DEBATE

Payments to gamete donors

Payments to gamete donors: position of the Human Fertilisation and Embryology Authority

Martin Johnson

In its 1996 Annual Report, the Human Fertilisation and Embryology Authority (HFEA) announced that, in due course, all payments to gamete donors, other than reasonable expenses, would be disallowed. The procedure by which this decision will be implemented, and the programme for implementation, remain to be determined. This paper sets out: (i) the background to the Authority’s decision; (ii) the Authority’s current approach on implementing its decision; and (iii) the need for further constructive debate on these issues.

Although the Authority has established that payments to gamete donors should be phased out, no decision has yet been reached about how, and over what period, the transition should take place. The Authority will take the time required to consider both these matters. In the meantime, there is no change to current practice.

Background

The HFEA was established by the Human Fertilisation and Embryology Act (1990) to regulate embryo research and all fertility treatments involving the creation of human embryos outside the body or donated gametes. It is answerable to Parliament. As a regulatory body, the Authority has a responsibility to promote good practice and establish guidelines that protect all those who are involved in these treatments. This means patients, donors, any children born or affected and clinics. In general, the regulation of this area of fertility treatment in the UK is acknowledged to be beneficial to all these parties and to society at large. When making policy decisions the Authority considers how best it can fulfil its full role and responsibilities.

One of the areas the Authority is required to regulate is payments to gamete donors by licensed clinics. Under the Act payments to donors may only be made if authorised by the Authority in Directions.

The Authority currently authorises some payments to gamete donors. This situation was established when the Authority began operating in August 1991. At that time the HFEA set a level of payment that reflected what was then current practice, namely a maximum of £15 per donation plus reasonable expenses. The Authority did not wish to encourage higher levels of payment, so any clinic paying less than £15 per donation on 31 July 1991 was not allowed to increase its payments to £15 and new clinics were not allowed to make any payments at all. This has continued until the present day.

The intention was always for the Authority to consider the whole issue in more depth at a later date. Therefore, the current situation was, from the outset, only an interim measure. This position was reinforced in the HFEA’s 1993 Annual Report where the Authority announced that it intended in the longer term to phase out payments to donors.

The desirability of reaching a conclusion about payments to donors increased with the development and spread of new clinical practices such as egg donation and egg-sharing. Moreover, because payments were frozen at levels operating in 1991, allowable payments vary from £0 to £15 between clinics. This variation is confusing for donors. New sperm banks, which are not allowed to make any payment, might also see themselves at a disadvantage in the present situation. For these reasons a resolution of the Authority’s policy was necessary.

The Authority began its consideration of the issue in earnest in 1993 when it commissioned two pieces of research: a survey of the clinics’ views of semen donation and a survey into the motivations and attitudes of semen donors (Golombok and Cook, 1994; Cook and Golombok, 1995). In the second study male donors reported that both a wish to help others and the offer of payment influenced their decision to donate. Donors and non-donors were also asked about the personal and social aspects of donating sperm. For donors the most common concerns were that they would be contacted by offspring or that changes in the law would result in offspring being able to identify them. The second study also included a comparison with egg donors. The women surveyed were almost all motivated by a wish to help others rather than by payment. They were more concerned than their male counterparts about the possible existence of children they would never know. This research indicated that there were clear differences in the attitudes of sperm and egg donors, but did not distinguish whether these differences were related to gender, to the different historical and cultural contexts of each type of donation, or to a combination of both these factors.

Once the report of the survey of donors had been received, a working group of Authority Members was set up in 1994 to consider the practical, social and ethical issues related to the payment of sperm and egg donors. The working group reported its findings to the Authority in November 1994, and it was agreed that a conference on payment for donors should be held to allow wider consideration of the issues.
That conference took place on 1 June 1995 at St Anne’s College, Oxford. About 80 delegates attended from a variety of backgrounds including lawyers, scientists, fertility practitioners, sociologists and experts in bioethics.

Several significant points emerged including that: (i) HFEA policy on payment should strive for equity and justice between all parties; (ii) supplies of donated gametes should not diminish; (iii) potential donors should not be subject to pressure or excessive inducement; (iv) compensation for inconvenience should be considered; and (v) a tariff system should be considered.

Interest was expressed in further research into how unpaid donors might be recruited, and there was widespread support for a co-ordinated effort to raise public awareness of the value and need for egg and semen donation.

A significant point to emerge for the Authority from the discussions was that the public perception of donation is an important influence on both the number and type of donors. For the supply of donors to be maintained in the absence of payment a change in culture would be needed. Public attitudes evolve over time and this process might be helped by raising awareness of the need for, and value of, donation. The HFEA felt that an important role in changing the culture of donation should be played by clinics, professional and patient organisations, with support from the Authority.

After the Oxford conference the Authority considered in detail the views and opinions that had been expressed by delegates. The Members of the Authority looked at the pros and cons of the arguments presented in favour and against payment and made comparisons with other forms of donation (such as blood, tissue and organs), adoption, surrogacy and policies in other countries. Additional consideration was given to the role the Authority could have, if any, in recruiting unpaid donors. This process took nearly a year, and it was during this time that the HFEA’s policy took shape.

Development of HFEA policy

As the Human Fertilisation and Embryology Act was drafted with a clear presumption of non-payment, the Authority felt that, if payments to gamete donors were to be authorised in the long-term, then it would have to provide reasons why payment was allowable. In considering this the Authority distinguished between two quite distinct issues: an issue of principle and an issue of practice. The issue of principle concerned whether payment ought to be given to donors in exchange for their gametes. The issue of practice concerned the practical consequences of paying donors. The Authority decided to resolve the issue of principle first as this would determine its objective, and then consider the issue of practice as this would determine how it might best reach its goal.

In considering whether donors should receive payment in principle, the HFEA took into account how payment might affect the values associated with a donation, for example, whether donated gametes should be perceived as a gift or a commodity and whether payment could affect this perception. The Authority also considered whether payment might be given for other aspects of the donation rather than for the gametes themselves, and whether payment for these different things could be clearly separated. In addition, the Authority was concerned about how the values attributed to donated gametes might affect the social context in which donor inseminated children were born.

In reaching its decision, two major principles emerged. These were that: (i) fully informed consent, free from any inducement and pressure, was fundamental to gamete donation; and (ii) the potential for human life inherent in a donation made with the specific intent of producing children should be respected.

The Members of the Authority were concerned that payments to sperm or egg donors could jeopardise these principles. Members concluded that it was possible for a donor to be financially induced. If this were the case, the inducement might compromise the ability of the donor to consider fully the implications of the donation. Of gravest concern was that a donor would regret their decision to donate later. Whilst Members of the Authority accepted that payment did not necessarily or inevitably mean that donors had been induced financially, they did agree that the risk of financial inducement was not acceptable. It therefore appeared to the Authority that, in order to promote best practice and protect the interests of donors involved, a system of non-payment was most desirable.

In the UK, blood and organ donors do not receive payment, and payments for children who are being adopted are forbidden. In this context, the Authority felt that payments to gamete donors was contrary to the accepted ethos in this country. Furthermore, the Authority agreed that gamete donation had more serious consequences than blood or organ donation as gamete donation may result in the creation of new life. Payment might generate the perception that any resulting children were commodities and that the donors themselves were being exploited.

This general conclusion is supported by the Nuffield Council on Bioethics in its report ‘Human Tissue: Ethical and Legal Issues’. This report, which included spermatozoa, ova and embryos in its definition of tissue, recommended that the altruistic nature of donors should be encouraged rather than eroded. In reaching its conclusions on the commercial procurement of human tissue the report noted that securing genuine consent might be threatened if donors were receiving payment. The report also questioned whether there were other means of improving the supply of urgently needed tissues that would not threaten the ‘gift relationship’.

The Authority also took into account the draft Convention on Human Rights and Biomedicine which has since been formally adopted by the Committee of Ministers of the Council of Europe (Council of Europe, 1997). The Convention states in Chapter VII ‘that the human body and its parts must not, as such, give rise to financial gain’.

The Authority considered the payment of compensation to donors on the basis of the risks or discomfort undergone in making a donation. This included consideration of a tariff system which has been suggested elsewhere as a possible way forward. The Authority felt that the tariff system used for medical trials was not an appropriate model for a number of reasons. This included the fact that volunteers in medical trials...
were involved in advancing medical science in a general sense rather than in giving their genetic material for the treatment of others. The context in which payment was made therefore appeared to the Authority to be very different. In addition, a recommendation made by a working group of the Royal College of Physicians (1986), that payments in clinical trials should not be associated with any level of risk, seemed to make payment for egg donation, where there were clear risks, unacceptable. Members also had difficulty in establishing a sound basis for calculating compensation for inconvenience that did not involve risk. The discomfort associated with a donation seemed even harder to quantify because of the range of individual responses. An additional problem that was identified with the payment of compensation was that the payment would be known about in advance of the donation. As a result, even if the payment were intended to compensate for inconvenience experienced it would be impossible in practice to introduce such a system that did not also have the potential to act as a financial inducement.

The Authority also considered the recipients of the donated gametes and the resulting children and the effect of payment upon them. The Authority acknowledged that the evidence that is available suggested that the majority of couples who receive donor insemination (DI) treatment did not tell their children, or did not intend to tell their children, of their reproductive origins. Couples may deny the fact of their treatment because of the stigma of male subfertility and/or DI. However, it has also been suggested that paying donors may encourage patients and clinics to marginalize the role of the donor in DI treatment. The Members of the Authority felt that, if payment were to be abolished, this might be the first step towards greater public acceptance and awareness of sperm donation. This in turn might encourage recipients to be more open about their treatment.

In relation to the children who result from DI treatment, the ‘gift’ nature of a donation appeared to be even more important where the child has been told of their reproductive origins. Although the initial concerns about payment focused on the donors themselves, the Authority took a view that paying donors did not encourage couples to be open about their treatment and that this was an additional consideration that favoured the non-payment of donors.

The Authority was clear, however, that the donors should not lose financially by donating. It wished a system of expenses payments to be put in place which was financially neutral for the donor.

The Authority concluded that a donation should be a gift, freely and voluntarily given with informed consent, and therefore that payments to donors should be phased out. In addition donors were to be reimbursed only for verified, necessary and consequential expenses incurred directly as a result of making the donation. This conclusion seemed to take into account in the best way possible the various interests of donors, patients and children conceived through the use of donated gametes.

The Authority also considered the giving of benefits in kind in exchange for donation. Having reached the conclusion that there should be a move away from payment, the Authority compared benefits in kind with payment to see whether any clear distinctions could be made between the two. It was felt that benefits in kind would be seen as payment in a different form, and that therefore the same conclusion should be reached. This means that in future an arrangement, such as an egg-sharing scheme, where the couple receive treatment at a reduced charge in exchange for donating eggs, should also be phased out.

Implementation of the policy

The Authority announced its decision of principle in its 1996 Annual Report. A Chairman’s statement was sent to all clinics at the same time to draw their attention to the issue.

The Authority also set up a Working Group to consider how its long-term policy objective should be implemented. In setting up the Working Group the Authority was aware that the means of implementation could affect the availability of services. Therefore the Working Group has been asked to advise the Authority on: (i) the effects of withdrawing payments to donors and benefits in kind; (ii) how any adverse effects could be countered; (iii) the role of the Authority; and (iv) timetable for the removal of payments to donors.

The Working Group comprises Martin Johnson (Chairman), Jane Denton, Liz Forgan, Brian Lieberman and Angela Mays. Preliminary consideration has been given to various issues, including: (i) alternative methods of recruiting donors; (ii) the evidence in the published literature on the possible effects of disallowing payments; (iii) the relationship between payment and anonymous donation; (iv) donation programmes overseas; (v) the factors that influence successful DI treatment; (vi) the expenses that may be paid; and (vii) the systems in place for donation of other body tissues.

In addition, a bibliography relating to donation has been compiled by the Working Group and represents the published evidence that has been considered by the Group to date.

In December 1996 the Working Group invited 12 relevant organisations (Royal College of Nursing, Child, British Infertility Counselling Association (BICA), Royal College of Obstetricians and Gynaecologists, Association of Clinical Embryologists (ACE), British Andrology Society (BAS), Project Group on Assisted Reproduction (PROGAR), Donor Insemination Network, British Fertility Society, National Egg and Embryo Donation Society (NEEDS), ISSUE, Progress) to a meeting at the Authority to discuss practical issues of implementation. That meeting provided an opportunity for those attending to raise issues of concern to them, and for the Working Group to hear a variety of views. Following that meeting each represented organisation was invited to submit a written report to the Working Group summarising firstly, what that organisation might do to facilitate the implementation of the agreed policy that payments to donors cease, and secondly, what the HFEA might do to facilitate the implementation of its agreed policy.

In making their submissions, the organisations were asked to bear in mind the statutory limitations on the HFEA’s role. The Authority may provide advice and information to clinics, donors and recipients, but cannot become directly involved in
promoting gamete donation as this would conflict with its regulatory role.

The Working Group expects to report to the Authority later this year. There will be further opportunities for consultation after the Authority has considered the Working Group’s report.

References

The internal coherence of donor insemination practice: attracting the right type of donor without paying

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Payment is one of the most fundamental rules in the semen donation procedure. Few guidelines have such an impact on the moral status of the act. The Human Fertilisation and Embryology Authority (HFEA) has taken a firm position on this point: ‘the donation should be a gift, freely and voluntarily given with informed consent’. By changing the rules on payment, the Authority wishes to alter the symbolic meaning of the Act (Johnson, 1997)

The role of the donor
The causal mechanism underlying the proposition of the Authority is that the guidelines of the procedure determine the type of donor. Payment recruits financially motivated donors while non-payment leads to altruistic donors. However, it never was the intention to select donors motivated by money. The payment rule was justified by the fear that an insufficient number of donors would come forward if no monetary reward was offered. The essentially negative reason underlying the rule makes it reasonable to postulate that the rule had at least no other major disadvantages. It would never have been maintained if, for instance, the wrong type of donor had been attracted by the financial remuneration. In the context of blood donation, the additional health risks generated by the blood donors in for-profit systems contributed significantly to the rejection of money as a means of recruitment. However, we are not referring to the health and intelligence of the average donor although the genetic quality is, of course, important. We want to stress the fact that the presentation of the donation as a commercial transaction attracts donors who have the right attitude for the job.

We should recall the main goal of the donor insemination practice: a donor gives his genetic material in order to enable others to fulfil their wish to have a child. The donor is an outsider who has no rights nor responsibilities in the newly created family. The procedure as it exists in most countries completely severs the link between the donor and his genetic material and thus, indirectly, isolates the donor from the recipients. For most people involved, donors as well as recipients, this is still how the positions should be established. Deviations from this basic scheme are only possible by mutual agreement.

Paradoxically, we might have to recognize that the donor with a financial interest is better suited for the position he has to take in the transaction than the donor with more altruistic motives. The detached and casual attitude towards the offspring is part of the attractiveness of the paid donor: he is (supposedly) only interested in the money. The parents need not fear an intrusion by the donor on their family. By insisting on other motives, we might be selecting donors who will grab every occasion to become more involved in the receiving family or who would insist on a much greater say in the procedure. Authors who reject payment (and anonymity) frequently argue for another type of donor who feels responsible for the offspring, who thinks about them frequently, who feels a connection and wants contact etc. These characteristics are mentioned in the description of unpaid donors but they are also implicitly given as normatively better. They are the expression of a sense of social responsibility which should be encouraged, not discouraged (Rowland, 1985). This may be true up to a certain point. The donor should feel enough concern and empathy for the infertile people to make the effort to donate but he should not become involved to the extent that he wants more than his role requires. The relationships between all the rules need to be studied to compose a procedure which is based on a call for help and which limits the degree of involvement of the donor. A discussion on the precise role of the donor should have first priority.
as an important incentive, they have to ‘fail to collect the offered reimbursement’ (Handelsman et al., 1985).

If the ‘gift’ nature of the donation is highly valued, the motives of the donor are crucial. We not only want to receive a certain supply of genetic material, we want it to be given with the right motive. In a general climate which favours efficiency and instrumental reasoning, one frequently fails to appreciate the importance of intentions for the moral evaluation of an act. However, the Authority is putting the principle much too strongly when it states that the consent for the donation should be given ‘free from any inducement and pressure’. This, by the way, would be acting without a reason. People who feel ‘pressured’ or ‘induced’ to donate by their sympathy and concern for the infertile are, I presume, precisely the kind of persons the Authority wants to select.

The Authority adds two reasons to justify disallowance of payment: (i) payment ‘might compromise the ability of the donor to consider fully the implications of the donation’, and (ii) the donor can be financially induced and thus would not be free. Both reasons are couched within a utilitarian context namely as protection for the donor. There are indications that the type of donor presently recruited in most clinics is prone to make ill-considered judgements. However, there exists no reliable evidence to corroborate the hypotheses that donors regret their decision afterwards or that the donation generates problems in their own family later on. Moreover, one needs to stretch the term ‘excessive inducement’ to argue that the attraction of £15 is strong enough to seduce some men to do things they really do not want to do. Nevertheless, the financial remuneration may hamper serious consideration by serving as a readily available and socially accepted motive. The donors can use the payment to account for their action to themselves as well as to others. Of course, the same objection can be raised against altruism: ‘helping infertile couples’ may also serve as a socially acceptable reason to hide or suppress other motives. Which motive is the most unacceptable in the context of donor insemination: financial gain or the wish to become a father? Some findings in the practice of oocyte donation, where payment is much less prevalent, incite to prudence. In particular the high prevalence of reproductive losses and family traumas in oocyte donors makes one wonder about the ‘real’ motives underlying their donation (Schover et al., 1991).

The main objection against the argument that payment should be withdrawn to protect the donor is that the protection can be better secured by increasing the minimum age of the donor and by requesting that the donor has already a family of his own. These recommendations were proposed by the HFEA itself some years ago (HFEA, 1993). The full informed consent by the donor is threatened by the lack of maturity and concern for the infertile are, I presume, precisely the kind of persons the Authority wants to select. This, by the way, would be acting without a reason. People who feel ‘pressured’ or ‘induced’ to donate by their sympathy and concern for the infertile are, I presume, precisely the kind of persons the Authority wants to select.

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The internal coherence of the procedure
Most guidelines are consistent with the basic structure of the gamete donation practice. This raises the question whether one guideline can be changed while all the others remain operative. Especially for essential rules, alteration will be difficult without also changing other elements. The abolishment of the payment rule might lead to internal contradictions in the procedure and should be accompanied by the adjustment of other rules.

The paid donor is compensated by the money he receives and, consequently, receives no other kind of ‘reward’. The most obvious and appropriate reward is the social recognition of the donor as helper. Recipients could write a note or letter to thank the donor for his kindness. A more institutional arrangement is to offer the donor information on the good brought about by his contribution and on what he helped realising. At present, most clinics offer no information on the number and sex of the children born from his material and some even downright refuse this kind of information, either because the clinic cannot be bothered or simply because it is considered none of the donor’s business. Moreover, the circumstances in which the donors have to ‘produce’ are frequently restricted to the bare necessities, as well in terms of facilities as in terms of personal contacts. In general, if we want to attract purely altruistic donors, we will have to treat them as such. The appreciation and respect for the donor’s altruism should be visible in the personal contact with the medical staff and in the conditions in which he is welcomed.

Another possible kind of reward is the assignation of power to decide about different aspects of the procedure. The allocation of more rights follows from the act being voluntary. Since donors give freely and voluntarily, they cannot be forced to accept the externally imposed rules. They should be convinced of the rightness of these rules or they should be given the right to decide about these points themselves. Donors who are concerned about the results of their donations may want to participate in the decision making (Pennings, 1995). Before forbidding all payment in practice, it would be better if we had a clearer view on how purely altruistic donors look at the various aspects of the procedure. The acceptance of non-payment by the donors is probably linked to the attitude towards the donor offspring, the view on anonymity, the right to select the recipients, the limitation of the number of children, the right to information etc. At present, there is little information about the interrelations. Future research should be directed at the differences of opinion between paid and unpaid donors. With this information, the whole procedure could be adapted in such a way that the transition from paid to unpaid is not accompanied by a drastic reduction of providers.

Conclusion
Disallowing payment may result in the recruitment of a type of donor which no longer fits into the scheme for which the donor insemination practice is designed. The donor should give with the intention to help others but without wishing to become involved in the receiving family (unless this is also desired by that family). Withdrawing payment guarantees that financial reasons do not guide the donor’s behaviour but it
does not assure good motives. These remarks should not be taken to imply that payment should be maintained. On the contrary, they are meant to make the transition pass off more smoothly by preventing that one overstates the involvement of the altruistic donor and thus comes into conflict with the basic goal of the practice.

References

Reproductive prohibition: restricting donor payment will lead to medical tourism

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No matter how well intended, introducing severe restrictions on the payment of oocyte donors will undoubtedly lead to the decline of egg donation in the UK (Johnson, 1997). I have been involved in both the development and maintenance of three different oocyte donation programmes in the past 10 years. During that time, the practice has significantly evolved and donor recruitment has become a very competitive activity (Sauer, 1996). I believe it is fair to say, that today in the USA, a programme could not be successfully established without solicitation and payment for donor services. If compensation policies were dictated by law I would certainly comply. However, without such mandates, I consider donor recruitment a necessary and difficult task inherent to the programme.

In a perfect world altruistic parous women would regularly come forward without solicitation to donate oocytes in order to help infertile couples start a family. The medications used to stimulate their ovaries would be risk free, and gamete procurement would require neither surgery nor anaesthesia. But this is not a perfect world, and if we are to provide service to an ever-increasing population of women in need of donated eggs, then we must work hard to find realistic ways to interest young women in helping us to help our patients. Oocyte donation is not without risk, and it is unreasonable to assume that on a large scale donors will be willing to provide the time and accept the risks required by a burdensome treatment regimen without compensation.

I am constantly asked, ‘Why pay donors?’ I reply to those that ask, ‘Why not?’ (Sauer, 1997). In the USA, men have always been paid to provide gametes. A lucrative industry has been built around sperm banking and has existed for decades, largely unquestioned. It is true that sperm donors are paid much less for their donation, but few would argue the time spent, and the risks inherent to procuring the product are not comparable to egg donors. Infertile patients who have experienced ovarian hyperstimulation and oocyte aspiration quite readily understand and accept why compensation is set at a higher level for oocyte donors. I would speculate that if men had to undergo a gonadal biopsy to donate spermatozoa the practice would quickly change and donors would be difficult to find. Other precedents exist for paying donors, as commonly practised for blood and plasma, as well as organ and tissue. Typically the greater the risk, the higher the compensation.

In the USA, oocyte and embryo donation has been associated with payment since its inception (Buster et al., 1983). Originally the practice was largely restricted to academic centres, where compensation was in line with other research projects, a mere $250 per cycle. As the popularity of the method increased, and private groups established donor registries, recruitment became a targeted activity, and ‘brokers’ entered the scene to compete in the open market for donor services. Reimbursements soared, and today in most major metropolitan areas patients must pay $2000–3000 per donor cycle. As troubling as this phenomenon may be, the practice has not been regulated. Certainly for those of us who have promoted the use of this method, and are anxious to see it thrive, the pragmatic choice is to pay donors and continue to do the work in a responsible manner.

The UK has the unique advantage of an HFEA to uniformly police the practices of its reproductive clinics and practitioners. Generally, I believe this to be beneficial. However, as an outside observer I also feel that regulation has its drawbacks, witness the recent thawing and destruction of thousands of cryopreserved embryos as required by law. Implementing law often sets into motion forces not easily stayed.

The American Society for Reproductive Medicine issued guidelines for recruiting and screening oocyte donors (American Fertility Society, 1993; American Fertility Society/ Ethics Committee, 1994), but compliance is neither required nor policed. Most programmes in the USA offer oocyte donation, and most pay donors to participate. However, fees are as varied as the centres themselves, and compensation is largely market driven. What can be said, however, is that donor payments continue to rise. Many clinics refer to fees as ‘reimbursement’ for time and expenses. Yet, at $2500 a cycle, a full 10-fold higher than fees charged a decade ago, we should not delude ourselves into thinking it is anything less than an enticement.

A growing number of patients are seeking care outside the borders of their country because of prohibitions and restrictions on the practice of oocyte donation. There may be no greater drive than the desire to reproduce. Patients will seek out
services. Restricting payment will lead to an even greater demand for donors than which already exists. More and more patients will travel to Italy and the USA where they can procure what they need. In the meantime, doctors in the UK will continue to struggle with the problems of their patients created by a shortage of oocyte donors, and women who cannot afford care abroad will be left untreated.

It is the freedom to choose and direct the care of our patients that defines us as professionals. If the practice of medicine is wholly dictated, and we relinquish all power of choice to the central government, then we will come to function as technicians, not physicians. We are entrusted with guarding our patients well being, and in the case of oocyte donation this includes both donor and recipients. The responsibility of caring for healthy young women who choose at least in part to donate oocytes altruistically, is perhaps our most challenging task. However, I truly believe that I understand their needs, and will safeguard their interests better than any person or agency outside my practice who would exercise authority over the right to provide them care.

References

Payment or altruism? The motivation behind gamete donation

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The Human Fertilisation and Embryology Act (1990) stipulated the need to consider phasing out the payment of donors in an attempt to remove financial inducement as the motive behind donation of gametes. In accordance with this act, over the last 12 months, there has been increasing pressure from the authority to implement the phasing out process. A directive ‘Payments to gamete donors’ circulated by the Human Fertilisation and Embryology Authority (HFEA) to all licensed assisted conception units in 1997 sets out HFEA’s stand point on the issue of payment to donors (Johnson, 1997). The HFEA’s wish is that, donation of gametes be a ‘gift’, free from financial inducement, as payment to donors is in essence disrespectful of human life. This view is also supported by the Nuffield Council on Bioethics (1995). It is true that altruism is by far the most attractive and ethically acceptable reason for donation, but how this will effect the provision of egg and sperm donation to patients in this country needs to be considered very carefully before further legislation is instigated.

As most egg donors are at present paid only reasonable expenses, there would be little change in the provision of egg donors who donate for altruistic purposes alone. This is reflected in a great shortage of donated eggs. Recipient couples have to wait up to 3 years before treatment can be offered.

Sperm donors, however, expect payment and it would appear that men are less altruistic than women! In their defence sperm donation is a very time consuming pastime requiring periods of abstinence from sexual activity prior to donation, screening on at least four occasions including repeated venepuncture and urethral swabbing. There is also a considerable psychological aspect to being a donor, despite the fact that there appears, to date, to be no data on apparent long-term psychological damage from such activities. Payment is in the order of £15 per sample plus the payment of actual expenses in attending the clinic. In our unit we produce up to 400 stored straws of spermatozoa per donor of which normally only 250 will be acceptable for use after examination of post-thaw sperm quality. This produces, over a period of 12 months, an income for the donor of ~£500 which is suggested not to be an excessive amount of remuneration. The effect of withdrawing funding to sperm donors has been carefully considered by our unit. Following a survey of current sperm donors, 95% have firmly indicated that they would cease being donors if payment was withdrawn. The shortage of donated spermatozoa would gradually increase and probably take an estimated 18 months to become apparent as the stocks of stored sperm were used up. If the payment of donors were to be reintroduced at this time it would take a further 18 months to reverse the process, thus giving up to three years of suboptimal sperm supplies and decreased choice.

If altruism is conceived to be the most acceptable form of donation then, with the help of the HFEA, it is important that units throughout the country consider alternative strategies to the provision of donor spermatozoa. Our unit, like many others throughout the country, has considered this and advertised for altruistic donors in the hospitals and the local press, and attempted recruitment of donors from post-natal and pre-vasectomy clinics but the uptake to date has been very poor. Setting up of such alternative strategies are also expensive both on ‘person power’ and on medical, nursing and counselling time. In addition to this it is debatable how many of the altruistic donors would be acceptable for use as sperm donors. We currently accept ~40% of sperm donor volunteers and this is because the remaining volunteers have either poor sperm quality or poor sperm cryopreservation profiles. A further 10–20% of volunteers fail to comply with donation protocols leaving only a 20–30% of donors accepted into the programme, although this figure differs greatly between units. A survey carried out in Denmark concluded that the motivation of 8% of sperm donors was purely altruistic, 32% purely financial and 60% a combination of both (Pedersen et al., 1994). Another
survey from the USA found that donors were motivated by money, with the majority (69%) unwilling to participate if financial incentives were withdrawn (Sauer et al., 1989). In the UK, a study into the motivations and attitudes of semen donors (Cook and Golombok, 1995) reported that both a wish to help others and the offer of payment influenced male donors’ decision to donate. A shortage of altruistic volunteers would force units to accept all donors as there would generally be so few of them and the spermatozoa from the majority would be of insufficient quality to fertilize oocytes via the routinely used cervical or intrauterine insemination techniques employed in donor insemination. We would therefore have to revert to in-vitro fertilization (IVF) with possibly the use of intracytoplasmic sperm injection (ICSI). This denial to patients of a cheap, safe and low risk treatment would place women at increased medical risk as they would be subject to more complex interventional reproductive conception techniques. The associated increase in cost, an important factor for the patients as most IVF is performed through the private sector, would further restrict fertility treatment to infertile women. Whether National Health Service Units would be able to afford to offer such treatment is debatable bearing in mind that the degree of funding they receive is unlikely to increase in the future.

Proponents from the other side of the argument suggest that payment should be increased and not decreased and that the donor should be paid inconvenience allowances similar to payments made to health volunteers who take part in drug and treatment trials. It is suggested that if infertility represents a health care need then restricting a service through reducing the availability of gametes constitutes a dereliction of duty and is unethical because it restricts the ability of practitioners to provide the duty of care to patients.

It is not known at present how patients and potential recipients view payment of donors in that there is no robust data from surveys considering this case. One can only suggest through discussion with patients that many prefer the idea that sperm donors are financially rewarded as this is a more healthy reason for donation than altruism. Most patients are alarmed at the thought that the change in legislation may reduce the availability of treatment whatever the motive.

We would suggest that there should be no change in the current practice of recruitment of either egg or sperm donors as this would allow the continuation of the current treatment provision. The current practice of egg donation does not need to be changed at present as this already fits in with HFEA’s plans. However one could argue that if sperm donors are paid, then egg donors should be similarly remunerated. Egg donors normally donate on one occasion only, but there are associated medical risks involved with ovarian stimulation and egg retrieval, therefore their degree of remuneration should at least be equivalent to that of the total payment to sperm donors. If it was decided that there should be no change in the current practice of sperm donation then with the co-operation of the HFEA we could explore other methods of recruitment involving altruism. These new methods of recruitment could take place in parallel with normal practice in units which could monitor its effectiveness and compare it to the old system. This would ensure that before any changes are implemented there is a viable alternative to allow current treatment levels to be maintained. Consideration of the setting up a national system of sperm banking as in France (CECOS) should also be considered.

Whilst new and alternative strategies for gamete donation are being explored, in order to continue the present provision of treatment services, we should not abandon our tried and tested methods until their replacements have been proved to be efficient and robust.

References