Should embryo donation be actively encouraged and advocated for couples with only one infertile partner?

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In many countries where commercialization of donated sperm and eggs in clinically assisted reproduction is banned, the resultant effect is often severe shortages and long patient waiting lists [1]. The situation is made worse by the abolishment of donor anonymity in some countries [2], which has further exacerbated the shortage of donor gametes [3, 4].

At the same time, there is a growing surplus of frozen embryos leftover by patients who have attained reproductive success, and have no further desire for additional offsprings [5, 6]. Some of these former patients would have consented to donate their surplus embryos to other infertile couples rather than discard them away. Hence, a common scenario in many countries is that many couples with just one infertile partner would opt for embryo donation, due to lack of availability of donated sperm or eggs.

The pertinent question that arises is whether such a practice should be actively encouraged and advocated by medical professionals and healthcare institutions, given that donated surplus embryos are also not easy to come by in many countries where altruistically-donated sperm and eggs are scarce. Shouldn't couples with two infertile partners be given priority over other couples with just one infertile partner? Nevertheless, in countries where there is a lack of centralized control of gamete and embryo donation by the national or regional health authority, priority for embryo donation is of-

ten not based on whether a couple has one or both infertile partners. Instead, it is usually on a first-come first-serve basis, depending solely on the financial ability of patients to fork out ready cash for immediate payment of medical fees.

This is ethically unsound because medical professionals and healthcare institutions should expend every effort to procure either donor sperm or oocytes for couples with just one infertile partner, rather than utilize embryo donation as a convenient and 'ready-made' option. Instead, the rather scarce donated surplus embryos must be held in reserve for couples with two infertile partners.

Moreover, there is a distinct risk that the fertile partner in the recipient couple may actually be an unwilling or reluctant party to embryo donation, but is somehow emotionally pressured and coerced to consent by his or her infertile spouse, as well as possibly by the 'hard-selling' tactics of medical professionals and fertility clinics, since substantial medical fees are earned from embryo donation. This in turn could have serious far-reaching consequences on the future happiness of the marriage and upbringing of children born from donated embryos. Hence, there is also a dire need for professional counseling independent of the fertility practitioner and clinic in question.

A possible solution may be for the national or regional health authority to establish centralized control of embryo donation, with the setting up of a registry and waiting list of patients, together with the provision of independent professional counseling to prospective embryo recipients. This would thus ensure that priority for embryo donation would always be given to couples with two infertile partners, rather than on a first-come first-serve basis depending on immediate ability to pay for fertility treatment, without the provision of adequate counseling.

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