Anonymous egg donation and dignity

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The continuing worldwide increase in demand for in-vitro fertilization (IVF) using donor eggs is a testament to the acceptability and increasing success of this procedure which can reach 90% live births by the fifth attempt. Thousands benefit each year when nothing else has worked for them. The very success of the procedure has led to an unanticipated shortage of donor eggs because fertile volunteers, known or anonymous, though welcome have proved insufficient to meet the demand for oocytes (Sauer, 1996). It is a fact that the problems of becoming an egg donor are more acute in those countries where IVF is more easily accessible to those who can finance their own treatment. For many, the cumulative costs of repeated IVF cycles and of access to embryo cryopreservation technology generally preclude a benevolent donation to others who need eggs for their own treatment.

How to overcome these difficulties and recruit sufficient egg donors is a serious challenge that practitioners must meet. It requires an awareness of the delicate balance that exists between acceptance of the ethical appropriateness of the procedures and the resources available to the donors. The media very often play a critical role in influencing acceptability and hence what the law will ultimately allow. The strategies devised for donor recruitment must always respect in equal measure both the medical needs of the donor and recipient together with the dignity of all the participants, including the practitioners; any compromises will generate suspicion and ultimately degrade the medical needs of patients who wish to receive treatment. It is valuable to reflect on these particular difficulties and comment on what we see as the relative merits of the three strategies currently used to recruit egg donors.

Commercial anonymous donors

By this strategy, absolute anonymity is maintained: a donor supplies an IVF centre with eggs for a ‘fee’ by arrangement. However, there is an ongoing debate in many countries about the appropriateness of cash awards to donors. Currently £15 plus reasonable expenses is all that is allowed by law in the UK. Some have expressed the view (Evans, 1995) that an inconvenience allowance based on phase I pharmaceutical trials would be appropriate compensation.

Inconvenience allowance

Inconvenience, time and discomfort are factors affecting egg donors, so in the USA they may receive a monetary reward for their contribution (Guidelines for Gamete Donation, 1993). This has resulted in a workable solution to the demand for oocytes in that country. During the past 10 years though, payments to donors have increased 10-fold; partly to cover the cost of advertising and of non-medical experts (i.e. insurers, lawyers, counsellors) involved in recruitment. Disillusionment with this commercial solution has now resulted in a leading and respected pioneer branding his fellow practitioners as unprofessional because they stoop to ‘tasteless advertisement and questionable business practices’ (Sauer, 1996).

Might the guidelines governing egg donation be responsible for this situation? The American guidelines make it clear that the payments to egg donors are intended to compensate for their inconvenience only and not as an inducement for offering their oocytes. However, in practice this difference could be considered illusory and perhaps no more than semantics to win approval for the concept. Egg donors participating in the scheme know in advance that a fee, an operative reason for the exercise, would be available in a sufficient amount to make it worthwhile. Failing that the number of donors is likely to decrease. Adequate cash awards which are known in advance cannot possibly be described as compensation for the inconvenience of donating gametes. This is by definition inducement; calling it ‘compensation’ or controlling it through legislation does not reduce its attraction to the impecunious. The amount of cash provided and the manner in which these inducements are displayed to the consumer both cause concern (Sauer, 1996).

Compensation cash payment

Healthy non-patient volunteers also participate in pharmaceutical phase I trials for payments. In the UK, the system is largely self-regulatory and the guidelines allow the individuals to be paid pro rata according to their inconvenience whenever participating in a trial. The payment is neither linked to the success of the trial nor to the risks undertaken by the individual, thereby protecting volunteers from undue pressure. It has been suggested that there are guiding parallels between this situation and payment to sperm and egg donors (Evans, 1995). However, whilst similarities between non-patient volunteers and semen donors are obvious, the suggested logic of its extension to oocyte donors is questionable.

The fundamental difference between healthy non-patient volunteers entering into pharmaceutical trials and young women of reproductive age donating eggs is the level of risk associated with the two activities. Whilst the former take no more than minimal risks, the latter participate in an invasive, highly personal procedure which involves extensive statutory medical screening followed by exposure to ovarian hormones and surgery with all its attendant risks. The donor undergoes an operation and controlled ovarian hyperstimulation which have well-documented complications. These include ovarian trauma, severe ovarian hyperstimulation syndrome, infection, infertility, vaginal bleeding and lacerations. There is an anaesthetic risk and the need for abstinence. There is nothing comparable when conducting drug trials. Those who are sufficiently motivated to embark upon IVF, with or without donated oocytes, will undoubtedly proceed come what may, but to equate egg donation in return for cash rewards with phase I clinical trials could be particularly dangerous as it trivializes the donor’s risk.
Critically, there still remains the longer-term uncertainty of the effects of fertility drugs on female gonads and the reproductive system (Fishel and Jackson, 1989; Rossing et al., 1994; Rossing, 1996; Bristow and Karlan, 1996). If, in the future, the use of these drugs for superovulation regimens is proven to carry a risk, no matter how small, society will not look kindly upon those who induced women into donating oocytes in return for cash rewards. It is one thing for the infertile to take these unavoidable risks, but quite another for a healthy fertile woman to do the same. No financial inducements can compensate for any adverse consequences.

Equally, no lasting solution to this problem can be based on a puritanical desire to achieve social correctness between the sexes. Semen donors also receive payments but they are not exposed to the same risks as egg donors. Any solution reached on this basis is likely to be unnatural and viewed with suspicion.

Finally, it is perfectly conceivable that the availability of cash rewards for eggs could lead to contractual disputes, perhaps more than in pharmaceutical trials. The threat of legal action to seek compensation from clinics, the recipients or the regulatory authority cannot be discounted. Yet, unlike the pharmaceutical industry, no directions for these likely risks exist.

In the UK, the Human Fertilisation and Embryology Authority (HFEA) moved in February 1996 to outlaw all forms of cash payments to brokers of egg donors. This might seem reactionary but it does ameliorate public anxiety. On the other hand, it does nothing to address the problem of egg availability.

**Known-anonymous donors**

In this scheme, recipient couples themselves recruit donors into the system. Whether or not recipients wish to pay the donor is of no concern to the centre. Anonymity is attained through the donors’ eggs entering a pool of donated eggs for allocation to other matched recipients. The recruiting agent (in this case the recipient) becomes entitled to priority treatment on the waiting lists though, unlike known donors, she could share her own donor’s pool of eggs with other recipients. This is distinct from equal egg-sharing between a donor and a recipient as discussed below. The attraction of this scheme is that it draws in donors who might otherwise be ignorant of the excessive demand that exists for unutilized oocytes. However, there are important considerations in this scheme which require attention.

Firstly, each donor is registered by the HFEA as an unknown altruistic donor for a matching recipient, yet her identity is known to a non-matched recipient who may have offered an attractive inducement. This may have implications for the future. Informing or not informing the child of its genetic origins is the choice of the legal parents. Unlike totally anonymous donation a third knowledgeable party is involved which could create anxiety for parents rearing an ‘egg donor’ child.

Secondly, the regulations ironically encourage one to think that recruitment through disinterested brokers is undignified (and possibly exploitative), but when conducted by recipient couples themselves is seemingly acceptable. In fact it could be argued that the reverse is the case: is it dignified to directly proposition a friend, relative or even a stranger to donate eggs, even if this is allowed by law? In adopting this attitude the law would appear to be preoccupied with protecting the donor rather than the recipient, whose needs under these circumstances are more urgent.

Thirdly, if the IVF centre distributes eggs amongst several recipients, as opposed to equal sharing with one recipient (see below), it might feel itself justified in charging the full fees to all the recipients on the grounds that they have all received IVF treatment even though only one egg collection operation was involved. Some might think that the clinic is profiteering, particularly if the eggs originate from a non-patient volunteer donor. This problem obviously does not arise in those countries where IVF is largely available free of charge (Frydman et al., 1990; Shenfield and Steele, 1995).

Fourthly, in the absence of other choices, open advertising and aggressive soliciting of young volunteers to participate might increasingly depend on an effective publicity campaign as occurs in the USA (Sauer, 1996). Here in the UK, the HFEA Act of 1990 allows IVF centres to advertise the need for donors so long as the wording used is discreet. However, this act does not and possibly cannot provide guidance to the recipients for publishing their own emotional appeals which are increasingly in evidence in all forms of the media.

**Infertile anonymous donors**

**Egg-sharing**

In this scheme, women who wish to undergo IVF treatment may consider donating an agreed proportion of their oocytes to an unidentified recipient. In return such women will themselves receive free or subsidized treatment (HFEA, 1996). Many countries, including the UK and the USA, accept IVF patients as oocyte donors and some, like Israel, legally allow no other solution.

Shared egg donation seems to have three great advantages over other alternatives. Firstly infertile donors require hormonal treatment and an operation for their own needs. Secondly, as the centre is responsible for compatibility and anonymity, it acquires the medical and social histories of participants. All this information is available to the regulatory body. Thirdly, two disadvantaged groups who are denied help from the NHS, benefit without recourse to financial inducements or direct personal transactions. Those who are accepted are also spared the frustration of having to wait for treatment on long waiting lists. Finally, the process is reassuringly easily monitored in a discreet and dignified way.

Desirable though all these advantages are, there are nevertheless some imputed objections that must be addressed. First of these is the possibility that the donor’s success might be compromised if her eggs are shared with an anonymous recipient. Conversely the recipient, who pays for the treatment, might receive sub-optimal oocytes because the donors are not necessarily multiparous women and of proven fertility.
Table 1. Features of anonymous egg donation scheme

<table>
<thead>
<tr>
<th>Donors</th>
<th>Advantages</th>
<th>Disadvantages</th>
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<tbody>
<tr>
<td>Altruistic-anonymous</td>
<td>Anonymous</td>
<td>Therapeutic impact of drugs and operation to the donor on behalf of recipient</td>
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<tr>
<td></td>
<td>Purely altruistic: no compensation or self-interest</td>
<td>Extremely scarce</td>
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<tr>
<td>Commercial-anonymous</td>
<td>Anonymity</td>
<td>Therapeutic impact of drugs and operation to the donor on behalf of recipient</td>
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<td></td>
<td></td>
<td>Exploitative of the impecunious</td>
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<td></td>
<td></td>
<td>Misleading/aggressive advertising</td>
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<td></td>
<td></td>
<td>Adult manipulation</td>
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<td></td>
<td></td>
<td>Commercing body parts: centres act as brokers</td>
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<td></td>
<td></td>
<td>Unsuitable donors being less than honest about their history for financial gain</td>
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<tr>
<td>Known-anonymous (First two parties known to each other but recipient anonymous)</td>
<td>Anonymity between donor and recipient</td>
<td>Therapeutic impact of drugs and operation to the donor on behalf of recipient</td>
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<td></td>
<td></td>
<td>Manipulation possible between the known donor and recipient who do not exchange gametes</td>
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<td></td>
<td></td>
<td>Subsequent disharmony: loss of confidentiality a risk</td>
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<td></td>
<td></td>
<td>Recipient responsible for recruitment</td>
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<td></td>
<td></td>
<td>Safeguards for perceived financial distortion necessary</td>
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<tr>
<td>Infertile-anonymous (Shared egg donation)</td>
<td>Donor requires drugs and operation for her own needs: no added risk to a third party</td>
<td>Safeguards for perceived financial distortion necessary</td>
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<tr>
<td></td>
<td>Medical solution to medical problems</td>
<td>Some degree of self-interest</td>
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<td></td>
<td>Anonymous: clinic has total responsibility</td>
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</tr>
<tr>
<td></td>
<td>Dignified: simultaneous help for two disadvantaged groups</td>
<td></td>
</tr>
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<td></td>
<td>Pragmatic shared altruism</td>
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However, at egg collection, egg quality cannot be determined accurately. Many prospective studies have shown that, provided the donors are chosen with care, the egg selection process is too random a process to compromise the overall success rates for either patient (Frydman et al., 1990; Flamigui et al., 1993; Check et al., 1994, 1995; Rosenwaks et al., 1995; Yaron et al., 1995a,b; Ahuja et al., 1996a,b; Borini et al., 1996). Indeed in this respect egg sharing is no different from the accepted practice of gamete intra-Fallopian transfer (GIFT) without IVF backup or IVF without embryo cryopreservation when only a small proportion of the oocytes are used for the couple’s own treatment, with the remainder being either disposed of or retained for research.

Some fear that donors, especially those who do not achieve pregnancy, might suffer psychologically through imputing success to the recipient. Many published studies on volunteer donors would appear to contradict this notion (Robertson, 1989; Schover et al., 1992; Braverman, 1995) and our own work does not support this view. On the contrary, many unsuccessful patients return because they feel that they have helped another infertile couple, as is the case with volunteer oocyte donors (Söderström-Anttila, 1995). Altruism is seldom absolute: different degrees of altruism can be displayed by caring people and organizations in a mutually beneficial way.

Another concern is that socially disadvantaged women or couples are coerced into an egg-sharing programme. Such a charge is speculative and has serious implications: it assumes that the patient is denied free choice and that the doctors involved are guilty of professional malpractice. In fact such disadvantaged persons in the UK who seek egg-sharing as a solution really have limited choices, for only a minority are fortunate enough to receive National Health Service (NHS) funding for their IVF treatment. The distinction between the private and NHS hospital based clinics has largely faded as the majority of IVF patients have to find the funds for their own treatments regardless of the clinic they attend.

It is also not true to say that only the socially disadvantaged participate in the ‘payment in kind’ egg-sharing scheme: the highest motive of mutual aid, in fact, seems to operate, since some who can afford to pay for their own treatment also participate in this scheme.

The principle of beneficence is badly served if the medical profession stands back and does nothing to find a practical solution for two informed and consenting couples (Robertson, 1989). In the UK, the HFEA guidelines provide the necessary framework within which a dignified solution is possible (Simons et al., 1995, 1996; Ahuja et al., 1996a,b). The mandatory provision of effective independent counselling should remove any possibility of exploitation but when it involves the donor’s general practitioner (GP) as well, it becomes doubly reassuring. The GP is the pivot of health care in the UK and he/she should ensure fair treatment for his/her patient.

Finally, to protect themselves from the indignity of answering charges of patient-exploitation for financial gain, centres could consider that only one recipient is paired with one donor and, if financially possible, only the equivalent of a single operation fee is levied for the joint treatment. This will be no more burdensome to a private clinic than a clinic based in the NHS as both are increasingly likely to levy broadly similar fees. Collectively these provisos protect the welfare of any offspring and should allay other fears in the public mind.
Conclusion

It is fair to say that there is no ideal method of anonymous ovum donation: there are medical and/or ethical pros and cons (Table I) in all the strategies discussed above. Nonetheless, one cannot dispute the fact that the demand for such donations outstrips the supply, so a diversity of policies for gamete donation has been advocated (Pennings, 1995). Medical practitioners are in a position to help. It is in no-one's interests if they adopt a paternalistic stance by denying patients the right to know that IVF methods are available and that they can be applied in an ethically sound and dignified manner. It is therefore the responsibility of the profession to examine the arguments presented here and to offer needy patients considered recommendations. Only in this way can one expect constructive assistance from both the media and the administering authorities.

References


Fools rush in where angels fear to tread

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When I became involved in oocyte donation in London in 1987 it was with anticipation that this new technology held incredible potential to transform the lives of women who until then had no hope of pregnancy: those with ovarian failure as a result of Turner’s syndrome, surgery, or chemotherapy for childhood cancers. It was also with concern that this was an ethical minefield and we were treading on uncharted ground.

Both the hopes and fears have been realized in the succeeding years. Hundreds of new families exist, whose gratitude for the ‘gift of life’ is proof of the tremendous benefits of egg donation, and success rates surpass all other fertility treatments, yet there has been no aspect of reproductive technology so heavily criticised. Scandal after scandal has broken in the media’s limelight. Stolen eggs from the infertile, transracial donation, paying or ‘pimping’ donors, 60 year old mothers; this catalogue of controversy has destroyed public confidence and alienated many, like Professor Sauer, working in the field. This situation has arisen from the uncontrolled application of new technologies in an unregulated marketplace where the demand for donated eggs has far outstripped supply.

It is sad that a doctor of the eminence of Mark Sauer should express such disillusion with an area of practice to which he has contributed so much. The problems he describes in the USA are mirrored across the Atlantic, but in the UK they are not as extreme; partly because of the ethos of the National Health Service (NHS), where monetary transactions were until recently not explicit in clinical practice, and in part because of the existence of a national regulatory body, the Human Fertilisation and Embryology Authority (HFEA), which addresses issues such as payment to gamete donors and publishes a national code of practice.

The availability of egg donors is the limiting factor for treatment. In contrast with semen donation, egg donation