donors and to share unknown oocytes. Why should (and how could) oocyte donation escape the general rules of the system in which it is implemented, being a high technology and expensive treatment with shortage of supplies?

This does not mean that Europe is not threatened by the same trends, the more now that the ‘free market economy’ is gaining government support in many European countries despite of heavy social costs. Medical treatments are part of this more general debate, in which oocyte donation is of course included. It is not by accident if the subject of ‘sharing of costs between IVF patients and oocyte recipients in an exchange of eggs’ is discussed in the UK, one of the European countries where social protection has dramatically decreased in the last 15 years. This is illustrated by Ahuja and Simons (1996) when they state that ‘disadvantaged persons in the UK who seek egg-sharing as a solution have limited choices, for only a minority are fortunate enough to receive National Health Services (NHS) funding for their IVF treatment’.

Our duties as medical doctor are double: firstly to be as careful and as imaginative as possible in our practices to decrease the shortage and to avoid a participation in ethically unacceptable practices. New knowledge from the field of research may increase available oocytes (egg maturation in vitro) within the next few years. Secondly, at a social level, to highlight the organizational constraints that we witness in our daily work hampering medical practices with high moral standards. This is why the courageous paper of Mark Sauer (1996) is a warning of great value.

A national oocyte donation society is needed

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This debate was previously published on Webtrack, Web2, Item 2, July 29, 1996.

The article by Sauer (1996) is rather disturbing; however, it confirms that two systems for donating oocytes cannot survive together. By this I mean a benevolent, known or anonymous, donation, and a fee paying donation. The fact that young girls, with no proven fertility, are enticed to donate oocytes for large sums of money, is the ultimate in medical exploitation and makes one as depressed as Mark Sauer is.

From 1988 until the end of December 1995, our programme has used more than 800 donors, all of them were benevolent and none paid. When we surveyed many of these donors about their motives for donation, the primary motivation was, of course, to help others, and they did not feel that payment for the donation would have enticed them to donate.

The scheme that has been devised by Ahuja and Simons (1996), however, is rather different, as both parties benefit from the act of donation, and I personally believe that they should be congratulated for their courage to stand up against a typical hypocrisy that has existed in the field of assisted conception in the UK. On the one hand the majority of people are turning a blind eye to the fact that some patients are unable to have any treatment in National Health Service (NHS) hospitals. However, when these patients undergo an egg-sharing scheme some accuse this of being a payment in kind and equate it with the miserable state of events that exist in the USA, where young women are enticed to come and donate. Women undergoing the egg-sharing scheme will benefit from the procedure and have no added risk by taking the medications. It is clear to me, therefore, that there is no inter-exploitation in this kind of relationship.

Increasing the public awareness of the need for oocyte donation remains the only effective way through which we can increase the number of egg donors for the ever rising demand for oocyte donation. It has been my experience that programmes and news items in the media addressing the need for oocyte donors, invariably result in women contacting us wanting to help. The UK has, in the past, provided the best example with blood donation, and as the campaign continues to increase the awareness of the population for the need to donate blood, a clean, benevolent system has continued to increase the awareness of the population for the need to donate oocytes. However, when these patients undergo an egg-sharing scheme some accuse this of being a payment in kind and equate it with the miserable state of events that exist in the USA, where young women are enticed to come and donate. Women undergoing the egg-sharing scheme will benefit from the procedure and have no added risk by taking the medications. It is clear to me, therefore, that there is no inter-exploitation in this kind of relationship.

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well as providing continuous counselling and information for potential donors. Such a body should be independent from clinics providing the procedures and perhaps should direct the donors towards the nearest hospital for them to donate oocytes. It should also take into account the waiting list of different clinics. Private agencies that help recruit donors and pay them either directly or indirectly should be outlawed, as the survival of both systems at the same time would be impossible.

Ahuja and Simons (1996) imply that, if the recipient were to help in recruiting donors, this would be either undignified or financial strings would be attached. I feel that this is an unjustifiable accusation, as it is important that their pioneering work in the UK should not be considered the only way to conduct oocyte donation. Successful clinics will encourage the recipients to become part of the recruitment force, and if we recognize that the primary objective is increasing public awareness of the need for donated oocytes, then who is more interested or motivated to participate in such an effort than those who are in need of the procedures themselves.

We strongly encourage anonymous donation, so much so that when a sister or friend comes to help a relative we try to direct them towards donating to the pool of oocytes, thereby bringing their friend or relative to the top of the list. We must however, recognize that there is a great diversity in the morals and beliefs of people, so much so that some of them prefer, and indeed in some cases will not accept, anything but known donation. Provided that all concerned are extremely well counselled we should be obliged to provide the procedure, if we, as the couples' carers, are satisfied that all concerned understand the implications of their actions and that plans have been made about how the child will be informed (or not informed) of their origin. The adoption of a paternalistic attitude towards patients, with the notion that doctors know best, or the assumption that these couples do not examine the issues involved, is incorrect and smacks of a high degree of arrogance.

Finally, the more that society understands and accepts that infertility is a disease, rather than an inconvenience, and that having a child is a basic human right rather than a desire, the more we will be able to increase the supply of benevolent donors of both sexes.

**References**


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**Oocyte donation using ‘known’ donors: it may seem the convenient answer but who pays?**

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This debate was previously published on Webtrack, *Web3, Item 3, August 8, 1996.*

In different countries, with differing systems of medical funding, the attempted ‘encouragement’ of women willing to donate oocytes is going down differing paths. Certainly in the USA with minimal financial support for assisted reproductive technology (ART), there are an estimated 2500 cases of oocyte donation annually (Sauer, 1996) with payments to the donor of up to $2500. In such an unregulated system, concern has been expressed about possible questionable practices developing. In the UK, the law allows £15 plus reasonable expenses (Ahuja and Simons, 1996) and the process is much more regulated.

In Australia, ART receives a government subsidy such that it is relatively inexpensive. In order to impose some control however, a limit of six cycles going to oocyte retrieval is applied. There is no limit to the number of frozen embryo transfer cycles. Therefore, some females who are undergoing stimulated cycles for themselves are less inclined to share oocytes, as it may compromise one of their own precious six cycles. In addition, there is the uncertainty following the recent establishment of ‘contact registers’ for adoption tracing, particularly using retrospective legislation. One state in Australia has already applied similar legislation to children conceived by donor gametes. Hence, it is probably understandable that in Australia there were only 331 donor oocyte cycles in 1992, (342 in 1993) compared with over 10,000 stimulation cycles.

It is now almost impossible for our unit to obtain sufficient oocytes from anonymous sources to treat women with a history of inherited diseases or premature ovarian failure. Demand from other women, whether peri-menopausal (aged >42 years) or menopausal (up to 50) cannot be met.

We are attempting to make up for the short-fall by asking the couples to provide a ‘known’ donor, usually a younger sister or friend. Experience with this has shown this is not necessarily an easy way out and we will quote two cases demonstrating complications involving financial and psychological costs. In our donor programme, we prefer the oocyte donor to be <38 years, and have completed her family. The last requirement is in case she proves to be infertile or prematurely menopausal herself in the future. As well as screening for infectious diseases in the donor and her partner, additional costs (frequently underestimated) are created by the time required for adequate preparation of donor and recipient couples.