Egg-sharing

Egg-sharing was introduced in the UK in 1992 by the medical team now leading the London Women’s Clinic. For the first time it enabled selected patients to receive highly subsidised or free IVF treatment in return for donating a proportion of their eggs to matched recipients. Initially, the authorities administering IVF (the Human Fertilisation and Embryology Authority), fearing that the concept might exploit vulnerable women, threatened to ban it. However, after an exhaustive examination of the arguments, the HFEA finally accepted that egg-sharing could indeed be beneficial to patients.

Egg-sharing is now strictly regulated by the Human Fertilisation and Embryology Authority and patients who take part in egg-sharing programmes benefit from a structured paperwork provided in the HFEA Code of Practice. The most recent results show that egg-sharing reduces the waiting time for donor egg treatments and, where appropriate, helps many women with free IVF treatment. Even though the eggs are shared, the birth rates for donors and recipients remain high.

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Assembling the evidence

Our first announcements ran immediately into opposition from the media and the HFEA, who reprimanded us for being driven by profit and announced that egg sharing would be discontinued. They demanded categorical assurance that women were not coerced into giving away their eggs and were not psychologically damaged after the treatment. Though disappointed, we also recognised the legitimacy of HFEA’s concerns, which we shared. Our patients and the Ethics Committee conceded that unless we found convincing answers to these profound concerns of the HFEA, the egg-sharing concept had no future.

The original case for egg sharing

The original ideas about egg-sharing came from our own patients in 1993. As a result, we proposed an egg-sharing scheme which offered a practical and dignified option for two groups of infertile patients, those with eggs who could not afford the high cost of repeated IVF treatment (or were interested in saving money), and those who had exhausted their own supply of good eggs. Donors could receive free or subsidised IVF treatment by sharing some of their surplus eggs with fee paying recipients.

We felt that the scheme had a good chance of success because women were intrinsically motivated to help each other - and they often produced more eggs than they required for their own treatments. What they needed was a transparent system that protected their anonymity and did not compromise their own success.

We consulted our own hospitals’ independent Ethics Committees who, after much discussion, saw egg-sharing firstly as an advantageous means of providing donor eggs - because we would no longer need to recruit donors for risky IVF treatments (which they did not need) and secondly we were not paying cash rewards. We expected the HFEA to endorse what to us appeared to be a potentially win-win situation for all the parties. The HFEA, however, did no such thing.

Advantages of egg-sharing

Brings together a surplus and a shortage, reduces egg wastage

Promotes practical altruism between patients

Achieves a therapeutic balance between risk and reward

Reduces dependence on non-patients, the NHS or brokering agencies

It would take us another five years to accumulate the necessary evidence. We first commissioned a national survey of the views of 750 British sharers and recipients with prior experience of egg sharing, whose answers were independently analysed by the National Opinion Poll (NOP). This exercise turned out to be an extraordinary event in the history of egg-sharing. It revealed that women entering egg share treatments held complex motivations. For the majority (over 90%), a drive to help others was the primary incentive. Their own lack of success did not diminish that feeling, even many years after their own treatment had been completed. Rewarded with subsidised or free treatment was acceptable, but receiving cash was not.
Egg sharing approved

On 9 December 1998 the HFEA announced that egg sharing could be beneficial to many patients and would now be supported. Dame Ruth Deech, the HFEA Chairman, announced in a press release: 'The overwhelming view of the Authority was that it would not be right to ban paid egg-sharing, which can be enormously beneficial to both sharers and receivers. We were influenced by the argument that egg-sharers are not motivated by money, but the desire for a baby.' She further added that the desire to protect the volunteer egg donors from the unnecessary IVF treatment was also a consideration.

The Authority determined to collect the data for egg-sharing treatments, to provide legal guidance for the clinics and to keep egg-sharing under constant vigil in the future. The centres were invited to apply for egg-sharing on their licences and the HFEA included egg-sharing in its Code of Practice, thus ending a prolonged and highly complex debate on a subject that involved patients, practitioners and policymakers in the constant glare of the media.

The public consultation paper for the HFEA produced many contributions:

'Donating my eggs did not worry me. I will never know who got the eggs or if it worked for them. I just hope it did. I thought even if I didn’t become pregnant, I had at least given the chance of a family to somebody else.'

M. Smith, egg share donor and mother of twins, 1999

'Egg-sharing is ingenious and harmless...it neatly brings together a surplus and a shortage.'

The Daily Telegraph, 24 November 1998

'I am so grateful to the donor. My only regret is that I can’t thank her personally. We feel truly blessed.'

Mrs Michelle Sneade, mother of twins, thanks to egg sharing, 1999

In my view the whole concept of egg-sharing as I understand it is a moving and lovely one. There is nothing about it which is base or selfish or disrespectful of life or immoral or unethical. There is a meeting of the needs of these two women; the one has eggs to donate but lacks the money for treatment, the other can afford the treatment but lacks the eggs. This union is one which we should respect and indeed applaud.'

The Honourable Mr Justice Johnson, Royal Courts of London, 1998

The survey also found that recipients respected the generosity of the donors. They did not begrudge donors their financial savings and sincerely wished them success in their treatment. At the time, little did the recipients know (because the guidelines prevented us from telling them) that in our programme we had had many cases of concurrent success in donors and recipients. Indeed, in one case of single egg collection in 1998 an egg donor and her two anonymously matched recipients were simultaneously successful, leading to three births. The two women (because the guidelines prevented us from telling them) that in our programme we had had many cases of single egg collection in 1998 an egg donor and her two anonymously matched recipients. Indeed, in one case of single egg collection in 1998 an egg donor and her two anonymously matched recipients were simultaneously successful, leading to three births. The story widely featured in the national press and produced even greater demand for donor eggs.

In our survey, the vivdness and individuality of the responses of the donors and recipients was also striking. Some of their statements, as shown on the facing page, added a sense of community to the statistical generalisation of the survey. Donors and recipients clearly showed a high sense of responsibility towards the needs of others.

The publication of our egg-sharing results from 1996-1998 in medical journals produced one immediate welcome result: it persuaded the HFEA to initiate by the HFEA in 1997 (the first of three over 10 years) would encourage a balanced and public examination of the arguments. And before long we began to register a perceptible change in attitudes. Commentaries, editorials and our patients’ own stories repeatedly appeared in the media. Patients with experience as well as learned individuals began to express their beliefs - and these would eventually move the HFEA to a remarkable announcement.

'Without egg-sharing schemes the recipient would have no chance of becoming a parent. If I couldn’t produce eggs I would be devastated, it is vital that egg-sharing continues.'

'A woman has to go through so much to get to egg retrieval, it therefore seems so worthwhile to be able to assist anotherinfertile woman to achieve a pregnancy.'

'I was very pleased with the treatment and would definitely do it again. I think it’s the best idea I’ve ever heard of.'

'This scheme gave me back my hope and I feel I’ve given hope to someone else in my position.'

'I feel so lucky to have the chance of becoming a parent. If I couldn’t produce eggs I would be devastated, it is vital that egg-sharing continues.'

'We felt very grateful towards the donor, she must be a kind, unselfish person.'

'I can afford to pay and can therefore help someone who can’t.'

'It’s wonderful, now we have a family to love.'

'I am six months pregnant – having a baby, being a family, being normal and having social acceptability is what I most look forward to.'

'I feel so lucky to have the chance of a baby, it’s nice to participate by helping financially.'

'When I read about it I thought what a great idea for people like me who are desperately seeking donors.'

'The medical preparation for egg-sharing was discreet and simple.'

Egg donors

I’m happy I participated; it gives both couples a chance to achieve the special gift they are both striving for:

'Very happy I have made a contribution to someone else’s happiness.'

'I was never comfortable asking someone to take drugs just for us – when we heard about egg-sharing we both felt it was a wonderful solution for us.'

'We were very relieved to find out about egg-sharing, we felt we would get treatment sooner with egg-sharing than trying to advertise for a donor.'

'When we heard of the scheme we both said ‘why didn’t someone think of this scheme sooner?’ It will encourage more donors.'
Egg-sharing today
With the HFEA’s stamp of approval, the practice of egg-sharing has changed beyond recognition. The idea of ‘voluntary gifting’, as the hallmark of the early years of egg donation, now seems to have given way to shared rewards. Indeed, according to the HFEA during the past four years, more women have received donor eggs from egg-sharers (59%) than from non-patient volunteers (41%). Having treated several hundred sharers with IVF at London Women’s Clinic, we have concluded that, if the embryo culture conditions are carefully controlled and the patients carefully selected, both donors and recipients are never disadvantaged in terms of their overall success rates. Our most recent results from 1122 consecutive treatments are shown in Figures 1, 2, and 3 on the facing page. Birth rates for sharers and recipients are comparable to the overall IVF birth rates for younger women.
In 2004 the HFEA, as part of its commitment to continually monitor egg-sharing, completed another review (SEED review), and reaffirmed its support for the practice of egg-sharing as a novel arrangement. With the HFEA’s approval, it is now possible for women in many parts of Africa, in some countries, like Israel and Canada, it is the only form of donor egg treatment permitted and in others, such as Spain, Russia and USA, it coexists with paid donation. We have accepted women for egg-sharing treatment from many countries. In a remarkable case some years ago a donor and her recipient delivered their children on the same day in two different countries several hundred miles apart. The geographical or national identities of sharers and recipients in our programme seem not to be a deterrent. They appear motivated by the same feelings of mutual reciprocity which are not dissimilar to the ideas expressed by the British women we surveyed in the summer of 1996. For example, a 2007 survey of the patients attending 38 different IVF centres in the USA showed that egg donors are motivated by both altruism and financial gain. Nearly 90% of the donors would donate even if they were no longer anonymous, a powerful sentiment similarly expressed by the sharers at our own clinic. The clear message is that women care for the welfare of other women. Egg-sharers accept financial benefits if they appear to be equitable and respectful (ie, free IVF treatment) but their contribution is predominantly because of a powerful desire to help others. When invited to write a personal message intended for the recipients’ future children, a facility provided on the obligatory HFEA consent form, a large number of sharers (nearly six times more than volunteer egg donors) take up this option. They produce thoughtful and touching accounts to be included on the HFEA register for the benefit of the recipient’s future children. In 1997, soon after the completion of our survey, Dr Ahuja had commented: ‘I can think of no other area of medicine where a woman can help herself and do so much to help other women at the same time.’ After several hundred egg sharing treatments, it is very reassuring that we can believe in those feelings even more truthfully than was the case ten years ago.

Egg-sharing worldwide
Shared egg donation is now a phenomenally popular form of IVF treatment in China, India, USA and many parts of Africa. In some countries, like Israel and Canada, it is the only form of donor egg treatment permitted and in others, such as Spain, Russia and USA, it coexists with paid donation. We have accepted women for egg-sharing treatment from many countries. In a remarkable case some years ago a donor and her recipient delivered their children on the same day in two different countries several hundred miles apart. The geographical or national identities of sharers and recipients in our programme seem not to be a deterrent. They appear motivated by the same feelings of mutual reciprocity which are not dissimilar to the ideas expressed by the British women we surveyed in the summer of 1996. For example, a 2007 survey of the patients attending 38 different IVF centres in the USA showed that egg donors are motivated by both altruism and financial gain. Nearly 90% of the donors would donate even if they were no longer anonymous, a powerful sentiment similarly expressed by the sharers at our own clinic. The clear message is that women care for the welfare of other women. Egg-sharers accept financial benefits if they appear to be equitable and respectful (ie, free IVF treatment) but their contribution is predominantly because of a powerful desire to help others. When invited to write a personal message intended for the recipients’ future children, a facility provided on the obligatory HFEA consent form, a large number of sharers (nearly six times more than volunteer egg donors) take up this option. They produce thoughtful and touching accounts to be included on the HFEA register for the benefit of the recipient’s future children. In 1997, soon after the completion of our survey, Dr Ahuja had commented: ‘I can think of no other area of medicine where a woman can help herself and do so much to help other women at the same time.’ After several hundred egg sharing treatments, it is very reassuring that we can believe in those feelings even more truthfully than was the case ten years ago.

Egg-sharing popular for lesbian women
A review of IVF treatment at the London Women’s Clinic shows that success rates in lesbian egg-sharers are just as high as in lesbian women having routine non-sharing IVF. The high success rates, of course, reflect the fact that lesbian women - unlike their heterosexual counterparts - are not usually infertile and are having IVF only because they have no male partner. Successes are expected to be - and are - very high.
A recent LWC study compared results in 74 lesbian women having routine IVF between January 2005 and July 2007 and 20 lesbian women who took part in the egg sharing programme. All of them used donor sperm from our own sperm bank. All 74 non-sharing IVF patients had embryos transferred (an average of 2.1) and many of them had spare embryos frozen. Results in the IVF group showed that 47% (63.5%) of the 74 women had babies at the end of their treatment.
These results, however, were almost exactly matched by the 20 lesbian egg-sharers who took part in the egg-sharing programme. They too achieved a live birth rate of 65% per patient treated, suggesting that lesbian women, first, make good candidates for an egg-sharing programme, and second, can achieve just as much success by donating some of their eggs as they can in routine IVF.
The recipients (21 in total) also achieved respectable live birth rates (29%), which were comparable with the live birth rates achieved in normal IVF cycles for this age group of patients (women aged 40-43 years).

In 1995, our committee found egg-sharing as proposed by Dr Kamal Ahuja and Mr Eric Simons a rather novel arrangement. With appropriate safeguards we felt that all the participants stood a chance to simultaneously benefit from the scheme and help each other. That is why we supported it.

Lady Alexandra Roche JP Chair (1991-2007), Cromwell Hospital Ethics Committee, London

Success at the London Women’s Clinic
Success rates for those receiving and those donating eggs - and how they compare with egg donation treatment in the UK

Latest HFEA pregnancy report shows LWC among the top performers
The Human Fertilisation and Embryology Authority (HFEA) - the statutory body created to license and monitor all UK clinics that offer IVF and donor insemination treatments - has recently published the centre specific IVF success rates for the period 1st January - 30th June 2007.
The verified results show that At 55.7%, the London Women’s Clinic (LWC) in Harley Street is rated in the top three amongst all licensed centres for women aged up to 35. The latest figures also reveal that women – in all the recorded age groups – attending LWC clinics have pregnancy success rates well above the national average.

If you have any questions about egg-sharing or need more information, you can contact the London Women’s Clinic by e-mail egg-sharing@londonwomensclinic.com or telephone 020 7967 0019.
Egg donors are given the opportunity by the HFEA to write goodwill messages to the recipient children born from their eggs. Below is a selection of some of these messages.

**to a child**

‘I donated my eggs to your mother because I wanted to give someone that special gift of parenthood, so take care of yourself and your parents...’

‘I hope you have a good life surrounded by a family who adore you and treasure you. Remember, this took place because of a deep love I shared with someone else and the same deep love that your parents share for each other.’

‘Your parents were very kind and gave myself and my partner the opportunity to have a baby together. This is something that I will always be grateful for! In return I gave your mum a tiny egg that she nurtured and made you, how brilliant is that! I hope how you came into this world will show you how wanted you were by your mum and dad and just how cherished you will always be no matter where you came from.’

‘My decision to be a donor came from my understanding of the need to become a mother. Something I am unable to achieve naturally. I wanted to give another woman in my position the opportunity to experience the greatest gift that God can give – to be your mother. You are a very special person and loved so completely, always be assured of this. I wish you a good future and a happy life.’

‘I want you to know that you are a very special child and are lucky to have parents who wanted you so much that they were willing to go to great lengths for you. I am happy that I was able to give your parents a gift to help them experience the joy of bringing you into the world. We hope that you have had a happy and fulfilled life and if you ever wish to contact us in the future we would be more than happy.’

‘We have always wanted children to enrich our lives and if it wasn’t for the kindness of donors we would never have been in this position to even think of having a family. It is for this reason that we decided to join the egg-share programme, to help give another family the possibility and gift of life. That thought is what got us through IVF; it was very hard and emotional process and if you are reading this I know that your parents loved and wanted you so much to also put themselves through this process as it takes so much determination, a lot of courage and strength to realise and walk towards your dreams.’

**Egg-sharing: how the story began**

Mr Eric Simons was one of the two London Women’s Clinic consultants to pioneer egg-sharing in the early 1990s. For 12 years he also acted as a clinical inspector for the HFEA, championing egg-sharing from his own clinic whilst at the same time inspecting clinics opposed to the idea. We asked him how the scheme was developed and what difference it has made to infertile patients over the past ten years.

**Why were donor eggs so scarce?**

Originally, if a patient needed egg donation you asked them to find the donor. Maybe a friend or relative. Then a requirement for anonymity was introduced, and that source of eggs disappeared. So patients started advertising. This was pretty demeaning for a woman to have her name put up in a local shop asking for eggs. I felt that the whole system as it stood was poor. Here you had a patient with a real medical problem, and we were just adding to her problems. The pressure was on the patient. This was why egg donation slowly became less and less popular.

**So why was egg-sharing an improvement?**

First, it was the patients’ own initiative, so there was no idea in our minds of coercion. Second, this was one way in which we in private practice - which was then responsible for 90% of all IVF in Britain - could extend IVF to those who couldn’t afford it. So here we had a source of donor eggs which took coercion away and meant that people who couldn’t access IVF treatments because of cost now had a chance.

**In that case, why were there ethical objections?**

Because people were donating freely - with an emphasis on free - the traditional focus of egg donation was seen as ethically sound. Egg-sharing was seen as offering payment in kind in subsidised treatment - and this was considered by some to be ethically wrong. But to be honest, I found egg donation ethically disturbing, even if it was politically correct. We were giving drugs to egg donors who had no medical need of them. Egg-sharers would be having IVF anyway and they often produced more eggs than they needed for their immediate needs.

**What were the origins of egg-sharing?**

In 1992 we had a small egg donation scheme at our clinics in London and County Durham, for women with an early menopause and other hormonal problems. But it was always difficult to find donor eggs. Then, on Monday morning in the spring of 1992 three of my IVF patients in Durham came into my office and said, we’ve been through IVF two or three times, we’ve produced eggs, they’ve fertilised well, but we haven’t been lucky. If someone else would pay for our treatment, we could give up some of our eggs in return. We might be lucky.

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Patients’ Stories

Today egg-sharing is accepted by the health authorities in Britain as a legitimate and useful means of treating infertility. But arguments in its favour and against are still thrown back and forth. Egg-sharing favours the donor . . . egg-sharing favours the recipient. But in fact there is no evidence that women who donate eggs in egg-sharing schemes do any worse - or any better - than women who receive them. In our own experience of 15 years, many egg sharers are successful in the same egg collection cycle as the recipients and, regardless of outcome, all are happy with their decision to share eggs. Indeed, even sharing couples whose treatment was unsuccessful express pleasure that they have been able to help others have a baby. Egg-sharing holds special feelings for those who take part, and whenever the arguments are raised, it’s the people who really matter. We asked three egg-sharing patients how they felt about the scheme and the outcome of their own treatments.

Michelle Sneade
TV Producer
London
January 2008

‘If I wanted to get pregnant, I knew my only chance was to have IVF with donated eggs.’

It is now ten years since our twins Lauren and Isaac were born - and ten years since we became a family. It was also ten years ago, after many rounds of discussion and review, that the HFEA announced its support for egg-sharing schemes. There is no doubt that egg-sharing enabled us to become a family, but in 1998 we were one of the first couples to enjoy the benefits of egg-sharing with the official “approval” of the authorities. Ours was no ordinary journey...

I had fought my first life-battle at the age of 24 when I was diagnosed with ovarian cancer. So it was no great surprise to me when, eight years later and having met ‘the man of my dreams’, we found out I was infertile. The cancer and chemotherapy had taken their toll on my remaining ovary and I had run out of time and eggs. So now I was facing my second battle in infertility and this seemed a far more daunting prospect. If I wanted to get pregnant, I knew my only chance was to have IVF with donated eggs.

And so we entered the world of the childless... a world of waiting-rooms and waiting-lists, and we soon found out that the supply of donor eggs - and of egg donors - was very limited indeed. The first few clinics we visited told us we would either have to find our own egg donor - a very daunting process - or join a two-year waiting-list.

Then we heard about a scheme run by Dr Ahuja and Eric Simons which was called egg-sharing and which for us we would either have to find our own egg donor - a very daunting process – or join a two-year waiting-list.

Dr Ajit Gill with baby Lauren in 1998

At this time none of the other clinics we visited were offering egg-sharing, and this always plagued us. It seemed such a logical idea. Another clinic had said that if we could provide someone to donate to an egg pool, we would be moved to the top of their waiting-list. A friend of mine did offer herself as a donor, but I had always felt uncomfortable with the idea of putting a healthy woman at risk. So it was imperative to be treated at a clinic where we felt supported. To us egg-sharing seemed the best of solutions for both donor and recipient where two families going through a similar situation could help each other.

We were very, very lucky, after a year of treatment and our second attempt of IVF our precious babies Lauren and Isaac were born. At the time of our treatment the future of egg-sharing seemed uncertain. Now I am pleased to say it is endorsed by the HFEA and is embraced by many clinics in Britain and worldwide. I hope that through egg-sharing many other couples have the chance of happiness that we have had.

Now ten years on we rejoice in being a family. I can honestly say I wouldn’t have had it any other way. I am extremely proud of our journey and of our children’s beginnings in life. We will always be eternally grateful to our generous donor who has bestowed this incredible gift upon us and made our lives complete.

Michelle Sneade with her husband Sam and children Isaac and Lauren.

‘For an NHS consultant confronted with growing requests for IVF treatments, egg-sharing schemes are innovative, ethical and good value for money for our patients.’

Mr Alex Franks MD FRCOG
The North West London Hospitals NHS Trust
Northwick Park Hospital
Harrow

Michelle Howells, FRCOG, Consultant in Obstetrics & Gynaecology, West Wales General Hospital, Carmarthenshire NHS Trust

Mrs Ruth Howells, FRCOG, Consultant in Obstetrics & Gynaecology, West Wales General Hospital, Carmarthenshire NHS Trust

‘Ova’ 12

It’s not just the clinic that matters. The people who really matter. We asked three egg-sharing patients how they felt about the scheme and the outcome of their own treatments.
‘Should I be denied a baby just because I was single?’

I was at the time 39 years old and not in any sort of relationship which was planning a future together, and certainly not children. But I did feel that, unless I did something about it soon, I would be spending the rest of my life without achieving the one thing that was most important to me - and that was having a child. Should I be denied a child just because I was single? I felt it was irresponsible to try to get pregnant “by accident”. Besides, how long might it take? I just couldn’t face it. But at 39 it didn’t occur to me that I might be leaving it too late. Little did I know.

Despite having a good relationship with my young, open-minded, female GP, I had to pluck up much courage to ask her about fertility treatment for a single woman. I knew it was possible, but it was not common, and certainly not conventional. I was referred to a consultant, who gave me a choice of three fertility clinics known to treat single women. In the end I didn’t make my choice based on statistics or league tables, but more on a gut feeling of how I found the clinic on the phone and how friendly they seemed. It was also important to know of the clinic’s experience, its sperm bank reserves and the types of treatment offered. And so my treatment began.

The tests were completed, I thought that with such good blood results I would soon become pregnant. But after three failed stimulated IUI cycles, my consultant thought it best to try IVF/ICSI. I felt sure that with one attempt… but three cycles and one frozen cycle later, all within one year, I was still not pregnant. I found it all hard to believe, but I wasn’t inclined to stop trying… yet.

I suspect that as early as after my second attempt I should have considered donor eggs. I now knew all about age and reproductive failure, but I was against the idea. Anyway, why shouldn’t my embryos implant? I had plenty of them and they seemed of good quality to the experts. But it wasn’t that I now had less time on my hands, I also had less money. In fact, it was becoming financially irresponsible to keep trying with my own eggs, so I decided to go on the donor waiting list at London Women’s Clinic.

I did think about how I might feel producing a baby which was not genetically mine, but I believed in the nature/nurture argument and felt 100% that I wanted to go ahead. The donor I was offered was of a different nationality from me, and I did debate for a short while about accepting her eggs, but again I returned to the nature/nurture argument and realised that nationality didn’t matter.

I had to travel some distance for my embryo transfer, but by then would have travelled across the world to have a baby.

With hindsight, I would have stopped treatment with my own eggs after two attempts, starting donor treatment then would have saved me financial and emotional expense.

In the end I was lucky because my attempt with donor eggs was successful and I now have a beautiful baby girl, Eleanor Peaches born in November last year. A young woman shared her eggs with me and I paid for both our treatments. As I sit here trying to share my experience with you, it’s hard to believe that Eleanor is here, after all I went through to get her. But I am so very grateful to the woman who shared her eggs with me. I feel that this may well have been the only way I could ever have had a child, and her egg-sharing was a true act of altruism.

Charlotte Ranger and her daughter Eleanor Peaches.

‘Altruism or greed? Supportive or selfish?’

As a couple who have been through several IVF cycles we know that financial pressures can be a stressful factor during each new cycle. And any type of stress, of course, may contribute to IVF failures. So after our third IVF attempt, we began to have difficulties raising the money and admitted to our doctor that we might have to wait a while before we could continue with our next cycle. We were devastated. We both wanted so much to have a family, but now, here we were, turned down by the NHS for treatment, neither of us are getting any younger, and three failed attempts behind us. And my condition, we were told, was quite treatable. In fact, the only reason I couldn’t become pregnant naturally was because both my fallopian tubes and one ovary had been removed because of chronic poly cystic ovary syndrome.

Our decision to try egg-sharing was not simple; the London Women’s Clinic wouldn’t let us make any snap decisions. We were given all the facts, the statistics, the good and the bads, and were given counselling to ensure that we fully understood all the implications.

My only concern was that the time was my husband’s, I was happy to accept my share. What if egg-sharing worked for the recipient and didn’t work for us? I had helped create a family somewhere but my husband hadn’t. We talked about it for a while and my husband’s immediate response was: ‘I hope that if we couldn’t create our own eggs then someone would donate eggs to us.’ And he was so right. Thinking in this way, it became clear to us that money was the main reason, not our age, why we really wanted to take part in egg-sharing. It seemed right and natural to offer this wonderful opportunity to someone else too. Indeed, if we had known about it sooner, we would have started sooner, regardless of the money. In fact, we would have done it without a price reduction.

My husband and I cannot wait to start our next egg-sharing cycle, not only because we are still hoping to be pregnant ourselves, but also to help another ‘family wanna-be’, to have their life fulfilled too. We all know the risks and chances of IVF success and failure, and to be truthful the odds aren’t great. But those odds are the same whether you are keeping all your eggs or sharing a few.

I feel altruistic and good knowing that even if egg-sharing doesn’t work for me, it might work for someone else. So in a small way I may have helped create life. I also feel that if I couldn’t generate my own eggs I hope someone would donate eggs to me. I want it one way, it has to work the other way too. Would you hope to have a blood transfusion if you needed one, but not be a blood donor yourself?

Eleanor Peaches born in November last year. A young woman shared her eggs with me and I paid for both our treatments. As I sit here trying to share my experience with you, it’s hard to believe that Eleanor is here, after all I went through to get her. But I am so very grateful to the woman who shared her eggs with me. I feel that this may well have been the only way I could ever have had a child, and her egg-sharing was a true act of altruism.

Charlotte Ranger and her daughter Eleanor Peaches.

Katy Roberts, 35, married
Managing Director
Hertfordshire
January 2008

So I feel that people who are anti egg-sharing are missing the real point. The point is that I want to egg-share. I want to know that if my body is never able to become pregnant, then my body was able to do it for someone else. I am a woman and there is, somewhere deep down, a natural intrinsic belief that I am meant to create life - I would be far more distressed being unable to do what a woman is meant to do than knowing that my egg donation worked for someone else and not for me. I will be far more content knowing that I still, in some small way, fulfilled my womandly role. By egg-sharing I fulfilled my womandly role if the recipient becomes pregnant. If I never become a ‘natural’ mother it’s because my body couldn’t do it. Why would I feel bitter or resentful because my egg helped another woman to be a mother?

My last attempt at egg-sharing did not work for my recipient either. My husband and I were totally devastated for her and her partner; we wanted to empathise and give them the whole next batch of eggs for free. It wasn’t a negative or destructive sadness, it was a mutual understanding that two strangers were going through what we were going through, and it actually helped as part of our own grieving process. Whilst going through our cycle it was wonderful knowing that someone else was going through it at the same time, with a little bit of our help. It really took the strain off thinking about our situation the whole time; we had someone out there going through it with us.

Katy Roberts and her husband. Glen.