well as providing continuous counselling and information for potential donors. Such a body should be independent from clinics providing the procedures and perhaps should direct the donors towards the nearest hospital for them to donate oocytes. It should also take into account the waiting list of different clinics. Private agencies that help recruit donors and pay them either directly or indirectly should be outlawed, as the survival of both systems at the same time would be impossible.

Ahuja and Simons (1996) imply that, if the recipient were to help in recruiting donors, this would be either undignified or financial strings would be attached. I feel that this is an unjustifiable accusation, as it is important that their pioneering work in the UK should not be considered the only way to conduct oocyte donation. Successful clinics will encourage the recipients to become part of the recruitment force, and if we recognize that the primary objective is increasing public awareness of the need for donated oocytes, then who is more interested or motivated to participate in such an effort than those who are in need of the procedures themselves.

We strongly encourage anonymous donation, so much so that when a sister or friend comes to help a relative we try to direct them towards donating to the pool of oocytes, thereby bringing their friend or relative to the top of the list. We must however, recognize that there is a great diversity in the morals and beliefs of people, so much so that some of them prefer, and indeed in some cases will not accept, anything but known donation. Provided that all concerned are extremely well counselled we should be obliged to provide the procedure, if we, as the couples' carers, are satisfied that all concerned understand the implications of their actions and that plans have been made about how the child will be informed (or not informed) of their origin. The adoption of a paternalistic attitude towards patients, with the notion that doctors know best, or the assumption that these couples do not examine the issues involved, is incorrect and smacks of a high degree of arrogance.

Finally, the more that society understands and accepts that infertility is a disease, rather than an inconvenience, and that having a child is a basic human right rather than a desire, the more we will be able to increase the supply of benevolent donors of both sexes.

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Oocyte donation using 'known' donors: it may seem the convenient answer but who pays?

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In different countries, with differing systems of medical funding, the attempted 'encouragement' of women willing to donate ooctyes is going down differing paths. Certainly in the USA with minimal financial support for assisted reproductive technology (ART), there are an estimated 2500 cases of oocyte donation annually (Sauer, 1996) with payments to the donor of up to $2500. In such an unregulated system, concern has been expressed about possible questionable practices developing. In the UK, the law allows £15 plus reasonable expenses (Ahuja and Simons, 1996) and the process is much more regulated.

In Australia, ART receives a government subsidy such that it is relatively inexpensive. In order to impose some control however, a limit of six cycles going to ooctye retrieval is applied. There is no limit to the number of frozen embryo transfer cycles. Therefore, some females who are undergoing stimulated cycles for themselves are less inclined to share oocytes, as it may compromise one of their own precious six cycles. In addition, there is the uncertainty following the recent establishment of 'contact registers' for adoption tracing, particularly using retrospective legislation. One state in Australia has already applied similar legislation to children conceived by donor gametes. Hence, it is probably understandable that in Australia there were only 331 donor oocyte cycles in 1992, (342 in 1993) compared with over 10 000 stimulation cycles.

It is now almost impossible for our unit to obtain sufficient oocytes from anonymous sources to treat women with a history of inherited diseases or premature ovarian failure. Demand from other women, whether peri-menopausal (aged >42 years) or menopausal (up to 50) cannot be met.

We are attempting to make up for the short-fall by asking the couples to provide a 'known' donor, usually a younger sister or friend. Experience with this has shown this is not necessarily an easy way out and we will quote two cases demonstrating complications involving financial and psychological costs. In our donor programme, we prefer the oocyte donor to be <38 years, and have completed her family. The last requirement is in case she proves to be infertile or prematurely menopausal herself in the future. As well as screening for infectious diseases in the donor and her partner, additional costs (frequently underestimated) are created by the time required for adequate preparation of donor and recipient couples.

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Of the 20 couples from our programme, two have spontaneously reported problems to us. As yet, there has been no follow-up of the other cases, so the frequency of occurrence cannot be reported with confidence. The two cases which we wish to refer to here (where all the above criteria were met), resulted in two normal pregnancies and three normal babies, but left four families with unresolved and ongoing problems.

Case 1: donor pressure to discard

The recipient was 29, with a premature menopause on presentation. Her sister (the donor) lived overseas with her husband and two children. They had completed their family. The family travelled from overseas for the donation cycle which resulted in the birth of normal twins. The donor became depressed due to lack of recognition from the recipient. The recipient wished to have a frozen embryo cycle, but the donor claimed that she was selfish for wanting more children. The embryos were discarded due to pressure from the donor.

Case 2: recipient denial and husband anger

The recipient was 32, with premature menopause. The donor had been initially recruited as a 35 year old when single, and promised to donate after marriage and childbirth. This went according to plan, but the donor's husband now claims that she is distressed by being excluded from the recipient's social activities and is upset that the child is not being told of the genetic origins as previously agreed The donor's husband blames the unit for 'starting it all', but does not want the unit to initiate counselling.

It is not unusual for the anniversary of an event or significant date to trigger an emotional response, which is referred to as a grief reaction. In case 1, the initial grief reaction for the donor was triggered by the birth of twins, and the disclosure of the crisis to the unit coincided with the anniversary of the donor's stimulated cycle. In case 2, the 'cry for help' from the donor's husband occurred 1 month before the baby's first birthday and then again 1 month after the baby's second birthday. Does this suggest that families and units could be 'paying the price of donation' on an annual basis. Is it the unit's responsibility to be pro-active about the long-term follow up of this unique style of the extended family, and if so at what cost?

The ART government subsidy does fund the donor for the medical component of her ART cycle (even though she technically has no medical condition), like it funds bilateral nephrectomy for kidney donation. However, there are the other costs for counselling that are not covered, and in a known donor situation issues must be discussed thoroughly and at length if a disaster is to be avoided. The long-term financial and emotional costs in these two cases have been considerable and some were unpredictable.

Whichever system is used, the question remains: who should pay? Is it the unit's responsibility to provide long-term information and counselling (at some cost)? This may be the government in Australia or the donor and recipient couples in the USA. If the known donor option is pursued, then care and time must be devoted to adequate counselling and long-term follow-up. This research may show that donors may 'pay' due to long-term regret, and that children may 'pay' with genealogical bewilderment if secrecy is maintained. The financial and psychological costs of known ooctye donation are still being calculated, but where do we send the account?

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