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Commentary

The advent of international 'mail-order' egg donation

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The rising demand and increasing scarcity of donor oocytes in developed countries have led to some fertility clinics sourcing oocyte donors from abroad, particularly from poorer countries, in what is referred to as 'transnational' or 'international' oocyte donation. In a further new 'twist' to this scheme, frozen sperm of the recipient's male partner is exported abroad through courier mail and is used to fertilise donor oocytes in a foreign clinic to produce embryos, which are then cryopreserved and imported back by mail for transfer to the woman. There are numerous ethical concerns with regards to such means of procuring donor oocytes. First, there is an issue of exploiting economically underprivileged women in poorer countries and disproportionate gains on the part of medical doctors and fertility clinics. Second, there is a question of abdication of responsibility for the donor's welfare on the part of the fertility doctor who takes charge of the recipient's treatment abroad if oocyte donors were to develop severe ovarian hyperstimulation syndrome. Third, the issue of responsibility and accountability becomes even more contentious if congenital defects were to appear in offsprings born from transnational oocyte donation or in the case of transmission of communicable diseases such as hepatitis B, syphilis and AIDS to the recipient. Last, cost savings from the lower prescription price of fertility drugs in economically less-developed countries may not be passed down to the oocyte recipient but instead be exploited to boost the already substantial profit margin of fertility clinics and doctors.

Keywords Commercialisation, donation, ethics, mail order, oocyte.

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In recent years, oocyte donation has become increasingly commonplace in clinical assisted reproduction.[1] This is due to the rising incidence of age-related female infertility in many highly urbanised and developed countries, as a result of increasing numbers of women opting to delay marriage and childbearing in pursuit of educational and career goals.[2] Even in countries which permit generous financial compensation to oocyte donors, supply is often scarce; and women have to contend with long waiting lists in addition to high medical fees.[3]

To meet up to this rising demand, some fertility clinics in developed countries have begun to source oocyte donors from poorer countries, in what is often referred to as 'transnational' or 'international' oocyte donation.[4] Proponents of such a scheme often argue that this brings about huge cost savings, as well as a shortening of the waiting lists for women. Due to harsh economic realities in less-developed countries, more young women, particularly college students, are willing to donate their oocytes in return for generous financial remuneration.[4,5] Nevertheless, they would need to be compensated much less, commensurate with the lower living standards and weaker currency of their home country, which could in turn translate to a substantial reduction in medical fees for the recipient.

More recently, there has even been a further new 'twist' to this scheme. Because of the low survivability of human oocytes with current cryopreservation protocols,[6] frozen sperm of the recipient's male partner is exported abroad through courier mail and is used to fertilise donor oocytes in a foreign clinic to produce embryos, which are then cryopreserved and imported back by mail for transfer to the recipient.[7] This would not only save on travelling expenses but also would make treatment more convenient for woman, since there is no longer any need for cycle synchronisation between donor and recipient. It is proposed that the term 'mail-order oocyte donation' would be most appropriate to describe such a scheme, since the commercial transaction of donor oocytes operates through courier mail.

There are numerous ethical concerns with regards to such means of procuring donor oocytes. The right and personal choice of women to earn money from oocyte donation is an ethically contentious and hotly debated issue that is not easily

resolved, which is well discussed by several excellent reviews.[8,9] Nevertheless, the pertinent concern here is the exploitation of economically underprivileged women in poorer countries. In particular, cash-strapped college students who need to pay tuition fees and living expenses might be coerced into donating their oocytes in return for money, while risking their health through exposure to superovulatory drugs. If not managed carefully, the regimen of hormonal stimulation during superovulation can lead to severe and potentially fatal ovarian hyperstimulation syndrome (OHS), the mild form of which is not uncommon among women undergoing clinical assisted reproduction.[10] Additionally, there is also a question of inadequate compensation to oocyte donors and disproportionate gains on the part of medical doctors and fertility clinics. For example, oocyte donors in Romania were reportedly paid only 150 pound sterling (UK) or about US$300,[11] a paltry sum compared with the hefty medical fees paid by foreign oocyte recipients, which is usually in the order of US$10 000 per treatment cycle.

Second, there is a question of abdication of responsibility for the donor's welfare on the part of the fertility doctor who takes charge of the recipient's treatment abroad. In the case whereby the oocyte donor develops severe life-threatening or dehabilitating OHS, only the local doctor administering the superovulatory regimen would be held accountable, while his/her foreign partner in the 'mail-order' oocyte donation scheme would remain unscathed. Ideally, both doctors should be held equally responsible and accountable for the welfare of the oocyte donor as well as the recipient.

Third, the issue of responsibility and accountability becomes even more contentious if congenital defects were to appear in offsprings born from transnational oocyte donation. Which particular doctor would then be held accountable for the appropriate screening and selection of oocyte donors based on familial history of hereditary diseases? There would probably be mutual pinpointing of fingers towards each other, which could in turn develop into a complex and long-drawn legal tussle across international borders. Additionally, there is also the question of transmission of communicable diseases such as hepatitis B, syphilis and AIDS. No doubt, oocyte donors can be screened beforehand, but many communicable diseases in fact have an incubation period of several weeks or months, which would render them undetectable during the initial preliminary screening of donors. Although newly developed regulatory framework such as the EU tissues and cells directive[12] will require traceability of gametes and embryos throughout Europe, this does not take into account the recruitment of 'Caucasian' oocyte donors from outside the European Union, such as countries of the former Soviet Union (i.e. Russia, Ukraine and Belarus) or even Latin America.

Last, there is an issue of lower prescription price of fertility drugs being used to superovulate the foreign oocyte donor. In many economically less-developed countries, the prescription price of the same brand and dosage of various pharmaceuticals is often cheaper,[13–15] commensurate with the lower income and higher purchasing power parity of the local currency. It must be remembered that in clinical assisted reproduction, the prescription cost of fertility hormones used in superovulation makes up a substantial proportion of the medical fees. Cost savings from lower prescription prices would probably not be passed down to the oocyte recipient abroad but would instead be exploited to boost the already substantial profit margin of medical doctors and fertility clinics.

It is therefore imperative that various local authorities and international bodies (i.e. European Commission), as well as scientific and medical organisations such as European society for human reproduction and embryology and American society for reproductive medicine should attempt to put in place a regulatory framework for the ethical recruitment of oocyte donors across international borders. Such a regulatory framework should make provisions for: i) mandatory counselling and informed consent of oocyte donors, ii) appropriate monetary compensation, iii) possible health insurance to cover medical risks to the donor, iv) professional obligation and accountability of medical doctors to both the oocyte donor and recipient and v) cost savings from using oocyte donors from poorer countries should ideally be passed down to the oocyte recipient in developed countries.

A long-term solution may be to look at various ways of reducing the incidence of age-related female infertility in developed countries, which may be achieved by encouraging women to have families at a younger age through the provision of appropriate resources (i.e. better/cheaper childcare, tax incentives). ■

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