

**Written Responses to the Consultation Paper on
“Donation of Human Eggs for Research”**

Organisations / Institutions / Fertility Clinics

1. The Catholic Medical Guild of Singapore
2. Christopher Chen Centre for Reproductive Medicine
3. Graduates' Christian Fellowship
4. Institute of Bioengineering and Nanotechnology
5. Institute of Mental Health
6. The Law Society of Singapore
7. Majlis Ugama Islam Singapura
8. National Council of Churches of Singapore
9. National Dental Centre Institutional Review Board
10. National Medical Ethics Committee, Ministry of Health
11. Noel Leong Fertility & IVF Clinic
12. Singapore Eye Research Institute Institutional Review Board
13. Singapore Nursing Board

Individuals

14. Mr Farhan Ali
15. Professor Chan Soh Ha
16. Dr Chuah Khoon Leong
17. Mr Patrick Goh
18. Dr Alexis Heng (2 sets of comments)
19. Dr Suresh Nair
20. Professor George Wei
21. Associate Professor Allen Yeoh
22. Member of the Public 1
23. Member of the Public 2

Bioethics Advisory Committee
11 Biopolis Way, #10-12 Helios
Singapore 138667

The Catholic Medical Guild of Singapore
2 Highland Road
#01-05 Catholic Archdiocesan Education Centre
Singapore 549102

Dear Sirs,

RE: Donation of Human Eggs for Research

We are grateful for this opportunity to provide feedback on the above issue.

Attached is the submission of The Catholic Medical Guild of Singapore.

Dr Gabriel Seow
Deputy Master
The Catholic Medical Guild of Singapore

DONATION OF HUMAN EGGS FOR RESEARCH

We are grateful for this opportunity to provide feedback on the above issue.

We agree with the BAC that the safety and welfare of donors are paramount, and that they should be “adequately safeguarded regardless of their status.” We also agree with the BAC that another concern in this issue is the “possibility that vulnerable women may be exploited, through various forms of inducement to provide eggs for research.”¹

These are valid concerns, and we are glad that the BAC has brought them up in the course of discussion on the subject.

We base our discussion on certain universally accepted moral principles.

PRINCIPLES:

1. Every human being is to be respected for his own sake and cannot be reduced in worth to an instrument for the advantage of others.²
2. His rights as a person must be recognized and respected from the first moment of his existence. The first of these is the inviolable right to life.³
3. As we accord the human person immense dignity, the pursuit of science as a means to improve the human condition, to treat disease, and to save human life is laudable and to be encouraged. However, the primacy of human dignity must always be maintained.
4. Science, powerful instrument that it is, remains but a tool to be ethically used to serve man, and never the reverse. Not everything that is scientifically possible is for that reason morally permissible. Ethics committees exist because we recognize the fact that the pursuit of science without a right conscience can only lead to humanity’s ruin.⁴
5. Informed consent is an important, but not the only, condition for an act to be considered ethically sound. Other considerations include that of ascertaining that the act, for which informed consent is given, is one that is good in itself.

SAFETY OF DONATION OF HUMAN EGGS

There is genuine concern about the possible harm that can befall women who donate their eggs, in particular the problem of Ovarian Hyperstimulation Syndrome (OHSS),

¹ BAC Consultation Paper on Donation of Human Eggs for Research, point 4.

² Donum Vitae, I.5

³ Donum Vitae, I.1

⁴ Donum Vitae, I.2

which can range from mild to severe life threatening forms. In addition, we also note the BAC's concern that ovarian stimulation "may lead to an increased risk of future cancers of the breast, ovary and uterus."⁵

Even though it may be argued that the risk of such serious side effects may be small, the fact is that these risks are real. Furthermore, considering that many, many women are required to donate their eggs in order that enough eggs are produced for research purposes, the absolute numbers of women who suffer such serious side effects will increase accordingly.

PAYMENT FOR DONATION OF HUMAN EGGS

Financial compensation for egg donors is a means of encouraging women to donate their eggs in spite of the medical risks and inconvenience of doing so. Even though the commercialisation of human body parts is illegal, it is possible that the most likely contributors for the procedure of egg harvesting would be women in need of the accompanying financial gain, that is, women from lower socio-economic strata.

Furthermore, such practice will encourage us to see humans, in particular women, as mere commodities, where a price has been put on their bodies and their parts. In this way too, the perception that others can be instrumentalised for our benefit will take root, with long-term negative implications for society.

IMPACT ON THE MEDICAL COMMUNITY

"Do no harm" is the core ethical norm that is upheld by the medical profession. The goal of medicine has traditionally, and rightly, been to "cure sometimes, relieve often, and comfort always."

Once the sale of human eggs is legislated and doctors get involved as co-operators in this trade, this core ethical norm of the medical profession will be violated.

Doctors may be seen to be opportunistic professionals who are prepared to cause potentially significant harm to their patients (donors) for the sake of financial or scientific gain. The unique doctor-patient relationship, one that has been based on trust in the former's interest in the welfare of the latter, may likely be compromised.

THE USE OF DONOR EGGS FOR CLONING/STEM CELL RESEARCH

While donated human eggs can be studied without being fertilized, we note that the main use of donor eggs has been in the area of cloning for stem cell research. This

⁵ BAC Consultation Paper on Donation of Human Eggs for Research, point 25.

involves the creation of a new human being through the insertion of a nucleus from a somatic cell into an enucleated oocyte (somatic cell nuclear transfer or SCNT). It is followed by the destruction of this new human individual in the blastocyst stage, in order to obtain its stem cells for research. This is done in the hope that such work will yield treatment for diseases such as Parkinson's disease, Alzheimer's disease and diabetes.

We fully support the research and development of new treatment options for diseases in order to improve the human condition. We affirm that such research should only be conducted in a fully ethical manner, which does not compromise the dignity of any human being at any stage of his life. In particular, we find morally unacceptable the practice of creating new embryos through SCNT, parthenogenesis, variations of chimerisation or any other method and subsequently destroying them or manipulating them for research.

At this juncture, we also note the following problems with SCNT as it is practised:

1. The stem cells derived from this procedure share the same problem as other embryonic stem cells, namely that of tumour formation. This problem has been a bane to scientists involved in embryonic stem cell research, and despite the best efforts of scientists the world over, appears to be one that is extremely difficult, if not impossible, to surmount.
2. There are serious ethical concerns with SCNT, in particular the fact that human beings are cloned with the view to their being destroyed in order that their stem cells be utilized for research.

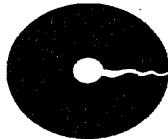
In fact, such concerns have been serious enough to prod many scientists to pursue other more scientifically viable, and in particular, more ethical, ways of obtaining stem cells for treatment.

Stem cells from adult sources (such as the bone marrow and umbilical cord) have seen many exciting new developments in research and therapy in recent times.

Dr Ian Wilmut, who led the team that created Dolly the cloned sheep, made a statement recently. For scientific reasons, he was abandoning human SCNT to pursue research in the area of "direct reprogramming" of adult human cells to generate stem cells known as induced pluripotent stem cells (iPSCs), a method pioneered by Dr Shinya Yamanaka of Kyoto University in Japan. While it is regrettable that embryonic stem cells were utilized in the process, the development of iPSCs points to the fact that adult cells can be used in many more ways than previously imagined. It adds to the view that therapy can indeed be developed while avoiding the ethical problem of destroying human embryos to obtain stem cells for research.

CONCLUSION

We thank the BAC for this opportunity to provide feedback on this important issue of financial compensation for egg donation. We strongly urge the BAC to look seriously into its implications on women's health, safety, and status. We, as doctors and scientists, are edified by research that is steered in a direction that respects the life of every human being in all states and stages.



CHRISTOPHER CHEN

CENTRE for
REPRODUCTIVE
MEDICINE
PTE LTD

ROC No: 199301062 H

5 January 2007

Professor Lee Eng Hin
Chairman
Human Embryo and Chimera Research Working Group
Bioethics Advisory Committee
11 Biopolis Way
#10-12 Helios
Singapore 138667

Dear Prof Lee

INVITATION TO COMMENT ON CONSULTATION PAPER

Thank you for your letter of 7 November 2007 inviting me to comment on the consultation paper entitled "Donation of Human Eggs for Research".

At the outset, BAC must be very clear and direct in its final recommendations to the SCLS as both the scientific investigators and the public require clear directives over the issue of donating human eggs for research. Whilst various countries around the world may have their own rules and regulations, we in Singapore must produce our own rules and regulations to suit our local conditions. To further emphasize the issue, we need to make up our minds and the BAC must ultimately give clear directions. There is no room for vacillation.

Singapore, undoubtedly, is trying to project itself as one of the world leaders in scientific research and progress, having invited top scientists to work here to supplement our local ones. It is therefore clear that Singapore must provide favourable conditions to realise its goal, and in the national interest. Biomedical research must therefore be given a helping hand.

It is very clear that human eggs are required for research, especially for embryonic stem cell research. The BAC must therefore keep this objective in mind, whilst at the same time not go overboard but keep within the confines of ethical, legal and social acceptability.

In order to obtain and increase donation of human eggs for research, it is of paramount importance that the right message be given to the public, promoting the public to donate eggs in the national interest, for research. We should avoid negative publicity.

For practical purposes, a realistic and major source of human eggs for donation will come largely from spare eggs during IVF treatments. Patients can be encouraged to donate their spare eggs; it is important that informed consent be obtained and that they be given full explanation as to what will happen to their donated eggs when used for medical research. Only after they have given their signed and informed consent should they be given monetary assistance to subsidise part of their expenses in their IVF treatment. This will overcome any criticism of obligation or inducement to donate their eggs.

The possibility of healthy females who wish to donate their eggs for medical research and who are not undergoing IVF treatment will be remote, if not exceptional. For those who are altruistic enough, they should be encouraged, and any potential obstacles removed.

An area that has not been given focus is the donation of **immature** eggs. IVF technology is continuing to advance, and one source of eggs for research which can be obtained, (perhaps in the not too distant future) can be further matured in the laboratory and then used for embryonic stem cell work. Women who require laparoscopy for investigation of infertility can donate some immature eggs during the procedure for medical research, which can also provide information to them about their egg quality. This information will be helpful in the further management of their infertility problem. I suggest the BAC pay some attention to this avenue of egg donation.

Thank you for your attention.

Yours sincerely



PROF CHRISTOPHER CHEN

Honorary Professor, School of Medicine, University of Queensland, Australia

Professor, Faculty of Health, School of Biomedical Sciences, University of Newcastle, Australia

Honorary Professor, Ricardo Palma University, Lima, Peru, South America

Honorary Professor, Sri Ramachandra Medical College & Research Institute, Sri Ramachandra University, India - A Harvard Medical International Associated Institution

World President Elect, International College of Surgeons, USA

CEO & Medical Director, Senior Consultant Obstetrician & Gynaecologist and Infertility Specialist, of Christopher Chen Centre for Reproductive Medicine

Director of Gleneagles IVF Centre, Gleneagles Hospital



To: Bioethics Advisory Committee
11 Biopolis Way, #10-12 Helios
Singapore 138667
Attn: Prof Lee Eng Hin

RE: Response to the Consultation Paper fro Donation of Human Eggs for Research
dtd 7th Nov 2007

The Graduates' Christian Fellowship (GCF) thank the Bioethics Advisory Committee (BAC) for your invitation to comment on the above mentioned paper. We applaud the continued efforts of BAC to ensure high ethical standards in a very delicate balance of pushing for cutting edge research for the possibility of saving and enhancing lives and protecting dignity of human lives.

It has been our position, as in the last submission, that GCF is not in favor of Embryonic Stem Cell Research (ESCR) because it involves the creation of a human life and subsequently the killing of it. It is also very sad that for an endeavor which for the time being (and after much financial and human resource) has not yielded any therapies that could be used for the cure of any existing disease. In the meantime, many lives had been sacrificed.

The key to this paper as we read it has one presenting issue and two main points; the lack of eggs to create embryos for ESCR and 1) should women be allowed to donate their eggs for research and 2) should there be payment for such donations?

Need for Human Eggs

We are certain that BAC has been keeping tabs with the most recent development in the Adult Stem Cell Research (ASCR) which was announced probably after the completion of the above mentioned consultation paper. These recent developments is critical in our response as we see the recent breakthrough by Prof James A. Thomson and his colleagues at the University of Wisconsin in Science and by Prof Shinya Yamanaka of Kyoto University and the Gladstone Institute of Cardiovascular Disease in San Francisco in Cell as the answer for the need for the presenting issue, the lack of human eggs.

We see that research institutes require the need for embryonic stem cells because of their pluripotent nature. It is stated in your paper that, 'There is currently little evidence that adult stem cells are pluripotent.' The above recent breakthroughs have found techniques which can manipulate adult stem cells so that they become pluripotent in nature. **There is therefore no real or critical need to harvest widely for human eggs from healthy women.**

This side steps most the ethical mine fields which currently plagues us in both the limitations to research and preserving the dignity of human lives. Though in its'



preliminary stages, we believe that this will be the new way forward to conduct future research which will be based on adult stem cells that are pluripotent in nature. Rather than putting much financial and human resources in the harvesting of human eggs and risking the lives of healthy women in the process, we implore the BAC to advise our government and biotechnology research institutes to develop and stabilize these new techniques and lead the way forward for biotechnological discoveries.

To quote Scottish stem cell pioneer Ian Wilmut (who led the team that in 1997 cloned Dolly the sheep) in his response reported in the Boston Globe regarding these new discoveries by Thomson and Yamanaka, announced that ‘his University of Edinburgh laboratory will abandon embryonic cloning in favor of reprogramming. Wilmut, in remarks to journalists, said he is motivated not by ethical concerns, but by the conviction that Yamanaka’s approach holds better chances for near-term scientific research and long-term medical therapies and cures. “The technique of changing cells directly from a patient into stem cells, without the step of making a clone, has better potential,” he said. “Plus, it’s socially more acceptable. This is the way science is going.”¹

Should women be allowed to donate eggs for research?

Deriving from our constant position that the beginning of a human life is at conception, and further from our view point in the above section, **GCF is not in favor to further harvest human eggs from healthy women.** We concede as a compromise that women who are currently undergoing IVF treatment can choose to ‘sign over’ surpluses for research with informed consent as is currently practiced. This compromise is with the view that these surpluses will otherwise be destroyed anyway.

We have found that there was no statement in the paper of any particular target number (women per year for example). It was only mentioned that ‘the risk of egg retrieval is relatively low’. Some facts and figures would be very helpful for assessments of the risk and provides objectivity to the proposal. According to a report from the World Health Organization, ‘The worldwide incidence of severe OHSS has been estimated at 0.2%–1% of all ART cycles (206) and the associated mortality at 1:45 000–1:50 000 per infertile women receiving gonadotrophins (207).’² It was cited in an article by Dr. Pia De Solenni of the Family Research Council in Washington D.C that ‘If we return to the lowest number of women required in order to use embryonic stem cell treatments for diabetes in the US, just one disease, 29 million women, that would translate into 580 deaths.’³ It is therefore only reasonable for us to ask, how much risks are we talking about precisely. We need to make sure that we are not knowingly taking lives in order to ‘potentially’ save lives. It does not make logical sense. One death is one too many, especially when the person is a healthy individual.

¹ Colin Nickerson, Breakthrough on stem cells. Boston Globe, 21 November 2007

² Jean-Noel Hugues, <http://www.who.int/reproductive-health/infertility/14.pdf>

³ Dr. Pia De Solenni, www.humanevent.com.



In view of the risks which the consultation paper have presented and the complexity of the procedure to stimulate eggs growth and donors subjection to multiple injections of Lupron™ (leuprolide acetate), we are of the view that 2 critical matters were not mentioned and could be enhanced.

- 1) There is insufficient clarity on the risks and side effects that are involving the use of leuprolide acetate as clearly spelled out in FDA web-site.⁴ Such information will also help access the risks involved, particularly for those who intend to make such a donation.
- 2) There is also no mention of restrictions as to how many times a year can someone donate eggs.
- 3) The onus of responsibility for medical expenses and future healthcare has to be absorbed by the government agency in the event of a reaction or complication due to the extraction procedure for human eggs. We believe there is currently insufficient safeguards to protect the women who are targeted as donors. There has been cases where women were not given proper aftercare due to Ovarian Hyperstimulation Syndrome (OHSS).

Anyway, the primary use of Lupron is to reduce the amount of testosterone or estrogen in the body. It is used for conditions such as cancer of the prostate, endometriosis (growth of uterine lining outside of the womb), uterine fibroids, and early puberty (before 8 years of age in females and 9 years of age in males).⁵ According to FDA approval, it was not specifically used for ovarian stimulation in the first place. Approval was given for

- 1) the management of endometriosis, including pain relief and reduction of endometriotic lesions; and**
- 2) preoperative hematologic improvement of patients with anemia caused by uterine leiomyomata (fibroids) when used concomitantly with iron therapy.**

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There was no specific mention of ovarian stimulation for human eggs extractions.

Should Women receive any payment for egg donation?

GCF is of the view that women who come forward should be reimbursed but not compensated.

⁴ http://www.fda.gov/medwatch/SAFETY/2004/oct_PI/Lupron_PI.pdf.

⁵ <http://www.drugs.com/lupron.html>

⁶ http://www.fda.gov/cder/foi/nda/97/20708_LUPRON%20DEPOT%203-MONTH,%202011.25MG_APPROV.PDF



We appreciate the BAC for making clear in section 39 of the 3 approaches and we affirm that there should be no substantial compensation (approach c.) that amounts to outright payments.

Our suggestion is to follow from current practices from Healthcare Services Authority (HSA) at the Center for Transfusion Medicine. Previously, blood donors were compensated with medical benefits at polyclinics. However, such practice was taken away due to abuses in the system. Currently, blood donation is mostly an altruistic act. Donors are not even reimbursed and have to pay their own way to the donation centers although schools give out CCA points and military provide days off or light duties at times.

Reimbursements such as transport and food would deem acceptable. Provisions for days off in collaborations with companies are also acceptable. However, it is impossible to gauge the 'proper' level of compensation for loss of earnings. For some, such 'compensation' amounts to 'significant salary', particularly a person from the low income group. Take for example the Ethics Committee of American Society for Reproductive Medicine guideline of USD 5000 is equivalent to 3 months pay for a single mom family, particularly if she is not able to find employment.⁷

On whether foreigners should be allowed to make egg donations, **GCF is of the view that only Singaporeans and Permanent Residents should be allowed to donate and not foreigners or work pass/permit holders.**

This stems from the wide socio-economical gap between Singaporeans / PRs and foreign workers in our midst. For example, domestic helpers (maids) receive only approximately S\$250 to S\$350 per month for their long hours of services. 'Compensation' for S\$100 as an example, is therefore very significant, though for many Singaporeans and PR may seem like a 'fair' amount.

The long term healthcare of donors is also another factor which as a caring and gracious nation which we aspire to be, need to manage the complications and side-effects of the extraction procedure. This can only be taken care of for Singaporeans and Permanent Residents. We will not be able to provide such longer term healthcare for foreigners and foreign workers. The cost of such after care will also have significant impact on taxpayers depending on the target number of donors required.

We also need to be wary of accusation by foreign governments in falsely charging Singapore in exploiting their people, particularly for Singapore who intends to be one of the leading countries for ASEAN. The costs, economically, socially and politically is great in return for the benefits of ESCR which at this point has yielded little.

⁷ The portion of Americans living in poverty declined to 12.6% in 2005...about 37 million people lived in poverty in 2005. Poverty was defined as annual income of \$19,971 or less for a family of four. (USA Today, 29 Aug, 2006 by Dennis Cauchon)



Conclusion

GCF strongly proposes the BAC to consider and advice government to take a fresh look into Adult Stem Cell Research as to Embryonic Stem Cell Research. Re-direct resources for ASCR and save significant time, money and literally pain (for going through the extraction procedure) of our people. This will not only side step many ethical issues but also put our research in pace with cutting edge research and methodologies. This approach to research using reprogrammed adult stem cell will also preserve the dignity of human lives rather than prancing on the edge of an ethical cliff from which our fall will mean loss of or significant scaring of lives.

Presented by

A handwritten signature in black ink, appearing to read "Timothy Liu".

Timothy Liu
President for 2007-2008
On Behalf of the Graduates' Christian Fellowship.



Institute of
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25 November, 2007

Professor Lee Eng Hin
Chairman
Human Embryo and Chimera Research Working Group
Bioethics Advisory Committee

Dear Professor Lee:

I am writing in response to your letter, dated on 7 November, 2007 to Professor Jackie Ying, Executive Director of Institute of Bioengineering and Nanotechnology (IBN), inviting to comment on the consultation paper entitled "Donation of Human Eggs for Research". I am a group leader in IBN working in the area of human embryonic stem (hES) cell bioengineering and glad to be given this opportunity to share with you our thoughts as follows.

Dedicated to improving the health and quality of life, Institute of Bioengineering and Nanotechnology (IBN) focuses its research activities on the following six areas:

- Pharmaceuticals Synthesis and Nanobiotechnology
- Delivery of Drugs, Proteins, and Genes
- Cell and Tissue Engineering
- Artificial Organs and Implants
- Biological and Medical Devices
- Bioimaging and Biosensing

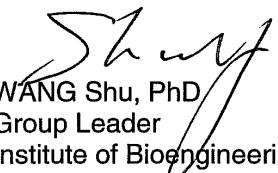
Although we are not directly involved in generating hES cell lines, several aspects of our on-going studies in IBN involve the use of hES cells, mainly in the areas of cell and tissue engineering, and delivery of drugs, proteins and genes.

Almost all existing hES cell lines were isolated from human embryos generated from fertilized human eggs during *in vitro* fertilization (IVF). Alternatively, somatic cell nuclear transfer (SCNT) has been proposed to produce genetically personalized hES cell lines, in which the nucleus of an unfertilized egg is replaced with the nucleus from a somatic cell. The method holds great promise both for understanding human developmental biology and disease development/progression, and for regenerative medicine with organ and tissue replacement. However, the efficiency of deriving hES cell lines in this way is estimated to be extremely low, requiring about 100 human eggs to generate a customized hES cell line for a single individual. This is why human eggs become highly sought after, which further triggers the concern in compensating egg donors.

Fortunately, advances published in the journals *Science* and *Cell* last week in the area of stem cell research have totally changed the landscape. The new method creates pluripotent human stem cells by gene delivery of 4 functional genes to reprogram human somatic cells, eliminating the use of human eggs. The advance overcomes ethical, political and practical obstacles in the generation and use of hES cells. Facing this successful breakthrough, even the British creator of the cloned sheep Dolly, Dr. Ian Wilmut, has voiced to abandon SCNT technique for cloning human cells.

With this progress, I would suggest reconsidering the issue raised in the consultation paper of "Donation of Human Eggs for Research" and placing more emphasis on issues related to the new technology. For example, gene transfer into human somatic cells to produce human stem cells will become a hot topic in stem cell research. Somatic genetic modification is also viewed as gene therapy. The related issues were discussed before by the Bioethics Advisory Committee under Human Genetics. We probably need to revisit the issues by incorporating the considerations based on the recent progress in human stem cells. In terms of the use of human stem cells, these cells have been tested for transplantation into human bodies, with some of these stem cells being genetically modified before the transplantation. While the general issues have probably been covered in the sets of recommendations for Human Genetics, the genetic manipulation of stem cells might need to be discussed separately.

Sincerely yours,


WANG Shu, PhD
Group Leader
Institute of Bioengineering and Nanotechnology

cc: Prof Jackie Y. Ying, Executive Director
Noreena AbuBakar, Director, Administration



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13 Dec 2007

Professor Lee Eng Hin
Chairman
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Dear Professor Lee

**INVITATION TO COMMENT ON CONSULTATION PAPER
IMH'S COMMENTS**

Thank you for inviting IMH's comments.

Our views (which are the consensus of myself, the VCMBs, and the Clinical Chiefs), in respect of paragraph 5 of the Consultation Paper on "Donation of Human Eggs For Research" are:

(a) Healthy women not undergoing fertility treatment should be allowed to donate eggs for research so long as

- all steps are taken to protect their interests and safety,
- they are mentally fit to give consent,
- informed consent is properly taken by a third party who is not involved in the research

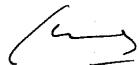
(b) Egg donors should be compensated for their time (including loss of earnings), inconvenience and risk. If individuals were sufficiently altruistic to volunteer as donors, it is fair to compensate them appropriately but not excessively so as to avoid any suggestion of inducement. Compensation should include the full costs of medical treatment incurred as a result of adverse events from the egg donation. Donors should be compensated on a standard basis that does not discriminate or favour particular groups of women. A team of appropriate professionals familiar with the research process should work out the exact formula for compensation.

(c) Sale of eggs should not be condoned while at the same time, compensation for voluntary donation should not be construed as a commercial transaction. Thus economically disadvantaged populations should not be specific targets of drives to encourage eggs donation. On the other hand, financially challenged volunteers should not be rejected on the basis of their financial status; eligible women should be afforded the opportunity to decide for themselves if they wished to donate. We acknowledge that the line between altruism and financial gain can be blurred in some situations but the onus is on the researchers not to specifically target the vulnerable population.

(d) Women without the mental capacity to make informed decisions should be excluded from voluntary donation. Consent for the donation may have to be taken by a medical practitioner in this respect. It is appropriate for the Ministry of Health to set up regulatory mechanisms with the relevant interested bodies to govern the supply and use of human eggs for research.

(e) The potential gains of such research are immense and will benefit millions of people worldwide. Mental capacity, informed consent, proper process of obtaining consent, and adequate (but not excessive) compensation are important to ensure the protection of the donors. Donations should be truly voluntary and entirely free of coercion or threat. An act of altruistic donation may help the donor fulfil a sense of humanity which is immeasurable but can improve self-esteem and actualisation.

Yours sincerely



CI A/P Wong Kim Eng
Chairman, Medical Board
Institute of Mental Health

LS/87/2007

Our Ref:

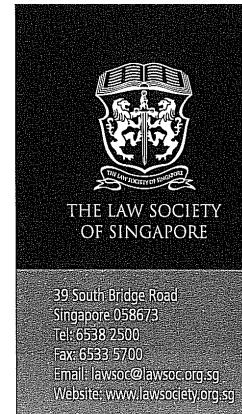
Your Ref:

7 January 2008

Professor Lee Eng Hin
 Chairman
 Human Embryo and Chimera Research Working Group
 Bioethics Advisory Committee
 11 Biopolis Way
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BY FAX AND POST

Fax No. 6478 9956
 No. of Pages: 6
 (including this page)



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Dear Sir

INVITATION TO COMMENT ON CONSULTATION PAPER

We refer to your letter dated 7 November 2007 inviting the Law Society to provide its comments on the issues set out in the consultation paper entitled "Donation of Human Eggs for Research".

The Society appointed an ad hoc committee to review the consultation paper.

We are pleased to enclose our ad hoc committee's feedback on the matter for your consideration.

Thank you for giving the Society the opportunity to give our views on the matter.

Yours faithfully

Alvin Chen
 Director
 Representation and Law Reform

Enc.

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4 JANUARY 2008

**THE LAW SOCIETY OF SOCIETY
AD HOC COMMITTEE'S FEEDBACK ON THE
BIOETHICS ADVISORY COMMITTEE'S
CONSULTATION PAPER ON DONATION OF HUMAN
EGGS FOR RESEARCH**



**THE LAW SOCIETY
OF SINGAPORE**

COMMENTS ON THE BIOETHICS ADVISORY COMMITTEE'S CONSULTATION PAPER ON DONATION OF HUMAN EGGS FOR RESEARCH

1. We have been appointed by the Law Society of Singapore to provide our comments on the Consultation Paper by the Bioethics Advisory Committee ("BAC") on Donation of Human Eggs for Research ("the Consultation Paper").
2. All members of this ad-hoc committee are involved in advising and representing individuals and organisations in the health care industry as part of their legal work.
3. We set out below our views on the issues raised at paragraph 5 of the Consultation Paper, in the order that they appear.

(1) Whether healthy women not undergoing fertility treatment should be allowed to donate eggs for research, and if so, under what conditions

4. It appears that the donation of eggs for research by women not undergoing fertility treatment is currently already permitted. In principle we have no objections to this being so, but are of the view that this should be subject to the following conditions:-
 - (1) detailed and informed consent to be obtained and documented. We would advocate that the consent be obtained by someone other than the healthy donor's doctor;
 - (2) there should not be any undue influence or incentives being paid to the donors;
 - (3) at the same time, we acknowledge that for healthy women who donate their eggs for research, in the event that they suffer injury or some harm as a result of their altruistic actions, they should have recourse to treatment without the burden of paying the medical expenses. We would propose a mandatory no fault based insurance coverage for donors which will provide for full payment of medical expenses in the event of an

immediate complication or risk materialising during the egg collection process as well as a compensation for the longer term risks that can be attributed to the egg donation. We recognise that with regards the risk of future cancer from ovarian stimulation, this appears to be low (paragraph 25 of the Consultation Paper) and that there may be difficulties in establishing that the cancer(s) have been caused by egg donation related procedures. Nevertheless, we are of the view that in principle compensation for these risks should be addressed in line with the current practice for clinical trials.

(2) Whether egg donors for research should be compensated for time, inconvenience and risk, and if so, what type of compensation or monetary amount would be acceptable and not amount to an inducement

5. We recognise that in clinical trials, particularly those involving healthy subjects, subjects are sometimes paid for their time and expenses during the course of their participation in the trial. We are of the view that similarly, some compensation should be paid to healthy women who donate their eggs for research because of the time and expenses that these donors would have to expend. This may indirectly help to increase the number of eggs obtained for research but we do not feel that merely compensating these donors in a modest sum to cover their time and expenses would necessarily amount to an undue inducement to them to participate. What may be appropriate to consider is a reasonable lump sum compensation for the time and inconvenience involved in the process on a per cycle basis and this would also bring this in line with current practices for clinical trials involving healthy participants.
6. We suggest the amount paid to donors be regulated by guidelines which prescribe a limited range of payment.
7. Compensation for risks can take the form of mandatory insurance as discussed above.

(c) Whether there are circumstances in which the compensation for eggs could amount to a sale and if so whether such sale should ever be contemplated

8. Egg donation can be said to be analogous to organ donation. Just as the sale of organs is prohibited under current legislation, the sale of eggs for whatever purpose should also be prohibited.
9. If a donor obtains payment in excess of reasonable compensation for time spent and inconvenience, and stands to profit financially from the donation, the donation could foreseeably amount to a sale. This is to be guarded against.
10. It is also important for there to be no co-relation between the amount of compensation payable and the quantity or quality of eggs obtained.

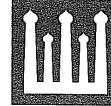
(d) Any prohibitions, limits or regulatory mechanisms that should govern the supply and use of human eggs for research in Singapore

11. Limits on donor age and the number of times a donor may make a donation should be considered. This can help to ensure that the risks to donors are minimized.
12. The issue of mandatory counselling for the donor should also be considered as the donation involves both immediate side-effects and possible long term consequences which are important for the healthy donor to know and deliberate upon. Consent should not be taken by treating physicians but by independent third parties.
13. We also suggest a formal regulatory framework which applies to research institutions, researchers and private companies involved in the procurement of eggs for research, which should all be licensed under the existing legislation and guidelines which apply to centres engaged in in-vitro fertilisation for treatment. This is to prevent a situation where the ethical standards of conduct may vary depending on whether or not the institution is regulated under the Private Hospitals and Medical Clinics Act.

(e) Any other matters related to donation of human eggs for research

14. In considering mandatory insurance, the possibility of donors exploiting the scheme for the benefit of insurance coverage for cancer should be addressed.

Dated this 4th day of January 2008



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11 January 2008

Professor Lee Eng Hin
Chairman
HECR Working Group
Bioethics Advisory Committee
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Dear Prof Lee,

REQUEST FOR FEEDBACK ON CONSULTATION PAPER

We refer to your letter of 7 November 2007, to Haji Mohd Alami Musa, President of Muis.

2 As requested, please find the enclosed attachment for our comments on the consultation paper entitled "Donation of Human Eggs for Research".

3 We hope the comments are helpful in BAC's deliberations on the ethical aspects of the issue.

Thank you.

Yours sincerely,

A handwritten signature in black ink.

Mohd Murat Mohd Aris
Director
Islamic Development
Majlis Ugama Islam Singapura

Feedback from Majlis Ugama Islam Singapura (MUIS)
BAC Consultation Paper
Donation of Human Eggs for Research

Introduction

The Majlis Ugama Islam Singapura (MUIS) has been invited to comment on the issues and recommendations contained within the Bioethics Advisory Committee's (BAC) consultation paper entitled "Donation of Human Eggs for Research". The comments are provided on the following points:

- i. Donation of Eggs for Research by Healthy Women Not Undergoing Fertility Treatment
 - ii. Conditions and Safeguards for Donation of Eggs for Research
 - iii. Compensation for Donation of Eggs
-

I. Donation of eggs for research by healthy women not undergoing fertility treatment

2 Islam encourages research that advances the welfare of human beings and removes harm and difficulties. The Muslim legal philosopher Ibn Al-Qayyim, state that the *Syariah* (Islamic jurisprudence) is established to promote the well-being of mankind in this world and the hereafter. The enhancement of human life by way of scientific research that can lead to the prevention and treatment of diseases is also recognised as an objective of the *Syariah* and a public welfare (*maslahah*) that should be secured.

3 In the pursuit of public welfare, harm must be avoided at all costs. As such, where there is a certainty that a research will be harmful to those involved in it, such as in this case, if a woman who donates her oocyte is certain to be exposed to some form of harm, then she is not allowed to participate in it. This is in accordance with the Islamic legal maxim that states "Removal of harm takes precedence over pursuing welfare/interest (*maslahah*)". However, if both benefits and harm are probable and not certain, then the potential benefits must outweigh the potential harm, in order to warrant the pursuit of such research work.

4 In light of the vast potential in increasing scientific knowledge that can benefit mankind resulting from oocytes donation, as discussed in the Consultation Paper, and taking into account the Islamic principles above, we take the position that healthy women not undergoing fertility treatment should be allowed to donate eggs for research, under the conditions explained in the next section. It is also highly crucial that researchers involved in such research projects exercise a great deal of caution, care and rigour, in assessing whether someone is an appropriate donor, as well as to ensure that the research participants are clear about the risks involved in such donations.

II. Conditions and Safeguards for Donation of Eggs for Research

5 True informed consent and extensive counselling, with regards to the full details of the research in which donors are involved in, as well as the whole donation process, including its medical, physical and psychological aspects, should be revealed and discussed with potential donors thoroughly.

6 Research projects requiring donation and use of oocytes should be carefully and extensively evaluated by the relevant review boards and ethics committees before permission

to proceed is granted. This is to ensure, in part, that such projects do not replicate any past or existing research conducted elsewhere, nor cause any unnecessary requests for donation of oocytes, which may lead to their wastage.

7 The recruitment of nulliparous women or those who have not completed their families as oocyte donors may need careful and further consideration as there is a small risk that the medical procedures involved may cause unintended consequences or side effects, and lead to potential infertility. Thus, the potential donor needs to be fully aware of all possible consequences in the event that she decides to proceed with the donation.

8 The medical risks involved in donation of oocytes should be minimised as much as possible. These may include the following suggested steps:

- a) Individualized medication regimens and close monitoring of research donors are absolutely necessary so as to reduce the probability of the occurrence of ovarian hyperstimulation syndrome (OHSS). Ovulation induction regimens should be adjusted according to a donor's response to previous ovarian stimulation cycles. If the potential donor has previously experienced OHSS, it is highly likely that she will react in the same way in subsequent stimulation cycles. Such potential donor should be rejected as donor, or can receive a safer level of stimulation.
- b) Researchers must opt to exclude certain potential donors altogether if they present high-risk factors such as young age and presence of polycystic ovaries. After all, these donors receive no direct benefit following their donation and the eggs can be obtained from different donors without any major drawbacks.
- c) There should be a general trend towards moderation in ovulation induction regimens to decrease the probability of the occurrence of OHSS. It is best to avoid regimens that lead to overstimulation so as to obtain as many eggs as possible. A well-informed research donor will definitely not want to put herself under the same health risks as an IVF patient since they do not benefit from a maximal number of retrieved eggs. If moderate regimens still lead to strong response in potential donors, the procedure should be abandoned immediately. Careful monitoring is therefore essential to ensure that the procedure is adjusted or cancelled whenever necessary.
- d) Potential donors should also be informed of the risks associated with long term effects on the use of drugs relating to ovarian simulation and egg retrieval. Long term follow-up is necessary to assess any possible dangers. There is also the possibility of cancer development in research donors who reach the age at which hormonally related cancers are common. As data on more recent treatment methods become available for such hormonally related cancers, further research is certainly advised especially those studies focusing on fertile egg donors. This is because infertility may itself be a factor influencing cancer susceptibility that is difficult to correct in research that are based on IVF treatments. Data on adverse effects of the procedure is preferably collected and analyzed by independent physicians. It is also advisable to avoid repeated donations by the same woman as long term effects of drug usage in these procedures are unclear and it is better to err on the safe side.
- e) Follow-up care is very important. Research donors should be entitled to free medical treatment for injuries resulting from research participation and

should be compensated for any resulting impairment, disability or handicap. This is an important issue because their personal health insurance may not want to cover medical expenses resulting from a procedure that was carried out without medical indications or necessity. Thus, research centers should guarantee free follow-up care for their research donors such as ensuring generous insurance coverage.

III. Compensation for Donation of Eggs

9 Islam does not allow for the commodification of the human body, or parts of it, as the Islamic theology teaches that the human body belongs to God. Oocytes fall under this category. However, Islam allows for the compensation of an individual for a work accomplished, or a contribution offered. Compensation or reimbursement for oocyte donation should be carried out to not only redress the burdens and inconveniences suffered by donors, but also to acknowledge their contributions. This is especially fair since the commercial potential of stem cell research is expected to be vast, but like all research subjects, oocyte donors have no ownership rights, nor are they considered stakeholders in any resulting technology and so will not share its financial or other benefits.

10 However, the shape of manner such compensation or reimbursement takes will need to be cautiously drawn so as not to represent unjustified financial inducement or undue psychological pressure. This will also help to prevent the exploitation of low-income women who may otherwise be inclined to become donors for monetary gains.

Co. Reg No. ROS 146/51/REL



National Council of Churches of Singapore

新加坡基督教會協會
சிங்கபூர் திருச்சபைகளின் தேவை மன்றம்

3 January 2008

Professor Lee Eng Hin
Chairman
Human Embryo and Chimera Research Working Group
Bioethics Advisory Committee
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Dear Prof Lee

Donation of Human Eggs for Research

Thank you for seeking feedback from the National Council of Churches of Singapore on the above subject.

We enclose herewith our response to the Consultation Paper on "Donation of Human Eggs for Research."

We trust that this feedback will receive careful and serious consideration.

Thank you.

Yours sincerely

Bishop Dr Robert Solomon
President
National Council of Churches

"Many members... One Body... with Christ." 1 Cor 12:12

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**Response to the Bioethics Advisory Committee's
Consultation Paper entitled, *Donation of Human Eggs
for Research***

Presented by the National Council of Churches of Singapore

The National Council of Churches of Singapore (NCCS) is grateful to the Bioethics Advisory Committee (BAC) for the opportunity to respond to the consultation entitled, *Donation of Human Eggs For Research*. It is encouraged by and welcomes the BAC's attempt to promote public discussion and consultation on this important issue. In this response, the NCCS wishes to address the two fundamental issues presented by the paper, namely, (1) should women be allowed to donate their eggs for research? and (2) should there be payment for donating eggs for research?

DONATION OF HUMAN EGGS FOR RESEARCH

Although the focus of this consultation paper is egg donation and the welfare of donors and not the ethical implications of the research itself, the NCCS must reiterate its position on embryonic stem cell research (ESCR). This is because the view taken by the NCCS regarding such research has direct bearing on its position regarding egg donation.

The NCCS maintains that ESCR, which involves the destruction of human embryos, should be prohibited. This is because human life begins at conception, and the human embryo, regardless of its age, is worthy of the respect and dignity accorded to all human beings. The NCCS therefore rejects the distinction between embryo and pre-embryo as academic and arbitrary because it fails to take seriously the ontological status of the being in question. In similar vein, the NCCS rejects the distinction between therapeutic and reproductive cloning because the cloning process is the same in both 'types'. The only difference is the intended use of the manufactured embryo. For the same reasons, the NCCS maintains that the creation of human embryos through parthenogenesis should be prohibited. Although some ethicists have argued that this method of manufacturing embryos poses less ethical problems because the parthenote is not considered a human person, the NCCS finds this line of argument untenable.¹ The primary reason as to why procuring eggs from women for the manufacturing of embryos for research should be prohibited is that such research results in the destruction of human beings.

There are other reasons why women should not donate their eggs for research. The procedure that is currently employed to obtain eggs from donors involves considerable risks. Some of these risks are discussed on page 9 of the consultation paper. One of the main health risks associated with egg donation is that donors may develop a condition called ovarian hyper stimulation syndrome (OHSS). While according to the paper, 'the risk of egg retrieval is relatively low', it does continue to be a serious problem for specialists working in the field of infertility. As Annick Delvigne and Serge Rosenberg have pointed out, 'as this is an iatrogenic complication of a non-vital treatment with a potentially fatal outcome, the syndrome remains a serious problem for specialist dealing

¹ Presently the human parthenogenic embryo is unable to complete gestation unless it is combined with normal trophoblast cells, the outer ring of cells in an early embryo that ultimately form the placenta. But the gestational incompetence of the parthenote due to lack of the paternal 'imprinting' of genes should not lead us to conclude that it is therefore a 'lesser human' or 'not human at all'. The NCCS maintains that the parthenote who contains the full human DNA complement but is unable to complete gestation must be viewed as a human being, albeit one with serious genetic flaws. The NCCS opposes the parthenogenic creation of human embryos for the purpose of experimentation and research. It maintains that parthenogenic embryos already created must be given the same respect that is due to an incapacitated person or a person with serious genetic flaws.

with infertility'.² The former Chief Medical Officer at the Food and Drug Administration (FDA), Dr Suzanne Parisan, describes other risks associated with OHSS:

OHSS carried an increased risk of clotting disorders, kidney damage, and ovarian twisting. Ovarian stimulation in general has been associated with serious life threatening pulmonary conditions in FDA trials including thromboembolic events, pulmonary embolism, pulmonary infarction, cerebral vascular accident (stroke) and arterial occlusion with loss of limb or death.³

The common drug used on egg donors is Lupron™ (leuprolide acetate). A range of side effects associated with this drug has been reported to the FDA.⁴ This is not mentioned in the consultation paper, but such information is important for a closer assessment of the risks of egg donation. Such information is also vital for healthy women who are considering donating their eggs for research. The hormones used to stimulate ovaries to produce eggs such as gonadotropins, human chorionic gonadotropin therapy and gonadotrophin-releasing hormone (GnRH) agonists are known to produce adverse side effects ranging from headaches to organ damage.

Alongside these risks human embryonic stem cells have enjoyed little success in clinical trials. Even in animal models of disease they not only have a lacklustre success but have also in fact carried significant risks including immune rejection and tumour formation. Thus in its December 2006 response to the British Human Fertilisation and Embryology Authority's (HFEA) consultation paper on 'Donating Eggs for Research: Safeguarding Donors', the Scottish Council of Human Bioethics states that '[T]he potential value of research on embryo is over-stated. Although the reasons given to justify embryo research are usually that it will lead to cures of various serious disorders, any benefits are, at best, likely to be in the distant future and there are grave doubts that "cures" will ever be realised using these techniques'.⁵

Principle 16 of the Declaration of Helsinki states that 'Every medical research project involving human subjects should be preceded by careful assessment of predictable risks and burdens in comparison with foreseeable benefits to the subject or to others'. Although it is not always easy to compute the risk-benefit ratio, it may be argued that in this case the ratio is not favourable. The NCCS therefore maintains that a woman should not be subjected to such a risky procedure that has no benefit to her and very doubtful benefit to others.

Additionally and importantly, it must be pointed out that while the potential outcomes of research on human embryonic stem cells have been overstated, those of adult stem cells have been grossly understated. It is important to note that adult stem cells, which include stem cells taken from umbilical cords, have already been used successfully in human therapies for years, including the treatment of spinal cord injury, leukaemia, and Krabbe's Leukodystrophy. To date, however, no therapies in humans using embryonic stem cells have been successfully carried out.

² 'Epidemiology and Prevention of Ovarian Hyperstimulation Syndrome (OHSS): A Review', *Humans Reproduction Update*, Volume 8, no. 6, 2002, pp. 559-577.

³ www.ourbodiesourselves.org.

⁴ They include rash, vasodilation(dilation of blood vessels causing a 'hot flash'), paresthesia (sensation of burning), tingling, pruritis, headache and migraine, dizziness, urticaria (hives), alopecia (hair loss), arthralgia (severe joint pain, not inflammatory in character), dyspnea (difficulty breathing), chest pain, nausea, depression, emotional instability, loss of libido (sex drive), amblyopia (dimness of vision), syncope (fainting), asthenia (weakness), asthenia fravis hypophyseogena (severe weakness due to loss of pituitary function), amnesia (disturbance in memory), hypertension (high arterial blood pressure), tachycardia (rapid beating of the heart) muscular pain, bone pain, nausea / vomiting. Asthma, abdominal pain, insomnia, swelling of hands, general edema, chronic enlargement of the thyroid, liver function abnormality, vision abnormality, anxiety, myasthenia (muscle weakness), and vertigo. See http://www.fda.gov/medwatch/SAFETY/2004/oct_PI/Lupron_PI.pdf.

⁵ <http://www.schb.org.uk/>

PAYMENT FOR HUMAN EGG DONATION

The position of the NCCS regarding egg donation for research has, in a sense, made the question concerning payment for egg donation less relevant. However, because the question of financial incentives for donors is not only restricted to women who donate their eggs, the NCCS would like to state that it categorically opposes any inducement of or payment to tissue and organ donors. The NCCS therefore fully agrees with the statement of the 1998 HFEA consultation on the *Implementation of Withdrawal of Payments to Donors* which maintains: 'In order to ensure beyond doubt that donors were not motivated by financial gain, it would be necessary to abolish all payments and benefits (other than necessary expenses).'⁶

At the outset it must be pointed out that the term 'commercial egg donation' is an oxymoron. As Thomas Murray has argued, 'Despite the repeated reference to "donors" of both ovum and sperm, paying individuals for their biological products makes them vendors, not donors'.⁷ While critics may be right to point out that gametes are not strictly speaking the 'product' of donors and receiving payment for them therefore do not make them vendors, there can be no side-stepping the issue that such a practice would result in the commodification and commercialisation of tissues and body parts. The buying and selling of human tissues would lead to the increased objectification of the human body, where the concept of the 'body-as-self' is replaced with the 'body-as-property'. This shift in perspective, which Murray tries to point out with his metaphor of the vendor, will no doubt encourage people to view individual humans as saleable commodities and this would surely compromise and degrade human dignity.

How we perceive the body is profoundly important because it will influence the policies that we put in place in securing important and valued body tissues. In recent history, the human body is not simply a subject of observation and study, but an object of manipulation. Biomedical science and technology has in the past quarter century found many revolutionary lifesaving potentials of the body in medicine as new life is created through reproductive technologies, and lives are sustained through organ and tissue transplant. In addition, biomedical science also seeks to preserve life through research on tissues and cells. The image of the body as property has become more prominent now more than ever before. But there is a need to ask whether it is appropriate to see the human body through the conceptual lens of 'property', and examine what radical changes are introduced to our sense of self-identity when this paradigm is embraced uncritically.

Yet, there is widespread if often inarticulate unease in society about the very idea of offering parts of the human body for sale at the right price. The sense of repugnance, which is firmly rooted in our collective psyche and moral sensibility, must not be taken lightly. This is because it reveals a resistance to the view that the human body is just a natural object that can be used at our disposal. We realise the need to increase the supply of organs for life-saving transplants, and we know that doing so exacts a cost. By insisting that organs must be given freely and must not be bought and sold we are finding a way to live with this cost. We know that by allowing organs to be bought and sold we could possibly increase their supply and save many more lives. But we have resisted this approach because we know that by doing this we would make the body or parts of the body simply natural objects, at our disposal if the price is right. There is, of course, nothing degrading about buying and selling, and there is a sense in which commerce can enhance human life. But life itself must never be viewed as a commodity. Our sense of repugnance is therefore rooted in the belief that some things are simply not for sale. In our society, we recognise that public offices and criminal justice may never be bought or sold. To this list we must include the human body.

⁶ *The Regulation of Donor-Assisted Conception*. HFEA, 2003, paragraph 8.

⁷ Thomas Murray, 'New Reproductive Technologies and the Family', *New Ways of Making Babies: The Case of Egg Donation*, C.B. Cohen (ed.) (Bloomington and Indianapolis: Indiana University Press, 1996), 51–69.

The NCCS therefore supports the position expressed in para 48 of the consultation paper that the donation of tissues 'should be outright gifts and there should be no financial incentives, although reasonable reimbursement of expenses incurred should be allowed'. The NCCS is therefore in broad agreement with the principles delineated in para 48 of the consultation paper (and other documents such as *Human Tissue Research* and Section 13 of the Human Cloning and Other Prohibition Practises Act [Cap 131B, 2005 Rev Ed]). The NCCS therefore recommends that this policy be retained because it is founded on sound ethical principles. These principles are articulated in other major guidelines, particularly those issued by the European Union and the Council of Europe, for example the *Additional Protocol to the European Convention on Human Rights and Biomedicine Concerning Transplantation or Organs and Tissues of Human Origin* (ETS No. 186),⁸ alluded to in the consultation paper.

Terms like 'compensation' and 'payment' commonly used in such documents are often ambiguous and fluid and must be therefore carefully defined. The compensations or payments that a donor might receive must be such that they can never be perceived as financial incentives to donate. These payments must only serve to compensate for loss of earnings or other justifiable expenses so that the donor will not suffer from any financial disadvantage due to the donation. Any form of payment that exceeds reasonable compensation must be deemed unethical. In similar vein, any benefits in kind such as reduction of fertility treatment costs for donors would be unethical. The NCCS therefore does not support 'egg sharing' in which a woman undergoing fertility treatment is induced either by reduced fees or a shorter waiting time to donate her excess eggs for research. Such a practice would tantamount to the commercialisation of human bodily parts by obtaining financial gains or comparable advantages.

⁸ Para 1 of Article 21:

The human body and its parts shall not, as such, give rise to financial gain or comparable advantage.

The aforementioned provision shall not prevent payments which do not constitute a financial gain or a comparable advantage, in particular:

- Compensation of living donors for loss of earnings and any other justifiable expenses caused by the removal or by the related medical examinations;
- Payment of a justifiable fee for legitimate medical or related technical services rendered in connection with transplantation;
- Compensation in case of undue damage resulting from the removal of organs or tissues from living persons.



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4 January 2008

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Dear Professor Lee

FEEDBACK ON CONSULTATION PAPER “DONATION OF HUMAN EGGS FOR RESEARCH”

I refer to your letter to Dr Yuen Kwong Wing, Clinical Advisor, National Dental Centre, requesting for feedback on the above consultation paper. I have been tasked to provide my comments.

Guidelines on donation of human eggs for research are timely and will be much appreciated by all involved in such research. National Dental Centre acknowledges the great effort put forth by the Bioethics Advisory Committee in consolidating the paper.

My comments in relation to the questions raised on Pg. 5 of the paper are as follows:

a) Whether healthy women not undergoing fertility treatment should be allowed to donate eggs for research, and if so under what conditions.

Healthy women not undergoing fertility treatment should be allowed to donate eggs for research if the process is voluntary, the subject understands clearly there are some risks involved in the procurement of the eggs and that she will derive zero benefit from the exercise. The selection of potential egg donors should be stringent, and subjects at greater risks for Ovarian Hyperstimulation Syndrome (OHSS), etc should be excluded. To avoid the possibility of foreigners from less privileged financial circumstances from being induced to participate in the donation of eggs for research, foreigners should be disallowed to make egg donations in Singapore. Permanent residents may be excluded from this caveat. Frequent monitor by an appointed panel should be carried out on the consent taking for the eggs donation.

b) Whether egg donors for research should be compensated for time, inconvenience and risk, and if so, what type of compensation or monetary amount would be acceptable, and not amount to an inducement.

I am not adverse to compensated “egg sharing” provided that the cost of undergoing fertility treatment by these donors may be offset partially but not excessively in return for the donated eggs for research.

Egg donors for research should be reimbursed for all expenses incurred in the procurement of the eggs. They could be reasonably compensated for their time, discomfort and inconvenience out of goodwill. Compensation should not be given for associated risk involved in the process. This is because the potential donor has been fully made aware of these risks. Nor should compensation be given for loss of earnings. Compensation given for “involved risks” or “loss of earnings”, even if capped, will raise some concern of element of commercialism. But should the egg donor require medical care as a result of complication of the egg procurement process, there should be a provision to pay for the medical costs incurred.

c) Whether there are circumstances in which the compensation for eggs could amount to a sale and if so whether such a sale should ever be contemplated.

Any compensation given to egg donors should not be excessive which may then amount to an inducement. An Ethics Committee or an IRB that reviews the study can keep the amount of compensation in check. Sale of eggs should be strictly prohibited, and laws/regulations governing this should be highly deterrent.

d) Any prohibitions, limits or regulatory mechanisms that should govern the supply and use of human eggs for research in Singapore.

There are usually check processes eg. by IRB, MOH, in the procurement of donated eggs for research. For laboratory research involving eggs that had been collected and banked, is the use of these eggs subject to the scrutiny of a committee/panel (equivalent to that of the SingHealth Tissue Repository Committee) that oversees the release of banked eggs to investigators upon application? If not currently in place, this should be looked into and guidelines be set up.

The use of human eggs to clone humans should not be allowed and to avoid this, any laboratory process that can potentially create an embryo capable of developing into a human baby should be disallowed. While it may be argued that the research will stop at derivation of stem cells from created embryos, the temptation to go further to create human clones will always be present.

The above are my personal views. I have further included the comments of my IRB members. They are as follows:

[View 1](#)

I agree with the comments put forth by Dr Teh. Apart from Singaporeans and permanent residents, foreigners should not be allowed to donate. As mentioned, there's possibility of foreigners who would donate for the sake of rewards. The acts of altruism are good but

realistically how many participants of research studies do it for altruistic purposes? Monetary compensation should commensurate with the level of risks involved and be regulated by the IRB.

View 2

All women should be allowed to exercise their option to donate their eggs if they choose to even if they are not on fertility programme. This choice should be applied to everyone - citizens, permanent residents and foreigners who wish to donate their eggs in Singapore. They have to be adults of sound mind and know of all possible risks and harm to themselves before they make the decision.

Donations are gifts made through acts of altruism. Altruism is rendering help with no thoughts of reward, capitalistic returns or compensations, so it is unwise to pay donors for transport, loss in earnings and the like - this way, there are no risks or perceptions of inducements or barter.

Costs of egg-harvesting and medical treatment to manage complications are necessary project-running expenditure and should be borne by research sponsors or funding agencies.

There should be oversight and regulation of such research so that there will be no misuse of human embryos, cloning or reproduction of a genetically modified child.

View 3

I have carefully considered this issue and spoken to other lawyers in my team on this issue. I agree with the position as expressed in View 2, but wish to emphasize that this whole exercise must be very strictly regulated and supervised to prevent the creation of abominable life forms e.g. crossing humans with animals comes to mind.

View 4

Foreigners should be allowed to donate their eggs. But if the race / nationality needs to be revealed, then confidentiality issues may arise.

Due to the difficulty to clearly demarcate compensation from inducement, I support the position in View 2- that no compensation is allowed. However, all the medical costs arising from complications involved in the procurement of eggs should be borne by the research institution / sponsor.

View 5

All women (after being informed of the possible risks) should be allowed to donate their eggs for research purposes. They should be reimbursed for their transport expense, compensated for their time, inconveniences and discomfort.

Donation of eggs for research is for the advancement of science, therefore foreigners can also donate their eggs in Singapore. But there is a high possibility of foreigners being induced to participate. Hence, there should be some restrictions on their participation e.g. they can donate once only.

View 6

- a) Healthy individuals should be allowed to donate. Selection of donors should be stringent.
- b) I agree to the views of Dr Teh with regard to compensation for donor subjects.
- c) No to sale of eggs and human cloning experimentation.
- d) Checks should be done in accordance to regulatory mechanisms by Ministry of Health and IRB.

View 7

Foreigners should be allowed to donate their eggs in Singapore, as long as they are residents.

Compensation should be looked at and not totally cut out. Donor subjects should be treated like subjects in other drug trials or product trials where they do receive some form of compensation or free treatment. In those trials - they are not considered inducements.

I hope the above feedback is useful to you.

Yours Sincerely



Dr Teh Luan Yook

Chairman, Institutional Review Board,
National Dental Centre

Cc. Dr Yuen Kwong Wing, Clinical Advisor, National Dental Centre
Dr Kwa Chong Teck, Executive Director, National Dental Centre



MINISTRY OF HEALTH

SINGAPORE

MH 24:63/1-26

20 Feb 2008

Professor Lee Eng Hin
Chairman
Human Embryo and Chimera Research Working Group
Bioethics Advisory Committee
11 Biopolis Way #10-12 Helios
Singapore 138667

Dear Prof Lee

INVITATION TO COMMENT ON CONSULTATION PAPER

Thank you for your letter, dated 7 Nov 07, inviting the National Medical Ethics Committee (NMEC) to comment on the issues set out in the Bioethics Advisory Committee (BAC) consultation paper entitled "Donation of Human Eggs for Research".

2 In an earlier reply, dated 31 Dec 07, the NMEC expressed its regrets for not having been able to provide its comments on the consultation paper by 7 Jan 08 as requested. Thank you for your kind understanding.

3 The NMEC has since discussed the consultation paper. The NMEC's comments are at Annex A.

4 The NMEC is grateful for the opportunity to provide its comments on the consultation paper.

Thank you.

Yours sincerely,

A handwritten signature in black ink, appearing to read "Lee Suan Yew".

DR LEE SUAN YEW
CHAIRMAN
NATIONAL MEDICAL ETHICS COMMITTEE



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Annex A

NMEC'S COMMENTS ON BAC'S CONSULTATION PAPER: DONATION OF HUMAN EGGS FOR RESEARCH

- (a) Whether healthy women not undergoing fertility treatment should be allowed to donate eggs for research, and if so under what conditions.**

The NMEC has no objections to allowing healthy women not undergoing fertility treatment to donate eggs for research, on the proviso that certain conditions are fulfilled.

Women undergoing assisted reproductive technologies should not be egg donors as such individuals may feel unduly obliged to comply with the requests from attending medical and scientific personnel who might face competing interests in obtaining best quality eggs.

2 There should be a minimum donor age to protect younger women who may not fully appreciate the long-term sequelae of the procedure at the point of donation, which may include unknown irreversible effects on reproductive capacity. There should be an upper limit on donor age, and the number of times a donor may undergo egg donation, established on the basis of medical risks of the procedure to the donor.

3 The actual and potential risks of the procedure, including any correlation with increasing donor age, should be adequately addressed in the informed consent process.

- (b) Whether egg donors for research should be compensated for time, inconvenience and risk, and if so, what type of compensation or monetary amount would be acceptable, and not amount to an inducement.**

4 The NMEC notes the BAC's earlier recommendation in its Report on Human Tissue Research that "donors should not be paid any financial incentives for the donation, although they may be given reasonable reimbursement of any expenses incurred in the donation for the sample".

5 The NMEC acknowledges that some may argue that reasonable compensation for egg donors for time and risks could be acceptable, as it has been offered for subjects of clinical trials. However, the NMEC also notes that, if any compensation for time, inconvenience and risk, were to be allowed, it would be difficult to determine the amount of compensation that would be reasonable and which would not amount to an inducement, as benchmarks vary with the perspective taken. Some members feel that compensation should not be provided at all, as this could be the start of a slippery slope for the commercialization of eggs.

6 If compensation were to be allowed at all, a predetermined fixed fee should be paid to all donors. The less preferred alternative would be to fix a limit to the maximum amount allowed for compensation to avoid exploitation of the poor. Any compensation could also be paid to the donor's Medisave, or prevailing health

insurance policy. Neither donor nor the professionals involved in the harvesting of the donor oocytes should gain, or be seen to gain financially from the procedure.

7 Any system of payment should be made transparent, uniform and limited. Guidance could be taken from international stands on acceptable payment practices.

(c) Whether there are circumstances in which the compensation for eggs could amount to a sale and if so whether such a sale should ever be contemplated.

8 Compensation could amount to a sale if compensated procurement of eggs were conducted by private companies set up for the sole purpose of collecting eggs for research, whether within or outside regulated fertility treatment centres.

9 Such a sale of eggs should not be allowed under any circumstances.

(d) Any prohibitions, limits or regulatory mechanisms that should govern the supply and use of human eggs for research in Singapore.

10 The NMEC takes the stand that any procurement of eggs should be restricted to regulated fertility centres or other healthcare establishments with access to tertiary care facilities, and performed by the appropriate registered specialist.

11 All procurement of eggs for research should also be undertaken as part of a research protocol, subject to ethics review and approval by an institutional review board. No blanket approval should be given for the procurement of eggs for "research purposes" not directly linked to a specific research protocol. The procurer should be part of the research team, so that responsibilities may be imposed on both the procurer and the researchers.

12 There should be guidelines on the storage of eggs. In addition, there should not be any importation or exportation of eggs.

(e) Any other matters related to the donation of human eggs for research.

Insurance coverage for complications

13 The NMEC opines that adequate medical insurance cover should be bought on behalf of donors, to provide adequate compensation for short-term and long-term medical complications. As the main beneficiaries of the egg donation, the research team should be responsible for providing the insurance.

Advertising for eggs

14 Advertising for egg donors should be regulated. IRBs could determine the acceptability of advertising as a means of recruitment, as part of the ethics review of the research protocol.

Definition of "egg"

15 As the term "egg" could refer to various stages of maturation of the gamete, there could be a clarification as to which stage of the egg was referred to for the donation.

Risk for ovarian hyperstimulation syndrome

16 It could be more accurate to state, in paragraph 24 of the consultation paper, that ovarian hyperstimulation syndrome (OHSS) could be “avoided”, rather than “prevented”, by careful selection of donors. Women could also donate eggs without undergoing ovarian stimulation, in which case, the risk for ovarian hyperstimulation would be markedly reduced.



NOEL LEONG FERTILITY & IVF
Healthcare from the Heart

Dr Noel K Y Leong
MBBS, M.MED (O&G), FRCOG, FAMS
Reproductive Endocrinology & Infertility
Obstetrics & Gynaecology
Advisor & Senior Consultant
Thomson Fertility Centre

10 January 2008

Professor Lee Eng Hin
Chairman
Human Embryo and Chimera Research Working Group
Bioethics Advisory Committee
11 Biopolis Way
#10-12 Helios
Singapore 138667

Dear Professor Lee

DONATION OF HUMAN EGGS FOR RESEARCH

I apologise for my delayed response and comments. I have missed out the deadline but I hope it is not too late. My comments are :

- (1) The consent forms should state clearly that the eggs are to be used for research purposes only and will not be used for reproduction and fertility treatment for other women.
- (2) The risk of severe ovarian hyperstimulation syndrome (OHSS) and the potential development of ascites, hydrothorax, renal failure, deep vein thrombosis with slight risk of pulmonary embolism should be included in the consent form.
- (3) As egg donation is an invasive procedure requiring a few weeks of treatment, I am in favour of monetary compensation (subject to a maximum amount), for time, risks, inconvenience and loss of income.

Thank you for inviting me to comment on the consultation paper.

Dr Noel Leong

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Company Reg. No.: 200103493R

Comments from Singapore Eye Research Institute IRB

6 March 2008

- 1) It is important that the Religious Bodies be consulted on this matter. We assume that BAC will have a dialogue with the various religious leaders.
- 2) BAC's present position is stated in the "BAC Report on Human Tissue Research": "Donation of Tissues (which includes eggs) should be outright gifts and there should be no financial incentives, although reasonable reimbursement of expenses incurred should be allowed".

Is BAC thinking of changing this?

- 3) Is donation of an egg so different from donation of an organ, say a kidney? Both procedures are just as perilous, and the donor may die. Therefore no inducement (other than reimbursement of expenses) should be given.
- 4) You may argue that donation of a kidney is to save a life, but donation of an egg is for research work. So the donor of an egg will need more motivation to donate. But is donation of an egg for research work so different from volunteering for a Phase I (1st in man) study? In both cases the volunteers are healthy subjects and exposing themselves to serious risks. As in phase 1 studies, there should be no inducements (other than reimbursement of expenses), because of the risks involved.

(In a Phase 1 study in UK recently (the TGN 1412 Trial); all six healthy volunteers became critically ill. One of the criticisms of the study was that the volunteers were unduly encouraged to participate as they were paid £3,000 each.)

- 5) There should be no soliciting for donors through advertising in the mass media. If advertising is done, there should be no mention of money. The problems with advertisements are:
 - i) Risks of the procedures are downplayed.
 - ii) The sale of tissues / body parts will be encouraged.
 - iii) Undue encouragement to participate.
- 6) As the donation of eggs is for research, the process should be reviewed by a Research Ethics Committee (IRB / DSRB), which will ensure that there is informed consent and compensation.

Dr Khoo Chong Yew
Chairman
Singapore Eye Research Institute IRB



SINGAPORE NURSING BOARD

3 January 2008

Professor Lee Eng Hin
Chairman
Human Embryo
& Chimera Research Working Group
Bioethics Advisory Committee
11 Biopolis Way
#10-12 Helios
Singapore 138667

Dear Prof Lee

INVITATION TO COMMENT ON CONSULTATION PAPER

Thank you for inviting the Singapore Nursing Board to comment on the consultation paper on Donation of Human Eggs for Research.

The following are our comments on the two most relevant purposes.

- (a) We are of the view that obtaining human eggs for research should be confined to women who are undergoing fertility treatment. The procedure is invasive and poses possible risks and adverse effects on the health and safety of healthy women.
- (b) Women who donate eggs should be given monetary compensation for the time and expenses incurred provided that control measures are in place. The compensation amount or type should be periodically monitored and reviewed by an independent panel.

We would like to commend the Human Embryo and Chimera Research Working Group for a thorough and comprehensive coverage of the underlying issues.

Yours sincerely


MRS NELLIE TANG
CHAIRMAN
SINGAPORE NURSING BOARD

Comments from Mr Fahan Ali

Farhan Ali [farnali@yahoo.com.sg]

15 January 2008

Consultation Paper on Donation of Human Eggs for Research – An Individual Feedback

I refer to the above.

I am providing feedback as a private individual interested in the ethics of biomedical research. I divide my feedback below into three areas: the general ethics and impact of human egg donation, issues concerning donation of excess eggs, and issues concerning donation by healthy women. In addition to general ethical concerns, I also bring up issues that BAC may want to consider, while the rest of the points invite clarification from BAC in future reports. I hope my feedback would be useful for BAC in drafting the guidelines to govern the donation of human eggs for research.

The general ethics and impact of human egg donation

The consultation paper cites ESHRE's stance that "the general principles of research ethics on the subject of compensation should apply to egg donation for research (para 44). An argument can be made that egg donation, especially by healthy women, is a case qualitatively different from normal clinical trials. First, healthy women who donate eggs are at double-risk; not only are their general somatic health at risk as is the case in typical clinical trials, but their reproductive systems are being unnaturally disturbed, bringing in further future risks dealing with reproduction and germlines (e.g., risk of uterine and ovarian cancer). Second, egg donation can only be done by women, who are "minorities" and are less powerful in many contexts (e.g., economically less well-off, under influence of more powerful agents like husbands, etc). This situation may present special problems dealing with issues of lack of informed consent. Third, unlike some clinical trials, egg donation involves contributing cells capable of germline reproduction that may carry risks of subsequent illegal use. Although other cells donated (e.g., blood) may also suffer from such risks, illegal use of germline cells may pose even more serious future implications (e.g., illegal reproductive use). Given the above concerns, I hope BAC can apply judiciously the principle of fair compensation to balance such risks that go beyond those of normal clinical trials.

Also, are the ethical concerns and the health risks worthwhile given that the BAC itself admits that donations by healthy women are unlikely to be substantial enough to help alleviate the lack of eggs for research (para 51)? Moreover, as it is now, Singaporeans are quite reluctant in donating tissues, participating in clinical trials, and giving away

information¹. Lack of egg donation may be reflective of a more general trend of reluctance in Singapore society that needs to be addressed beyond the current consultation process. However, in keeping with the current issue, BAC can perhaps clarify the impact of the 2002 “Human Tissue Research” guidelines on donations, specifically highlighting how many cases of healthy volunteers donating eggs exist heretofore in Singapore and if new guidelines providing a wider definition of payment can increase participation.

Donation of excess eggs

I would like to expand further the issue of consent sought by an independent person of women undergoing fertility treatment to donate excess eggs. The current practice is for someone other than the medical doctor tasked with the clinical care of the woman in a fertility clinic to ask for consent to harvest excess eggs for research. However, the medical sector in Singapore is changing rapidly with lines between clinical care and research being blurred². Hospitals are increasingly becoming the place for basic research with medical doctors being scientific researchers too. In cases such as these, although the person asking for consent (e.g. another doctor in the hospital) may be considered independent enough, the institution where the fertility clinic resides may have a vested interest in seeking a consent (e.g. more eggs in the hospital for medical research in the hospital). It is recognised that a typical IRB would already consist of a layman not related to the institution or the healthcare group altogether. But it is still imperative that in donation of excess eggs, this importance of independence is properly enforced not just internally in the IRB but also in the eyes of the women concerned. Otherwise, these women may feel pressured to agree to donate excess eggs and place themselves under more risk.

Donation of eggs by healthy women

I would like to draw the BAC’s attention to three issues surrounding donation of eggs by healthy women. First, there is the issue of egg donation by healthy women who are affiliated with the research institution. This issue is particularly important given recent reports of female staff in the laboratory of Dr Hwang, the disgraced South Korean stem cell researcher, donating eggs for their own research, possibly under pressure from the senior doctors as precondition for promotion. Can such women be allowed to donate? One could argue that it is hard to believe that the donation would be altruistic since they have a stake in the research or that they might have been under pressure to donate. Yet, it is still possible that these women donate out of a genuine sense of belief in the

¹ See recent reports in the Straits Times in the past few years on the lack of twin volunteers coming forward as well as the Shorvon controversy which was caused by a principal investigator too eager to conduct the research when there were not enough patient volunteers. The recent BAC guidelines “The Use of Personal Information in Biomedical Research” were aimed at addressing this problem of access to patient data and in making the case for the importance of use of personal information for medical advances.

² For example, very recently, the National University of Singapore Medical School and National University Hospital were merged under one management, to allow greater synergies between clinical care and research, but also complicating further issues of care vs. research.

importance of research for humankind, a cornerstone of volunteering for clinical trials. Does BAC have special provisions for cases like these?

There is the second issue of medical subsidies being extended to healthy women donors. Some guidelines in other countries extend medical subsidies for fertility procedures to those women who donate excess eggs in the course of their fertility treatments. Can such arrangements be extended to healthy women donors? On the one hand, it seems like a fair arrangement for healthy women to receive subsidies perhaps for closely-related medical procedures (e.g, gynaecological examinations) in the same way that women undergoing fertility treatments enjoy some subsidies for fertility procedures if they donate excess eggs. Such arrangements are also routinely done for clinical trials (e.g, participants given free medical examination). However, there are related considerations of whether extending the same privilege to healthy women is ethical; whether healthy women may end up donating just to access otherwise inaccessible medical procedures; and whether there can be a fair way of deciding what treatments qualify for the subsidies and what do not.

The final issue pertains to when payment is given. In standard participation in experiments and trials, volunteers are given payments sometimes before they undergo the procedure. Can this be applied to egg donation? Can a woman also withdraw at any time without worry that her participation would not be compensated for? I am of the opinion that healthy women donors should be compensated immediately upon signing up and that any subsequent withdrawals be completely the prerogative of the women. There is, however, potential for abuse (e.g., women signing up just to get money but not committed to the treatment). But such considerations are relatively minor compared to the ethical minefield associated with women donors feeling compelled in continuing the egg donation treatment for fear of not being compensated for all her efforts thus far. On the flipside, such an arrangement of paying upfront may be a form of pressure to continue with the treatment despite discomfort and risks. This, however, can be limited by carefully explaining to the woman donor that she is under no obligation to continue if she wishes not to. Also, payment before embarking on the treatment is only possible under a compensation scheme and not under a reimbursement scheme where payment to donors is only given after all costs incurred are tabulated. I hope BAC can carefully weigh these considerations.

Conclusion

In general, I support the timely effort to reexamine the issue of egg donation in light of the progress of stem cell research in Singapore. However, I believe there is a need to consider human egg donation and its risks in greater detail as well as to address issues associated with it as outlined above.

Comments from Professor Chan Soh Ha

Yong Loo Lin School of Medicine
National University of Singapore

9 January 2008

- a) Research on stem cells should if possible make use of the already existing stem cell lines that have been available for some time.
 - b) If experiments strictly require fresh eggs, the first choice is left over fertilized eggs, from successful in vitro fertilizations that are no longer required and written informed consent for this purpose has been made. No compensations are required.
 - c) Healthy females not undergoing fertilization treatment may be allowed to voluntarily donate eggs. Informed consent and counseling for possible dangers and risks should be done by an independent body. There must be no coercion or inducement. Reasonable compensation for time, inconvenience or lost earnings should be allowed.
-

Comments from Dr Chuah Khoon Leong

3 January 2008

Dear Sir/Madam

I am writing in response to the Bioethics Advisory Committee request for feedback from Fellows of the Academy of Medicine who are in the Chapter of Pathologists.

While scientific pursuit in the area of medical treatment is commendable and to be encouraged, this pursuit should be morally acceptable. Therefore in the area of human egg donation, there is great concern whether the safety and welfare of women are adequately protected regardless of their social status. Furthermore, the possibility of exploitation remains.

One cannot deny that there are risks involved in the procurement of human eggs. Firstly, there is the problem of ovarian hyperstimulation syndrome which may be life threatening and also the increased risk of subsequent breast cancers, ovary and uterus. Is there a need to subject healthy women to such risks even though these risks are supposedly small? For the woman bearing the effects of these risks, it will be looked upon as 100% tragedy for her. In addition, the woman will be subjected to anaesthesia which again is another procedure that carries a certain percentage of risks.

Among the suggestions made is the possibility of payment for women who donate eggs for research. I do see the potential of commodification of women and their body parts if this is to be pursued, leading to a loss of respect of women as human beings. In addition, medical professionals may look at this as a source of potential for personal gain regardless of the fact that there is a potential risk of harming the patient. This may have a long-term negative impact on the medical profession since as doctors; we must safeguard the patient's medical interests above our own interests.

Cloning is the main reason for the procurement of human eggs. The number of eggs required in the formation of a single successful human clone is not known and research with monkeys indicated 304 eggs were used for the creation of 2 embryonic stem cell lines using the somatic cell nuclear transfer technique (Reference: David Cyranoski. Cloned monkey stem cells produced. Nature News. 14 November 2007). One wonders how many women are needed to ensure an adequate supply of eggs for the production of a successful cell line and how many women will therefore be subjected to unnecessary risks. Besides, this method involves the destruction of human individual in order to obtain embryonic stem cells and I do find this unacceptable from an ethical perspective for human life begins at the moment of conception and as such, to be respected. Moreover, stem cells derived from such method are prone to the formation of neoplasms which limits the usefulness of such therapeutic cloning.

Given the above scientific and moral issues, alternate ethically sound methods of obtaining stem cells should be looked into. After all, the creator of the cloned sheep Dolly, Professor Ian Wilmut, had abandoned the so called somatic cell nuclear transfer technique and is now concentrating on direct reprogramming of adult human cells in the production of induced pluripotent state cells, a method devised by Dr Shinya Yamanaka of Kyoto University, Japan.

With the availability of non-controversial methods, is there a need to subject women to unnecessary risks?

Thank you.

Sincerely

Dr Chuah Khoon Leong, FRCPA, FAMS (Pathology)
Senior Consultant Histopathologist

Comments from Mr Patrick Goh

3 January 2008

I understand that those who donate are well informed so that the decision is theirs.

My questions:

- 1) What concrete proofs are there that this donation helps the betterment of science given that cloning of Dolly the sheep had taken turn for the worst?
- 2) Is there any emotional or psychological trauma that the donator goes through?
- 3) Also, even when the donator goes under anesthesia, I understand that the process can be exhaustive and the donator has to go through vigorous checks, procedure, etc, which may be detrimental to her health towards the later part of life? Therefore, is compensation meant to cover her throughout her life existence?

Perhaps, one should consider more on the emotional and psychological compensation as these are the hidden concerns of which many individual do not reveal and not so easily detected? Even, with this said I do not agree at all for any reason whatsoever, in human egg donations. It leads to the manipulation of life at it's minutest (littlest) form and since the researches are allowed to do so, any other individual person (human being) can be manipulated for one's selfish reasons and glory.

The case in Irvine California, USA where the couple was not told that their spare egg were sold to other couple, speaks volumes on the ethical issues and dilemmas we will face. We do not know or even understand that there are boundaries when we undertake what is meant to be of Nature. There are other methods that have proven more positive such as using of umbilical cords, skins, etc.

The IVF does not have high success rate and the cost is exorbitant which goes to prove that it is not feasible as well as we are wasting precious resources (time and money) in this area when other avenues (methods) should be looked into instead. An area is that there is to be an acceptance if one unfortunately is unable to conceive and there are orphans to adopt. There are also other proven natural ways of conceiving and it is a shared responsibility between the spouses. Other areas that couples could conceive is creating an awareness and better education that contraception can affect future births.

These are my consideration.

Comments from Dr Alexis Heng

13 November 2007

Feedback on egg donor compensation

I generally agree with the principle that donors should receive additional compensation for their time, effort and inconvenience in egg donation, over and above reimbursement for direct expenses [1-8]. Nevertheless, I would like to make the following proposals in response to various potential pitfalls and ethical challenges in egg donor compensation. The views and opinions expressed here are entirely my own, and do not reflect the stance of any institution or organization that I am affiliated with.

1) There should be a cap on the maximum amount of money that can be reimbursed for direct expenses

In some countries such as Hong Kong [8] and Canada [9], the reimbursement and compensation of egg donors is strictly limited to direct expenses incurred by the donor herself. This is easy to justify on moral and ethical grounds, based on the premise that if a healthy and fertile woman is genuinely altruistically-motivated to help a childless couple start a family, there should be no reason why she should suffer any financial loss from acting as an egg donor i.e. travel and accommodation costs. Nevertheless, it may also be prudent to put a cap on the total amount of direct expenses that can be reimbursed to the egg donor, as in the case of the Human Reproductive Technology Ordinance of Hong Kong [8]. As discussed previously, it is possible that the provision of travel opportunity and accommodation abroad [10] may in fact serve as undue inducement to foreign egg donors i.e. an ‘all expenses-paid free holiday’ for economically disadvantaged women. Hence, a clear line has to be drawn on the appropriate levels of travel and accommodation provided to egg donors that should ideally be comfortable, but not border on the lavish and luxurious [11]. It is imperative to ensure that free accommodation provided to the donor should not exceed the time-frame required for participation in the egg donation program. Of course, the pertinent question that arises is why should we pay for the highly expensive air-travel and hotel bills of foreign egg donors? Should not local women be recruited for egg donation instead? As highlighted by Schneider [12], it is unethical to export one country’s infertility problem to another country. Egg donation is associated with significant health risks to the donor [13, 14], and it would be absolutely immoral to expose foreign women from poorer countries to such health risks, in order to solve the infertility problems of richer developed countries [12]. Instead, each country should ideally develop self-sufficiency in egg-donation, through the recruitment of local women as donors [12]. Perhaps a cap on the maximum amount of money that can be reimbursed for direct expenses may be utilized to discourage air-travel and hotel accommodation of foreign egg donors.

2) Reimbursement claims for loss of earnings and childcare expenses should be accompanied with documented proof.

Superficially, reimbursement of egg donors for loss of earnings and childcare expenses would appear rather easy to justify on moral and ethical grounds. Nevertheless in most countries, it is almost universally required by law for employers to give their workers a fixed number of days of paid holiday leave annually. Hence, the pertinent question that arises is what happens if a woman makes use of her paid holiday leave to participate in an egg donation program? She would not face any true loss of income, which would make her claim to any loss of earnings rather dubious. This does not imply that the donor should not be compensated for her time and inconvenience in donating her eggs during her holiday leave (which will be discussed later). Instead, the key issue of contention here is honesty and veracity in her claim for loss of earnings. In the case of prospective egg donors without regular full-time employment (i.e. housewives and university students), they should at least provide evidence that they are con-currently holding a part-time or holiday job, before making any reimbursement claims for potential loss of earnings. Another pertinent issue is childcare expenses faced by women in taking time-off to participate in egg donation. It is often the case that women with young children would rely on their network of female relatives (i.e. mothers, sisters and aunts) and friends for help in child-minding, whenever they need to take time-off for other commitments. Hence, there is a possibility of abuse in the form of dubious claims for childcare expenses, when in reality free child-minding is being provided for by the donor's own relatives and friends. It is therefore proposed that any claims for loss of earnings and childcare expenses should be accompanied with documented proof and evaluated on a case-by-case basis to prevent falsification and abuse. In particular, egg donors on paid holiday leave should be denied any form of reimbursement for loss of earnings. They can of course still be compensated for their time, inconvenience and effort in egg donation (which will be discussed in the next section). The underlying principle here is that reimbursement claims for loss of earnings must truthfully reflect genuine loss of earnings by the donor, so as to maintain accounting integrity and ensure transparency. For childcare expenses, reimbursement claims should be accompanied by bills and receipts from registered government-approved childcare centers.

3) Additional compensation based on minimum wages or fixed sum payment given to clinical trial volunteers is ethically justifiable, due to the inconvenience, discomfort, pain, loss of time and medical risks faced by the egg donor. However, payment should be pro-rated to the donor's actual wages, so as to avoid undue inducement to poorer women.

Besides reimbursement for direct expenses, potential loss of earnings and childcare expenses, it is often argued that egg donors should also be given additional compensation for the inconvenience, discomfort, pain, loss of time and medical risks faced in egg donation [15, 16]. A typical egg donation cycle takes up several hours of a

donor's time [15, 16], in addition to the hassle of commuting to and from her home, workplace and fertility clinic. It has been proposed that egg donors should be compensated for at least the statutory minimum wages per hour set by law for this period of time spent on egg donation [15, 16]. Additionally, it has also been suggested that extra financial compensation should be given for discomfort, pain and medical risks faced by the egg donor, similar to the fixed sum payment given to clinical trial volunteers. These proposals for additional financial compensation above that given for direct expenses, potential loss of earnings and childcare expenses may have some grounds for ethical and moral justification. Nevertheless, it is imperative that the amount of payment should not be too great so as to entice women to donate their eggs solely for the sake of money; without regard to their own health and safety (i.e. undue inducement). Special caution should be exercised in the case of poorer foreign women from developing countries. It is a well-known fact that differences in living standards, currency exchange rates and purchasing power parity, can easily magnify a petty sum of money in developed countries to an inordinately large amount in poorer countries. For example, the recommended £250 (\approx US\$400) compensation for egg donors (SEED report, 2005 [17]) proposed by the Human Fertilization and Embryology Authority (HFEA) in the UK would appear to be a paltry sum by UK standards. However, to young working women in some Eastern European countries and the former Soviet Union, this could very well represent a couple of weeks' wages [11]. Hence, it is suggested that payment of egg donors should be pro-rated according to their actual wages, as attested by bank statements and income tax slips provided by donors themselves. This will avoid undue inducement to poorer women. For this purpose, the concept of purchasing power parity [18] in international currency exchange rates would prove particularly useful. The Big Mac Index [19] readily demonstrates this point by showing that the price of the same MacDonald hamburger varies considerably in different countries, based on local currency exchange rates with the American dollar.

4) Financial compensation should be given for time spent in the egg donation program, even if the donor opts out half-way

Based on the premise that egg donors should rightfully be compensated for their time, inconvenience and discomfort, in addition to being reimbursed for direct expenses and loss of earnings; the pertinent question that arises is whether compensation and reimbursement should also be given to women who opt out of the egg donation program half-way, if they are feeling genuinely unwell? It is often argued that payment to egg donors does not constitute direct purchase of her donated eggs per se, but instead serve as due compensation for her time, inconvenience and effort. To maintain ethical and legal consistency on this line of argument, prospective donors who opt out half-way from an egg donation program should also receive payment for the time that they had spent in the program. It is well-known that superovulation regimens involving administration of purified recombinant gonadotrophins (i.e. follicular stimulating hormone) to the egg donor, often result in the development of mild to moderate symptoms of ovarian hyperstimulation syndrome (OHSS) [13, 14, 20, 21], most

commonly characterized by feelings of nausea and ‘bloatedness’. Hence if the donor is feeling genuinely unwell and wishes to withdraw her participation in the egg donation program, there should be no undue inducement or coercive pressure for her to continue, as this might lead to serious medical complications later. It is often the case that fertility clinics and doctors will give either the bulk or full sum of financial compensation to the egg donor upon her completion of the entire program. This is ethically and morally contentious, because there is now undue inducement and even some degree of coercive pressure on the egg donor to complete the entire program at the risk of her own health, if she is feeling genuinely unwell. Hence, it is proposed that some financial compensation should be given for time spent in the egg donation program, even if the donor opts out half-way. Preferably, the donor should receive payment on a daily basis. This would reduce coercive pressure and undue inducement for the egg donor to continue her participation at the risk of her own health.

5) *Medical professionals and scientists directly involved in fertility treatment or research should be excluded from the recruitment, counseling and compensation of egg donors*

Medical professionals and scientists directly involved in fertility treatment or research face conflicting interests in the recruitment, counseling and compensation of egg donors. At the crux of conflicting interests is the issue of informed consent, as highlighted by Spar [22], and the ESHRE task force on Ethics and Law [23]. There are both short and long-term health risks posed to women by egg donation [13, 14, 20, 21]; and the ability of medical professionals and biomedical scientists to provide sound advice and informative counseling on this particular issue to egg donors may be severely compromised by their ‘commitment’ to the fee-paying recipient patient or to their own research. In many countries with lax regulations on donor counseling and informed consent, it is often the case that prospective egg donors would only be told what brokers, fertility clinics and research laboratories choose to tell them [22]. Additionally, if medical professionals and biomedical scientists are directly involved in reimbursement/compensation of direct expenses, loss of earnings and childcare expenses, there is a risk of ‘creative-accounting’ being utilized to increase the sum of money given to egg donors, which might serve as undue inducement. Because the cost of donor compensation is likely to be paid-up by the recipient patient, the fertility clinic and medical doctor does not suffer any financial loss; but in fact can attract more egg donors by increasing the reimbursement/compensation pay-out from recipient patients. Hence, it is proposed that the Ministry of Health in Singapore should set up a specialized department or agency for the ethical recruitment, counseling and compensation of egg donors, which would function independently of medical professionals providing fertility treatment and biomedical scientists conducting research. Perhaps, the National Gamete Donation Trust (NGDT) in the United Kingdom could provide such a good example of an independent-functioning agency [24]. Moreover, it must be remembered that in many countries, transplant surgeons are not allowed to procure and allocate donated organs for their own patients, due to

obvious and undeniable conflict of interests [25, 26]. There is usually a centralized registry and waiting list of patients requiring organ transplantation, and priority is given based on medical conditions and needs. If transplant surgeons were given a free rein to decide which patients should receive priority for organ transplantation, there is a high probability that they would favor their own patients, who would eventually pay them medical fees. Likewise, a similar principle should be followed for the procurement and allocation of donated eggs for infertility patients, based on a centralized registry and waiting list maintained by the Ministry of Health in Singapore. A government monopsony on donor eggs would prevent profiteering by medical professionals; as well as maintain a reasonable donor compensation rate, so as to avoid undue inducement to vulnerable women.

6) The import of donor eggs should be prohibited, to ensure legal and ethical consistency in donor compensation and informed consent policy

In recent years, there have been increasing transactions of donor eggs across international borders [27, 28]. As discussed previously [27], there are varying policies on egg donor compensation and informed consent in different countries. Hence, the Ministry of Health in Singapore faces a legal dilemma and ethical conundrum, if they permit the import of donor eggs from foreign countries with significantly different legislation and policies on egg donor compensation and informed consent. For example, the Ministry of Health in Singapore has established rather stringent and rigorous procedures for egg donor counseling and informed consent. It is stated in section 8.6 of the Directives for Private Healthcare Institutions Providing Assisted Reproduction Services [2] that: “All prospective oocyte donors (i.e. patients who come primarily to donate their oocyte for research and not as part of fertility treatment) must be reviewed by a panel (may come from the hospital’s ethics committee) consisting of a lay person and 2 medical practitioners, one of whom is an authorized Assisted Reproduction practitioner. The panel must interview the prospective donor before commencement of the ovarian stimulation and be satisfied that the prospective donor (a) is of sound mind (b) has clear understandings of nature and consequences of the donation and (c) has given explicit consent for donation (freely without coercion or inducements) before allowing procedures leading to the donation to proceed. In addition, the panel should take into consideration the public interest and community values when assessing an application for donation of oocyte for research.” The pertinent question that arises is whether it is possible to maintain such rigorous and high standards of donor counseling and informed consent, if donor eggs are imported from abroad? There is clearly a risk that donor eggs imported from a foreign country may be procured from ill-informed women, with little awareness of both the short- and long-term health risks of egg donation [13, 14, 20, 21]. Also, even if the amount of financial compensation given to egg donors in Singapore is tightly-regulated to avoid undue inducement, there is no guarantee that such a lofty principle would be followed in a foreign country. As mentioned earlier, differences in living standards, currency exchange rates and purchasing power parity, can easily magnify a petty sum of money in developed

countries to an inordinately large amount in poorer countries [11]. It would therefore be fallacious to claim that there is no undue inducement, if the amount of donor compensation abroad is the same as that in Singapore, after currency conversion. Hence, the import of donor eggs into Singapore should be prohibited, to ensure legal and ethical consistency in donor compensation and informed consent policy. Additionally, it must be noted that imported donor eggs are usually frozen or cryopreserved to facilitate transportation, and there are significant health risks associated with the process of freezing and cryopreserving unfertilized Human eggs. The Practice committee of the American Society for Reproductive Medicine [29] states that: “The metaphase-II oocyte is extremely fragile due to its large size, water content, and chromosomal arrangement. In the mature oocyte, the metaphase chromosomes are lined up by the meiotic spindle along the equatorial plate. It has been well documented that the spindle apparatus is easily damaged by intracellular ice formation during the freezing or thawing process [30, 31]. In addition, hardening of the zona pellucida can adversely affect the normal fertilization process [32].” Subsequently, the committee recommended caution with regards to the use of frozen human eggs in assisted reproduction [29], by stating that: “Due to the known effects of cryopreservation on the meiotic spindle of the oocyte, there remain concerns regarding the potential for chromosomal aneuploidy or other karyotypic abnormalities in the offspring. Concerns similarly remain regarding the potential for organ malformations or other developmental problems. Despite the few promising studies on vitrification, even less is known about the potentially detrimental effects of vitrification when compared with conventional cryopreservation techniques.”

7) *Ovarian stimulation of foreign egg donors should not take place abroad.*

In the case whereby foreign egg donors are recruited from abroad, it would be particularly convenient to start her ovarian stimulation regimen (i.e. 2 to 3 weeks of gonadotrophin administration) abroad through a foreign collaborating fertility clinic [28]. This would limit her duration of stay upon arrival in Singapore, which in turn could save on accommodation costs. Nevertheless, this is ethically and morally contentious for two major reasons. Firstly, there is a question of abdication of responsibility on the part of Singapore-based fertility doctors for the donor’s welfare. If the donor develops life-threatening or debilitating ovarian hyperstimulation syndrome [20, 21] prior to arrival in Singapore, only the foreign collaborating fertility doctor administering the ovarian stimulation regimen would be held accountable, whilst his or her foreign partner in Singapore would remain unscathed. Ideally, both doctors should be held equally responsible for the welfare of the egg donor, as well as the recipient patient. Moreover, to ensure continuity in medical care, there should preferably be only one doctor taking charge of the egg donor superovulation regimen. Secondly, there is an issue of lower prescription price of fertility drugs being used to superovulate the foreign egg donor. In many economically less-developed countries, the prescription price of the same brand and dosage of various pharmaceuticals is often cheaper [33-35], commensurate with the lower income and higher purchasing power parity of the local

currency. Additionally, cheaper generic fertility drugs that violate international patent laws may also be available. In many developing countries, there is often scant regard for international patent laws and intellectual property protection with regard to pharmaceutical drugs [36, 37], probably because of political pressure from the local populace who desire cheaper medications. Because Singapore is signatory to the World Trade Organization (WTO) agreement on intellectual property and patent protection; it would be ironic if superovulation of egg donors from poorer countries were induced using cheaper generic fertility drugs and the donor eggs thus obtained are utilized in Singapore by local patients or researchers. It must be remembered that in clinical assisted reproduction, the prescription cost of fertility hormones used in superovulation makes up a substantial proportion of the medical fees. Cost savings from lower prescription prices would probably not be passed down to the recipient patient in Singapore, but could instead be exploited to boost the already substantial profit margin of medical doctors and fertility clinics. To prevent such abuses, it is thus recommended that ovarian stimulation of foreign egg donors should not take place abroad.

8) Egg donors should preferably be restricted to Singapore citizens and permanent residents.

It is recommended that egg donors be restricted to Singapore citizens and permanent residents for three major reasons. Firstly, if foreign donors were to develop life-threatening or debilitating medical complications upon returning to their home country, it may be difficult to carry out legal redress against Singapore-based fertility doctors, as well as claim health insurance; since it is mandated by law that all patients undergoing fertility treatment in Singapore must have insurance cover [2]. Secondly, there is no medical follow-up and aftercare of egg donors by Singapore-based fertility doctors, which could be tantamount to shirking professional responsibility. Thirdly, medical records of Singaporean citizens and permanent residents are readily accessible, for checking the personal medical history of prospective egg donors, as well their familial record of hereditary diseases. By contrast, it is much more difficult to check on the past medical records of foreign egg donors coming from abroad, which may even be written-up in a foreign language.

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Comments from Dr Alexis Heng

22 November 2007

Feedback on donation of surplus eggs by IVF patients for discount in medical fees - egg sharing

I would like to give an additional feedback on the donation of surplus eggs by IVF patients for a discount in medical fees – more commonly known as “egg sharing”.

Egg sharing in return for subsidized fertility treatment has often been proposed as a more ethically acceptable means of procuring donor oocytes, as compared to the direct payment of egg donors (Ahuja et al., 1996; 2001). In recent years, the concept of egg sharing has caught on in popularity; and among the various countries that have permitted egg sharing in clinical assisted reproduction includes the United Kingdom (Blyth et al., 2004), Belgium (Pennings and Devroey, 2006) and the People’s Republic of China (Heng and Zhang, 2007). Nevertheless, there are some pertinent ethical challenges that have largely been overlooked.

First and foremost is the issue of appropriate dosages of gonadotrophins (Follicular Stimulating Hormone) being prescribed for the ovarian stimulation of prospective egg-sharing patients. To maximize the number of oocytes retrieved, it is often the case that prospective egg sharing patients would be restricted to younger women with indications for either male-factor sub-fertility or mild female-factor sub-fertility (i.e. fallopian tube occlusion). Poor prognosis older patients with ‘tricky’ medical indications, such as polycystic ovarian disease and endometriosis are likely to be excluded. Hence, the pertinent question that arises is whether it is medically necessary to subject good prognosis younger patients to high dosages of gonadotrophins, just for the sake of maximizing the yield of retrievable oocytes for egg sharing? Should not natural cycle or minimal ovarian stimulation protocols be more appropriate for such patients (Edwards, 2007; Nargund et al., 2007; Heng, 2007)? Indeed, there is much evidence to show that the use of natural cycle or minimal ovarian stimulation protocols for good prognosis younger patients results in a more physiological endocrine profile (Ubaldi et al., 2007), which in turn leads to improved quality of retrieved oocytes (Fauser et al., 1999), as well as better endometrial receptivity and luteal support for subsequent embryo implantation (Devroey et al., 2004; Lindhard et al., 2006).

Moreover, it must be remembered that high dosages of gonadotrophins are associated with increased risk of debilitating and potentially life-threatening ovarian hyperstimulation syndrome to the patient (Budev et al., 2005), in addition to other not so well characterized long-term health risks such as future reduction in fertility and increased propensity to develop gynecological cancers (Pearson, 2006). This in turn touches on the core guiding principle of medical deontology, by which all treatment

administered to the patient must be in the best interest of his/her welfare. A paradoxical situation can thus develop as follows: “To maximize the yield of retrievable oocytes for egg sharing, high dosages of gonadotrophins are being administered to the patient. However, high dosages of gonadotrophins contribute to a significant portion of expensive medical fees in the first place (Gleicher et al., 2003; Ubaldi et al., 2007). Because poorer patients are unable to cope with high medical fees in fertility treatment, they participate in egg sharing to obtain a discount. Nevertheless, a discount in medical fees may not be needed, if poorer patients with good prognosis had instead opted for natural cycle or minimal ovarian stimulation protocols, in which nil or low dosages of gonadotrophins are administered.”

Secondly, another pertinent ethical issue is the appropriate levels of discount in medical fees that should be given to the prospective egg-sharing patient. Currently, there is a dire lack of guidelines and regulations in this area, and different fertility clinics display considerable variation in the level of discount of medical fees given to egg-sharing patients, even in the same country. For example, in the People’s Republic of China, the discount can range from as low as 50%, to as high as 100% of total medical fees billed to prospective egg sharing patients (personal communication with Dr. Zhang Xiao of Peking University Medical School). Hence, the pertinent question that arises in this case is which particular component of the medical fees should be eligible for discount? The first thing that comes to mind is the prescription price of gonadotrophins and other drugs (i.e. GnRH antagonist or agonist) utilized for ovarian stimulation of the egg-sharing patient. Besides this, medical fees for the surgical retrieval of oocytes from the egg-sharing patient can also be eligible for discount. Nevertheless, it would be morally and ethically dubious to give a 100% discount for these two components of the medical fees billed to the egg-sharing patient, since she should in principle bear some of the costs of her own treatment to avoid undue inducement. Instead, it is recommended that the level of discount in medical fees be pro-rated according to the exact proportion of retrieved oocytes being shared with the recipient. For example if ten oocytes are retrieved, and three of these are being shared with the recipient, then the percentage of discount given to the egg sharer should be 30%, to be paid-up by the recipient patient. Other components of the medical fees such as for consultation, IVF/ICSI procedures and embryo cryopreservation should ideally be borne separately by the egg-sharing and recipient patient, so as to ensure transparency and avoid undue inducement in the procurement of shared donor oocytes.

Thirdly, there must be rigorous auditing to ensure that the amount of financial subsidy given to the egg sharing patient is exactly equal to the surplus medical fees billed to the recipient patient. There is a possibility that medical professionals and fertility clinics might charge the recipient patient much more than the actual financial subsidy given to the egg sharing patient, thereby making a profit in the process. This is ethically and morally dubious; because the money earned in this case is not directly related to medical services rendered to the patient, but is instead attributed to the brokerage and transaction of donated human material.

Lastly, the abolishment of donor anonymity in many countries (De Jonge and Barratt, 2006) has potentially more ramifications for prospective egg sharing patients, as compared to non-patient donors. This is because egg sharing patients are themselves trying to conceive, and it would be a daunting prospect for them to be confronted by their own biological offsprings several years later, if they fail at clinical assisted reproduction themselves. In such an eventuality, they would likely feel being ‘shortchanged’ or ‘cheated’ by egg sharing in return for subsidized fertility treatment.

Although egg sharing is a novel concept that has proven to be of much benefit to patients undergoing clinical assisted reproduction, it is imperative that some thought should go into the ethical challenges outlined above; so as to prevent abuse by medical professionals and protect the welfare of the patient.

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Comments from Dr Suresh Nair

7 January 2008

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Dear Prof Lee

Thank you for asking me to comment on the "Bioethics Advisory Committee" consultation paper on "Donation of Human Eggs for Research". I have read the document and researched the topic and these are my comments.

First and foremost, I agree and fully support research involving human oocytes donated for non-reproductive purposes. However, as regards involving women already undergoing IVF fertility treatments themselves, I feel we should exercise extreme caution and not unnecessarily burden these women who are already under great duress from these treatments. As regards the issue of their benefiting from monetary compensation in the way of reduced and more affordable treatment – that is an issue that should be decoupled from oocyte donation for research. We should address the affordability of IVF in Singapore by reviewing the cost of drugs, services and the trend towards single embryo transfer and hence more subtle stimulation protocols using lesser quantums of stimulation drugs and hence decreasing the overall cost of IVF.

The reasoning behind keeping the IVF population as a secondary source of oocytes if at all for research is that this would absolve institutions providing IVF treatments and also involved in oocyte research or providing oocytes for research of concerns that the patient's ovaries may be stimulated more than is required for her reproductive needs leading to a greater propensity for ovarian hyperstimulation syndrome (OHSS). This issue persists even if two mutually independent institutions were involved in the stimulation/ART treatment and the other collecting surplus or immature eggs.

It could be argued that women undergoing IVF are a cohort who are well-informed and hence prepared for the risks that ovarian hyperstimulation that can result in OHSS. Further, they need to undergo these treatments that have the clear benefit of providing them children of their own. Critics might say that this will absolutely circumvent the dangers of ovarian hyperstimulation and the invasive oocyte recovery process requiring anesthesia and its attendant risks upon an otherwise healthy population not at all requiring to go through this potentially "dangerous" procedure.

To counter this argument, which I feel might not be adequately consolidated in the paper; the following points can be emphasized.

- That the risk of ovarian stimulation is low and through the conduct of stimulation by MOH accredited practitioners and ART centres who are already closely monitored by the regulatory authorities, and because of the good track record of ART in Singapore, the process of ovarian stimulation and OHSS risk upon oocyte donors would be very small.
- In addition, for oocyte donors, stimulation protocols that are gentler / milder can reduce the risk of OHSS far below the 1% quoted for ART cycles.

The suggestion that using only surplus or immature eggs of ART women for research would negate the need for healthy donors is also not feasible as the quantum of oocytes is extremely small and the ART patient may still not escape the fear, albeit inadvertent, of being lower in the priority ladder should they be not sufficiently prolific egg producers to be a "good" research oocyte source.

We must therefore endeavor to make the involvement of healthy individuals as oocyte donors as palatable a concept and eventually a reality for public and professional acceptance.

Firstly, all research involving oocytes must be centrally governed and scrutinize through the BAC. In this regard, all institutions involved in oocyte stem cell research must have their research protocols and the recruitment practices examined by the relevant authorities with independent unrelated counselling centres / counselors to ensure that potential donors are under no pressure / duress to submit themselves for the research and also be provided with informed consent in a language they fully understand. The requirement of a basic educational level e.g. secondary schooling, to be eligible as an oocyte donor and that there is freedom for the individual to "bail out" at any time during the stimulation process must be clearly spelt out and reinforced. Indeed, the segment of the paper that addresses informed consent should be further expanded such that a well-defined stringent step by step procedural pathway must be developed such that omission of one stage / step disallows the donor from progressing towards eventual recruitment into the study. The rigor with which this recruitment phase is spelt out will clearly appease those who are concerned about potential donors being misled and unwittingly channelled into the programme. This is to hopefully prevent another "Shorovsky debacle".

In addition, it must be more vehemently emphasized that any organization / university / research group intending to do research on human oocytes in Singapore will be held to the very stringent requirements that already exist and, in addition, that the regulatory authorities would ensure that there is not a repetition of established research completed elsewhere but can include the studies meant to analyze the peculiarity, if any, in the genetic / physiological characteristics of oocyte / stem cell properties in the Eastern / Asian population in comparison to research done in Europe / USA. That no effort would be spared to see if the research cannot be conducted using non-human oocytes and that protocols that are wasteful of human oocytes and not efficiently utilizing oocytes for research would be disapproved must be reiterated and reinforced.

Should there be an age limit?

Clearly there should be an age limit to define the suitable donor. The lower age limit based on well accepted social norms of the definition of adulthood where it is presumed that the individual has reached a sufficient degree of maturity and independent thinking both in the legal and societal context is 21 years of age.

As long as there is no demonstrable / detectable disease that can potentially jeopardize the health of an older individual, older women should also be allowed to donate oocytes for study so that research into ovarian and oocyte senescence can be conducted as well.

Oocyte from other sources – should be allowed but preference from healthy donors

As regards oocytes from other sources such as the fetuses from pregnancy termination (which is legal in Singapore) is a good source but there should be no connection between the decision to terminate the pregnancy and the potential for oocyte donation. Other sources are mid-trimester or later trimester pregnancy losses e.g. anencephalic babies, cadaveric (both young and old) are also valuable sources of oocytes that can help in elucidating problems in the different age groups through tactful in-vitro maturation. However, this point can be omitted or deferred for the time being as they present a very small albeit important resource of oocytes and might bring about other complex social and religious issues.

The issue of payments

Oocyte donors must clearly not only be reimbursed but definitely compensated for making this ultimate sacrifice of going through a not painless regimen of treatment and an invasive procedure to retrieve eggs.

In Singapore, the regulatory bodies can work out what is a reasonable compensation (taken into consideration current costs of living which must be updated regularly) in regards time away from work not only during the process but if the individual is not well enough to go back to work. I feel that we should not just compensate but provide such women with more tangible support be it in cash or kind.

My argument in support of this is that provided the sum of money is a widely accepted fixed quantum and is not ludicrously high in which the incentive of huge riches would blind women into adopting high-risk behavior, I think our society is mature and sensible enough to accept the concept / idea of payment to oocyte donors for making this major sacrifice for the betterment of all, particularly when the public is educated and made to realize the somewhat arduous process toward oocyte donation.

In order to counter the knee-jerk reaction of critics and those who fear that this would lead to a huge number of under-privileged women into the “business” of egg donation, having stringent regulatory agencies applying checks through independent localities with officers and independent reviewers unrelated to the research organization / IVF centres to monitor and marshal the practices is the sensible and prudent way to safeguard these women from allegations of abuse or exploitation. This is not to suggest a policing / watch-dog function but more to monitor the public’s response and if it is too exuberant a response to the “oocyte donation for research” programme then we have to rethink the remuneration scheme. This is very unlikely as it takes a lot of convincing in order for a woman to want to put herself through the process of oocyte donation before she agrees to it.

The issue of compensation should not be considered inappropriate in “oocyte donation for research” because the context within which it is conducted is similar to the realm of research involving participants recruited into a drug trials when the risks to health can be different and higher because the therapeutic element is likely to be recent and not well-established like the protocols of ovarian stimulation which has a long history of use with an established safety record.

Safety of treatment protocols – recent developments increasing the safety profile and convenience

The process of ovarian stimulation and collecting eggs is now a finely tuned low risk procedure. Currently very efficient drugs and regimens using highly purified recombinant drugs delivered by easy to use pens and fewer and shorter duration of injections i.e. using antagonists, and minimizing OHSS using agonist to trigger oocyte maturation are all very significant steps in making ovarian stimulation safe. This should be highlighted to assure those not knowledgeable about ART practices to understand that it is a fairly low risk and user-friendly process. The long term implications as regards breast ad ovarian cancer is thus far not unfavourable.

Non-monetary support and benefits

In order to improve the risk-benefit equation, potential donors can be provided with comprehensive health screening as it is necessary in any case to determine that they are healthy enough to be suitable donors free from disease, including genetic disorder that might interfere with the research.

Of course critics can argue that health screening of low risk healthy individuals have always had a low yield in detection of problems / diseases and that this is not as useful a benefit. Nevertheless, it provides the donor with useful information such as after the viral screen, to see if she needs important vaccinations so that if she decides to have her own pregnancy she would be protected e.g. hepatitis, rubella, chicken pox, etc.

In more recent times, HPV vaccination to prevent HPV infection in addition to Pap smear is also valuable to young women in prevention of cervical cancer – this hopefully might appease the public and critics who might view oocyte donation with disdain.

Yet another component of protection and benefit for the oocyte donors which is often a very key emotive issue that bogs down efforts at recruiting oocyte / embryo donors is that of the impact these treatment regimens have on the donor's fertility potential.

There is sufficient data to show that women continue to lose oocytes at a phenomenal rate of 1000 oocytes per cycle. This ovarian and oocyte senescence occurs in everyone, some deplete earlier because of a diminished primordial follicle pool to maternal illness / environmental effects during the intrauterine period or adulthood. This human phenomenon goes unabated irregardless of what we might do to maintain and promote our health. That being the case, oocyte donors must be assured that the act and process of egg donation does not accelerate the depletion of one's ovaries of eggs. These eggs if not utilized are destined to be lost and become atretic in any case.

Donors must be made aware of their rights to protect their own reproduction potential. Oocyte freezing particularly vitrification has come of age such that good revival and retrieval rates are now achievable coming close to the thaw survival rates of embryos. The Ministry of Health had recently sent out a notification to all IVF centres that the Ministry supports oocyte freezing for women undergoing cancer treatment.

Hence, another non-monetary benefit to oocyte donors is the opportunity to freeze and bank some of her own oocytes for her later reproductive use or if stem cell research produces useful

therapeutic benefit, that she, the donor, has access through her banked eggs to such treatments in the future. This is a strong counter argument to the criticism of the risk albeit small, of the impact if any, that the process of ovarian stimulation and / or oocyte retrieval might have on the donor's fertility reserves or potential. This I feel is an important enough point that should be stated and reiterated because from our experience with oocyte donors for infertile couples, it has been shown, time and time again to be a contentious issue.

New problems may arise as to how long the establishment involved in oocyte donated research should "bank" the oocytes of the donor. As the cost of oocyte banking is still inexpensive and the number of donors not likely to run into large numbers, I feel this component of the cost of cryopreservation should be incorporated into the funding for the research.

This is an important issue that I feel should be mentioned in our paper and in the research protocols as this would strengthen the ethical standing of the study that could help to not only to bring the study closer to regulatory approval but also successful award of funding as the welfare of the oocyte donor is clearly taken care of.

In the reckoning of the quantum of funding the research investigators can incorporate the cost of oocyte cryopreservation as a "compensation" for potential donors.

Extrapolating from this idea, the BAC and our government should steer legislation towards ensuring that all research projects involving oocytes donated by women undergoing invasive procedures have an insurance arrangement, best made, mandatory, to cover the donor against untoward complications because insurance companies usually do not cover any fertility treatments let alone donor oocyte research programme associated problems – this literally leaves the donor vulnerable and totally unprotected from untoward mishaps during the process of oocyte donation.

This is not a new or unusual concept as drug companies do take out insurances to safeguard against liabilities and costs of unexpected outcomes that might result in unexpected complications and hospitalizations during drug trials.

Will all these moneys set aside for "complimentary" oocyte banking or protective insurance coverage stifle oocyte research? I think not. On the contrary, placing high regard to human life and the sacrifice of the donors and placing the focus in protecting the individual's rights first and foremost will only pave the way to more successful research endeavors whose study subjects feel valued, know that they will be taken care of and therefore become committed to putting forth their best effort to the project.

This, it is hoped, will quell the nay-sayers and the critics who might "sing the same song" of exploitation and / or abuse of women for research that they mistakenly believe has not been adequately explored using alternative sources of oocytes.

I hope these comments will help the BAC to complete this already comprehensive guidelines. Please feel free to email me at _____ or call me on my mobile _____ at any time should any clarification be required.

Yours sincerely,



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Comments from Professor George Wei

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Consultation Paper on Donation of Eggs for Research

Introduction

The Singapore Bioethics Advisory Committee (BAC) published a consultation paper on 7 November 2007 entitled “Donation of Eggs for Research”. The comments set out below are in response to that paper. The comments of the author do not necessarily reflect the view of the Singapore Management University.¹

The paper identifies 5 main areas for which comments are sought. These are:

- Whether healthy women not undergoing fertility treatment should be allowed to donate eggs for research and if so under what conditions;
- Whether egg donors for research should be compensated for time inconvenience and risk and if so, what type of compensation or monetary amount would be acceptable, and not amount to an inducement;
- Whether there are circumstances in which compensation for eggs could amount to a sale and if so whether such a sale should ever be contemplated;
- Any prohibitions, limits or regulatory mechanisms that should govern the supply and use of human eggs for research in Singapore; and
- Any other matters related to the donation of human eggs for research.

Given the significance of stem cell research (embryonic or otherwise) the broad open ended nature of the inquiry is unsurprising. However, for convenience, and as suggested by the BAC² the two key issues (for the paper) are (i) whether women should be allowed to donate eggs for research and, if so, (ii) whether any payment may be made to, or received by, the egg donor.

Before setting out some comments on these two key issues, a brief summary of the previous work of the BAC is set out to provide the context in which the present issues are to be discussed. This will be followed by a summary of the author’s understanding of current regulatory framework. The Comments follow thereafter.

¹ The Comments are not intended at date of writing for publication. The author is responsible for all errors and omissions.

² BAC Paper at p.10.

Previous Work of BAC

The BAC was formed in early 2001 and is charged with the task of examining the legal, ethical and social issues arising out of human biological research and to suggest recommendations to the Government.³ Since its inception the BAC has produced a number of consultation papers and published reports on various aspects of life sciences. Some of these have resulted in legislative responses by the Government. The papers and reports include:

- Report on Ethical, Legal and Social Issues in Human Stem Cell Research, Reproductive and Therapeutic Cloning (June 2002);
- Report on Human Tissue Research (November 2002);
- Report on Research Involving Human Subjects: Guidelines for Institutional Review Boards (2004);
- Report on Genetic Testing and Genetic Research (2005); and
- Report on Personal Information in Biomedical Research (2007).

The first report (June 2002) made a number of important recommendations touching on the need for an independent regulatory body to supervise and control biomedical research, the banning of reproductive cloning of human beings whilst allowing medical research on embryonic stem cells (less than 14 days old). The main recommendations were subsequently implemented by the Human Cloning and Other Prohibited Practices Act (Cap 131B Rev Ed 2004) which sets out prohibitions against human cloning and related practices.

The second report (November 2002) concerned human tissue research and set out 4 main recommendations. The first concerns the adoption of ethical principles: that the health and welfare of the donor is the paramount consideration in taking any tissue; that no tissue should be taken without full, free and informed consent of the donor, that the human body and its remains should be treated with respect, that gifts of tissues should be accepted only on the basis that the donor renounces property rights or claims in the tissues, that all research involving human tissues be approved by research ethics committees or institutional review boards and that all researchers involved in human tissue banking be under a duty of confidentiality so as to respect the privacy of donors. The second recommendation was that research tissue banking only be conducted by or through approved institutions. The third recommendation was that there should be statutory regulation and supervision of research tissue banking and that a statutory body be set up for this purpose. The fourth recommendation was for a continuing professional and public dialogue on the principles to govern research tissue banking. Initially, it appeared that there might well be new legislation on these matters as the Regulation of Biomedical Research Bill was presented for discussion in 2003. The Bill was not, however, passed by Parliament.

³ This is partly based on a Chapter on Biotechnology and the Law, prepared by the author and to be published shortly in Singapore Business Law by Thomson Learning (now Cengage Publishing).

The third report (2004) concerned research involving human subjects and guidelines for institutional review boards (IRBs and referred to in the second report). This Report resulted in a long list of recommendations. In brief some of the more important points are as follows. First, that all human biomedical research be reviewed and approved by properly constituted IRBs and these should be accredited by the Ministry of Health. Second, that IRBs be accountable to their appointing institutions and to be responsible for (amongst other things) conducting ethics reviews of proposed human biomedical research programmes. Third, that researchers must comply with all conditions laid down by IRBs that approved the project and (amongst other things) inform and discuss with research subject's attending physicians if the research interferes with the subject's medical management. Fourth, institutions should have the overall responsibility of ensuring the proper conduct of human biomedical research carried out by employees on their premises.

The fourth report (2005) concerned genetic testing and genetic research. The Report sets out a list of 22 recommendations. Key recommendations include: that genetic testing should be voluntary and subject to informed consent and that non-consensual or deceitful taking of human tissues should be prohibited. Further, germ-line genetic modification should not be allowed (at this time) and pre-natal genetic diagnosis should be limited to serious medical disorders and should not be used for selection of desired traits, gender or non-medical reasons. It was also recommended that laboratories carrying out clinical genetic tests are to be accredited by a relevant authority and that predictive genetic tests should not be offered direct to the public.

Since the fourth report, the BAC issued a consultation paper (2006) on the use of personal information in biomedical research. This consultation paper set out a number of complex recommendations for public feedback and discussion. In brief, these concerned the need to establish a legal framework for the use of personal information in biomedical research. The suggested framework touches on the need for specific consent when the research involves identifiable personal information or tissue samples and the use of general consent for subsequent research when this involves de-identified or remnant tissue. The consultation paper also suggested that the legal authorities clarify the legal basis for disclosure of medical information by health care institutions and physicians and to establish mechanisms enabling health care institutions and physicians to increase accessibility of personal information that significantly advance public welfare whilst safeguarding privacy concerns. The general tenor of the consultation paper was to advocate the anonymisation (de-identification) of the personal information as far as and as soon as possible so as to protect individual rights of privacy. The consultation paper also recommended that the Government consider a moratorium on the use of predictive genetic information for insurance purposes and that an authority should be set up to consider the long term implications of accessibility to predictive genetic test results by employers and the insurance industry.

After deliberation, the BAC produced a fifth report entitled Personal Information in Biomedical Research (May 2007). This embodied 11 recommendations touching on the

legal protection of personal information, privacy and confidentiality, consent and proportionality, consent and reciprocity, vulnerable persons, withdrawal of consent and access to predictive genetic information by employers and insurers.

It will be appreciated that the issues raised by the present Consultation Paper on egg donations overlap with some of the points discussed in earlier BAC Reports. Of especial significance is the 2002 Report on Human Stem Cell Research.

Current Regulatory Framework for Egg Donations

Human Organ Transplant Act (HOTA)

Prohibitive Provisions

This law, first enacted in 1987 deals with human organ transplantation as well as “trading in organs and blood.” Of particular note is section 14(1) which provides that a contract (for valuable consideration) for the sale or supply of any organ or blood from any person is void. Section 14(2) sets out a parallel criminal provision punishable by fine (\$10,000 maximum) and/or imprisonment (12 months maximum).

Do these provisions apply to egg donations? Organ for the purpose of section 14 is defined as “any organ of the human body”.⁴ Clearly, sale of ovaries will be caught by the bars in section 14. But, what of eggs that have been extracted in the manner outlined in the Consultation Paper? At first sight, it seems unlikely that a human egg will be regarded as an “organ” under the present HOTA provisions. Dictionary definitions suggest that organ refers in this context to any part of the human body adapted for a particular function. Thus, insulin is a product of the pancreas (the organ).

Ambiguity, however, arises in the guise of section 14(4). This allows the Minister to exempt specified classes of product derived from any organ or blood that has been subjected to “processing” or “treatment”. Two points arise. First, given the technical interventions required to induce ovulation etc, can it be suggested that ova obtained in the manner described by the BAC amounts to “processing” or “treatment”? Whilst I have not looked for any relevant Parliamentary discussions in Hansard, as a matter of principle, it seems probable that treatment has indeed taken place, albeit, treatment of the ovaries *in vivo*. The induced ova are very much a product of technical human intervention (hormone injection etc) and the fact that natural biological processes are also involved should not mean that “treatment” has not occurred.

If the harvested ova can properly be regarded as a product derived from treatment of the ovary, the question arises as to whether section 14 applies. The point being that

⁴ Compare the more limited definition of organ for other statutory provisions such as right to remove organs after death. For the latter, organ is defined as the kidney, liver, heart and cornea. See s.2 HOTA.

there would have been no need for section 14(4) if organ and blood was not intended to apply to derived products. At present, the Minister has used his power under section 14(4) to exempt human blood products and plasma fractions, human hormones, vaccines and toxoids and diagnostic agents derived from human blood.⁵ No mention here of ova or indeed stem cells derived from embryos developed out the ova. If “organ” in HOTA was intended to include parts of organs as well as derived products, then as a matter of policy, it is understandable that down stream products requiring human intervention and ingenuity should be capable of being exempted under Ministerial discretion. Otherwise, the reach of section 14 will be very broad and carry prohibitive implications for all sorts of useful products derived from human organs and blood.

It is also noted that section 14(5) sets out provisions catching sale or supply of derived products (other than exempted products). The contract is again void and the vendor/supplier subject to criminal sanctions.

So, if HOTA does extend its prohibitive provisions to derived ova (as distinct from ovaries), the question that arises is whether the Minister should exercise his powers of exemption. If section 14 does indeed apply to sale of induced ova (and query derived stem cells), clarification/amendment may be needed in the light of the conclusions reached by the BAC. Indeed, even if the decision is to leave the matter alone, for the time being, it may be good counsel to seek legislative clarification of the scope of the prohibitive provisions of section 14 and whether it is generally intended to apply to (any) products derived from (any) human organ or blood.

Re-imbursement of expenses

Whilst section 14(1) and (2) generally catches the sale of human organs and blood for valuable consideration, section 14(3) HOTA does permit:

- (a) Reimbursement of expenses necessarily incurred by a person⁶ in relation to the removal of any organ or blood in accordance with the provisions of any other written law; and
- (b) Any scheme introduced/ approved by the Government granting medical benefits or privileges to any organ or blood donor (or their families or nominees).

Depending on the position reached by the BAC, this provision may also need clarification. Assuming, for example, that the view is to only allow reimbursement of expenses arising from the ova donation process, does section 14(3)(a) apply? Do induced ova fall within “removal of organ...”? What is the “other written law” that will activate this provision? In the present context this will most likely refer to the provisions in the Human Cloning and Other Prohibited Practices Act.

⁵ Human Organ Transplant (Specified Products) Notification.

⁶ This may cover costs of the procedure as well as costs necessarily incurred by the donor.

Human Cloning and Other Prohibited Practices Act (HCPP)

Relevance to the technology: somatic cell nuclear transfer etc.

It is understood that the ova (once induced and removed) can be used for a wide variety of research purposes. These will not necessarily involve the creation of a human embryo. In some cases, however, it seems that the creation of an embryo by somatic cell nuclear transfer (SCNT) etc is necessary as a prelude to the obtaining of stem cells. Section 7 of HCPP prohibits the development of any human embryo other than one created by fertilization of a human egg by human sperm for a period of more than 14 days. Human embryo is defined as any live embryo that has a human genome or an altered genome and that has been developing for less than 8 weeks since the appearance of 2 pro-nuclei or the initiation of its development by other means.

The implications for embryonic stem cell research are clear. My understanding is that SCNT results in the creation of a human embryo: one that possesses a human genome that is a clone of the donor of the somatic cell. If that is so, section 7 prohibits the development of such an embryo for a period of more than 14 days. My understanding is that this is not a problem (in this context) as embryonic stem cells are usually harvested within 5 to 6 days.

Prohibition against importing/exporting prohibited embryos

Section 11 prohibits import/export of prohibited embryos. The latter includes any human embryo developing outside of the body of a woman for more than 14 days. Whilst this is an important provision, it does not apply to derived stem cells and in any case is only relevant to 14 day plus human embryos. It is assumed that this provision will not have any immediate impact on the research into embryonic stem cells.

Prohibition against commercial trading in human eggs, embryos etc.

Section 13 prohibits commercial trading of human eggs, human sperm and human embryos. Any contract is void and the offender subject to criminal sanctions (fine not exceeding \$100,000 and/or imprisonment for a maximum of 10 years).

Points worth stressing are (i) the prohibition specifically applies to human eggs (compare HOTA), (ii) commercial trading by way of sale to foreign research bodies will also be caught, (iii) the provisions catch both seller and the buyer and (iv) the criminal sanctions are somewhat more severe than those applying under HOTA.

Thus, whatever view is taken on the scope of HOTA (above) there is no doubt that the commercial supply of human eggs is caught by section 13 of HCPP. A female donor who enters into any such contract/arrangement will be caught by the provisions as they currently stand.

HCPP does not, however, currently prohibit the supply of human eggs *gratis* or otherwise than for valuable consideration. Reimbursement of “reasonable expenses” is allowed including expenses arising from the collection, storage or transport of the egg.⁷ Whilst there may be some ambiguity in assessing what amounts to reasonable expenses, it is clear that Parliament intends a conservative approach whereby profit is to be excluded. Altruism (subject to reasonable expenses) is the cornerstone of the provision. In particular, it is to be stressed that HCPP does not permit any inducement, discount or priority in the provision of a service to the person supplying the egg. There is no discretion, for example, vested in the Minister to provide for better access to health care for donors⁸.

Clearly, section 13 of HCPP will need careful consideration if the BAC forms the view that egg donors should be allowed to receive a benefit over and above reimbursement of reasonable expenses. Even if a view is formed that the status quo should be maintained, there may be need for a system whereby the Ministry can issue guidance regulations as to what amounts to reasonable expenses.

Private Hospitals and Medical Clinics Act and Related Material

This legislation deals with the control, licensing and inspection of private hospitals, medical clinics, clinical laboratories and healthcare establishments. Section 22 authorizes the Minister to issue regulations on the same.

Private Hospitals and Medical Clinics Regulations

Regulation 4 requires all licensees to comply with directives and guidelines issued by the Director of Medical Services. Failure to comply is currently punishable with a maximum fine of \$2,000 and/or maximum imprisonment of 12 months.

Directive for Private Healthcare Institutions Providing Assisted Reproduction Services

Under the Directive dated 31st March 2006, paragraph 8 deals with research on oocytes and or human embryos. The details of paragraph 8 unsurprisingly mirror the provisions in HCPP. It is noted that this Directive is primarily concerned with assisted reproduction services (AR). It is understood that AR procedures may result in an excess supply of eggs and that in this regard, requests for permission to undertake research can arise.

It does not appear that the Directive is primarily concerned with oocytes obtained specifically for research purposes although clearly, similar issues can be expected to

⁷ Collection will presumably include expenses necessarily incurred by the donor in participating in the procedure. Perhaps this should be clarified.

⁸ Compare HOTA. Also note that section 13(4) HCPP makes clear that supply of human egg etc does not include supply for purpose of subsequently implanting the donated human egg etc in the body of another human whether or not for consideration.

arise. Hence it is noted that there are in fact also provisions on donors who are not involved in fertility treatment. I believe that it will be helpful to clarify the scope of the Directive in relation to excess eggs and AR treatment and non-therapeutic (non-AR) egg donations.

Key provisions in Paragraph 8 worth highlighting include:

- The principal physician and embryologist in charge of the patient's AR treatment must not be the same as the principal investigator of the research team.
- Human ova fertilized with human sperm not to be cultured *in vitro* for more than 14 days.
- No research is permitted on human embryos after 14 days from creation. (This presumably will also apply to embryos created by SCNT).
- No research or experiments on human gametes/embryos without explicit consent of donor. Information to be provided must be comprehensive and there must be no inducements, coercion or undue influence. (This really concerns three issues: sufficiency of information; consent and absence of inducement. A donor may have been given all information and still be induced by some proffered benefit or affected by undue influence etc.)
- In the case of prospective oocyte donors (patients who come primarily to donate oocyte for research and not as part of fertility treatment), there must be a review by a panel comprising a lay person and 2 medical practitioners one of whom is an authorized AR practitioner. The panel must be satisfied that the donor is of sound mind, has clear understanding of nature and consequences of the donation and has given explicit consent free of coercion or inducement before allowing the donation to proceed. In addition, the panel must take account of the public interest and community values when assessing the application. It appears (subject to clarification) that this covers human egg donation for non-therapeutic research purposes. (One might query why there is no reference here to undue influence although it may be said that this is subsumed within the requirement of consent).

Under the existing regulatory framework outlined above, donation of human eggs for research is permissible.

There are two main scenarios whereby eggs can be obtained. The first is where the donor is also an AR patient. Here, my understanding is that the research will involve "excess" eggs not needed for the AR treatment. The research program must be approved by the institutional review board/ethics committees and also by the Ministry of Health. Whilst it appears that some overlap in manpower may arise (between the AR

teams and research teams) a clear distinction is drawn between the principal physician, embryologist and the principal investigator. Explicit consent must be obtained and inducements, coercion and undue influence avoided.

The second are donors who are not seeking AR treatment and whose eggs are sought primarily or solely for research. Again, the research programme must be approved and the donor must give explicit consent, absence of inducement etc. I do not know how many egg donors fall into this category in Singapore. Even if there are very few, it seems that the Directive already contemplates non-therapeutic egg donations.⁹

Permission must also be obtained from the Ministry before any eggs are released to other research centres (presumably whether inside or outside Singapore).

In short, Singapore currently allows voluntary human egg donation subject to explicit consent, absence of inducement and coercion. Payment in cash or in kind so as to provide an inducement is not permitted by the Directive. The supporting legislative framework allows payment of reasonable expenses: but not an inducement.

The line between reasonable expenses and inducement is a real but fine line that may be hard to apply in practice. On one view, even payment of costs incurred by the donor might in one sense be regarded as an inducement of sorts. However, if that interpretation is taken, then the provision allowing for reasonable expenses will be rendered illusory! It is suggested that the better interpretation is that expenses look towards the donor's direct costs and that reimbursement of these should not be regarded as inducement. Some cost elements may be easy to quantify such as cost of transport to the hospital or costs of medication post procedure. Others may be much more difficult. Suppose the donor has taken 5 days leave for the medical procedures: will payment based on what she would or could have earned be allowed? What if she was given paid leave by her employer? Should expenses be limited to direct out of pocket costs or extend to lost opportunities? Would compensation for time spent/lost amount to an inducement? What if the donor is unemployed: what will be the allowable reasonable compensation for the time spent given that there is no real expense as such? Is compensation driven by reasonable objective expenses incurred or can it also include judgmental components such as time spent and risks taken? Rather than leave this to the discretion of the hospital/research clinic, will it be better for the Ministry to issue guidelines so as to reduce the uncertainty?

⁹ For convenience, this Comment uses the terms "therapeutic" and "non-therapeutic" research. The former refers to procedures involving both therapy for the donor/patient as well as medical research. The latter is concerned with "pure" research and with no immediate benefit for the donor. The author accepts that there will be cases where the line between the two types of research are less than distinct. See generally, G. Dworkin, *Law and Medical Experimentation: Of Embryos, Children and Others with Limited Legal Capacity*, MULR, Vol 13 1987 189 at 191. See also Michael Jones, *Medical Negligence* at p.570.

Comments

Singapore's drive to take a pole position in the life science industry is well known. The core of the industry is biotechnology: a marriage between the science of genetics and the life science industry including of course information technology.

Much of the raw material for modern biotechnology is genetic in origin. Human genetic resources is one thing that Singapore is not short of; although her limited indigenous bio-diversity will mean that she may need to gain access to biodiversity of other countries in certain areas of biotechnology such as plant and seed variety based research. It is thus not surprising that Singapore appears to have focused her biotechnology push on the life sciences and human genetic (medical and therapeutic) research. However, whilst there may be no intrinsic shortage of human genetic material, society will likely demand and expect restraints in the manner in which that material is obtained (and used) as a result of ethical and related concerns.

Modern biotechnology is big business that relies heavily on scientific discoveries and innovative applications. Modern biotechnology is knowledge intensive and capital intensive. The development of new successful commercial products may be months or years or decades away. But when they come: the social, economic and commercial impact is likely to be considerable. On the other-hand, failures and false leads are also likely to be common-place. Can the product or application in mind (example gene therapy based on cloning of human stem cells) be achieved and if so will the technology be socially/ethically acceptable: not just in Singapore, but in the international community as a whole where the innovation may be exploited? Some genetically engineered products that do appear to work (such as genetically enhanced soya beans) may not be socially acceptable because of perceived health risks or other ethical concerns. Modern biotechnology is not just knowledge and capital intensive: it is also risk intensive.

All knowledge intensive industries require protection of the economic or commercial fruits of intellectual effort, labour and the investment of capital against unauthorised use. It is here that the intellectual property right system comes to the fore. But, biotechnology, law and society, is not just about protecting business and commercial interests. It is also about the need for public regulation and control: the need for ethical standards for research and development of new practical applications, the need for ethical patenting and acquisition of intellectual property rights and also ethical use and exploitation of the products of biotechnology as in the case of claims of a bio-diverse rich country for equitable benefit sharing where inventions are made based on bio-diversity that their indigenous communities have conserved and made available for research. Good business practice is not been just about securing the commercial interests of the enterprise. A balance has to be achieved between commercial interests, the interests of consumers and the public at large. In the increasingly globalised world and open markets, the balance is becoming ever more complex: good corporate

governance and ethical standards for business operations are likely to become even more important than they already are.¹⁰

One of the most exciting areas of biotechnology concerns stem cell research. The medical and therapeutic applications are eagerly awaited. Even President George W. Bush is not against stem cell research (for medical and therapeutic applications). His problem is with the source of the material on which that research is heavily dependant: human eggs and embryonic stem cells. Hence the current US Government position to limit Federal Funding to stem cell lines derived from embryos whose “life/death” decision had already been taken before 9.00 pm EDT August 9 2001. In addition the stem cells must have been derived from an embryo that was created for reproductive purposes and which was no longer needed. Informed consent must also have been obtained for the donation of the embryo and that donation must not have involved financial inducements.¹¹

How long the wait for success will be in areas such as Alzheimer’s disease, Parkinson’s disease, diabetes, spinal cord injury, macular degeneration etc is uncertain: what is clear is that thus far the promise and hope has been much more than the reality. Risks there are. Aside from financial risks (for the industry), there are the obvious risks to health, the environment and biodiversity as well as ethical risks aplenty for society as a whole. Singapore has recognised the significance of the ethical risks from an early point: hence the setting up of the Bioethics Advisory Committee in 2001.

The ethical question that has arisen for this Consultation Paper concerns not stem cell technology *per se* but the source and means by which a sufficient supply of stem cells can be acquired and maintained. Two issues in particular come to the fore. To begin, there are the pro-life arguments and the status (and argued sanctity) of a human embryo. Second there are the issues concerned with consent: information and inducement. A “conservative” resolution of these issues, lie at the heart of the current US Federal Funding Policy on Stem Cells. Singapore and many other countries have taken a different view especially in respects of the first issue. The status of a human embryo and the circumstances in which a human embryo can be “artificially” created and/or terminated for use in research are clearly extremely important and deserving of full consideration. The issue transcends biotechnology and embryonic stem cell research into other equally controversial and important areas including of course abortion. Hence the earlier work of the BAC especially on stem cell research was timely and necessary. The current position in Singapore has been summarised earlier and the debate over stem cells and use of human embryos will not be re-canvassed here. Stripped of the details, Singapore, along with many countries, permits the use of embryonic stem cells provided the 14 day rule is strictly followed. So it is the question of the supply of human eggs or oocytes that is now in issue.

¹⁰ This section is partly based on a Chapter on Biotechnology and the Law, prepared by the author and to be published shortly in Singapore Business Law by Thomson Learning (now Cengage Publishing).

¹¹ <http://stemcells.nih.gov/policy/>

Whilst it is my understanding that stem cell research is not necessarily dependent on use of embryonic stem cells (stem cells with varying degrees of pluripotency being available from a number of other sources such as cord blood) obtained from human embryos, up to very recently, this was the “preferred” route. By “preferred” I refer to scientific and industrial research preferences.¹² My understanding is that early stage embryonic stem cells possess the highest pluripotency or ability to develop into specialised cells and indeed organs and tissues. Use of cloned embryonic stem cells also have the advantage of overcoming immune defence reactions and opens the door to patient specific (but presumably very costly) treatment programs. This is the context in which the present Consultation Paper raises the two questions: (i) whether women should be allowed to donate eggs for research and, if so, (ii) whether any payment may be made to, or received by, the egg donor.

But, before addressing these important questions it may be necessary to revisit the threshold scientific question as to whether embryonic stem cells are in fact the preferred or best or better basis on which stem cell research is to be conducted. Of especial importance are the exciting developments announced in November 2007 concerning induction of pluripotent stem cells from a variety of human somatic cells. As I understand it, two different teams (in US and Japan) have pioneered a method of re-programming specialized adult cells so that these return to their original undifferentiated or unspecialized state. These adult cells were taken from a number of non-ethically controversial and widely available sources such as skin cells, connective tissue and cells from the foreskin of a newborn.¹³ According to the published reports and a variety of “news sources”, the technology involves insertion of 4 transcription factors (genes) into the cell nucleus.¹⁴ These factors effectively re program the cell back to its undifferentiated state: becoming an induced pluripotent cell. Shorn of the details, it is understood that a retrovirus is used as the carrier for inserting the factors into the cell nucleus. It is also understood that questions remain as to the risk of damage (to the genome) arising from the insertion, the use of onco-genes (such as C-MYC as one of the transcription factors) in the procedure and the danger of cancer and risks associated with use of viral vectors. Beyond this, it is assumed that there may still be questions as

¹² It must also be recognized that a substantial body of researchers and scientists support the pro-life view that stem cell research should not focus on embryonic stem cells.

¹³ The Japanese team used adult skin cells and connective tissue. The US based team used foetal skin cells and cells from the foreskin of a newborn. See Takahashi et al., Induction of Pluripotent Stem Cells from Adult Fibroblasts by Defined Factors, *Cell* (2007) doi: 10.1016/j.cell.2007.1.019. See also Junying Yu et al., Induced Pluripotent Stem Cell Lines Derived from Human Somatic Cells. *Scienceexpress/ www.scienceexpress.org/20 November 2007/ Page1/10.1126/science.1151526*. Use of foetal skin cells can of course give rise to concerns of source. The other sources do not appear to raise any ethical dilemma other than very broad questions as to whether science should tinker with nature. That is not an issue that is considered in these comments or indeed the Consultation Paper.

¹⁴ See for example: Ian Sample, *Guardian Unlimited* at <http://www.guardian.co.uk/science/2007/nov/21/stemcells>. Seattle Times at http://seattletimes.nwsource.com/cgi-bin/PrintStory.pl?document_id=2004031975&zsection_id=2003912685&slug=stemed26&date=20071126.

to whether IPS cells are as effective as embryonic stem cells obtained in the “traditional way”.¹⁵

If we assume for the sake of argument that IPS cells do indeed possess all the characteristics of ES stem cells including those produced by cloning, the ethical issues surrounding the use of human eggs and human embryos for stem cell research can be neatly sidestepped.¹⁶ But this appears to be a pretty substantial assumption that will require further research. The safety issues referred to above will also need to be dealt with although it is my understanding that some of these (such as use of oncogenes and retroviruses) may not be too difficult to overcome.¹⁷

Should Singapore switch tact and proceed down the line of IPS research? This is an issue for the scientific experts advising the BAC and Ministerial Life Sciences Committee. I don't know whether Singapore has any research teams using or hoping to use the newly published technique. Doubtless, the Japanese and U.S. research teams and their industrial backers/supporters will have filed for patents. If patents are granted any Singapore researcher will of course have to obtain the necessary licences from the patent holders. Whilst there will be an economic cost in complying with any new patents I understand that the position is no different with ES stem cell procedures since the University of Wisconsin is reported to hold key patents on ES technology in any case.

If we assume that the economic costs of complying with intellectual property rights over the two methods (ES and IPS) are comparable and if it accepted by the scientific

¹⁵ See BAC Consultation Paper at p.5-8. See also Chapter 2 of BAC Report on Ethical, Legal and Social issues in Human Stem Cell Research, Reproductive and Therapeutic Cloning, 2002.

¹⁶ But query whether this will really be so? Assuming that the technique really does return the adult skin cell into a completely undifferentiated state: does this mean that the transformed cell is just like an embryo and which now has the capacity to develop into a viable newborn? See Gina Kolata, The New York Times, November 21 2007 where it is reported that the Japanese team had previously been able to add 4 genes to mouse cells and to turn these into mouse embryonic stem cells which then developed into mice! Apparently some 20% of the resulting mice developed cancer. Leaving aside cancer risks from using onco genes as transcription factors etc. how does society view the re-programmed somatic cell? Is it just a transformed skin cell or has it effectively become an embryo! If the latter, will this attract the same ethical debate as surrounds human embryos obtained/made in the “normal” way bearing in mind that SCNT cloning technology also requires technical intervention by a human. See

<http://www.nytimes.com/2007/11/21/science/21stem.html?em&ex=1196312400&en=bac7288684b3db31&ei=5087%0A>.

¹⁷ In December 2007 it was reported that researchers were able to produce mouse IPS cells for treatment of mouse sickle cell anemia. See, Sickle-cell Mice Cured with Their Own Cells. New Scientist, Dec.6 2007 at <http://www.newscientist.com/channel/life/genetics/dn13007-sicklecell-mice-cured-with-their-own-cells.html>. See also Heidi Ledford, Stem cells treat Anaemia in Mice, Naturenews 6 December 2007 at: <http://www.nature.com/news/2007/071206/full/news.2007.347.html>. It has also been reported that Japanese scientists have found a way of producing IPS cells without use of onco genes. See Makoto, Adult Cells Reprogrammed to Pluripotency without Tumours, Naturenews, Dec 6 2007 at: <http://www.nature.com/stemcells/2007/0712/071206/full/stemcells.2007.124.html>.

community that IPS cells are “as good” as ES cells: then it seems that Singapore should reconsider the use of human embryos for this area of life science research.¹⁸ Indeed I note that the BAC in its 2002 report on stem cell research, whilst supporting ES research, recommended that:

“The creation of human embryos specifically for research can only be justified where (1) there is strong scientific merit in and potential medical benefit from, such research; (2) no acceptable alternative exists, and (3) on a highly selective, case by case basis, with specific approval from the proposed statutory body”.

It is also important to stress that the BAC had earlier recommended that emphasis should be placed on cell lines already in existence and surplus human embryos created for fertility treatment less than 14 days old. Writing in 2002, the BAC view was that as for source of ES cells “there should be a sufficient supply from ES cell lines (the established lines) followed by surplus embryos” and “that it is unlikely that it would be necessary to create new embryos by IVF for human stem cell research.”¹⁹

Has the position, with the benefit of experience, changed since 2002? Are existing ES stem cell lines together with surplus AR embryos sufficient to meet the needs of research teams in Singapore for ES stem cells? If yes and the shortage of ES stem cells is in other countries which have very strict restrictions on use of embryonic tissues etc: caution will be a very wise counsel before expanding Singapore supply to meet research needs overseas.

The current Consultation Paper (2007) certainly takes the position that surplus eggs from fertility treatment are often retained for use in connection with fertility treatment and that insufficient human eggs are available for research (presumably whether for ES research or other research on human eggs apart from stem cell generation). The present BAC and the current Consultation Paper appear to accept that the scarcity of human eggs is a key limiting factor in stem cell research.²⁰ If this is indeed the position, then given the (apparent) general acceptance of the utility and desirability of stem cell research in connection with medical treatment of diseases and injuries, the question arises as to what steps can be taken, within ethical limits, to increase the supply of human eggs.

¹⁸ See Economist. Report on Stem Cell Research, Nov. 22 2007 reporting that Dr Ian Wilmut (Dolly the Sheep) is so impressed by the new data on IPS that he intends to focus his efforts on “this alternative approach.” See <http://www.economist.com>.

¹⁹ BAC Report, Ethical, Legal and Social Issues in Human Stem Cell Research, Reproductive and Therapeutic Cloning, 2002 at p.28.

²⁰ See Consultation Paper at p.8. Note however that Dr Benjamin Capps in his helpful background paper entitled “Oocyte Procurement for Research”, April 2007 puts the matter more neutrally: “the issue has again come to the fore because of claims that there may not be enough human oocytes to facilitate the advance of embryonic stem cell research. See <http://www.bioethics-singapore.org/>.

Has the recent announcement over IPS stem cell technology avoided the issue?²¹ Whilst this must depend on the views of the scientists and researchers, it is probable that it will be quite some time before the full impact of the “breakthrough” is known and a consensus reached. A quick glance at news sources on the Internet reveal a polarization of views. Some hail the development as a major breakthrough that will obviate the need for any further liberalization of the law on embryonic stem cells. Others beg to differ arguing that a twin track approach will be needed for some time yet: that IPS technology currently supplements but does not replace ES techniques.²²

For the purposes of this comment, I will assume that exciting though the IPS technology doubtless is that there is still a clear and present need for an adequate supply of human eggs for ES stem cell research. I am also prepared to accept, but on a necessarily tentative basis, that supply of ES stem cells from existing cell lines and surplus AR embryos is inadequate to meet current research needs *in Singapore*.

I turn then to the two issues at the heart of the current Consultation Paper. First, there is the question whether women should be allowed to donate eggs specifically for research purposes. As indicated already, my understanding is that under the HCPP and the Private Hospitals and Clinics Act (together with the Directive), donation of human eggs for research is already permitted subject to compliance with the established procedures. If that is so, there seems to be no sufficient reason to change that position: at least not until the impact and implications of IPS technology becomes much clearer.

Consent and the Law

Leaving aside specific statutory requirements, consent is driven by the common law torts of battery and negligence. Battery in this context is primarily concerned with individual autonomy whilst negligence is mainly concerned with ensuring that medical/research conduct does not fall below standards of reasonable medical practice. Adequate consent is essential to avoid liability under either tort. That much is clear.

²¹ The BAC Consultation Paper at page 6 recognises that IPS may reduce need to rely on human embryos. There it is stated that “SCNT may be used to study nuclear reprogramming which is a process by whereby a somatic cell is converted into one that has the capacity of an unspecialized cell to develop into a living organism (totipotence) or differentiate into all types of cells (pluripotence). Understanding this process may lead to the possibility of achieving direct reprogramming, which does not involve the use of eggs or the need to create embryos.” Have the recent announcements on IPS research already proven the case for direct reprogramming of somatic cells?

²² Apparently some scientists at the leading edge of IPS research accept that there is still a need to push ahead with embryonic stem cell research. See Artificially Created Stem Cells Cure Sickle Cell in Mice. Dailytech, December 8 2007 at: <http://www.dailytech.com/Artificially+Created+Stem+Cells+Cure+Sickle+Cell+in+Mice/article9937.htm>. See also the AFP Report Nov 27 2007: Stem Cell Pioneer says Embryonic Research still Needed. <http://afp.google.com/article/ALeqM5jIUGHePXLAdS4Rc52rHOk7fHAAg>. According to this report, Shinya Yamanaka who led the Japanese research team on IPS accepts that embryonic stem cell research is still needed. In particular it is noteworthy that Yamanaka is of the view that it will be a long time before researchers could treat stem cells from skin like those from embryos. Compare this with the article by Doyle, Promising Stem Cell Breakthrough is a Moral Milestone, say Catholic Ethicists, December 7, 2007 at: <http://www.the-tidings.com/2007/120707/stemcell.htm>.

The question of what constitutes a valid consent is less certain: different common law jurisdictions may well take different views on this. For the purposes of this Comment, the author assumes that Singapore courts are likely to take a position that is similar to that taken in England.

To avoid battery, the general approach taken is to ask whether the patient has been informed in broad terms of the nature of the procedure and armed with that knowledge, gives consent.²³ Failure to explain risks and implications is generally regarded more as the concern of negligence.

To avoid negligence, the doctor must of course carry out the medical procedure with reasonable care. But, even before carrying out the procedure, he/she must provide the patient with sufficient information. How much information must be provided and the reference point for sufficiency (patient or doctor centric) is a matter of some controversy. Nevertheless, Professor Dworkin writing in 1987 states that Sidaway “appears to have established a test loosely based upon what a reasonable doctor would tell the patient in the circumstances...” From this perspective, Professor Dworkin concludes that “...full rein is not given to the concept of patient autonomy and there is considerable scope for a patient’s information to be limited, and, indeed, for the doctor in some cases deliberately to withhold information by using his therapeutic privilege...”²⁴

Using the above framework as the starting point, two important issues arise in the context of egg donations. First, does consent validate all medical/research procedures as a matter of law? Second, whether a stricter approach should be taken in cases of non therapeutic research.

So far as the first issue is concerned, it is clear that the law does not permit all and any type of bodily intrusion under the cover of consent.²⁵ Thus in one well known English case, the fact that sadomasochistic acts of mutilation were consensual was no defence to a prosecution.²⁶ In the case of medical treatment or medical research, public policy of course allows and supports bodily intrusions but not without limits (especially in the case of medical research).

Where is the line to be drawn? Professor Dworkin with some force argues that “clinical research, within reason and subject to a reasonable risk/benefit ratio, is clearly not against public policy...” It follows that the greater the risk of harm to the patient/donor,

²³ Chatterton v Gerson [1981] QB 432; Sidaway v Bethlem Royal Hospitals [1985] AC 871; Freeman v Home Office No.2 [1984] 1 All ER 1036. Cf Tan Keng Feng at (1987) 7 LS 149.

²⁴ Dworkin, Law and Medical Experimentation: Of Embryos, Children and Others with Limited Legal Capacity, MULAR Vol 13 189 at 193.

²⁵ Professor Dworkin ibid. notes at p.193 that in some countries, statute law prohibits tattooing of persons under 18 even though they have consented and that the common law, as a matter of public policy, will not allow a person to consent to be maimed unless there is some sound justification, such as medical treatment.

²⁶ R v Brown [1993] 2 All ER 75.

the greater the importance of counterbalancing benefits. Where the risk of harm is high and where the consequences to the patient/donor are severe, it is difficult to see how the procedure could ever be justified under common law. Even where the expected benefit counterbalances the risk, the degree of risk must have an effect on the information to be disclosed to avoid a suit in negligence. Professor Dworkin rightly stresses that in the case of non therapeutic research, the therapeutic privilege has no application and that in *Halushka v University of Saskatchewan*²⁷ it was said that “the subject of medical experimentation is entitled to a full and frank disclosure of all the facts, probabilities and opinions which a reasonable man might be expected to consider before giving his consent.” Professor Dworkin was of the view that “indeed, the law may be more demanding, in that a patient is entitled to information about all the facts which may be material to him, even though they may not be of significance in scientific terms.”²⁸

What then is the current position in Singapore on egg donation? I turn first to adequate consent.

At present, the Directive for Private Healthcare Institutions Providing Assisted Reproduction Services provides in paragraph 8.6 that in the case of prospective oocyte donors (patients who come primarily to donate oocyte for research and not as part of fertility treatment) that:

- There must be a review by a panel comprising a lay person and 2 medical practitioners one of whom is an authorized AR practitioner.
- The panel must be satisfied that the donor is of sound mind, has clear understanding of nature and consequences of the donation and has given explicit consent free of coercion or inducement before allowing the donation to proceed.
- In addition, the panel must take account of the public interest and community values when assessing the application. (One might query why there is no reference here to undue influence although it may be said that this is subsumed within the requirement of consent).

I am unable to comment on how this provision has actually worked in practice. In principle, the requirements are in general unobjectionable in the light of the legal framework outline above. Some points of clarification may however be helpful.

Clearly the donor must be of sound mind. Is there any need to protect vulnerable female donors such as teenagers? Is there a case for a provision that the donor must be over the

²⁷ (1966) 53 DLR (2d) 436. See also Michael Jones, *Medical Negligence*, at 6-177.

²⁸ Ibid at p.194. Note also that a difference may have to be drawn between consent by a competent adult and proxy consent for example on behalf of an infant. In the case of proxy consents (by parents for a female child under the age of majority), arguably a stricter view should be taken on the degree of acceptable risk. It is one thing to consent to a risky research procedure on one's own body: quite another to do so for another by way of proxy. In England, it seems that proxy consents for children are only justified where the risk is *minimal*.

age of 18 or indeed 21 or, that at the very least, consent of parents are also obtained? This may well be the practice: but if so will it be helpful to build this into an explicit affirmative requirement?²⁹ As a matter of principle, my view is that it is likely that the common law will permit a person under the age of 21 to consent to medical research provided he/she has sufficient maturity and understanding. But, as Professor Dworkin notes, the younger a person is or the more intrusive the research, the more difficult it will be to persuade the court that the child had capacity to consent.³⁰

Clearly the donor must have an adequate understanding of the nature and consequences of the donation. But, is there a good understanding even amongst the medical profession as to what the nature and consequences are? To be sure, the nature of the medical procedure (use of hormones, anesthesia etc) and the associated medical risks must be disclosed in language that the donor understands. But what are the risks associated with ovarian stimulation etc? The Consultation Paper states that the risk in egg retrieval is relatively low. The Background Paper on the other hand appears more cautious recognizing that “some specialists in reproductive medicine are concerned that there is insufficient information about the long term effects of these drugs to encourage healthy volunteers to undergo such procedures when there is no reproductive benefit to balance against the risks.”³¹ Risks of infection are also mentioned as are psychological risk factors.

But supposing that all *the risks and uncertainties* (short term and long term) are explained: why shouldn’t the donor be allowed to proceed? After all, drug trials on healthy patients, carry similar if not even greater risks. All pioneering medicine involves risks and uncertainties. Even if it is entirely uncertain as to how long it will be before successful treatments are developed for diseases such as Alzheimer’s disease or spinal injury: the benefits if successful will be incalculable. What is under consideration is not stem cell research for the sake of eugenics or human vanity: it is stem cell research in the hope that it may lead to treatments for severe debilitating

²⁹ The age of majority in Singapore is 21. In the absence of statutory provisions, the position of minors and consent depends on the common law. In some cases consent by proxy (usually parental) will be necessary. In other cases, were the procedure is minor, the child may have capacity to consent if he/she is capable of understanding the treatment. *Gillick v West Northfolk and Wiesbech Area Health Authority [1985] 3 All ER 402*. Professor Dworkin, *ibid.* at p.196 states that the age and seriousness of the procedures are directly related: a child may have legal capacity to consent to a trivial medical procedure at an earlier age than to a more serious medical procedure. Egg donation procedure would appear to involve a serious medical procedure.

³⁰ *Ibid* at p.197. Assuming that parental proxy consent is needed, there remains the tricky question as to the criteria by reference to which the proxy consent is to be judged: best interest of the child, substituted judgment, not against interests of child etc. Professor Dworkin notes at p.202 (1987) that the English view was that a socially responsible parent might think that there was merit in taking social interest into account and contributing to medical research provided always that the risk to the child was minimal. Professor Dworkin also supports the case for legislative clarification of the power to give proxy consent for the purposes of research on children.

³¹ Dr. Benjamin Capps at p.7 citing Pearson, H. 2006. Health Effects of egg Donation May Take Decades to Emerge, *Nature* 442: 607-608.

diseases and injuries. It seems to me that this hope is well worth encouraging: provided full information on the medical risks and uncertainties are explained to the donor.

Would it be helpful in this context for the MOH to issue guidelines as to the medical information that should be explained to women considering becoming egg donors? In this regard, recognizing the importance of giving the prospective donor adequate time to reflect, should a minimum period of time be required to elapse between the explanation and her making of the decision or the carrying out of the procedure (a cooling off period as such and always allowing for a change of mind)?

Still on consent and the importance of explaining the nature and consequences of the donation: what about the non-medical consequences? Much research into stem cells is likely to take place with a view towards commercial application. Distinction between pure academic research and applied or industrial research is increasingly blurred: academics are now often partners with industry. New IPS or ES procedures may be patented. New drugs or treatment products such as “replacement neurons” may also be subject to patent claims of one form or another. The desire or need to protect the investment of the pharmaceutical/industrial arm of the research effort is understandable. Should this be made clear to the donor: for example, that the research may lead to valuable commercial applications and that under most legal systems, she as donor will have no share in any resulting intellectual property? This is quite apart from the inducement issue. Is it not fair and reasonable to make clear to a prospective donor, that the research may well result in downstream commercial applications.³²

A connected point is whether as a matter of principle, the donor should be given information as to who is conducting the research and the use to which the eggs are to be put.³³ On this I note the earlier recommendations of the BAC in its 2002 Report on Human Tissue Research which touch on the question of human tissue banks.

That the consent must be explicit is understandable: perhaps this should be clarified to mean “written” consent. The requirement of “no coercion” is equally understandable although there must be some ambiguity as to what coercion refers to. The obvious case of threats will be easy to deal with. It is the less clear cases where perhaps greater clarity is needed. Experience in other countries actively pursuing stem cell research suggest that female members of research teams may be under subtle or sometimes not

³² See *Moore v Regents of the University of California* 793 P2d 479.

³³ See Helsinki Declaration. Art 22: “In any research on human beings, each potential subject must be adequately informed of the aims, methods, sources of funding, any possible conflicts of interest, institutional affiliations of the researcher, the anticipated benefits and potential risks of the study and the discomfort it may entail ...” See <http://www.wma.net/e/policy/b3.htm>. Brazier, Medicine, Patients and the Law, 3rd ed. rightly underscores also the need to demonstrate volition. She asks the highly relevant question at 404: “Do medical students feel under compulsion to assist in drug trials mounted by their teachers? Do patients feel obliged to help their doctor if he asks them to participate in non-therapeutic research”? See also Michael Jones, Medical Negligence, 2003 at para 6-165 where it is argued that non disclosure of research objectives may well invalidate consent (for purposes of tort of battery). A similar view is taken by Kennedy & Grubb, Medical Law, at 1710.

so subtle pressure to donate eggs. A person may be “unduly influenced” without being “coerced” as such. The mere fact that there is informed consent does not mean that there is no coercion or undue influence.³⁴

Where the donor is in a vulnerable position (medical student, employee of research team etc) the institutional review panel should be under a positive duty to ensure that no undue influence has been brought to bear.³⁵ The medical researcher should bear the burden of establishing that no undue influence or coercion was used to obtain the consent.³⁶

A more extreme (but simpler) position will be to exclude medical students, employees, members of research team or the institution concerned from volunteering as donors.³⁷ Is the latter realistic? Is there any reason why medical students and the like should not be allowed to give consent subject to the proviso that the researcher proves that no undue influence has been used and the donor given the opportunity to receive independent advice? Is there any consensus in Singapore on this? If patients seeking IVF/AR treatment are permitted to donate excess eggs for stem cell research, is there any reason to disallow medical students/members of research teams from volunteering always assuming that proper consent has been obtained. Both are vulnerable donors (in that they may be susceptible to influence). If a proactive requirement of ensuring independence in the consent procedure suffices for patients, why should it be any different for medical students and research team members?

Then what of the question of inducement? As currently framed, the consent must be free of any inducement.³⁸ Non-financial inducements are also caught. That said, in the majority of cases where this may be relevant, the inducement is likely to be in the form of money or money’s worth such as priority medical treatment. For convenience these will be considered under a number of headings of increasing difficulty.

³⁴ Professor Dworkin, *ibid* at p.204 whilst recognizing that students may be vulnerable, agrees that it does not follow that all financial inducements should destroy the voluntary nature of all responses. On the other hand, the fact that the consents were fully informed is not conclusive on the question of volition.

³⁵ Kennedy & Grubb, *Medical Law* at p.1722 where the issue of voluntariness is discussed in the context of persons who may volunteer for research because of some felt pressure.

³⁶ See Professor Dworkin, *ibid* at p.204 where he argues that fiduciary principles can be relied on to impose an affirmative burden on the researcher. Professor Dworkin also stresses at p.205 that ethical research committees in deciding whether to approve the research must take account of the risk/benefit factor. In the case of proxy consent for non therapeutic research on children, it appears that England allows these where the risk to the child is minimal. The assessment of risks is bound to be controversial. Minimal risks (in the case of proxy consent) are said to be those where the probability and magnitude of physical and psychological harm are no greater than that encountered in daily lives or in routine medical or psychological examination of healthy children.

³⁷ See generally also the discussion by Michael Jones, *Medical Negligence*, 2003 at 6-164.

³⁸ Inducement in this sense vitiates consent. Threats can be a powerful form of inducement such as a threat to withhold treatment or to dismiss from service. Inducement can also take the form of offer of benefits. Either way, what the law is concerned with is the free will of the patient/donor.

Reimbursement of costs/expenses

Reimbursement of costs/expenses incurred by the donor does not appear to run counter to the spirit of altruism that society seeks to encourage. If the donor could not be paid direct costs/expenses incurred then not only is she altruistic she is also in a real sense being asked to underwrite part of the research costs. Section 13(3) of HCPP does allow the payment of reimbursement for reasonable expenses incurred by a person in relation to the supply of any human egg. This is not limited to the donor but includes any person in relation to the supply. So, if a donor incurs transportation fees to go to the clinic or has to buy creams or drugs to mitigate discomfort in connection with collection of her egg: reimbursement should be permitted. If a research team having extracted her eggs with her explicit informed consent (and complying with the necessary procedures) transfers the eggs to another research team in a different institution, they will not be allowed to charge a fee but may recover reasonable expenses incurred in respect of the collection, storage and transportation. From the perspective of the donor, how much “out of pocket” expense will she likely incur in undergoing the extraction procedure? It is unlikely in most cases to be substantial. If this is the sum total of her entitlement: then as Dr Capps points out, the donor may well be financially worse off as a result of the procedure.³⁹

But, is there any reasonable alternative? Reimbursement of direct “out of pocket” expenses of the donor should not be regarded as a prohibited inducement. Whether there should be some other payment for loss of time and risks incurred is likely to be far more controversial.⁴⁰

Compensation for loss of time

What then about the time expended by the donor? This is less clear and in any case the circumstances can vary considerably. The time lost may translate into lost wages or opportunity to work (if self employed). In other cases, the medical procedures may be conducted after working hours or at weekends etc. In some cases, the employer may have given permission to take paid leave to make the egg donation. In other cases, the donor may be unemployed and without any or any regular source of income. Loss of earnings may be considerable: it may also be non-existent. If the donor has indeed suffered objective financial losses, such as lost wages, payment of compensation restores her to the financial position she would have been in but for the donation procedures. In this sense, the compensation whilst still a form of inducement, does not result in any “profit” for the donor. On the other hand, if the donor was out of work, any payment for the time expended will represent a very real financial gain. An

³⁹ Background paper at p.12.

⁴⁰ Questions may arise as to how direct out of pocket expenses are calculated. Should these be subject to some overall requirement of reasonableness? How will the scheme deal with a foreign donor who claims the cost of air flight to Singapore etc to participate in an egg donation procedure? This may be dealt with either by having a cap on direct out of pocket expenses or by limiting participation to donors resident in Singapore and who are either citizens or permanent residents with a specific exclusion for donors who are merely on a social visit/work permit.

inducement in the sense of compensation for actual financial losses may be less controversial than an inducement that is founded on financial benefit.

But, even in the case of compensation for loss of earnings: problems may arise. In the case of actual lost wages: objective assessment may be relatively easy: at least in some cases. Troublesome cases will not be hard to find. What if the medical procedures take place on her off days or after office hours or if the employer continues to pay her salary? What if she is self-employed and the time lost is loss of work opportunity?

Should there in any case be a “cap” on the amount payable? As an alternative, is it preferable to have a fixed/standardized payment in recognition of the time spent and the general inconvenience of the medical procedure?

Payment of compensation for loss of time, wages or earning opportunity appears to be fraught with difficulties of assessment, proof and limits. Even in UK, Dr. Capp notes that compensation for loss of earnings is capped at £55.19 a day with an absolute limit within each cycle of oocyte donation of £250.⁴¹ For some donors, this amount may not be of any financial significance. For others, the amount may be of considerable significance and may even attract cross border movement.

Benefits in Kind

The idea of payment by way of benefits in kind in return for contributions towards medical treatment is not new. Indeed, section 14(3) HOTA expressly recognizes any scheme introduced/ approved by the Government granting medical benefits or privileges to any organ or blood donor (or their families or nominees).

Where the donor is also seeking AR treatment it may, as Dr. Capp points out, be possible to provide subsidized IVF treatments in return for donation of excess eggs for research. This obviously is irrelevant where the donor is providing the eggs specifically for research and is not seeking AR treatment. My understanding is that the main thrust of the BAC Consultation Paper is concerned with the latter scenario. If so, then the provision of benefits in kind in the form of subsidized IVF does not address the problem. Even where the linkage is made between use of excess eggs and AR treatment, Dr. Capp rightly points out that problems of “abuse” may arise. Under such a scheme, there may be an “incentive” to induce as many eggs as possible with an eye to using the excess for stem cell research. The tensions that this creates between the goals of medical treatment and research are clear. It is understood that there are real health risks associated with the oocyte stimulation procedure. It must follow that from a pure AR or IVF perspective: the lesser drugs used and the lesser induced oocyte cycles the woman undergoes, the safer it will be for the woman’s health.⁴²

⁴¹ This is about 745 Singapore dollars.

⁴² I do not know how many excess eggs on average there are left after completion of AR treatment for a donor. Doubtless this is a matter for the scientific experts and medical profession to investigate. If

Indemnity for adverse medical consequences

Leaving aside inducements, another issue that may be worth examining concerns the position of a donor (especially one who provides eggs specifically for research and not as a result of an AR or IVF program) who suffers ill effects from the procedure: the drugs used to induce ovulation, anesthesia, removal procedures etc. Granted, the BAC Consultation Paper indicates that few cases of adverse side effects have been reported. Nevertheless these may become more common and in any case it will presumably be a while before long term effects become clearer. The donor may not necessarily have any legal cause of action against the doctors, medical researchers and hospital. If proper consents have been obtained, and if the necessary information provided before the procedure and if due care is taken, an action for battery or negligence will be hard to maintain. A successful suit will be even more difficult where the adverse consequences only appear many years after the event. There must be some risk that the donor will find that she has to bear the consequences of her decision to donate. Some may say that medical risks are part and parcel of medical research and if a donor has decided (with the necessary information) to consent, that decision and risk is part and parcel of the altruism underlying the donation.

But can society do more in return to protect the interest of such a donor from adverse consequences? What is the position in respect of the costs of medical treatment in the event that some complication arises: whether short or long term? These could be substantial. What about compensation for pain and suffering and any loss of earnings arising from any disability? How significant will causation issues be: especially in the event of injuries or disabilities that only surface years after the event? This is a tricky issue that requires a considered response. In UK, one commentator notes that liability in tort (based on fault) may be hard to establish. For this reason it is said that:

“... all modern guidelines or directives as to the management of research projects emphasize the importance of compulsory protection of subjects against the possibility of mishap. Thus the mandatory EC Directive states unequivocally that a clinical trial may be undertaken only if, inter alia, provision has been made for insurance or indemnity to cover the liability of an investigator and sponsor ... while before approving a proposal, a REC in the UK must, currently be reassured as to insurance and indemnity arrangements for

subsidized IVF is considered for such donors, care must be taken to ensure that the best interests of the patient (and fetus assuming the IVF is successful) from the medical perspective has priority over any research objectives. To this end, strict compliance with the rule requiring the principal physician to be independent of the principal researcher must be adhered to. The MOH should consider whether a simple requirement that they are to be different persons is sufficient to ensure independence. They may be different persons but working in close cooperation! In the case of vulnerable donors, what is needed is a system to ensure that the donor has a reasonable opportunity to discuss the matter with persons independent of the research exercise.

treatment and compensation in the event of injury, disability or death of a research participant attributable to participation in the research.”⁴³

The commentators continue by noting the uncertainty as to what amounts to sufficient reassurance. Recommendations of the Association of British Pharmaceutical Industry state that compensation should be paid when on the balance of probabilities the injury was attributable to the administration of the medicinal product under trial or any clinical intervention or procedure provided by the protocol that would not have occurred but for the inclusion of the patient in the trial. Two points may be worth raising. First, this recommendation seems to be concerned only with medical risks arising from drug trials. What about risks associated with provision of tissues, ova and the like? Second, it is just a recommendation. To what extent is the recommendation followed in practice? How will the research team provide reassurance: insurance, industry funds?⁴⁴

In principle, this commentator agrees that some scheme should be implemented (supported by law) to provide compensation for individuals injured in the name of non-therapeutic medical research. The scheme should not be limited to participants in drug trials but should extend to include persons volunteering in human egg donation programmes.⁴⁵ If such a scheme is implemented, the question as to whether it is made applicable to both therapeutic and non-therapeutic research participants will also need consideration. If such a scheme is established, there is no reason why it should be seen as diluting the moral value of the donor’s contribution. Such a scheme may go some way to reassure volunteers in all types of medical non-therapeutic research that society values and respects the risks they are undertaking.

Indeed, the issue of compensation for adverse consequences arising from drug trials is not new in Singapore. In 1999 Dr Woo wrote:

“Singapore, the government has decided will be shaped and poised to become a hub for R&D of drugs. The government, through the Economic Development Board, will be investing and inviting companies locally as well as overseas, to commit and invest in Singapore as a regional hub in Asia for pharmaceutical

⁴³ Mason, McCall Smith and Laurie, *Law and Medical Ethics*, 6th ed.592. The authors explain that the provision on reassurance is found in Guidelines para. 9.15(1).

⁴⁴ See also Brazier, *Medicine, Patients and the Law*. 3rd ed at 412. The author notes that the English Pearson Committee recommended a no fault strict liability system. Writing in 2003, the author states that no change in the law had been effected. Instead, various ex-gratia schemes have been implemented by the pharmaceutical industry. She notes that “the case for no-fault compensation of persons injured in the course of research has long received wide support among doctors too. The burden of compensating those injured in the course of research to benefit us all should have a wide base. A fund could be financed from all bodies promoting research, from the medical profession, the pharmaceutical industry and the Department of Health”.

⁴⁵ This is without prejudice to the requirement that the research must be approved in the usual manner.

R&D... There will be a greater need for more clinical trials ... All clinical trials must be conducted in accordance with the Declaration of Helsinki”⁴⁶

More recently, the National Medical Ethics Committee (NMEC) has issued updated recommendations on Phase 1 Clinical Trials.⁴⁷ The very early point underscored in its Recommendations was that investigators should preserve and maintain the public’s confidence in medical research by offering care and adequate compensation for adverse events arising from their studies. Specifically, the NMEC recommends that:

“11 Institutions that allow non-physician investigators to do clinical studies should take out specific insurance cover for liabilities that these investigators may incur.

12. Research ethics committees should ensure that there are no gaps in responsibilities for providing compensation for relevant no medical costs and for medical bills that arise from adverse events ...

13. Medical costs and relevant compensation should be awarded on a no-fault basis.”

The NMEC rightly stresses that the UK Guidelines of the Association of British Pharmaceutical Industry are based on the assumption that the injured in the UK have access to free and continuing health care under the National Health Service. The position is different in Singapore. The NMEC stresses and this commentator agrees, that:

“the individual’s own medical insurance cover may not apply to injuries sustained in a clinical trial and even if it did it would not be right for sponsors of clinical research to draw upon this source of income of insurance for injuries

⁴⁶ KT Woo, Conducting Clinical Trials in Singapore, Singapore Medical Journal 1999 Vol 40(04). <http://www.sma.org.sg/smj/4004/articles/4004ra4.html>. Dr Woo notes that it is the responsibility of the Medical Clinical Research Committee to, amongst other things, ensure the protection of the rights, safety and well being of human subjects involved in a trial. Dr Woo also stresses that Hospital Ethics Committees have the responsibility of reviewing the amount and method of payment to subjects to assure that neither presents problems of coercion or undue influence on the trial subjects. Issues of compensation available are also within their purview.

⁴⁷ http://www.moh.gov.sg/mohcorp/uploadedFiles/Publications/Guidelines/NMEC_Guidelines/NMEC%20Compn%20Clin%20Trials_24%20May%2007_final_public_clean.pdf. Interestingly, the Recommendations note (in the context of clinical drug trials) the practice in Singapore that participants are reimbursed at modest rates for time, transport and inconvenience. Free medical assessment and comfortable accommodation for overnight stays are sometimes offered. It is also said that the centres are guided by principles to avoid encouraging people to participate in trials for financial gain. This indicates support for the view that in the case human egg donations for non-therapeutic purposes: financial gain should not be the basis of the donation. Can any distinction be drawn between clinical drug trials and ES research using donated eggs?

due to their studies, nor should the participants suffer the recurring increase in annual premiums that would result there-from.”⁴⁸

If it is right and proper to require a no fault compensation scheme for adverse consequences arising from participation in clinical drug trials, this commentator can see no reason why a similar scheme should not be made available for human egg donors for non-therapeutic research (or indeed any person who participates in medical research where that research is for the public benefit).

Assessment

TYPE	BENEFIT	FIVE YR SUCCESS	RISK PROBABILITY	SEVERITY	ETHICAL ISSUES
Blood donation	Clear (I)	High	Low	Low	Consent and vulnerable donors. Commodification
Kidney	Clear (I)	Good	Medium	High	Consent and vulnerable donors. Commodification
Drug trials	Clear (S)	High	Medium	High	Consent and vulnerable persons. Commodification
Participation Survey	Unclear	Unclear	None	None	Privacy issues
Oocyte Donation	Possible (potentially enormous)	Uncertain	Low/uncertain	Low but uncertain	Consent and vulnerable donors Commodification Pro-life issues

⁴⁸ Interestingly, the NMEC accepted that payments for participation in trials should be commensurate to the burden of participation and that the remuneration and other benefits offered should not be such as to induce people to volunteer against their initial judgment. This suggests that NMEC is against payments by way of inducement and that remuneration should be limited to expenses of participation.

Before attempting to reach some conclusions to the questions raised by the BAC, a comparative assessment of different types of “medical” altruistic behaviour involving living healthy donors may be of some help. The above Table selects 5 such activities. There are of course many more activities that could be included but for convenience, these will suffice.

The assessments are entirely judgmental and based on current the understanding (or lack thereof) of the author. The Table and assessments are simply used to assist the author in reaching a view on the questions raised. They are in no way based on empirical research data.⁴⁹ “Benefit” refers to benefit to the recipient (I) and/or society (S) as a whole. “Five Years” success refers to the likelihood that after 5 years the benefit will be ongoing. “Risk Probability” refers to the likelihood of adverse health consequences (primarily to the donor). These include short, medium and long term risks. “Severity” refers to the likely seriousness of the adverse consequences.⁵⁰ “Ethical issues” refers to the main ethical issues have arisen in respect of the donation in question.

Blood Donation. In the case of blood donations, the benefit to individual recipient is clear and obvious. My understanding is that whilst there are some alternatives such as “artificial blood” and saline solutions etc, the preferred choice will always be compatible human blood. The 5 year probability of success in the sense that the donor/recipient will still be alive and/or derive a benefit is high. The risk of adverse effects is understood to be low. For the donor: it is primarily risk of infection and some discomfort associated with the procedure. For recipient, it is also primarily risk of infection but this time from the blood itself. Overall, the severity of adverse effects to the donor is presumed to be low (although for the recipient it can be high as where the recipient receives HIV or Hepatitis B infected blood). What are probably more important to the BAC questions are the risks to the donor. It is likely that blood donation is now regarded as a “routine” medical procedure. Whether the medical risks

⁴⁹ In particular, the author stresses that the difficulty in deciding the applicability/relevance of some of the factors was in itself a useful exercise. The author accepts that other commentators may single out other factors or come to a different view as to relevance and applicability of the factors referred to. The author apologises in advance if the risk assessments are off the mark.

⁵⁰ The author understands that in the United Kingdom the term “minimal risk” refers to those where the probability and magnitude of physical or psychological harm is the same as that encountered in routine medical or psychological examinations. See Dworkin *ibid* at 205. Dworkin also notes that in the USA, a minor increase over minimal risk for proxy consents refers to risks of harm or discomfort greater in probability of magnitude than those encountered in the normal life of children but not posing a significant threat to the child’s well being. See also PJ Nicholson, *Communicating Health Risk*, *Occup. Med.* Vol. 49 No 4 253 at 255 where minimal risk is described as “1/100,000 – 1/1,000,000 eg railway accident.” Nicholson refers to a classification that places being struck by lightning as a “negligible risk”, death from playing soccer as “very low risk”, death from influenza (low risk), death from smoking 10 cigarettes a day (moderate risk), transmission of measles as “high risk”. Minimal risks are between negligible and very low risks. See also Kennedy & Grubb, *Medical Law*, 3rd ed at 1726. Minimal risks are said to be those where the risk of death is less than 1 in a million and risk of major complication less than 10 per million and risk of minor complication less than 1 per thousand.

are “minimal” or “negligible” it seems that in most cases the risk to the donor is very low. Ethical issues are also likely to be few and to primarily concern vulnerable donors, consent and commodification issues. By this, I refer mainly to the issue as to whether donor should be paid a sum over and above “out of pocket” expenses.

Kidney Donation. Again, the benefit to the recipient is clear and obvious (as also in many other living organ transplant cases such as donation of liver lobes). Alternatives do exist such as dialysis, artificial kidneys and trans-species transplants. The most common alternative I understand is dialysis. The long waiting list for human kidneys underscores the obvious point that the latter is much preferred. The 5 year success probability is likely to be good. The risk of adverse effects to the donor is medium. There are the risks inherent with the invasive medical procedure, infection and the use of associated drugs. Whilst many kidney transplants from living donors are successful, adverse health consequences can be high. For the donor, there must be some risk of death during the procedure and the fact remains that post operation, he/she will only have one kidney instead on two. I am not sure how high the risk is to the donor but this much is clear: kidney donations are not routine medical procedures and the risk of adverse consequences must be quite a bit higher than in the case of blood donation. Ethical issues can arise. These concern commodification, integrity and even “sacredness” of the human body (donor is giving up a healthy organ). In some cases, the ethical dilemma may be far worse as in the case of alleged forced donations (for example from prisoners) and donations by vulnerable persons.

Drug Trials. The benefit of drug trial participation is also clear. This time the benefit is to society at large. Alternatives may exist in the form of animal studies and *in silico* testing. These are however unlikely to replace human drug trials and it is assumed that for the foreseeable future, drug trials will remain essential. The 5 year success probability is good in the sense that the knowledge obtained will still be of relevance and utility. The risks to the donor are likely to be medium and presumably largely concern unexpected adverse reactions. Long term risks may be even less predictable. Participation in drug trials is far from being routine and the risks may vary quite a lot depending on the nature of the drug. In some cases, it is presumed that the severity of adverse consequences can be high. Ethical issues largely concern commodification. In some cases, there may also be problems associated with forced or deceptive testing.

Participation in Survey Studies. By this, I refer to general research studies into the social/life style backgrounds that may have an impact on disease incidence. Whilst such studies can benefit society, it is probable that the benefit will not be as clear. That said, the risk probability is very low and ethical dilemmas largely concern the need to maintain confidentiality and privacy of the identity of the participants.

Donation of Oocytes. The immediate benefit to society is not as clear as in the case of participation in drug trials or blood or organ donation. The chances of success after 5 years (in the sense of a proven benefit), is also uncertain. Some suggest that it may be decades (if ever) that embryonic stem cell research will lead to new therapeutic

treatments. Others are far more optimistic. If ES stem cell technology does succeed, the benefits however may be immense or incalculable. Organ transplantation (kidney, liver, heart, corneas etc) may cease to be a problem, spinal cord injuries corrected and the ravages of Alzheimer's and Parkinson's disease brought under control. But, the "if" remains significant. ES stem cell research lies somewhere near the start of the long "R&D" process behind new medical therapies. The further back or nearer the start of the R&D time-line: the greater must be the uncertainty of what and when practical benefits will arise. In the case of drug trials, the position is different. These typically are near the end of the R&D process. The drug has been researched and tested on animal models. Commercial release into the market may be just around the corner. Studies have been conducted and patents obtained. Whilst unexpected and sometimes disastrous adverse effects may arise (short term, medium or long term) drug trials are conducted with a real expectation of benefit in the immediate future.

But, the story behind many scientific/medical breakthroughs often begins with a "journey into the unknown". The potential benefits of ES research are enormous and broad based (multi- disease/injury). The risk of adverse consequences to the donor appears to be low (especially in the case of short term consequences). Long term risks including increased incidence of ovarian cancer from the hyper-stimulation of the ovaries is less clear. Similar risks are undertaken by women undergoing IVF/AR procedures (although here the risk is balanced by the benefit of pregnancy). The consequences of ovarian cancer may be severe. But, it is likely that equally if not more severe risks may arise from participation in drug trials. Aside from rejecting stem cell research in its entirety, are there real alternatives to ES stem cell research? To be sure, there are some research paths that involve the use of adult stem cells or cord blood. It is understood however that these may not be as useful as ES stem cells: either because of lesser degree of pluripotency or because of problems associated with immune responses.

IPS technology may be different. Immunological problems will not arise but there may be problems associated with the use of oncogenes and viral vectors. Doubts remain as to whether IPS cells truly mimic ES cells. If the promise of IPS holds true, then it may well offer a viable: indeed better route to stem cell technology than the current dominant ES model. But, if there is a big technical "if" for ES stem cells, there appears to be an equally big "if" over IPS technologies. Supporters of ES may well argue that the "if" over IPS technology is greater: at least by reference to present knowledge.

The ethical issues with oocyte donation arise in a number of ways. First, there are pro-life arguments especially where the oocyte is fertilized during the process. Even if cloning technologies are used, some may question the status of the cloned embryo and whether such technologies should be permitted.

Second, some may raise the question of commodification and exploitation of women for benefit of human kind.

Third, there is the danger of risk to the health of the donor.

Fourth, there is the slippery slope argument: the same technology that is used to develop new medical therapies out of stem cell research may also lead to a brave new world of eugenics and supermen and superwomen. These are significant questions. But, to be fair, will IPS technology really be as ethically neutral as first appears. IPS technology appears to possess the same ability to open the door to brave new worlds. Even more difficult may be the status of the re-programmed undifferentiated somatic cell. Does this cell truly possess the ability to develop into a range of adult tissues including a fully viable new born? If so, does this mean science has the power to turn any cell in the adult body into an embryo? If so, what are the ethical considerations? A woman oocyte donor who is allowed a profit based payment will be receiving payment for her participation in a fairly intrusive physical procedure over several occasions and with some uncertain long term risks. The short term risks and discomfort appear to be low and largely manageable. The practical benefit to society in terms of if and when therapeutic treatments will develop is far less clear. The potential seems enormous: the uncertainty high and the impact likely to be reserved for generations down the line.

Who is most likely to donate blood and organs? Leaving aside post mortem donations, it seems probable that in most cases, it will be a relative or friend of the recipient in need. True, donations from complete strangers can arise: especially in the case of blood. But for organs (and quite often also for blood) it is assumed likely that bonds of friendship, love and affection underlie the act in question.

Who is most likely to participate in drug trials? This is different. I don't know of any studies into the profile of drug trial participants. It stands to reason that they will not necessarily be related to any loved one suffering from the disease or injury. They may well be ordinary members of the public who participate for a large variety of reasons.

Then, who is most likely to donate oocytes? At present, it seems that these by and large are women seeking AR treatment. It is assumed that very few (if any) women have been approached to make donations solely for the purpose of research in a non-therapeutic context. If these AR connected donations are inadequate to support ES research in Singapore, should Singapore adopt a system whereby women are encouraged to donate eggs purely for research purposes? Voluntary donation of eggs for approved research is as I understand it already permissible. Should an incentive scheme be supported? Who is likely to be attracted by such a scheme? Given the discomfort and invasiveness of the procedure and the uncertain long term risks and uncertain benefits: who is likely to participate? It may be that payment of a small incentive will only be attractive to those who are in dire financial straits or those who are already vulnerable to "persuasion". On the other hand, those who participate because of the "adventure of scientific discovery" are likely to do so in spite of that payment and not because of the payment. For these, recognition and coverage for any adverse consequences may be far more important.

Conclusion

The issues raised by the present BAC Consultation Paper are important and timely. Indeed, some of the points stretch beyond research on embryonic stem cells and human eggs to any type of medical non-therapeutic research such as drug trials and the like. It is hoped that the discussion set out above is of some assistance to the BAC. The writer accepts that expert evidence as to the degree of risks associated with human egg donation and possible benefits are critical to reach a proper conclusion of where the balance lies.

The balance is likely to be dynamic in the sense that it will need review from time to time in the light of new scientific knowledge and experience such as with IPS technology.

Given the matters discussed above the writer's views on the two questions raised by the BAC are as follows.

- (i) Whether women should be allowed to donate eggs for research. Yes, I am of the view that women should (subject to proper approvals for the research proposal and proper consent) be allowed to donate eggs for research. I do not see any distinction between donation of eggs surplus to AR treatment and eggs obtained solely for the purposes of research (non-therapeutic research).⁵¹ However in the former case, I underscore the importance of ensuring that a clear line is drawn and maintained between the medical IVF/AR team and the research team. The system must clearly require independent taking of consent. I am also in favour of careful review of the scope of information that must be revealed to validate the consent. Such information should include not just information about the medical risks but also the research affiliations and commercial interests that may be involved.⁵² Where the donor is a vulnerable person such as an employee or research assistant of the research team, the burden should be on the researcher to prove that the consent is truly voluntary and that the donor has been given reasonable opportunity to obtain independent advice. Special consideration should also be given to the case where a proxy consent is sought for a female child donor. Given the uncertain long term risks and the

⁵¹ Even if contrary to earlier discussions, Singapore does not currently permit oocyte donations purely for research (not connected with AR): there does not seem to be any good reason why this should not be allowed subject to proper consent and compliance with research regulations of the MOH. The fact that the benefit is uncertain has to be balanced against the possible benefits to society as a whole. Participation in drug trials also does not necessarily always confer an immediate benefit to the participant.

⁵² By way of comparison, the Medicines (Clinical Trials) Regulations mention over 20 specific areas to be discussed and explained to the person considering participation in drug trials. These include: any compensation and treatment available to the subject in the event of injury arising from participation in the clinical trial. It is also noted that Reg 20 provides that the holder of a certificate or any person assisting him in a clinical trial or any subject in a clinical trial shall not directly or indirectly have any financial interest in the trial.

uncertain benefits, I am not in favour of parental proxy consent for minor females. At the very least, the consent of the minor female must be sought alongside parental consent. The minor female must of course be of sufficient maturity to understand what is being asked of her. Special consideration may also be needed to take account of any possible increase risk to young female donors from the procedure.

- (ii) Whether any payment may be made to, or received by, the egg donor. Aside from payment of direct “out of pocket expenses” I am not at present in favour of any payment for the donation.⁵³ This is so whether the payment is in respect of loss of earnings during the medical procedures or for the time spent. I am also unconvinced that purely notional sums will have much impact in any case on the number of women volunteering. If the sum is more than notional, there may be adverse consequences such as women from poorer levels of society (within and from outside of Singapore) making donations: ostensibly altruistically but in reality for the payment being offered. Individual autonomy and freedom of choice must be balanced against interests of society as a whole. If a conservative approach has been adopted in respect of payments for participation in clinical drug trials, why should the position be any different for human egg donation procedures?

Is it right that the health risks to the donor from egg donation are so “small” as compared to those associated with drug trials and organ donation, so that a policy against commodification has less relevance? But even if the health risks for the donor are relatively low, why should this lead to a more favourable view on commodification? How do we factor in the reality that long term risks are still uncertain? Is the argument in favour of payment better supported by the assertion that the potential benefits to society of successful human stem cell research are incalculable (albeit still unproven)? But if so, how is this any different from the societal benefits of individual participation in drug trials? Is the urgency driven by scientific need or commercial interests or both? These are tricky questions and different views are bound to arise. The fact that Singapore has invested in the life science industry in general and embryonic stem cell research in particular does not mean that the Government places commercial considerations ahead of all other concerns. The setting up of the BAC and its broad mandate clearly underscores the importance attached to ethical considerations.

On balance, given that there are emerging technologies (particularly IPS stem cell research) that *may* well lessen the need for ES stem cells and given the uncertain (particularly long term) risks arising from the egg donation procedures, the principle of altruism should remain underscored. Yes, the potential benefits of stem cell research to society are likely to be enormous.

⁵³ I understand that South Korea in late 2007 amended its law to clarify that sale or purchase of ova is not allowed. http://www.koreatimes.co.kr/www/news/nation/2007/09/113_10900.html.

But, against this there remains the real danger of abuse of the technology. It is often said, and rightly so, that technological development always involves risks especially those arising from abuse. The present BAC Consultation Paper is not directly concerned with stem cell research and use of genetic information to treat disease or infirmity and the dangers of abuse (for example cloning of individuals beyond the 14 day limit). Indeed, I make no comments on the general question of ethics and research on human embryos.

The BAC Paper looks at the specific issue of the *source* of human stem cells and in particular, supply of eggs to advance permitted embryonic stem cell research.⁵⁴ Nevertheless, proper attention to ethical issues concerning the supply of human eggs is an important first step that supports the development of an ethical stem cell research and development program. Payment, over and above direct out of pocket expenses, raises too many questions. Will this be acceptable to Singapore society?⁵⁵ What impact might this have on other forms of medical altruism? Given the globalised world and Singapore's increasing international status, is there a real and unacceptable danger that "poorer" donors from the region might come to Singapore to participate in egg donation payment schemes? How much payment over and above direct out of pocket expenses should be provided under a payment scheme? Should this be linked to lost earnings or capacity

⁵⁴ It is also noted that other approaches to stem cell research such as human/animal chimera (chimerids) involving insertion of human genome from somatic cells into animal ova may also be "promising" from a purely scientific point of view. But, even here, whilst no human embryo is involved as such, there will be hard issues of definition: what is it to be "human" and what is it to be an "embryo"? Behind these definitional issues, tough ethical questions will not be hard to find. Also there may be questions as to whether remnant animal DNA such as mitochondrial DNA has any impact on the harvested stem cells. The debate over chimerids has been fierce in UK with UK only accepting the creating of human/animal chimeras (for stem cell research) in late 2007. See <http://www.publications.parliament.uk/pa/l200607/lhansrd/text/70503-0002.htm> and also <http://www.guardian.co.uk/science/2008/jan/01/science.review.2007>.

⁵⁵ Indeed, experience in UK suggests that the taking of public opinion is by no means an easy task. Some have even queried whether participants in opinion surveys have the necessary scientific knowledge to properly grasp the issues that have arisen. For example, in the debate in the UK House of Lords on chimerids, some speakers queried whether 70% UK acceptability of embryonic stem cell research was reliable. See for example, the speeches by: Baroness Kennedy, Baroness O'Cathain and Lord Crisp. Baroness Kennedy (Chairperson of the Human Genetics Commission) lays great importance on public consultation as "good policy and progress in science are made in a context of public acceptance...Public engagement is essential to achieving that acceptance. From experience, what we have seen is that where science outpaces public acceptance, for example with genetically modified foods, it can lead to inhibition of research and of the benefits of that research." Nevertheless, Baroness Kennedy states that the consultations of the Human Genetics Commission (unsurprisingly) reveal a wide range of views on the ethics of stem cell research. If the taking of informed public opinion is hard in UK, it is likely to be no less difficult in Singapore and especially ASEAN as a whole. But, it does not follow that just because a wide range of views are likely (with no dominant or universal consensus) that the consultation exercise is pointless. Consultation and public engagement will at the very least result in better public understanding of the issues and should prove helpful to the policy makers.

to earn? Should the payment simply be based on what the market is prepared to pay? Should there be a cap and if so how is this to be assessed? Is there any “international” consensus of what is an acceptable payment? If the payment is notional: does it serve any purpose? If more than notional, will this exacerbate the problem of “exploitation” of poorer donors whether within or from outside Singapore?

- (iii) I am also strongly in favour of society providing some form of safety net for donors who suffer adverse health consequences as a result of the procedures. I agree that this should be done on a strict liability basis: either through insurance or some industry wide fund. I am unconvinced that an *ex gratia* system is sufficient. Some form of dispute resolution scheme might also be usefully developed to handle cases where problems do arise.

The current science suggests that there are a number of avenues to pursue the goal of human stem cell research. These include: use of adult stem cells, use of embryonic stem cells, induced pluripotent stem cells and possibly human/animal chimera methods. Whilst none of the approaches are entirely free of ethical considerations, it does seem that use of embryonic stem cells and possibly chimerids will be the most controversial and for some time yet to come. Stem cell research should have as its goal the benefit of human kind: new medical therapies with dignity and respect for life as a whole. The different methods of stem cell research should not be seen as commercial competitors and research decisions should be made based on which line(s) offers the best hope of progress for humankind as a whole.

Addendum: Scenario Postulated by the BAC

Since the preparation of the comments, my attention has been drawn to a hypothetical scenario posted on behalf of the BAC and designed to help elicit focused responses. The scenario concerns a Parkinson's patient and possible donation of eggs by a number of individuals.

1. Do you think Abi, who is 35 years of age and a mother of three children, should be able to donate eggs to MMS for research?
 - Abi is the daughter of the patient.
 - She is of age and is legally competent.
 - This is a case of non therapeutic research.
 - Assuming Abi is informed of the health risks (including uncertainties) and understands the medical procedures involved, I would support her right to make the donation.
 - Abi should also be given information that the research may well lead to commercial applications and any questions that she may have on the research at MMS be fully answered.
 - Her identity as donor must be kept in strictest confidence.
2. If Abi needs to take time off from work, do you think she should be compensated either in full or part for the loss of income, inconvenience and risk involved?
 - Even assuming that she suffers provable loss of income, I am not in favour of Abi receiving compensation for that loss. Compensation in full or part raises too many problems and in any case goes against the supposed altruistic nature of the donation. Person's like Abi donate because they want to do so: because they feel it is the right thing to do.
 - Inconvenience and risk will be very hard to quantify. Any sum is likely to be notional. For individual's who might be persuaded by "financial inducements" the offer of a notional sum to compensate for inconvenience and risk is unlikely to make any difference. For those who might be persuaded by such payments, it is probable that they will come from highly disadvantaged sections of society. Some may even come from overseas.
3. If so, what type of compensation would be acceptable and not amount to inducement?
 - Generally I am not in favour of a "compensation" package for loss of time/inconvenience and risk.
 - Payment of direct out of pocket expenses is acceptable. This should include the costs of any consequential medical treatment and/or medicines.

- A no fault strict liability scheme should be established to compensate for any adverse effects of the donation procedure. Granted there may be some difficulties of proving causation especially where the adverse effect arises many years down the road: nevertheless as a matter of principle, this seems the right response for society.
4. Carol who is 21 years of age was inspired by her aunt Abi and she wants to donate her eggs to help advance the work of her research team. Do you think she should be allowed to do so?
- Carol is of full age and is legally competent.
 - Nevertheless, as a member of the research team she may be regarded as a “vulnerable” person in that she may be subject to “contextual duress”.
 - Whilst her expressed desire is said to be “inspired” by the altruism of Abi, it is important for society to ensure that she has not be subject to any undue influence arising from her position as member of the research team.
 - The burden must be on the research team to seek approval from the relevant IRB and to demonstrate that Carol’s consent is truly independent. At the very least, Carol must have had an opportunity to obtain independent advice and given reasonable time to reconsider her decision.⁵⁶
 - Carol must be given the same information as to risk and consequences as is given to any other non therapeutic donor.
 - Carol’s identity as a donor must be kept in strictest confidence.
5. Do you think Carol should receive any payment for the time, inconvenience and risk?
- No, her position should be the same as for Abi.
6. If Betty decides to donate her “spare” eggs to MMS, do you think she should be subsidized by MMS for the cost of her IVF treatment?
- Betty is undergoing IVF/AR treatment. She should be allowed to donate her excess eggs subject to her consent being obtained based on provision of the same information as is provided to Abi.
 - Aside from the consent being informed, it is very important to dispel any “suggestion” of undue influence as she is a “vulnerable” donor.
 - The taking of her consent must be by individuals who are independent of the MMS research team. I am not sure that a bare requirement that the principal

⁵⁶ It will be important to discover what is the international practice and experience on donations from research team members. Leaving this aside for the moment, as a matter of principle even vulnerable donors should be capable as a matter of law of giving real consent. Vulnerability does not mean legal incompetence. What is essential is that a strong system be put in place to ensure that situational duress is not the reason for the donation. If the view of the medical profession is that it will be hard in practice to protect research team members from situational duress or to discover if the donor is affected by her situation, the egg donation should not proceed.

investigator must be a different person from the principal physician is sufficient.

- The IRB must be satisfied that the eggs are truly “excess” or “spare” and were taken in the first place for the purposes of IVF treatment. In short, the practice must not be allowed to develop where a deliberate “over supply” is obtained from the IVF patient so as to “create” an availability of spare eggs.
- I am not sure of a scheme that permits the cost of her IVF to be subsidized. Given that her wish is to become pregnant and given that pregnancy involves a new life, I would tend towards utmost caution.
- The health of the IVF patient and the prospective health of any implanted fetus are of the utmost importance. Whilst I do not understand the risks involved it seems probable that the less physical intrusion/stimulation of the ovaries, the safer it will be for mother and hopefully, the child that is desired. Having a link between IVF costs and donation of surplus eggs may create/exacerbate any tension between the IVF and Research Team. This is especially so where the decision to donate excess eggs is made prospectively (in advance of the IVF egg obtaining procedure). I am not sure what the position is for donation of blood. There, it may be that the blood donor receives priority or subsidized access to blood transfusions should he require these in the future. Arguably, the position is different. The blood donor is in essence getting back nothing more than what he/she has given. The taking of blood (presumably) involves a much lower health risk to the donor as compared with the far more invasive procedure of egg donation. The question of linkage between IVF costs and donation of surplus eggs is a matter on which I would prefer to express no concluded view.

A final point concerns confidentiality of the identity of egg donors. Confidentiality is always an important concern of medical patients and research subjects. In the case of embryonic stem cell research it is worth underscoring this point: not the least because of the important background debate over use of human embryos for research. I am not sure of the practicalities but would urge consideration of a system whereby even members of the research team are unaware of the identity/source of the eggs being used. If medical students/members of research teams are allowed to make egg donations, is it possible that these could be to a “central egg bank” controlled by a body independent of embryonic stem cell research teams? Any research team can then request release of eggs for embryonic stem cell research approved by the relevant IRB. Would this better protect the identity of donors and reduce any tension between the research team and female members who wish to contribute their own eggs for stem cell research? Human egg donation raises many hard policy driven issues. The controversy emanating from South Korea in 2005 will remain fresh in the public conscience for some time to come. What are the lessons to be drawn on egg donations and members of research teams? Is it enough/helpful that the research team is unaware of the identity of the donors? From one point of view, this may reduce the possibility of pressure on research team members to donate. But, is that enough? Is there a danger that research

teams will be able to hide behind a veil of ignorance? Much will depend on the system Singapore puts in place to handle human egg donations. If the donations are processed by each research team, donor anonymity will be hard to maintain and the research team should be under a positive duty to ensure informed voluntary consent has been obtained prior to obtaining the eggs. If the eggs come from some centralized authority, then it will be the duty of that authority to ensure that the research team's use has been authorized by the IRB and that the eggs in the bank are all covered by voluntary informed consent donations within the legal framework for the making of such donations. Under such a scheme, research teams in Singapore will not be allowed to use human eggs obtained otherwise than from the central authority. I am not sure how realistic such a procedure may work in practice and I do accept that donor anonymity should not excuse undue influence that has affected the volition of a donor/member of the research team. Whether there is a centralized system or whether individual hospitals/centres are allowed to collect eggs themselves, it is important that vulnerable donors including employees and students be protected from contextual duress.⁵⁷

⁵⁷ http://www.guardian.co.uk/korea/article/0,2763,1650066,00.html#article_continue. See this link for a short piece on the egg donation controversy in South Korea.

Comments from Associate Professor Allen Yeoh

Yong Loo Lin School of Medicine
National University of Singapore

9 January 2008

Paper is clear and not controversial. As a clinical translational researcher, I strongly feel that the current ethical regulations are unduly restrictive and stifle research without corresponding improvement of protection of subjects.

- a) Reimbursement of expenses only is inadequate and requires an overly “altruistic” commitment from the donor who sees no immediate direct benefit of the cause.
 - b) Compensation of time and inconvenience is appropriate and should not be deemed excessive. Given the high average social income of Singaporeans, it is unlikely that donors are “coerced” into donation by the reasonable reimbursement. The guide should be similar to the reimbursement for drug trials of normal subjects. The suggested compensation of \$760 per cycle by UK HFEA, in my opinion is inadequate while the US\$5000 by American Society for Reproductive Medicine is probably excessive, given the easy accessibility in Singapore.
 - c) Provision of medical insurance cover of possible side-effects of ovarian hyper-stimulation and the harvesting procedure, as in any drug trial, is important. The authority responsible for the Donation of Human Eggs for Research should set up the guidelines of insurance coverage for such matter.
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Comments from a member of the public (1)

Received via email on 8 November 2007

Dear Prof Lim Pin

I support the use of human eggs in research for the potential good it can bring.

I also fear the temptation to abuse it when it is allowed.

Therefore the following suggestions:

To encourage donors to come forward, it should just only be a vague general sense of altruism. The donors are encouraged to feel more involved; their contribution more purposeful, effort more directed and meaningful.

1. Donors are educated on what current ongoing or future research works are about both the difficulties and promise they hold. This can be done before and/or after donation.
2. Donors are encouraged or can choose to allocate some of the eggs (the rest can be set aside for a 'general pool') to specific cause or project/s they feel strongly for. E.g. Miss A may come forward and want to donate some of her eggs towards works on Parkinsonism after reading the plight of actor Michael J. Fox or his foundation. Madam B may volunteer her eggs for studies on cancer after knowing a friend/relation who has been diagnosed with a malignancy.
3. Donors can choose to be updated regularly on the general progress of whichever areas/studies they feel strongly affiliated to. With the periodic updates, reminders on by what new portals there are that they can also urge other fellow friends or colleagues to step forward to donate too.

Rewards should comprise both the intangibles and the more concrete. More so if it involves some discomfort, time and maybe medications e.g. Drugs to stimulate eggs release.

4. Any monetary rewards should be accredited into medisave/medishield. The donor can choose the account holder to be any of her family members and herself. Or she can choose to donate it any charity of her wish, preferably one with IPC status. This is to reward like with like.
 - a) This will help avoid cases in some developing countries where the poor and deprived are coerced to donate blood/kidney for immediate money and food, neglecting efforts to correct the underlying poverty.
 - b) This will help avoid situations in many developed countries where recruitment for human trials always attract a disproportionate number of drugs addicts and

gamblers who readily spend this perceived 'easy \$' on drugs, sexual workers and gambles.

5. Any benefit that derives the outcome of the particular research can be shared with the donors involved in various form.
 - a) It can monetary.
 - b) Or subsided therapy if the donor or any person named by the donor --does develop the condition or disease.
6. To encourage repeat donations, for each year or each additional batch of eggs donated, a new nominee can be named as beneficiary.

My grandmother-in-law has just passed away. After cremation, my wife asked me how would I like my body to be dealt with.

Me: "Please donate my cornea, kidneys, heart/lung, bone, skin and whatever it's useful"
Wife, not surprised, pressed on:"what about the rest, they don't need everything"
Me:" Donate it to medical school" (wonder if they still need it now that's computed aided visual teaching
And by then my body will have missing anatomical parts)
Wife....silence.....:"but they will cut you up, gulp"

If some of the above suggestions are workable, please also consider it for bold donation and organ transplant.

I am not involved in any research work and have no vested interest.

Comments from a member of the public (2)

Received via email on 25 March 2008

Healthy women should be allowed to voluntarily donate eggs for medical research, provided legal safeguards including the following are in place:

1. Exclude women who are unsuitable as egg donors or have higher risks of ovarian hyperstimulation e.g. Women with PCOS, menstrual disorders, reproductive structural defects, allergies to drugs used in the procedures, family history of ovarian, uterine, cervical or breast cancers, low BMI, women intending to conceive in future.
2. Exclude tourists & foreigners on short term visits.
3. Informed consent to be properly taken.
4. Donors to be allowed voluntary withdrawal at any time without penalty.
5. Procedure to be done free of charge in MOH approved institutions only, which should be subject to regular audits by MOH.
6. Free medical examinations to be performed to assess risk & suitability after informed consent are given.
7. Donors to be allowed to opt for either donation via ovarian stimulation or without stimulation (i.e. collection via natural ovulation) if the latter is feasible.
8. OHSS or other complications/adverse reactions arising from the procedure to be managed free of charge.
9. Donors to be adequately treated & compensated if harmed in the procedure through medical negligence or improper techniques.
10. No monetary or other forms of compensation other than transport reimbursement based on cab fares or mileage & parking claims.
11. Donated eggs are to be used locally for medical research and not sold or exported.

Wrt to points 8 & 9, institutions performing the procedure may wish to provide free insurance to donors against medical problems arising from the procedure.
