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.

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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.

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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 county 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