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...
requires invasive medical procedures and few women are willing to undergo the discomfort, inconvenience, and risk. Donation from another infertile woman undergoing in-vitro fertilization (IVF) is an easily available source but is unfair on the donor, whose own treatment may be prejudiced, and who is statistically less likely to conceive than her recipient. Donation from a relative is appropriate for some families, but there is a risk of coercion, and of long-term difficulties in the complex family inter-relationships which result. Paid donation is a pragmatic solution but inevitably payment (beyond the reimbursement of expenses) attracts a population of donors who are financially motivated. As Mark Sauer notes, donor fees have escalated in the USA. There are parallels in the history of blood transfusion, which has always been unpaid in the UK. Paid donors may conceal a medical history which would disqualify them. Payment objectifies the donor and the gift by creating a commercial transaction. It also in a sense distances or even protects the egg donor from examining her beliefs. Altruistic unpaid donation is a safer method. The ideal donor, to my mind, is a volunteer who already has children, whose partner supports her decision; she knows the realities of parenting and the value of her gift.

As the number of voluntary donors is limited, and the indications for egg donation have widened, unpleasant decisions on rationing of treatment have to be faced. In the UK, couples without a known donor already experience long waiting-lists. Oocyte donation is virtually unavailable in the NHS and entry to treatment programmes is therefore based on ability to pay; obviously an inequitable method of rationing. More justifiable is access to treatment on medical or ethical criteria. For example, most units operate an age limit, citing the natural age of menopause and the risks to health of older mothers. It is worrying that in the UK different units have individual ethics committees, sometimes making widely different judgements. If priorities for treatment have to be set (consider a hypothetical choice between two recipients: a young woman with a genetic disorder and a 45 year old whose career ambitions postponed childbearing until too late) are some patients more ‘worthy’ than others? This is an invidious decision for the practitioner who looks in vain for guidance from the regulatory body, the ethical committee, or the counsellor.

In the UK, most media criticism of reproductive technologies has been directed at the private sector. Are lapses in practice more likely to occur than in the state sector? In fact so little egg donation is performed within the NHS that there is no basis for comparison. It may be easier to regulate hospital- or health service-based practice as within large units there is peer review of standards of care and peer pressure to conform. The licensing and inspection of all units by the HFEA is an important safeguard. In countries where practice is unregulated and consumer-driven, one would expect more risk of malpractice. The infertile are vulnerable and monetary reward (for doctor and for donor) may lead to abuse by the unscrupulous.

Problems may also occur when doctors genuinely doing their best for their individual patients say ‘yes’ (or cannot say ‘no’) to procedures which are not appropriate in the broader context. The relationship between doctor and patient in which the doctor is focused on the patient’s needs, is a venerable one. However, the implications of treatment for the couple, the donor, their existing families, and the potential child must be explored. Some couples request egg donation as a last resort in their desperate search for ‘success’. Sometimes in counselling it is apparent that what is available is not necessarily what the couple want or need. In the UK there is an obligation to offer counselling but unfortunately no ‘quality assurance’ of prescribed standards of training and experience for counsellors in this complex field.

Society has a stake in these developments. The creation of new families by egg donation, the impact on the donor and her family, and the children’s development as members of our community, affect our future social health. The momentum of change in reproductive technology has been too fast for our society to assimilate; it is breath-taking even for us as reproductive scientists. The future will bring even more difficult issues: ovarian grafts, cadaveric donation, and the use of fetal ovarian tissue. How far do we uphold patients’ rights to treatment? If a couple’s treatment requires fetal eggs, do we set their individual freedom above society’s mores? These decisions should be societal ones, and may be culturally relative. I would encourage informed public debate and the creation of national or international guidelines which will restore public confidence and set a framework within which I can securely practise as a clinician. Public consultation on donated ovarian tissue was undertaken in the UK in 1994, leading to a ban on the use of fetal eggs in fertility treatment. Because things can be done does not mean that they ought to be done. For some couples seeking treatment this may seem a harsh judgement, but whilst confirming the immense benefits of oocyte donation, I believe that a more thoughtful approach to the application of our technology is the correct one.