confounding may exist in other defect categories or, indeed, overall.

We would like to emphasize that their results should be interpreted with caution and those for Down syndrome regarded as subject to residual confounding.

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Regulatory safeguards needed for the travelling foreign egg donor

Sir,

In recent years, egg donation has become increasingly commonplace in clinical assisted reproduction (Sauer and Kavic, 2006), due to the rising incidence of age-related female-infertility in many highly urbanized and developed countries, as a result of increasing numbers of women choosing to delay marriage and child-bearing in pursuit of educational and career goals (Pinnelli and Cesare, 2005). At the same time, a number of factors have led to increasing scarcity of donor eggs. In particular, restrictive legislation on monetary reimbursement for gamete donation in many developed countries (Daniels, 2000; Daniels et al., 2006) has led to a loss of incentive for many prospective donors (Sauer, 1997), who also face much hassle and inconvenience in egg donation i.e. lost time and potential earnings, daily injections of superovulatory drugs, regular blood-tests, outpatient surgery and medical risks of ovarian hyperstimulation syndrome (OHSS) (Budev et al., 2005). The situation is made worse by the abolishment of donor anonymity in some countries (De Jonge and Barratt, 2006; Dyer, 2004), which not only discouraged altruistically motivated gamete donors (Dyer, 2004), but also prospective donors among patients who might consider participating in compensated egg-sharing (Blyth, 2004; Ahuja et al., 1996) i.e. heavily subsidized medical fees in return for donating some of their eggs to other patients. Certainly, the scenario of failing at clinically assisted reproduction, and subsequently being confronted by one’s genetic offspring several years later, would be a daunting prospect for many potential egg-sharing patients.

Besides egg donation for infertility treatment, there is also increasing demand for donor eggs in scientific research, in particular, somatic cell nuclear transfer for the generation of immuno-compatible patient-specific embryonic stem cell lines, commonly referred to as therapeutic cloning (Hyun, 2006; Spar, 2007). Presently, this is a highly controversial issue that has sparked fierce debate among politicians and legislators, religious leaders and even among scientist themselves (Hyun, 2006; Spar, 2007). This is because utilizing donor eggs in scientific research does not result in any direct therapeutic benefit to a second party or to the donor herself (Spar, 2007). Moreover, there are also underlying doubts on the usefulness of such research for future clinical applications (Cobbe, 2006).

To meet up to the rising demand and increasing shortfall of donor eggs, some fertility clinics in developed countries have resorted to sourcing egg donors from abroad (Fishman, 1999; Dickenson, 2002), most often from economically less-developed countries. Due to harsh economic realities in poorer developing countries, many young women are willing to travel abroad to donate their eggs in return for what they perceive as generous financial remuneration, but in fact might be considered a petty amount in richer countries. It is well known that differences in currency exchange rates, purchasing power parity and living standards can easily magnify a small sum of money in richer countries, to an inordinately large amount in poorer countries. For example, the recommended £250 (~US$400) compensation for egg donors (SEED report, 2005) proposed by the Human Fertilization and Embryology Authority in the UK would appear to be a paltry sum by UK standards. However, to young working women in some Eastern European countries and the former Soviet Union, this could very well represent a couple of weeks’ wages.

Hence, it is imperative to look at regulatory safeguards to prevent exploitation of economically disadvantaged women who travel abroad to donate their eggs—most appropriately termed the ‘visiting egg donor’ or ‘egg donor tourist’. First and foremost is the issue of informed consent, as highlighted by Spar (2007), and the ESHRE task force on Ethics and Law (2002). Of particular concern are the long-term health risks posed to women by egg donation. Currently, there is a lack of knowledge and available clinical data on this subject (Pearson, 2006). In countries whereby regulations on donor counseling and informed consent is lacking (i.e. USA), it is often the case that prospective egg donors would only be informed on what brokers, clinics and research laboratories choose to tell them (Spar, 2007).

Hence, the health authority should make provisions for independent professional counseling of foreign egg donors, without undue influence or interference from fertility clinics, medical doctors and scientists who might harbor conflicting interests. This may by achieved by ensuring that counselors and social workers involved in donor counseling are government employees from the local health authority or social service department. This would obviously involve additional costs, and hence, an appropriate administration fee might be billed to the patient (egg recipient). Alternatively, the state might absorb these costs, as a form of pro-family subsidy.
In providing independent professional counseling to foreign egg donors, it is imperative to ensure that there is no language barrier to the communication of information, so as to enable a fully informed consent by the prospective donor. Hence, professional translation services in the native language of the foreign egg donor should also be provided simultaneously with counseling. It is suggested that the signed consent form should be re-written in the native language of the donor, so as to avoid any potential miscommunication of information. This is of utmost importance, given the serious medical risks faced in egg donation (Budev et al., 2005; Pearson, 2006), as well as other pertinent legal issues such as the abolishment of donor anonymity in some countries (De Jonge and Barratt, 2006; Dyer, 2004).

A particularly controversial issue not easily resolved is the appropriate amount of monetary reimbursement that should be given to egg donors, as compensation for their time, effort, inconvenience and potential loss of earnings (Steinbock, 2004; Hyun, 2006; Check, 2006). Too much money would invite accusations of undue inducement, whereas on the other hand, if too little money is given, there could instead be accusations of exploiting economically disadvantaged women from poorer countries (Schneider, 2006). A possible solution may be to peg the reimbursement rate to the daily wages earned by the individual donor in her home country, as attested by bank statements and income tax slips provided by the donor herself. This is ethically justifiable, because the amount of money would be a true representation of the potential loss of earnings faced by the egg donor in taking leave to travel abroad. In the case of non-working donors without an income i.e. university students, the reimbursement rate may possibly be pegged to the average or median income of their home country, which could represent potential loss of earnings from a vacation job. Another pertinent issue is whether additional allowances should be given to cover meals and other living expenses of the foreign visiting egg donor. Perhaps, a daily living allowance based on that given to airline cabin crews or visiting academic staff at universities might be ethically justifiable. To adjust for varying costs in different countries and cities, the daily allowance can also be based on the regularly updated per diem rates set by the US Department of State for traveling federal government employees (US Department of State, 2006). Whatever the case, counselors and social workers involved in donor counseling should expend every effort to ensure that there is no additional ‘under-the-table’ payment to donors by either patients or medical professionals, which might serve as undue inducement.

Additionally, it is also suggested that the entire process of donor reimbursement should be made more transparent, by informing patients (egg recipients) on the exact amount of money given to the donor, as well as her travel and accommodation costs. This would prevent fertility clinics and doctors from ‘overcharging’ their patients for non-medical costs incurred in egg donation. Certainly, it would be justifiable for fertility clinics and doctors to charge an appropriate administration fee for their effort in sourcing foreign egg donors for patients, but the exact amount should be made known to patients, donors and counselors. As discussed previously, it is possible that the provision of travel opportunity and accommodation abroad (Heng, 2005) may in fact serve as undue inducement to foreign egg donors i.e. an ‘all expenses-paid free holiday’ for economically disadvantaged women. Hence, counselors and social workers should also draw a line on the appropriate levels of travel and accommodation provided to egg donors that should ideally be comfortable, but not border on the lavish and luxurious. Free accommodation provided to the donor should not exceed the time-frame required for participation in the egg donation program.

Another pertinent issue is the right of egg donors to change their mind and withdraw their consent at any time before embryos derived from their fertilized eggs have been transferred to the prospective recipient, or utilized in scientific research. It must be noted that superovulation regimes involving intramuscular or subcutaneous administration of purified recombinant gonadotrophins (i.e. follicular stimulating hormone), often result in donors developing mild to moderate symptoms of OHSS (Budev et al., 2005; Pearson, 2006), characterized by feelings of nausea and ‘bloating’. Hence if the donor is feeling genuinely unwell and wishes to withdraw her participation in the egg donation program, there should be no coercive pressure for her to continue, as this might lead to serious medical complications later. Counselors and social workers should stay readily contactable with the donor for this purpose and constantly monitor her physical and emotional state. Additionally, they should also ensure that passports and air-tickets are kept by the donors themselves and not instead be in ‘safekeeping’ by fertility clinics, medical professionals or research institutions, as this can potentially be used to coerce donors.

Last but not least is the issue of professional responsibility and accountability if foreign egg donors were to later develop serious medical complications. If not managed carefully, the regimen of hormonal stimulation during superovulation can lead to severe and potentially fatal OHSS, the mild form of which is not uncommon among women undergoing clinical assisted reproduction (Budev et al., 2005). Hence, there should be a means of legal redress, if foreign donors were to develop life-threatening or debilitating medical complications upon returning to their home country. Perhaps, it should be mandatory for foreign egg donors to be covered by health insurance.

In conclusion, there is an urgent and dire need for an internationally binding legislative framework overseeing the ethical recruitment of egg donors across international borders. It is the moral obligation and duty of both local and international medical professional bodies to advocate and draft new legislation and regulatory guidelines for this purpose.

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