

DEBATE

Oocyte donation

Oocyte donation: reflections on past work and future directions

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Recently I left the University of Southern California (USC) School of Medicine in Los Angeles. Many projects relating to oocyte donation were initiated during my 8 years there, and a great deal was accomplished to change the way most of us now view ageing and reproduction. Over the years I have frequently been asked to help set up programmes or review the ongoing progress of centres involved in oocyte donation. Accordingly, one might think it relatively easy to move sites and begin anew. However, as I began to reorganize the programme at Columbia University in New York, I found myself facing serious controversies that have altered the public's perception of this technique. Indeed, the entire field of reproductive medicine has recently come under fiery criticism over issues involving gamete donation. The news media appear to be fanning the flames knowing that a distrusting public has realized its worst nightmare. Unfortunately, many of these criticisms are justified.

When I arrived at USC in 1987, most members of our department were sceptical that oocyte and embryo donation would ever play a significant role in assisted reproduction. Certainly, outside of research circles there was little demand for the service. Previously, while working at Harbor-UCLA I had witnessed years of debate regarding the ethics of embryo donation. The payment for services, anonymity of participants, and the rather unconventional arrangement inherent to the method were debated then as they are today. Many of these concerns puzzled me since men had provided similar services without evoking fear or criticism. The double standard was obviously sexist, yet could not be dismissed. To appease critics certain 'safeguards' were invoked to address the myriad of newly identified concerns. Psychologists were introduced into the formal screening process of donors and recipients. Lawyers and hospital administrators were consulted over policies governing employment and insurance to protect against injury, disability or death. Many of these practices have remained standard features of programmes. As a result, oocyte donation has grown to become complicated and expensive, partly due to the addition of outside consultants. Duties once assumed by primary physicians are now commonly subcontracted or delegated to others.

In the early days, emphasis was placed on the recruitment of 'fertile' women as donors. Today in the USA, groups openly advertise and aggressively solicit young women to participate. A decade ago the idea of unmarried, nulliparous women, typically still in school, undergoing an invasive procedure as part of a study protocol was unthinkable. This proposal would have undoubtedly been rejected by the institutional review board (IRB) as unreasonable since the risks of ovarian hyperstimulation and follicle aspiration far outweighed any benefit to the patient-donor. So what's different today? Labelling the practice 'standard' or 'conventional' seems to have justified it. Unfortunately, it appears the obligations of 'standard practice' are less rigorous than those imposed upon the same subjects undertaking peer-reviewed clinical trials. More than 2500 cases of oocyte donation are currently performed annually in the USA and issues of supply and demand have become paramount. There do not appear to be enough fertile young mothers available to meet the public's need. But there has arisen a demand for younger female students which seems to be generated by more selfish interests.

The demographic character of recipients has also changed. Originally most women I evaluated were similar to those in the general pool of infertile patients. The first reports of oocyte and embryo donation principally involved young women with tubal disease wishing to avoid surgical attempts at oocyte retrieval. By the mid-1980s, the method was offered to functionally agonadal patients. This dramatically altered the focus of care. Patients with premature ovarian failure and individuals with genetically inheritable disease states, were followed by peri-menopausal and menopausal women seeking services. The right to access reproductive care became a real issue. Should assisted reproduction be used to treat single older women and lesbians? How do we prospectively test for the ability to parent? What standards for parenting apply to these new groups of patients? Presently, there appear to be a lot more questions than answers.

Debate over limiting oocyte donation to younger recipients continues. There are concerns over the health of the older mother and her fetus during pregnancy. There is worry as to whether older women have the stamina to raise a child to adulthood. In the USA the practice of oocyte donation has been essentially unrestricted except for constraints imposed by individual physicians. However, elsewhere in the world laws have been passed to limit care. Again, are these concerns justified by the clinical work reported to date, or is this another unfair prejudice?

Costs continue to escalate; 10 years ago donors received \$250 per cycle. Today \$2500 is not uncommon. Is a 10-fold increase really merited? Again, I doubt the IRB would have approved such an enormous fee in 1984. What is reasonable compensation for donor services? Payments at

this level are more easily justified as business expenditures than reimbursements to human subjects for time spent in a clinical trial. If inflated compensation justifies exaggerated risk then perhaps no one should participate. A \$2500 payment may certainly be considered an enticement, especially when offered to students.

While attending the World Congress of in-vitro fertilization (IVF) in Vienna I was impressed by the almost unanimous criticism levelled at practitioners in the USA by colleagues abroad with respect to the payment of donors. Allegations of 'pimping' for patients in need of eggs seemed a rather cruel accusation at the time, and yet as donors' fees continue to rise I am increasingly reminded of the obvious shift away from altruism. Yet, one cannot blame the donors when advertisements read 'We pay top dollar' as recently advertised in Los Angeles.

I don't believe any of us expected oocyte donation to establish itself so quickly nor did we anticipate how well it would ultimately work. Life-table analysis of 500 consecutive cycles performed at USC demonstrates live births in >50% of the women by the third consecutive cycle and >90% by the fifth try. Although five cycles of oocyte donation is fiscally draining, few if any fertility treatments come close to matching these statistics. Donor oocytes add an unexpected element of success into situations traditionally viewed as grim. This infusion of hope is inherently uplifting and a welcome addition to most programmes where failure is more commonly the norm.

If I sound somewhat pessimistic and dismayed at the state of things today it is because I am. We have accomplished so many great things in so short a time. I am afraid that these accomplishments may soon be overshadowed by the increasingly questionable practices taking hold of oocyte donation. Lest it become like surrogacy, unaffordable to most, and fraught with legal entanglements, it is time to guard against moneyed and special interests profiting from the desperation of our patients and exploiting the goodwill of most donors. We should be vigilant in protecting against tasteless advertisements and questionable business practices. I would like to believe that strong condemnation by professional peers may still have some impact. I have always believed it best for physicians to choose the way in which they wish to practice medicine. After all, that is what defines us as professionals. However, it is also up to us to police ourselves and our practices unless we wish to forfeit this right.

Problems with oocyte donation

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The rather pessimistic paper by Sauer (1996) leads me to a few comments. Firstly, new advances in medical science happen in a rectilinear and univocal manner. There are

always excesses, interdicts and contradictions which, over time, would make one believe that the image of progress is altered or misled.

It is also possible to consider that oocyte donation does not represent either social or medical progress. If so, then sperm and embryo donation should also be condemned. I, for one, cannot accept such arguments. If oocyte donation allows women who are totally infertile to bear the child they and their partners so much long for, we should express our satisfaction that medically-assisted procreation has permitted this, and search for the most constructive ways to carry it out.

Secondly, the problem of money is a very important one. I know little about the situation in the USA, but in France, any gratuity paid for gamete and embryo donation must be comparable with that paid for organ donation. Nevertheless, the principle of payment for expenses incurred by the donors for conservation and preservation is accepted; this is also the case for sperm donation. We have always considered that our American colleagues should tend to act towards gratuity; the American Society for Reproductive Medicine (ASRM) advises them to do so. The number of donors will surely diminish and, as a consequence, questions will arise about the problem of donor anonymity. These questions are all being discussed worldwide and solutions to them are likely to be drawn into an international consensus in a few years. They should not alter our confidence in the fundamental aim of our work which is to give a child to infertile women.

Thirdly, the problem of the indications for donation must also be discussed. While there is apparently widespread agreement for using it for infertile women, its role for premature menopause, risk of transmission of a genetic disease, and the maximum age at which donation can apply is still under discussion. Maybe the choice should be guided by the well-being of the child to be born. If decisions were taken on the basis of the child's welfare and not only the desire of the parents to conceive, many cases apparently shocking in current practice would become humanly acceptable. This progression seems to happen gradually throughout the world and exceptional cases only remain as anecdotal cases.

To sum up, I agree in the main with Professor Sauer's criticisms, although I differ in my vision of the future. I am more optimistic about medically-assisted procreation in general, and oocyte donation in particular, which allows couples to have the child they long for and for a desired and happy child to be born. Criticism is necessary, for these procedures can influence choices of behaviour in the recipients. International debates allow each country to compare its methods with others. As each day passes, the shocking aspects of donation will disappear little by little, and what will remain will be the great happiness of couples bearing the child they wish for when Nature has apparently forbidden it.

Reference

Sauer, M.V. (1996) Oocyte donation: reflections on past work and future directions. *Hum Reprod.*, **11**, 1149-1150.