Egg sharing in return for subsidized fertility treatment—ethical challenges and pitfalls

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Received: 2 December 2007 / Accepted: 29 January 2008 / Published online: 22 February 2008
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Abstract Some pertinent ethical challenges in egg sharing have largely been overlooked. To maximize the number of retrievable oocytes, prospective egg-sharers are often restricted to younger women with indications for either male-factor or mild female-factor sub-fertility. Recently, there is increasing evidence that such group of patients would do better either with natural cycle or minimal ovarian stimulation. The quality of the fewer oocytes retrieved is better and there is also improved endometrial receptivity for embryo implantation. Moreover, high gonadotrophin dosages are associated with increased health risks and expensive medical fees. Hence, there could be an irony because such good prognosis patients may not require a discount if they had instead opted for nil or low dosages of expensive gonadotrophins. Secondly, there is a dire lack of guidelines and regulations specifying the appropriate discounts in medical fees given to egg-sharing patients. Perhaps, only the prescription price of gonadotrophins and medical fees for surgical retrieval of oocytes should be eligible for discount. Other medical fees such as for consultation and ART laboratory procedures should be borne separately by the egg-sharing and recipient patient. Thirdly, there must be rigorous auditing to ensure that the amount of financial subsidy given to the egg-sharing patient is exactly equal to the surplus medical fees billed to the recipient patient, or this might lead to profiteering by fertility clinics and doctors. Lastly, the abolishment of donor anonymity in many countries has potentially more ramifications for prospective egg-sharing patients, as compared to non-patient donors.

Keywords Donation · Egg · Ethics · Fees · Oocyte · Subsidy

Egg sharing in return for subsidized fertility treatment is often proposed to be a more ethically acceptable means of procuring donor oocytes, compared to the direct monetary payment of egg donors [1, 2]. In recent years, the concept of egg sharing has caught on in popularity; and among the various countries that have permitted egg sharing in clinical assisted reproduction includes the United Kingdom [3], Belgium [4] and the People's Republic of China [5]. Nevertheless, there are some pertinent ethical challenges and pitfalls that have largely been overlooked.

First and foremost are the appropriate dosages of gonadotrophins that are being prescribed for the ovarian stimulation of prospective egg-sharing patients. To maximize the number of retrievable oocytes, it is often the case that prospective egg sharing patients would be restricted to younger women with indications for either male-factor sub-fertility or mild female-factor sub-fertility (i.e. fallopian tube occlusion). Poor prognosis older patients with 'tricky' medical indications, such as polycystic ovarian disease and endometriosis are likely to be excluded. Hence, the pertinent question that arises is whether it is medically necessary to subject good prognosis younger patients to high dosages of gonadotrophins, just for the sake of maximizing the yield of retrievable oocytes for egg sharing? Should not natural cycle or minimal ovarian stimulation protocols be more appropriate for such patients [6, 7]? Indeed, there is accumulating evidence that the use of natural cycle or minimal ovarian stimulation protocols for good prognosis younger patients results in a more physiological endocrine profile [8], leading to improved quality of their retrieved oocytes [9], as well as better endometrial receptivity and luteal support for subsequent embryo implantation [10, 11].

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Moreover, it must be remembered that high dosages of gonadotrophins are associated with increased risks of debilitating and potentially life-threatening ovarian hyperstimulation syndrome [12], in addition to other not well characterized long-term health risks such as future reduction in fertility and increased propensity to develop gynecological cancers [13]. This in turn touches on the core guiding principle of medical deontology; by which all treatment administered to the patient must be in the best interest of his or her welfare. A paradoxical situation can thus develop as follows: “To maximize the yield of retrievable oocytes for egg sharing, high dosages of gonadotrophins are being administered to the patient. However, high dosages of gonadotrophins contribute to a significant portion of expensive medical fees in the first place [8, 14]. Because poorer patients are unable to cope with high medical fees in fertility treatment, they participate in egg sharing to obtain a discount. Nevertheless, a discount in medical fees may not be needed, if poorer patients with good prognosis had instead opted for natural cycle or minimal ovarian stimulation protocols, in which nil or low dosages of gonadotrophins are administered.”

Secondly, another pertinent ethical concern is the appropriate discounts in medical fees that should be given to prospective egg-sharing patients. Currently, there is a dire lack of guidelines and regulations in this area, and different fertility clinics display considerable variation in the level of discount of medical fees given to egg-sharing patients, even in the same country. For example, in the People’s Republic of China, the discount can range from as low as 50%, to as high as 100% of total medical fees billed to prospective egg sharing patients (personal communication with Dr. Zhang Xiao of Peking University Medical School). Hence, the pertinent question that arises is which particular component of the medical fees should be eligible for discount? The first thing that comes to mind is the prescription price of gonadotrophins and other drugs (i.e. GnRH antagonist or agonist) utilized for ovarian stimulation of the egg-sharing patient. Besides this, medical fees for the surgical retrieval of oocytes from the egg-sharing patient can also be eligible for discount. Nevertheless, it would be morally and ethically dubious to given a 100% discount for these two components of the medical fees billed to the egg-sharing patient, since she should in principle bear some of the costs of her own treatment to avoid undue inducement. It is thus recommended that the discount in medical fees be pro-rated according to the exact proportion of retrieved oocytes being shared with the recipient. For example if ten oocytes are retrieved, and three of these are being shared with the recipient, then the percentage of discount given to the egg sharer should be 30%, to be paid-up by the recipient patient. Other components of the medical fees such as for consultation,

IVF/ICSI procedures and embryo cryopreservation should ideally be borne separately by the egg-sharing and recipient patient, so as to ensure transparency and avoid undue inducement in the procurement of shared donor oocytes.

Thirdly, there must be rigorous auditing to ensure that the amount of financial subsidy given to the egg sharing patient is exactly equal to the surplus medical fees billed to the recipient patient. There is a possibility that medical professionals and fertility clinics might charge the recipient patient much more than the actual financial subsidy given to the egg sharing patient, thereby earning a profit in the process. This is ethically and morally dubious; because the money earned in this case is not directly related to medical services rendered to the patient, but attributed to the brokerage and transaction of donated human material.

Lastly, the abolishment of donor anonymity in many developed countries [15] has potentially more ramifications for prospective egg sharing patients, as compared to non-patient donors. This is because egg sharing patients are themselves trying to conceive, and it would be a daunting prospect for them to be confronted by their own biological offspring several years later, if they fail at clinical assisted reproduction themselves. In such an eventuality, they would likely feel being ‘shortchanged’ or ‘cheated’ by egg sharing in return for subsidized fertility treatment.

Although egg sharing is a novel concept that has proven to be of much benefit to patients undergoing clinical assisted reproduction, it is imperative that some thought should go into the various ethical challenges and pitfalls outlined above; so as to prevent abuse by medical professionals and protect the welfare of the patient.

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