Expectations of Recipient Couples Awaiting an Anonymous Oocyte Donor Match

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Purpose: Our purpose was to survey recipients in an ovum donation program and report on their expectations while waiting for their potential donor recipient match.

Methods: Accepted or rejected anonymous ovum donor matches ($n = 80$) from January 1996 to May 1997 were evaluated. Patients generated a "wish list" of desired traits and physical characteristics. From an approved donor pool of medically and psychologically screened women, candidates were drawn upon as potential matches and presented to the potential recipient, who decided whether to accept the donor. Reasons for accepting or rejecting the donor were tallied and were compared to the patient's wish list.

Results: Medical history and race were ranked by 33 and 23% of recipient couples as the two most important characteristics, while 74 and 54% stated that these were among the three most important factors in a potential donor compared with other traits. Fifty-seven (71%) recipients accepted, while 23 (29%) rejected, the first donor presented to them. Eleven were subsequently given a second choice within 6 months, with 10 (91%) accepting the next presented match. Recipients waiting for a donor were just as likely to accept or reject a potential candidate whether waiting <3 months (33%; 15/46), 3–6 months (25%; 4/16), or >6 months (22%; 4/18) ($P > 0.05$; NS). In all but five recipients, the reason for rejection was consistent with their top three priorities reported in their wish list.

Conclusions: Phenotypic, ethnic, educational, and other interests are important in the selection of an ovum donor. Recipients are proactive in their decision process, making educated and well considered decisions in spite of the limited pool and the extended time frame in waiting for an appropriate ovum donor.

KEY WORDS: oocyte donation; matching; attitudes; rejection.

INTRODUCTION

Infertility and its treatment create stress, both personal and interpersonal, for infertile couples (1). The infertile partner often feels abnormal, betrayed by his or her own body. Patients struggle with the burdens of feeling responsible for interfering with a major relationship goal: parenting. Stress also stems from the decision of coming to closure with their infertility by pursuing treatment (2). The excitement and hope of infertility treatment are confronted by the anxiety inherent to therapy. Difficult and demanding decisions regarding treatment options coupled with emotional and ethically complex decisions often confront participants of assisted reproduction programs. Altered physiologic responses to behavioral induced stress in those undergoing infertility treatment have been observed (3,4), and it is likely that active decision-making processes may be altered because medical treatment is usually dictated with minimal patient input.

This compromising position is even more apparent in patients undergoing gamete donation. The psychological issues surrounding gamete and ovum donation vary widely and may include grieving the loss of one (or both) partner's reproductive capability and the loss of his/her potential biologic children, anger, and guilt. Berger *et al.* found that 60% of recently diagnosed infertile men experience 1–3 months of impotence, as well as guilt, sadness, and marital conflict (5). Wives of these men reported dreams expressing anger at their infertile partners. However, in couples who successfully resolve these issues, most request insemination to conceive a second child (6). As sperm donors far exceed demand, selection gives recipients of sperm donation a sense of control because they have many choices, often with detailed descriptions of each donor from phenotypic characteristics to special interests and hobbies.

Recipients of ovum donation convey similar needs and expectations in selecting a potential donor. However, the demand of ovum donors far exceeds the sup-

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ply, with waiting lists commonly in excess of 12 to 18 months. Seemingly, this delay could alter the perspective, expectations, and demands of a recipient. Therefore, we surveyed recipients waiting for an ovum donor and report on their expectations toward making their potential donor recipient match.

MATERIALS AND METHODS

The program for oocyte donation was reviewed and approved by the Institutional Review Board at Columbia–Presbyterian Medical Center. Accepted or rejected anonymous ovum donor matches ($n = 80$) from January 1996 to May 1997 were evaluated.

All recipients, as described previously (7), were required to undergo a series of screening medical, reproductive, and psychological examinations. During that time, issues including ambivalence and reservations about using donor oocytes and mechanisms of emotional support during and following the oocyte donation were discussed. Furthermore, issues related to the potential matching of donors to recipients using a patient-generated “wish list” of desired traits and physical characteristics were discussed.

From an approved donor pool of medically and psychologically screened women, candidates are drawn upon as potential matches. The potential donor is presented by telephone by the medical director using only nonidentifying information including medical history, all screening blood work, sexual history, family history, education, occupation, and other interests and talents including sports, personality, marital status, religion, and reasons for donating of the women. Each recipient is encouraged to give careful consideration of the presented donor and is given up to 1 week to decide whether to accept her. Regardless of the decision, reasons for accepting or rejecting the donor are asked. If a donor is rejected, she is placed back to the donor registry to be matched again with another recipient. A questionnaire is given at the time of embryo transfer to list and rank from most to least important the characteristics most desired of an oocyte donor. The ranking of the wish list was tallied with respect to the most important traits and also the top three most desired characteristics expressed by recipients within the practice. Chi-square analysis was used for categorical comparisons, with P less than 0.05 defined as significant.

RESULTS

From January 1996 to May 1997, 80 couples awaiting anonymous ovum donation submitted wish lists for

Table I. Percentage of Recipients Listing Trait as Most Important and as One of the Top Three Priorities in Accepting an Ovum Donor

Trait	Top priority (%)	Top three priorities (%)
Medical history	33	74
Race	23	54
Intelligence	18	39
Smoking/alcohol/narcotics history	8	28
Age	5	10
Past pregnancies	3	5
Psychiatric history	3	3
Education	3	3
Family history	0	21
Sexual history	0	5
Temperament	0	3

review. Table I lists the 10 most important traits expressed by couples in order of importance. Medical history and race were ranked by 33 and 23% of recipient couples as the two most important characteristics, while 74 and 54% stated that these were among the three most important factors in a potential donor compared with other traits.

Fifty-seven (71%) recipients accepted, while 23 (29%) rejected, the first donor presented to them. Eleven were subsequently given a second choice within 6 months, with 10 (91%) accepting the next presented match. Recipients waiting for a donor were just as likely to accept or reject a potential candidate whether waiting less than 3 months (33%; 15/46), 3–6 months (25%; 4/16), or greater than 6 months (22%; 4/18) ($P > 0.05$, NS). Data are depicted in Fig. 1. In all but five recipients, the reason for rejection was consistent with their top three priorities reported in their wish list, with three couples not financially ready to start a cycle, thus declining their donor. The other two recipients stated that medical history was a top priority, but one declined the donor because of religion and the other because she was not “cosmopolitan enough.” Figure 2 tallies various reasons for rejection.

Fig. 1. Percentage of recipients rejecting an ovum donor in relation to time of presentation.

- Weight (n=2)
- Too short (n=2)
- Too tall (n=2)
- Carrier of Mendelian inherited disease (n=2)
- Skin complexion (n=2)
- Proven fertility or response to COH (n=2)
- Family History (n=2)
- Too anxious (n=2)
- Education (n=2)
- Sexual history (n=1)
- Not cosmopolitan (n=1)
- Religious background (n=1)
- Ethnic background (n=1)
- Age (n=1)

Fig. 2. Reason for rejection in the presented ovum donor.

DISCUSSION

Couples undergoing assisted reproductive technology and, particularly, those using donor gametes are often confronted with difficult emotional and ethical decisions. Upon electing gamete donation, an active decision is necessary to decide whether the donor should be anonymous or known. Known donation mandates the need for extensive psychological counseling in an attempt to identify ambivalence and/or subliminal coercion and prevent conflicts between parties that may occur later in their relationship (8). For many, using a known donor is reassuring because it provides some idea as to what the child may look like and gives certainty about the child's ethnic and religious background. In some cases known donors do not require monetary compensation, especially when siblings or relatives are enlisted (9).

In contrast, anonymous donation offers the advantage of protection from disclosure, protecting patient confidentiality and minimizing liability exposure. In addition, for those who do not intend to tell their families and friends of the underlying circumstances behind the pregnancy, there is the option of secrecy and control.

Nonetheless, much like sperm donation, recipients of anonymous ovum donation demand to know as much about the donor as possible, particularly those characteristics that uniquely personify them including interests, background, ancestry, and skills (10). However, unlike with sperm donation, where the cost is significantly less and the supply of donors exceeds the demand, waiting lists for oocyte donor in many programs are reported to be in excess of 12 to 18 months. Thus, finding a suitable ovum donor often is a formidable task, undoubtedly compounding the frustration, anxiety, and stress of infertility and its treatment. Therefore, one would expect far fewer

expectations in a potential candidate and greater acceptance of any medically suitable candidate.

Our results show that phenotypic, ethnic, educational, and other interests are as important in the selection of an ovum donor as with sperm donor selection (10). Rejection of a donor is slightly less at greater than 6 months than at less than 3 months from entry into the program. This implies that recipients continue to be proactive in their decision-making process regardless of the time frame in waiting for a donor.

In summary, the decision to use ovum donation is fraught with many issues including social and cultural attitudes, secrecy and disclosure, and the use of anonymous versus known donors. An enormous trust is placed in the hands of the in vitro fertilization unit in helping find an appropriate donor. The establishment and maintenance of a donor registry should help to meet the needs of these couples. It is apparent that, despite the limited pool of ovum donors and the extended period to find a candidate, couples will continue to make educated and well considered decisions.

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