Lesbian intra-partner oocyte donation: A possible shake-up in the Garden of Eden?

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Abstract
Treatment of same-sex couples using infertility therapies has become more acceptable over the years, but remains controversial. In December 2005, two law changes came into force in the UK that impact same-sex couples. Firstly, the Civil Partnership Act 2004 acknowledged legal relationships between same-sex couples; and secondly, the Adoption and Children Act 2002 allowed same-sex couples to adopt. In view of these law changes, it is timely to consider procreation in same-sex couples and, particularly, the possibility of intra-partner oocyte donation within a lesbian relationship. Such treatment would require one female partner to provide the oocyte and the other female partner to act as embryo recipient. The embryo(s) could be created using IVF with registered anonymous donor sperm. The novelty of allowing a lesbian couple to cause a pregnancy in this way could allow the recipient to give birth to a baby that was genetically related to her partner. If society finds this acceptable, intra-partner oocyte donation using donor sperm for IVF could successfully provide a family for lesbian couples, offering an alternative to individual donor insemination. The ethical aspects of the treatment are discussed.

Keywords: Lesbians, oocyte donation, recipient, ethics, reproductive law

Introduction
In Europe, lesbian couples are increasingly seeking fertility treatment (Baetens et al., 2003). In order to conceive with screened donor sperm, lesbians may seek fertility treatment through donor insemination (DI), provided they can find a clinic that will treat them. Clinics presently have the right to refuse lesbians treatment, in accordance with the current wording of Section 13(5) of the Human Fertilisation and Embryology Act 1990, which specifically refers to ‘the need of the child for a father’. Most NHS Trusts give priority to heterosexual couples accordingly.

Where lesbians are accepted, treatment is commonly restricted to one partner who enters the DI programme on an outpatient basis. If DI is unsuccessful, the couple may consider upgrading their treatment to IVF with donor sperm (IVF–DI). If applicable, further treatments could be considered, such as use of donor oocytes for IVF–DI, or even donor embryos. In this respect, the management of lesbian couples is similar to that of heterosexual couples referred for IVF–DI.

In July 2005, there was much media coverage of a British lesbian couple who were about to embark on intra-partner oocyte donation using anonymous donor sperm. One headline proclaimed the woman was ‘set to make history by getting pregnant with her lesbian partner’s fertilised egg’ (New!, 2005). Whilst this is not the first case of intra-partner oocyte donation within a lesbian relationship in the UK (Human Fertilisation and Embryology Authority (HFEA) personal communication), the story has brought to the public’s realm the possibility of intra-partner oocyte donation within a lesbian relationship.

Oocyte donation is a treatment option normally reserved for heterosexual women who have a low chance or inability to produce chromosomally normal oocytes themselves. Older women may also seek donated oocytes, as their own oocytes often decrease in number and quality, and there is an increased risk of aneuploidy in the conceptus due to factors such as changes in meiotic spindle integrity (Baird et al., 2005). Oocyte donors are usually less than 35 years of age, with a healthy chromosomal make-up. During treatment, the oocyte recipient undergoes a uterine transfer of embryos created from...
the anonymously donated oocytes fertilized in vitro. If treatment is successful, the birth parent (the recipient) is automatically recognized as the legal mother, whilst the oocyte donor remains unaware of whether or not her donation was successful.

Anonymity remains an integral part of oocyte donation. However, a recent change to British law means that oocyte donors may now be traceable by children born as a result of oocyte donation, if the donors registered with clinics after 1 April 2005 (HFEA, 2004). When the offspring reach the age of 18 years, they will be allowed to access information about the identity of their oocyte donor. Before this time, and hence at the time of treatment, anonymity prevails, and the donor and recipient should not know one another’s identities and circumstances. An exception to this rule is if the donation is pre-arranged between people known to one another, such as one sister to another sister (Human Fertilisation and Embryology Act 1990). For lesbian couples, intra-partner oocyte donation would also have to be exempt from the anonymity ruling.

Presently, the HFEA will consider allowing intra-partner oocyte donation in a lesbian couple provided the treatment concurs to the guidance set out in the HFEA Code of Practice (HFEA, 2003). If the reasons can be justified, the decision is ultimately left to the individual clinic. For example, if a lesbian has failed to conceive after several attempts with DI and then IVF–DI treatment, the further option of oocyte donation may be considered reasonable. However, donated oocytes remain a scarce resource, such that some patients even travel to other countries to seek oocyte donors (Heng, 2006). Due to the difficulty in recruiting oocyte donors (Byrd et al., 2002), an obvious option may be to ask the lesbian partner to act as the oocyte donor, providing she suitably fits oocyte-donor criteria. This would also solve the ongoing problem of a reduced supply of anonymous donated oocytes available to lesbians, since some donors may specifically request to exclude homosexuals as recipients of their donation.

For many lesbians, age may be a predominant factor influencing the possible justification of using donor oocytes. Lesbians often delay seeking fertility treatment due to concerns regarding breaches of confidentiality (Brogan, 1997). Lesbians may also fear negative responses to their sexuality from the health service (Evans, 2000), even though attitudes towards lesbians and gay men have become increasingly more positive in recent decades (Steffens, 2005). As a result of delay, chances of conception with their own oocytes may be reduced by the time they eventually embark on treatment, and oocyte donation may be the treatment option that offers the highest success rate. In a lesbian relationship, if there is a younger partner who is suitable to donate her own oocytes, then intra-partner oocyte donation could appear to be a logical treatment option.

Another point to consider is the common genetic origin of a lesbian partner, which is likely to be far more preferable to the unknown origin of anonymously donated genetic material. This would enable one lesbian to carry a child that is genetically related to her partner. Thus, if successful, the birth parent (the recipient) would be the legal mother, whilst her partner (the donor) would remain the genetic mother. By undergoing intra-partner oocyte donation, it may be that the respective parental desires of the couple are met and the partnership bond is strengthened due to the exchange of genetic material. Oocyte donation from a sister or a close friend may be perceived as a proof of altruistic, unselfish love. For a lesbian couple, this perception may perhaps be considered stronger, as the donation is not from a relative but from the partner. Only one of the couple will have genetic input into the resultant child, but the surrogate partner is just as vital for the child to be born.

Intra-partner oocyte donation would allow the genetic origin of the oocyte to be known, but the sperm donor would remain anonymous. However, since 1 April 2005, changes to the UK anonymity law would mean that the sperm donor may be traceable by any children born as a result of sperm donation, once the offspring reach the age of 18 years (HFEA, 2004). Whilst this may be seen as a possible disadvantage of intra-partner oocyte donation, this is no more so than for a lesbian having straightforward DI treatment. Since the sperm will have been screened for HIV, Hepatitis B and C, and sexually transmitted infections, one might consider the advantages to outweigh any disadvantages.

This raises the question as to whether a lesbian couple could request intra-partner oocyte donation as a matter of choice, ahead of other options such as DI, to achieve parenthood. At present, such decisions are in the remit of individual clinicians, preferably following consultation with the medical and counselling teams. Cautious regard would need to be given to the medical, emotional and practical issues. If agreed, treatment should only commence once all aspects regarding the welfare of any resultant child are fully satisfied according to UK law. However, a review of the Human Fertilisation and Embryology Act is presently underway (Department of Health, 2005), whereby the UK Government is specifically looking at who should make the final decision regarding the ‘welfare of the child’, and whether this should remain at the clinician’s discretion or be subject to Government guidance and regulation.

If intra-partner oocyte donation were to be accepted as a matter of choice, another point to
consider would be the age of the lesbian donating the oocytes. Should the upper age limit be restricted to 35 years as it is for standard oocyte donors? Or should lesbians be allowed to try intra-partner oocyte donation within the same female age limits as heterosexual couples can try IVF with their own oocytes? According to Clause 3.7 of the HFEA Code of Practice, ‘women over 35 and men over 45 are expected – like all patients – to be offered clinical advice and counselling from the outset. Advice and counselling is expected to focus on the implications of age for success in treatment. Gametes of patients in these age groups are expected to be used only for their own or their partner’s treatment’ (HFEA, 2003). This wording was most likely written with heterosexual couples in mind, but could also apply to lesbian couples seeking intra-partner oocyte donation. Provided a lesbian couple was offered ‘advice and counselling on the implications of age of success in treatment’, it is questionable whether their desire to proceed with treatment should be restricted due to age, particularly if they are over 35 years.

Under present UK law, the lesbian who opts to become the oocyte donor would have to register as a donor with the HFEA, undergo independent donor counselling and undertake the full screening process to confirm her suitability as a donor. This would include tests for Hepatitis B and C, HIV and sexually transmitted infections. As an oocyte donor, she would also need to endure the physically arduous and time-consuming work-up of repeated blood tests and ultrasounds, daily injections of fertility drugs, frequent medical monitoring and an invasive medical procedure to retrieve her oocytes. The medications, the retrieval process under anaesthesia, and the possibility of ovarian hyperstimulation, are all risks associated with oocyte donation (McShane, 1997). There is also concern regarding the association between ovulating-inducing agents and a variety of malignant tumours, so much so that Israel, Denmark and Canada now disallow or discourage non-patient volunteer oocyte donors (Ahuja & Simons, 1998).

Sisters who have donated to their sisters have admitted a naiveté about the donation process, being unaware of the lengthy, invasive and complicated nature of the whole medical procedure (Winter & Daniluk, 2004). The realities and pragmatics of the donation process may be enough to dissuade some lesbian couples. However, for others this may reinforce the desire to be part of the process of intra-partner oocyte donation, for which the potential end goal of having their partner carry their child is worthwhile.

The need for a father figure

As reproductive science and society evolve, one must question whether homophobic prejudice remains in the field of assisted conception, or whether reproductive medicine is keeping pace with society’s increasing acceptance of homosexuality (Steffens, 2005). Whilst the right to explore reproductive options has become socially acceptable for the heterosexual couple (Paulson, 1999), the acceptance for homosexual couples to explore their reproductive options remains restricted. Many clinics continue to refuse lesbian treatment, as they feel two female parents do not provide an appropriate family environment: two mothers, no father, no genetic relation to one of the mothers and anonymous paternity (Balun & Jacobs, 1997). They consider lesbians unable to satisfy the legal requirement for clinics to take into account the child’s need for a father, as stated in the Human Fertilisation and Embryology Act 1990, Section 13(5), which states that ‘a woman shall not be provided with treatment services unless account has been taken of the welfare of any child who may be born as a result of the treatment (including the need of that child for a father)’.

However, it could be argued that it is inappropriate to single out this one factor and not others. For example, there is no clause requiring ‘the need for that child for a mother’. Thus, the provision for a father may be considered discriminatory and out-of-date insofar as it does not reflect the range of family structures that now exist in the UK. To this end, the HFEA recently issued new guidance on ‘Welfare of the Child’ assessments (HFEA, 2005a), following a consultation document that gathered views on the limitations of current guidance in Section 3 of the HFEA Code of Practice (2003) and sought improvements for the future (HFEA, 2005b). A specific issue addressed was the treatment of single women and lesbian couples.

From 1 January 2006, the HFEA has shifted the focus on the welfare of the child to concentrate more on the risk of any serious medical, physical or psychological harm. The new guidance also advises clinics to encourage donor conception patients to be open with their children from an early age about the circumstances of their conception. The emotional, psychological and social implications of lesbian intra-partner oocyte donation may potentially impact upon any resultant child. However, substantial evidence exists to show that a child’s psychological health, social relationships, development of gender identification, gender role behaviour and adolescent sexual orientation are unaffected by parental sexuality (Patterson, 1992; Wainwright et al., 2004). Rather, it is the quality of parenting that seems to be the more determining factor (Golombok & Tasker, 1994). When compared to two-parent heterosexual families, lesbian mothers showed a high quality of parenting and positive relationships with their
children, with no difference in the child’s psychological well-being (MacCallum & Golombok, 2004). Indeed, the need for a father figure is questionable, since it has been reported that mothers in fatherless families show greater warmth and interaction towards their children than mothers in father-present families (Golombok et al., 1997).

As they grow up, children from lesbian and heterosexual families showed no difference in the likelihood of experiencing peer teasing (Vanfraussen et al., 2002). In a recent study of children raised in fatherless families from infancy to early adolescence, the absence of a father per se did not appear to result in psychological disadvantages for the children (MacCallum & Golombok, 2004). Thus, the absolute ‘need of that child for a father’ could be considered less essential than originally supposed when the Human Fertilisation and Embryology Act was passed in 1990. The issue of assisted conception without a father is addressed in Section 3.14 of the HFEA Code of Practice (HFEA, 2003): ‘Where the child will have no legal father the treatment centre is expected to assess the prospective mother’s ability to meet the child’s needs and the ability of other persons within the family or social circle willing to share responsibility for those needs.’ By including this clause, Parliament acknowledged that a subset of the population, namely single women and lesbians, might also desire children.

Two recent British law changes acknowledge an increased acceptance of homosexuality in the UK. Firstly, on 5 December 2005, the Civil Partnership Act 2004 came into force in the UK, to acknowledge legal relationships between two people of the same sex. This follows other international legislation of same-sex relationships such as same-sex marriage in Belgium, Canada and the Netherlands; same-sex partnerships in Denmark; and registered same-sex cohabiters in France, Germany, Hungary, Iceland, Israel, Norway, Portugal, South Africa and Sweden (Eskridge, 2001). Secondly, on 30 December 2005, a fundamental change to the adoption law also came into force in the UK, with full implementation of the Adoption and Children Act 2002. This Act allows gay and lesbian couples to adopt jointly, provided they are living in a secure and stable relationship. The British Association for Adoption and Fostering (BAAF) welcomed the new Act, describing it as ‘the most radical overhaul of the adoption law for 30 years’ (BAAF, 2005).

If society is now more accepting of homosexuality, then fertility clinics in the twenty-first century may have to consider not just whether, but how, assisted reproductive technology could be used to meet the requests of this changing society. The rapid development of new treatments, especially with donor gametes, has created new expectations and demands for fertility therapy from more than just infertile couples. It has been argued that families resulting from reproductive technologies such as oocyte donation actually mirror society’s norms (Seibcl et al., 1996). In a society where the concept of the family is becoming increasingly more complex, perhaps the arrangement of intra-partner oocyte donation may prove to be acceptable.

A review of the Human Fertilisation and Embryology Act

To cope with changes in society, a review of the Human Fertilisation and Embryology Act 1990 is both timely and desirable. The British Government recently announced that it intends to carry out an independent review of the Human Fertilisation and Embryology Act 1990 via public consultation. As a result of gathered viewpoints, it is hoped a new bill formulating policies on who should have access to reproductive technologies will eventually be put before Parliament to update the Human Fertilisation and Embryology Act 1990. If a new bill emerges, it will be of interest to see whether same-sex couples are acknowledged and how much importance is placed on ‘the need of a child for a father’, particularly following the new guidance on ‘Welfare of the Child’ assessments (HFEA, 2005a).

However, the House of Lords has already condemned any improvement to lesbian treatment. The chairman of the Lords recently stated that ‘this would be a retrograde step – to rule out the requirement for a father in the family – but it suggests once again that ministers have succumbed to the politically correct brigade’ (Daily Mail, 2005). This quote is not dissimilar to a 1978 quote from the British MP Rhodes Boyson who stated, on the subject of lesbian women being allowed to raise children, that ‘this evil must stop for the sake of potential children and society, which both have enough problems without the extension of this horrific practice’ (Golombok, 2005). Whilst these were acute points of view from two politicians, the prejudice against parenthood for homosexuals appears to be on the wane, as exhibited by Parliament’s recent passing and implementation of the Civil Partnership Act 2004 and the Adoption and Children Act 2002.

Any changes to the Human Fertilisation and Embryology Act 1990 as a result of the Government’s public review are unlikely to appear in statute until 2008. Until then, many NHS service providers may exercise their right to continue to operate blanket bans on lesbian couples because they seek fertility treatment for non-medical reasons (Puri, 1997; Saffron, 2002). Others maintain the NHS should continue to restrict fertility treatment to infertile couples only (Blacklock, 1997).
According to the introduction to the HFEA’s latest Code of Practice (HFEA, 2003), one of the factors influencing HFEA policymaking is ‘the right of people seeking assisted reproductive treatment to proper consideration of their request.’ This is expanded upon in Section 3.12, which states, ‘those seeking treatment are entitled to a fair assessment. Treatment centres are expected to . . . have regard to the wishes and sensitivities of all those involved.’

The avoidance of arbitrary or discriminatory criteria is supported by the UK Codes of Professional Conduct for nurses and clinical embryologists, which require their members to respect patients as individuals, irrespective of their sexuality (Association of Clinical Embryologists, 2004; Nursing & Midwifery Council, 2004). However, since acceptance for treatment remains at the individual clinic’s discretion without legal obligation, accessibility to fertility services for lesbian couples remains inconsistent.

In conclusion, this paper has discussed a new concept in fertility treatment for lesbians. Intra-partner oocyte donation is a medical therapy that offers the possibility for a lesbian to give birth to a child that is genetically related to her female partner. If lesbians are given equal opportunities to reproduce using assisted conception technology, and the welfare of any resulting children is satisfied, one may question whether intra-partner oocyte donation should be on offer from the start. British law has recently experienced groundbreaking changes that affect lesbian welfare: firstly, the Civil Partnership Act 2004 now acknowledges legal relationships between homosexuals; and secondly, the Adoption and Children Act 2002 now allows homosexuals to adopt jointly. The question that society urgently needs to address is to what extent homosexual couples should be allowed control over their method of assisted reproduction.

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