear on this. Under these circumstances, human beings become commodities.

Altruistic help to infertile couples who dream for children, or complicity in a commodities market for designer babies? Which moral judgment does a young woman's behavior reflect when she chooses to give the "Gift of Love and Life?"

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VIEWPOINT

Giving Oneself: When Researchers Become Subjects

Kayhan Parsi, JD, PhD

In the late 19th century, one of the worst scourges known was yellow fever. In 1878, for example, the disease killed more than 20,000 in the United States alone. Although it infected and killed many in the southeastern United States, its epicenter was in Havana, Cuba. Enter Walter Reed and his team of physicians who confirmed the causes of yellow fever a hundred years ago. Perhaps the most heroic member of the team was Jesse Lazear who experimented on himself to learn about the cause of the dreaded disease.

With the Spanish-American War a recent memory, the United States set out to rid Havana of the yellow fever pestilence. Though Havana was at the time one of the world's cleanest cities, a new epidemic broke out in its most sanitary sections. This raised a conundrum: why did some areas, no matter how clean, harbor the disease while other areas did not? In 1900 Major Walter Reed headed a Yellow Fever Commission whose other members included Drs. James Carroll and Jesse Lazear.

Reed at first decided to test the hypothesis of Dr. Carlos Finlay (1833-1915) that yellow fever is carried by the stegomyia mosquito (Finlay was a Cuban physician who first proffered the theory in 1881 that the mosquito was the carrier of yellow fever). Carroll and Lazear allowed themselves to be bitten by some of these mosquitos which had already fed on the blood of fever patients. They both contracted the disease and Lazear died. Reed then built a camp at Quemados near Havana for a complete study of the cause of yellow fever and called for volunteers. The commission established that the fever can be carried only by the stegomyia mosquito and not by filth or contact with the victims as hitherto believed. This species of mosquito was eradicated in Havana and later in Panama, enabling the United States to build the Canal.

Many unsung heroes fought in the battle against yellow fever. But the example of Dr. Lazear who gave his life deserves special recognition and respect. Today, in a busy corridor at Johns Hopkins Hospital, a brass plaque commemorates Jesse Lazear. The inscription includes the following: "With more than the courage and devotion of the soldier, he risked and lost his life to show how a fearful pestilence is communicated and how its ravages may be prevented." Dr. Lazear gave the ultimate gift; both he and Dr. Carroll took the ultimate risk in the effort to save others. For that we name Drs. Jesse Lazear and James Carroll role models in the field of research medicine.

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