

Women and Equalities Committee

Oral evidence: Egg donation and freezing, HC 1903

Wednesday 28 January 2026

Ordered by the House of Commons to be published on 28 January 2026.

[Watch the meeting](#)

Members present: Sarah Owen (Chair); Alex Brewer; David Burton-Sampson; Dame Nia Griffith; Christine Jardine; Kim Leadbeater; Kevin McKenna; Rebecca Paul; Rachel Taylor; Nadia Whittome.

Questions 1-56

Witnesses

I: Timothy Bracewell-Milnes, Consultant Gynaecologist and Subspecialist in Reproductive Medicine and Surgery, Lister Fertility Clinic; Dr Giulia Cavaliere, Lecturer in Engaged Philosophy, University College London; Professor Nicky Hudson, Professor of Medical Sociology, Loughborough University; Professor Petra Nordqvist, Senior Lecturer in Sociology and Co-director of Morgan Centre for Research into Everyday Lives, University of Manchester.

Written evidence from witnesses:

Dr Giulia Cavaliere, Lecturer in Engaged Philosophy, University College London
[\[EDF0016\]](#)

Professor Nicky Hudson, Professor of Medical Sociology, Loughborough University [\[EDF0051\]](#)

Professor Petra Nordqvist, Senior Lecturer in Sociology and Co-director of Morgan Centre for Research into Everyday Lives, University of Manchester
[\[EDF0031\]](#)

Examination of witnesses

Witnesses: Timothy Bracewell-Milnes, Dr Giulia Cavaliere, Professor Nicky Hudson and Professor Petra Nordqvist.

Chair: Welcome to the Women and Equalities Committee. Today we have the first of our sessions on egg donation and egg freezing. We are looking at the practice, the standards, the regulations, the health implications and the ethics. I am sure this will be a fascinating session. We have Mr Timothy Bracewell-Milnes, consultant gynaecologist and subspecialist in reproductive medicine and surgery at the Lister Fertility Clinic; Dr Giulia Cavaliere, lecturer in engaged philosophy at University College London; Professor Nicky Hudson, professor of medical sociology at Loughborough University; and Professor Petra Nordqvist, senior lecturer in sociology and co-director of the Morgan Centre for Research into Everyday Lives at the University of Manchester. Thank you all for being here. I will pass straight over to Nadia.

Q1 **Nadia Whittome:** How does the UK regulatory framework differ from that of other countries? Are there different approaches in devolved nations? It would be good to hear from all of you.

Professor Hudson: The UK is often held up as a world leader in the area of reproductive health and infertility treatment broadly. I think that is important to highlight. There are differences around key areas, such as identification of donor offspring, the number of families that can be conceived using donor gametes, and whether donors need to be counselled and how. There are some key differences. It is important to note that the UK has led the field in a lot of those areas.

I would say there are some interesting examples globally. The other thing to say about international regulation is that it is specific to each national context, so we cannot transplant regulations from one context to another. There are places, for example—New Zealand is an interesting case—where donors and recipients can meet before they engage in donation. There are places where donors must be counselled before they donate their gametes. That is not the case in the UK. There are countries we could learn from, but I also think we do it very well in the UK.

Nadia Whittome: It would be interesting to hear anything specific you can say on devolved nations.

Professor Hudson: In devolved nations, there are differences in practice. In Scotland, donors are not paid. They are not paid anywhere in the UK, but they are not compensated in Scotland. There are differences around funding of fertility treatment generally in the devolved nations, which is really important and has a bearing, for example, on whether donors are recruited easily or not.

Professor Nordqvist: We differ quite a lot on how much we pay donors. Obviously, payment is not allowed in the UK, but we compensate our donors. I have been involved in studies with Dr Leah Gilman, at the

University of Manchester, that show that the level of payment we offer our donors in the UK meets quite a good level. People are very much influenced by the social and cultural context in the UK, where donation is very much framed as an altruistic act. They do it because they feel it is a good thing to do, but they are also compensated for the effort and the travel, and maybe for losing out on going to work and things like that. Our studies show that that is at a good level, whereas the commercialised practice we see in the US, where egg donation works very differently and is very heavily commercialised, is a very different context, if we compare internationally.

On one more issue of international practice, we have identity release in the UK, and have done since 2005. That means that donors recruited after that date go into donation knowing that a donor offspring can contact them at the age of 18. That is becoming something that we need to look at, because of DNA testing and because of how things are moving on. For example, New Zealand has a much more open and flexible framework. That might be something the UK would benefit from looking at.

Nadia Whittome: Timothy and Giulia, do you have anything to add?

Timothy Bracewell-Milnes: They are the main two major regulatory decisions you make when you are talking about egg donation: whether you pay the donors—in the UK, we don't; there is a compensatory payment, but that is never a motive for a patient to do the donation process—and anonymity. I think the treatment in the UK at the moment is very good, open and fair.

Dr Cavaliere: I have something to add on compensation, but will there be a specific question on that?

Chair: Yes, there will be a specific section on compensation to donors.

Dr Cavaliere: Okay; I will hold on then.

Q2 **Nadia Whittome:** To what extent do you think the UK has got it right in terms of regulation? Are there areas where you think there should be changes? For example, do you agree with the regulator that the Human Fertilisation and Embryology Act should be revised or amended to include more of an overarching focus on patient protection?

Timothy Bracewell-Milnes: The HFE Act is held as a benchmark internationally, in terms of regulation. On egg donation, there are two major things, the first of which is the counselling aspect, which is very much encouraged by all doctors and clinics. Patients will have a very detailed medical assessment, see a counsellor and be able to make a very careful and very informed decision on whether they go ahead, based on all the information they are provided before they commit.

The second aspect is vigorous consent. Patients are provided with verbal and written information and have to consent to literally every aspect of their treatment and what is done in the lab. That is revisited every time

they come to the clinic. It is a very open and transparent process that they can change at any point—it is not just at one time point.

We have talked about the compensatory payment. In countries like the US, where you pay a lot of money for patients to do it, there is a huge risk of exploitation, but obviously that is not an issue in the UK.

Professor Hudson: I think we have broadly got it right in the UK, as I said, but there is an opportunity for horizon scanning around the changes. Petra has mentioned the increasing use of ancestry testing as one example of where technology is outpacing the legal context. When the Act was last amended, that wasn't available. If there is the potential for us to look at that, alongside questions like whether we have still got it right around informed consent for everybody, that is a good idea.

Also, in the context of egg donation, it is not necessarily about regulatory changes but, potentially, about some areas of best practice that we could look at. That comes out of the research that we have been doing with egg donors in the UK. There probably are areas where we could make improvements, but that may be more about best practice and less about regulation. I do agree with what has been said about anonymity and identification of donors—the field is moving very quickly, and we need to look at the law in the context of that change to see if it is still fit for purpose.

Dr Cavaliere: Another good thing about the UK is the HFEA as an organisation; to my knowledge, no other country has a similar apparatus on top of the Act. The licensing, inspecting of clinics, setting of standards and the code of practice of the HFEA are excellent, in my view. In terms of changes to the Act, I do not have much to suggest.

Building on what Nicky said about keeping up with societal and technological changes, the fact that people postpone more and more the time of conception, the phenomenon of reproductive ageing and the fact that people have children later in life, obviously will affect the use of fertility treatments like IVF, but also may cause an increased need for donors if women have children later in life. That is not covered by the Act, but it is important that the policy landscape is attuned to those societal changes.

Professor Nordqvist: Something that comes out clearly in the qualitative studies that we have done with egg donors that aim to understand their experiences in-depth, as opposed to surface mapping donors' experiences, is that many egg donors understand their donation as a personalised gift that puts them in connection with their recipient. That may be an anonymous connection; nevertheless, it is often felt to be something that connects them with that person. That comes through particularly strongly among egg sharers: if both women are successful, they conceive very closely—one the day after the other, or so. There is a sense of connection there.



Some donors who we spoke to want to maintain anonymity—they do not sense that connection—but others feel that very strongly, and they must go down the known donor route. At the moment, we do not support known donation in clinics; even though it is not illegal, it is not something that clinics support. I think a more flexible framework would target more what women actually want. Some may want to remain anonymous, but others are really keen to connect in some way, or are open to some form of connection. I think that could be looked at, and would benefit egg donors.

Q3 Nadia Whittome: That is really interesting. What has been the impact of unregulated fertility services, such as online fertility treatments, on the safety and wellbeing of patients?

Dr Cavaliere: When you say, “online fertility”, do you mean fertility testing, or something else?

Nadia Whittome: Just the quite wide array of services that are available online but are not really regulated—in a general sense.

Dr Cavaliere: Okay. I will say a few words and then perhaps others can jump in. One of the things that has changed the most in the past few years is the online availability of what is sometimes called fertility testing or fertility screening. Basically, that is companies that offer, as a service, checking blood tests, hormone levels and ovarian reserve, and so on. A problem with that is that they are marketed as assessing fertility, but what they actually do is just assess hormone levels and ovarian reserve, which does not say much about the actual chances of pregnancy.

There are lots of other things that my colleagues are better suited to speak about, such as ancestry testing and so on. It is quite a concerning area, because the NHS does not offer blood tests or tests for ovarian reserves or the anti-mullerian hormone, which together indicate the broad ability to have children but are very loosely connected to the actual ability to have children. The NHS does not offer that unless there is a diagnosis of infertility or an ongoing investigation. Therefore, also connected to the fact that people are having children later in life, there has been a growing use of this kind of testing. I think that is quite concerning, because then you get lots of women who might be worried for no reason, and they do not have any outlet to seek help, because they might not be trying to conceive at that moment, and there is no cure for potential future infertility. That is one area.

Q4 Chair: One specific example on this front is Apricity, which was an online concierge service. When that shut down, there were people left without any kind of support or communication directly with the fertility providers. They fell out of scope of any of the protections because they were not providing any fertility treatment themselves; they were just a gateway for people. Do you have feelings about that? Is that a responsible way to be doing things?

Timothy Bracewell-Milnes: The whole concept of that, which has now shut down, was for patient convenience. The patients who were going there were paying for that service, so if they wanted to go somewhere for



HOUSE OF COMMONS

a scan one day and somewhere else for a scan another day, they could do that. Very few patients chose to do that; most prefer to be in a clinic and know the team, the nurses and their consultant. It was an unfortunate example. Because Apricity was not actually responsible for the decisions and care itself, I think that it would be something that is quite difficult to legislate against.

Professor Hudson: I think it is a signal of where the field is moving as well. It raises the question of what need it is fulfilling that falls outside the protections. We know that most fertility treatment is funded by patients themselves—most of it is not funded by the NHS. Patients are looking for efficient ways to access treatment, and the world is moving to an online model, so I think the kind of platformisation of IVF generally is attractive. We need to think about safeguarding around the potential for that. That is where some of the push to look at the regulation in the context of patient safety is moving, because it is moving into a new space.

Fertility medicine is one of the most regulated areas of treatment, but it is also one of the most commercialised areas of medicine. It is not just the kind of concierge services in IVF; there are also concierge services in egg donation. We have quite a lot of egg agencies in the UK, but also across Europe and internationally, which I think is very relevant for this Committee in terms of the implications for egg donors who might engage with those services, as well as the recipients. Some of that work falls outside of the regulatory context of the UK, because they are not based in the UK.

It is difficult. How do we regulate for the sorts of commercial organisations that do not fall under the HFE Act? Part of that is about—this is probably beyond the scope of this Committee—how we fund fertility treatment in the UK and how we give information to patients.

Q5 **Chair:** You said that they are paid-for services. Do you know roughly how much they would cost an individual? Are they expensive?

Professor Hudson: I do not think they are cheap. I think that in terms of egg agencies, a package would potentially be £3,000 to £5,000 for recipients to be matched with a donor and supported through that process. I do not know how much they charge for general concierge IVF services.

Professor Nordqvist: Because of the price tag attached to IVF and private reproductive medicine in this country, there is a growth in people who use online social media and digitalised platforms to find donors, because they simply cannot afford to go via established clinics. That is part of how the whole field looks.

Q6 **Nadia Whittome:** Are the safety standards and limits on stimulation cycles aligned with current evidence?

Timothy Bracewell-Milnes: In terms of the complications from an IVF cycle?



Nadia Whittome: Yes.

Timothy Bracewell-Milnes: A cycle of IVF is a lot for a patient to go through. It is invasive and inconvenient. You have to come in for four or five scans, then an invasive, transvaginal procedure to collect eggs and then, depending on the treatment, an embryo transfer. That said, it is extremely safe, with very, very few complications. The common ones are just the physical effects, like bloating and a bit of abdominal pain, and the hormonal effects that almost all women report. The numbers of serious complications, like ovarian hyperstimulation syndrome, have really plummeted over the last 10 to 15 years with the advent of something called the agonist trigger and a freeze-all approach if the response is high. The levels of significant OHSS are now well below 1%, which is a very good standard and very much in line with or much better than other countries.

Then, in relation to long-term safety, there is, again, a very, very high number of patient cohort studies and numerous meta-analyses showing no long-term effects in terms of female cancers and other long-term morbidities. So it seems like a very safe treatment that we are offering.

Q7 **Rebecca Paul:** I want to move us on to advertising. Some of the discussion we have just had about the financials emphasises how important the advertising oversight is to make sure that the balance is right in terms of providing a service that people want and not moving into exploitation. Some of these girls have been paid £985 and then someone is doing egg matching for £3,000 or £4,000. A lot of money is being made, and some of these girls could be vulnerable. Do you think there is sufficient oversight of advertising and marketing of these activities, in the light of the delicate balance that we need to reach here?

Professor Hudson: In this area of fertility medicine, there is a great deal of regulation in relation to advertising. The Competition and Markets Authority have provided some guidance for clinics on this. That came about because of the debates that we had a few years ago about fertility add-ons and whether clinics were marketing fertility add-ons in an accurate and responsible way. This area of recruitment of donors falls within that scope as well.

I think there are signs that that is starting to work. As part of our research on egg donation, we looked at the UK, Spain and Belgium, three countries where egg donation happens, and we looked at recruitment of donors through fertility clinic websites. We didn't look at social media advertising; we looked at websites. And what we found was that there are areas for improvement around not necessarily the compensation levels, but the ways risks are communicated to potential donors. Partly that is because we have so little evidence about the long-term risks for egg donors. That is a gap. I think one of the things that we need to think about recommendations on is more research, and funding for more research, on this.



HOUSE OF COMMONS

In the absence of information about long-term risks, clinics, at least in the analysis that we did of those three countries, can provide kind of ambiguous information and perhaps do not give donors enough information about some of the more practical, short-term risks that Tim mentioned. So there is still some work that could be done around that. But the moral panic, shall we say, that we have had around advertising is potentially a little bit misplaced, in my view. We didn't find horror stories, shall I say, in relation to recruitment of donors through those sorts of adverts.

Q8 Rebecca Paul: But you said that you had just looked at websites; you did not look at social media. The stories that I have heard from young women, which prompted me to raise this issue to the Committee and do this inquiry, are that it is all over their social media. I was really confused. I thought, "I don't see any of this. Is that true?" Then I realised that I am too old. I am in my late 40s—they don't want my eggs! I am hearing this from young women often at university or at school. We all know what it is like for young people at the moment—it is very difficult. That gives me quite a lot of cause for concern.

You say you think it is a moral panic. It would be good to get input from all of you on this, because I am concerned that we are potentially targeting young women. As you have said, we do not understand the long-term health impacts. There is a risk. Do they understand that? They may be likely to take something for short-term financial gain if they need to pay the rent. There is also the psychological side of all this when there is potentially a child at the end of it. It would be good to get your perspective.

Dr Cavaliere: I understand the concern. I have also been targeted in the past, so I also saw these ads. They were all over my social media. I have three thoughts. First, I checked the Competition and Markets Authority's last review, which was done in 2022. The results were generally positive in terms of not breaching the standards set for advertising. The main problem was pricing and success rates. Certain clinics were not so transparent, especially for egg freezing. The CMA wrote to those clinics and the change has been implemented. I think there are some mechanisms in place that work really well.

Secondly, I totally understand the concern about young women being targeted. However, there are two things that are relevant to this. The first one is that if you want egg donors, they need to be young women. There is obviously the tension that they might be more vulnerable than a 30-something with a permanent job, but the 30-something woman with a permanent job has lower one-year reserves. They could still be a good candidate, but not an excellent candidate. There is a tension where the nature of the process requires recruitment of young women, although not aggressive targeting. I also want to say that I was quite disturbed by a submission in the evidence that said that the brains of young people are not developed until 25. I know the study the evidence is from, but it means that brain plasticity continues to develop past the age of 18, not that people under 25 are unable to decide for themselves.



HOUSE OF COMMONS

I am not sure about a moral panic—I kind of agree, actually—but aside from that there is an issue of considering young women as not able to decide in this respect, although we let them decide in many other respects. In a sense, studying philosophy, like I did, is a much bolder choice than donating your eggs, if you think of the long-term effect. I know that people disagree, but I still think that; I was not just making a joke. There are no specific studies on the long-term effect of egg donation, but IVF has been practised since 1978 and is exactly the same process. Although there are no specific studies on that, there is a lot of evidence of the long-term effects of ovarian stimulation and all those things.

I totally understand the concern about exploiting vulnerability, but I also worry when we go too much on the other side and do not consider women to be able to make decisions for themselves. I think it is a balance. That is why I said the thing about philosophy. Young women make lots of choices that affect them long-term, and I do not want this to be picked as the most significant one and one that they are not able to make for themselves. It is not that I do not share the concern; I just want to fine-tune the narrative around it, if that is okay.

Rebecca Paul: It is very helpful. This is the whole point of this inquiry. We want to hear all the different views.

Timothy Bracewell-Milnes: About 17% of our egg donors are under the age of 25. The vast majority are between 30 and 35 years of age. That is No. 1. No. 2, if I flip it the other way, is that advertising is important for women to be able to make a choice in their treatment.

We conducted research for egg sharing, which is a process where patients wanting to have a baby also give away a proportion of their eggs during treatment. There was huge frustration among patients who eventually came to us for that treatment that the average time before coming to us was about three and a half years because they did not know about it as an option for them. That could actually deny them treatment, because you have a cut-off of age 36, and they only find out about it when they are 37 and have been trying for a baby for four years, and they cannot afford IVF privately. Advertising is important.

Professor Nordqvist: I agree that research would always be welcome to explore how young women, particularly, experience egg donation. But the evidence that is there is partly saying that egg donors do not go to egg donation for the money. They live in a society where egg donation is very much conceptualised as an altruistic act, and the egg donors that have been part of my studies have been really proud of doing it.

Q9 **Rebecca Paul:** Could we see those studies? It would be helpful.

Professor Nordqvist: Absolutely, they are in the public domain. They come to egg donation as a good thing to do, and they talk about it as a good thing that happened. It is something they are really proud of, and comments that they are doing it for the money are like an insult, because that is not why they are there. That is the context for the majority of egg



donors, for which we have evidence. They are not that category of vulnerable women and there is no evidence, as far as I am aware, that it attracts vulnerable women. Certainly, the age bracket we see from the HFEA is an average of 31 to 32 for egg donors. That is the picture of egg donors' experience that comes from the research.

Professor Hudson: From speaking to prospective donors, we have quite a lot of research from public surveys that shows that when people are asked whether they would consider egg donation, they do not know that it is an option. The fact that people are surprised when they receive the social media adverts shows that we are not doing a very good job at raising awareness more generally about the need for egg and sperm donors.

Part of the answer to that question is that we no longer have a national charity or organisation that is tasked with the kind of awareness raising that we did historically—sadly, it folded—so that work falls to clinics and agencies, and we do not have the nationally co-ordinated campaign that we see in other countries, a bit like the campaigns we have on blood donation and so on. Perhaps if we had that, we would not need so much of the targeted Facebook advertising, or when people receive it, it would not be so much of a surprise to them and they would not feel targeted in the way that they sometimes do when they receive those social media adverts.

To pick up on the points that have been made about the average age of egg donors. In my experience of working with clinics over a really long period of time, they take very seriously the care and ethics around the management and counselling of egg donors. If they had concerns about someone being particularly vulnerable, in my experience they would investigate that and take it very seriously. That will not uniformly be the case, but I have worked in this field for 25 years—I do not work in a clinic, but I work very closely with clinics—and the counselling and screening of donors is taken very seriously.

People are perhaps concerned about younger women and if they just doing it because they want to pay the rent and have not thought about the long-term implications, particularly in a context where they could be contacted by a donor-conceived person in the future. That would be discussed very carefully with them in a counselling setting. It does not come out of our research and work that there are huge numbers of extremely young, vulnerable women that are moving into egg donation.

- Q10 **Chair:** I want to come back on a couple of Rebecca's points. I do not think that any of us are sat here thinking the majority of people are not doing this for altruistic reasons. We know that it is quite invasive, although you have said it is safe. The Advertising Standards Authority wrote to us ahead of this Committee to say that it had taken the decision to ban two paid Facebook ads for Egg Donors UK. When you read the example of that advert, it was very much targeting, in a way that had put the financial compensation front and centre. It was in large, bold text in bright pink colour, and all the rest of the text was very muted. The pictures and

images that accompanied the advert were three women going out for a party to celebrate, after receiving the payment.

If commercial entities are targeting and advertising in that way, they would have done focused research, and they would not have spent money on an advert like that if they did not think there was a market for it. At the moment, what you are seeing and telling us is not necessarily what we will have in the future, if we continue to go down the road that we are going down. It is great that the ASA did stop that, but there will probably be examples where we have not stopped that, or it has reached out into a space that the ASA are not able to block.

Are there concerns that we would move to that commercialisation, where they are fulfilling a need that the NHS is not? Is there a concern around the strength of the regulations we have around the advertising side of this and the commercialisation of it?

Professor Hudson: Yes, for sure. I think that that shows that we are moving into a new space and that the regulation in this area is working, but they might have a bigger job down the line.

Part of the answer to that question relates to the emergence of agencies that are not necessarily linked to a licensed clinic, and also the emergence of egg banks, and we are seeing that increasingly in the European context. It is something that, in our research, we saw a lot of in Spain: commercial egg banks that are shipping eggs around Europe and internationally, and are potentially approaching this in a very different way to clinics, because their business model is entirely different to a fertility clinic. That is growing for sure.

We have examples of commercial egg banks in Europe, and there is potential for that to happen in the UK as well. At the moment, we do not have stand-alone commercial egg banks in the UK. We have clinics that have their own frozen egg banks, and that is because the freezing of eggs has become so successful that they are able to freeze, and clinics are using those for their own internal purposes. But we know from the Spanish context that clinics are potentially making the move into the development of stand-alone commercial egg banks because they have an in-house egg bank, and it makes commercial sense for that to be the next logical step. There is nothing to say that that will not happen in the UK.

In our research, we spoke to donors about that, and they hated the idea, frankly. I think that donors are not always aware of the shifts in the marketplace, and, again, we need better counselling and information for donors, because they see those ads. I agree with Petra that, if someone is going to donate their eggs, they are going to do it anyway, and an advert like that might tip them into, "There is somebody who is advertising here. That speaks to me, and it's something I want to do".

It is so invasive and time consuming that the vast majority of people, if they were going to do it for £985, hear what is involved and, if they were not committed to the process, would step aside at that point, but those

marketing commercial practices are a sign of the way that things could be heading.

I go back to the fact that, in the UK, we do not have a fully commercial model, and we have very good regulation, but we need to be aware of it. It would be mistake to think, "Our regulation is great. We don't need to worry about this." We know from our research that it is moving in a more commercial way in the UK.

Chair: Thank you; that is really helpful.

- Q11 **Dame Nia Griffith:** I am going to touch on compensation, which you have already mentioned several times. I think that Dr Giulia, in particular, wanted to add a bit, so, in answering my first question, if there is something that you want to add to what you have already said, please do so. It is a general question: to what extent does the compensation involved actually incentivise women, and have we got the right model here in the UK?

Dr Cavaliere: Thanks for the question. The available evidence, which I reviewed in preparation for this meeting, suggests that women don't do it for the money. Either they do not cite financial reasons at all or, as Petra was saying, they explicitly reject the idea that they are doing it for the money. Obviously, there might be people who are not captured in this research who might be doing it for the money.

There are two things about compensation. First, England and Wales switched from the reimbursement model—where receipts were handed in and the donors could get the money back for travel, loss of work and whatever they had to do—to a flat rate as a sort of compensation model, which is not payment. Personally, I think that is a change in the right direction. We have all submitted expenses. It is a prolonged, annoying process. The process is already burdensome in itself, so this model is better suited for donors. The HFEA explicitly states that the change from £750 to £985 is in line with the cost of living and inflation. I know there were concerns about increasing compensation again, but prices of things have changed a lot in the last few years, so I think that is also justified.

In terms of the ethics, I understand the worry that has been raised about exploiting vulnerability and women doing it for the money. At the same time, £900 for going through all this is really not a lot. Getting a job in a pub is perhaps less burdensome and you get more money. We need to compare it with other things that people might do to get the same amount of money, and then we see that it is not a lot of money considering what is involved. That is the first thing.

The second thing is that it is very burdensome in some ways, and very invasive. It requires a big time commitment—you need to go to appointments. Everyone here probably knows that I have been through it because I did egg freezing; it was in the evidence, and I am happy to speak about it. It is basically like a full-time thing for a few months. In some ways, it is good to consider it as work that people do. We should be



paid for the work that we do and this is compensation, not payment, but it requires quite a lot of involvement and effort. I think it would be unfair on the donors to not recognise that. It would fit into the narrative of women just doing it because they are women and because that is their role in reproduction, which is also a really bad model. The idea that it is still altruistic but we recognise the burdens associated with it is a very good way of looking at it.

Professor Nordqvist: It really comes through in our research with egg donors that even though, as a culture, we might think of pure altruism as something that exists, in real life, an other-directed gift can also sit quite nicely with self-interest. As we go about living our everyday lives, that is perhaps not the huge contradiction that culturally we think it is. For example, the donors we interviewed who egg share might think, "This is great, because it means I can actually afford IVF and have the number of children or the child I want, and I can do something good for someone else." It is not a contradiction for them.

The other thing is that since the introduction of identity-release donation in 2005, the donors who are recruited are also made very aware that a child may well contact them in the future. Many of the donors we spoke to felt like if they had done it for the money, that would be a really hard story to tell that child when they contacted them. That framework was cementing the feeling that, "I am not here for the money and it wouldn't be right if I was." There is a high degree of awareness that the child who may be conceived actually may come along and get in contact. There is a very strong moral story that, "If that happens, the child will need to be in the lead of that relationship and I will not impose myself on that child." Egg donation is very much understood in that frame.

Q12 **Dame Nia Griffith:** Clearly, the primary motivation of a woman who is going to share is either to have a baby or to freeze her eggs. Is there a temptation for the price of the IVF to be inflated in order to make women more likely to want to take advantage of the discount for having shared their eggs?

Professor Nordqvist: It is not something I have come across in the research, so I do not have evidence to say that that is true. Others might be better placed to answer that.

Timothy Bracewell-Milnes: If you look at self-funding patients and how many fertility clinics there are in London, if you, as a clinic, sky up your prices, patients will just go to another clinic.

Dr Cavaliere: This is very much connected to my research, which considers more the price of IVF and egg freezing. It might be that there is a case that the price gets inflated, but I agree that the competition model helps in this case, because you could just go to another clinic.

At the same time, the vast majority of patients who go through IVF in the UK go through privately funded treatment. Considering that it is quite costly for some people, and sometimes they are not able to afford IVF or



HOUSE OF COMMONS

egg freezing, there is this incentive to do egg sharing, just because the price is already quite prohibitive. One cycle of IVF is about £5,000, but one cycle is very often not enough, so people usually go through multiple cycles. It is the same with egg freezing; it is around that price, or maybe a bit lower depending on the clinic.

So there is already an incentive to share, because the funding for IVF is so poor that people tend to go private. Therefore, it might not be a concern moving forward, in terms of inflated prices, but it is already a worry. I don't think that should be tackled by reducing the number of people who donate; it should be tackled by increasing the funding for IVF and egg freezing. Obviously, that is beyond the scope of this inquiry, but I think that is an important thing.

Q13 Dame Nia Griffith: Thank you. Are there any other pressures, or do you think you have already covered the main pressures that might affect women's decisions?

Dr Cavaliere: For me, there are two things. The financial aspect is the biggest because, as I said, people are having children later in life, so they struggle more to conceive, and therefore IVF becomes more popular, as does egg freezing, as we have seen in the last few years.

The second aspect is more about the social context in which these choices are made. There is still a big push for women to have children. Having children is still considered the gold standard of the kind of life one could have. That is not something that can be easily addressed through legislation, but I think it is important to keep it in mind as the context in which these choices are made. Even if that pressure is very loose and non-direct, it is still there.

Q14 Rachel Taylor: I am going to ask about the demographics of donors. You have already touched a little on the age of most donors, but what else do we know about the demographics of donors, such as their income, ethnicity and education?

Professor Hudson: In terms of ethnicity, there is a long-standing shortage of donors in the UK from minority ethnic communities. That is something I have done research on historically, and the picture has not changed a great deal; that shortage persists. I think that is partly related to what I mentioned earlier about lack of awareness. That is where increased and improved advertising could really help. In research that we did quite a few years ago looking at British south Asian communities, people were not aware of the need for donors.

There is a range of reasons for shortages around ethnicity. It is partly about awareness, partly sometimes about cultural and religious barriers to donation, and partly because people do not discuss infertility so much in certain communities. Ethnicity is therefore a big marker of difference in the donor profiles that we see, and we do still have shortages.



HOUSE OF COMMONS

In terms of income, the latest data from the HFEA show that egg donors are no less likely or more likely to be represented in more deprived areas; they are kind of average in terms of socioeconomic status.

In terms of parenthood status, about a third of donors in the UK are likely to have their own children. That has reduced—it used to be that women were more likely to have their own children than that, and now we see more women without children donating. I think that part of the answer to that is that people are having children later and clinics are recruiting in different ways. It is a mixed picture—I think we have covered age already.

Q15 Rachel Taylor: Petra, is there anything you want to add on the class or educational background of donors?

Professor Nordqvist: It is not something that has stood out in the studies that I have done. As I said, women tend not to be motivated by money. In qualitative studies, you have quite a small sample, so it is not a big representation and does not tell us about what the overall population of egg donors in the UK looks like.

Q16 Rachel Taylor: So there is no particular evidence of higher education students being targeted—

Professor Nordqvist: No.

Rachel Taylor: As opposed to young women who might be working in the local pub .

Professor Nordqvist: What we know about women who go into egg donation through egg sharing is that they already have the resource to consider privately paid-for IVF, so you are already talking about a demographic that has resource, even though it might not be quite enough to pay for IVF treatment. As far as I am aware, there is no evidence to suggest that more vulnerable groups of women are being targeted.

Q17 Rachel Taylor: Is there any evidence about what motivates different demographics of donors to donate?

Timothy Bracewell-Milnes: Egg-share patients are motivated more by financial gain than standard egg donation patients, because they are getting access to treatment that is frankly very expensive. From our research looking into egg sharers, financial motives were lower down than altruistic motives. Don't forget that the majority of egg sharers are infertile and have been going through that struggle for a few years, so they have great empathy and really like the fact that "I've got a good egg reserve—a good number of eggs—so I can help another couple to have a family." Those altruistic motives for egg donors were still very important.

Q18 Rachel Taylor: Has any research been done on the sexual orientation of egg donors?

Timothy Bracewell-Milnes: A significant minority of our patients are in same-sex couples. When we have done interviews with them, and from



survey data, they needed donor sperm, and therefore they want to help in a similar way.

Professor Nordqvist: Similarly, we have data showing that people want to give back. Many recipients of donor sperm want to give something back to the community.

Professor Hudson: This is an area where there is not much research. We do not have a lot of evidence about different cohorts of donors generally, at a large scale.

Q19 **Rachel Taylor:** Is that something that we should be looking at?

Professor Hudson: Definitely.

Timothy Bracewell-Milnes: Touching back on what Nicky was talking about with ethnicity, that is a big problem that we have. Certainly in our clinic, 85% of our egg donors—whether they are egg sharers or altruistic donors—are Caucasian. If you think about it from the other side, the women who need the eggs of ethnic minorities, they often will want to match physical characteristics, and if we cannot provide them with those choices, that drives them abroad, potentially to less-regulated clinics.

Dr Cavaliere: I checked, and only 3% of the eggs used for egg donation are imported from abroad, and the main reason for that is ethnicity matching—the fact that we do not have enough eggs. It is quite interesting, because that is a very low number, but it is very specific because it is exactly related to that reason.

Timothy Bracewell-Milnes: There are two big differences with getting eggs from abroad. If we, as a UK clinic, have a licence with an egg bank abroad, all those eggs are under HFEA regulations, so the women who donated were not paid more than £985 and they did all the consent forms and blood screening. With cross-border reproductive care, where a patient takes themselves off to another clinic and goes to another bank, they are completely outside of any UK legislation. There are two very different patient groups getting eggs from abroad.

Rachel Taylor: That is helpful; thank you.

Chair: It is probably worth noting that £985 will be a huge amount of money in some countries.

Q20 **David Burton-Sampson:** I am finding this fascinating; it is an area I know very little about, so thank you all for your contributions. To continue the topic of eggs from abroad, Nicky, is there sufficient oversight to ensure that eggs imported from abroad are ethically sourced? What are the risks of importing and exporting donor eggs?

Professor Hudson: Yes, hopefully the regulatory system works in the way that Tim has just described, in that if clinics in the UK are importing eggs from an overseas clinic or egg bank, they have to demonstrate quite clearly that they fulfil the HFEA criteria. We can probably assume that clinics take that quite seriously, because a breach in that regard would risk



HOUSE OF COMMONS

them having their licence revoked. We do have pretty stringent regulation around import. Again, as Giulia has just pointed out, the number of eggs being imported is currently quite low, and they are generally specifically targeted for certain patients.

One of the areas that has come up in our research is the limits on the use of donors. Some of you might be aware of the documentaries that have aired recently on Netflix about the sperm donors with hundreds and hundreds of children. We are not in that territory yet for egg donors, but because we do not have global limits on how many families egg and sperm donors can conceive, we could potentially be moving into territory where egg donors, where their eggs are being exported from the UK because they have met the family limit in the UK, could potentially be creating more than 10 families. That is true of donors being imported as well. We currently have a strong need for regulation in the area of global limits on egg and sperm donors.

At the moment, that really is critical in the context of sperm donors, because they can donate again and again and create hundreds and hundreds of families. Egg donors are not quite in that landscape, but we know, for example, that for some donors donating to egg banks in Spain the number of eggs retrieved averages around 19 per cycle. The registries in Spain are not as thorough as they are here, so there is the potential for donors to move around and donate multiple times. It is not unfeasible that we could be in a situation where we have multiple children being born from egg donors, and we do not really have a cultural script for that. We have a narrative around a family where there are lots of children born from one man, but not from one woman.

It is another area where we are not there at the moment, but the import-export question raises really interesting questions now that eggs can be successfully frozen and shipped. It is somewhere that regulation needs to look, because we do not currently have that situation, but we could do feasibly. We are currently okay, but it might be an area where we want to keep a watching brief on what is happening, both on the import of eggs and how closely that is monitored, and certainly on the export of eggs.

Q21 David Burton-Sampson: Would anyone like to address how those concerns could be addressed longer term? Clearly, as you said, it is not a big concern at the moment, but it could become one. What measures could be put in place to prevent it from becoming a concern? Petra, perhaps you could answer.

Professor Nordqvist: It is not something that I have looked into in my research, but it is my understanding that a donor who donates in the UK can only give rise to 10 families—a number of children, but within the limit of 10 families. But there is nothing stopping their egg or sperm then being exported. That is the sort of thing we could possibly stop happening through UK-based regulation.

Timothy Bracewell-Milnes: The only thing that I can think of is preventing the egg banks from exporting to multiple countries, because



HOUSE OF COMMONS

once it has gone out of your country, it depends on the other country's legislation and there is nothing you can do about it.

Professor Hudson: We need international co-operation, which is notoriously difficult. We have to look at it from a national perspective first and then think about how we co-ordinate with other countries.

- Q22 **David Burton-Sampson:** I have one final question. I am just trying to understand something for myself. We have heard about the demographics of people likely to donate and about compensation—which we are not calling payment. Can the witnesses explain the time commitment to being an egg donor? Maybe Timothy or Giulia could explain the actual process and the time commitment required?

Timothy Bracewell-Milnes: The donor would book an appointment and have a thorough initial consultation to go through their medical history. They would have tests to make sure that they are suitable from an egg reserve point of view and MH and have an ultrasound scan and that assessment. The doctor would then make a welfare decision based on that donor. Like Nicky has touched on, if we have any concerns about that donor's vulnerability or them not being suitable, we would flag it at that stage and not put them further down the process.

Once they are okayed for treatment as an egg donor they would have some screening bloods, which tend to take about six weeks or so to get the results of back. In terms of the actual treatment itself, part of okaying them for the treatment would be a thorough counselling session where the counsellor would explore all of the issues surrounding egg donation that we have talked about today, such as donor anonymity—the process they go through and the emotional things to think about with potential future contact.

In terms of the actual treatment process, it involves giving some injections to stimulate the ovaries to produce multiple follicles. When you are doing that treatment you need to regularly monitor the patients, so they do those injections themselves at home, but then come into the clinic for regular ultrasound scans. It tends to be four to five scans that they have to come in for and the amount of time they have injections is approximately two weeks—about 12 days on average—and the egg collection procedure is two days later. From active treatment, it is about two weeks from the start of injections to egg collection.

The egg collection is the most invasive part of the process. Most clinics would put the patient to sleep on a low-dose anaesthetic. It is done transvaginally where you puncture through the vagina looking at what you are doing on a scan, straight into the middle of the follicle and drain all the fluid from them. The procedure is very much a day case; the patient will be in the hospital or clinic for about two to three hours on average and that is the end of the process.

- Q23 **David Burton-Sampson:** That is really useful. The reason I was asking, and my concern, is the data we have seen suggests that it is the most



HOUSE OF COMMONS

deprived demographics that have a higher percentage that are likely to donate eggs. That seems like quite an intensive procedure, and you are right. If someone is short of money, should I be concerned that they may be doing this to support their income? Do you have proper procedures in place to—I mean you cannot prevent people from doing it to support their income—protect people from going through quite an invasive and long procedure just to support their income?

Timothy Bracewell-Milnes: I understand what you are saying and it may be part of the motivation for certain patients to do it, but there is no evidence whatsoever that it is the driving force. There is just no evidence out there for that when you compare it to commercial donation where it is the number one factor and therefore those women are at risk of exploitation. I have just described the process of what giving an egg involves, and look at it from the other side; I think it is really unfair. Why should a woman put herself through that to try and help someone and be out of pocket from doing it? Think about how expensive a train fare is. A lot of these women live a long way from the clinic. By the time they have commuted to the clinic, had the scans, seen the nurse and left, they are probably off work for two or three hours at least.

From our research surveying the UK population, of about 1,000 patients that we surveyed over 90% were in favour of a compensatory payment. When they were told that admittedly at this point it was £750, the majority of respondents felt that was not sufficient. It is an imperfect world where, unfortunately, it is very difficult for a woman to donate her eggs compared to donating sperm, but I think it has been very carefully thought through by the HFEA in terms of coming up with that figure. It is a compensatory payment, not a commercial payment in my opinion.

Q24 **Rebecca Paul:** The £985 is a flat amount that they automatically get given, so they do not have to come with expenses do they and say, "These are the costs"?

Timothy Bracewell-Milnes: Traditionally, we did that but it was so complained about and people would say, "Oh, I haven't got the receipt for that journey." It became a bit of a logistical nightmare, so it has changed now.

Dr Cavaliere: Before, it was a submit receipt model, but I think the reasoning behind this is quite sound. We know more or less how much people would have to give up in terms of work and travelling, so that is how it was calculated. It is more worrying, but at the same time I think it is already quite a heavily admin-intensive process and adding that is a bit unfair to donors—that "I need to keep track of everything, I need to talk to my employer"—so there are reasons to transfer to the flat rate model, so long as we are okay with the number.

Q25 **Chair:** Thank you. Petra wanted to come in, and then I have a question about the international element.

Professor Nordqvist: It is about your comment on time. Egg donors in the UK donate under identity release, as I already said, and something to



keep in mind in terms of time is that it is not just the time at the clinic, which Tim described eloquently, but the time going forward that may well come into it. As I said, many of our egg donors go into egg donation and experience a sense of commitment and connection, particularly with the recipient parents, but what they will never know is if someone will reach out to them. There is a real element of uncertainty. Part of the imagining of some of the egg donors we spoke to was, "I wonder if I will ever meet this family?" or "Will I ever meet this woman?", that sort of thing.

What we see in the project that Nicky and I have been involved in, about how DNA testing impacts on donor conception, is that the relational questions that come up over time can be quite significant. As a society, we do not really know how an egg donor might relate to a child—or an adult who is now 25. The donor is not their mother, but there is a connection. Those relational challenges are not just in terms of that connection but can also be with your own family, especially if you kept it secret all those years. Time is a big question, and it is important to get the relational side recognised.

- Q26 **Chair:** I want to come back to the international element. Has any work been done on the numbers of women that leave the UK to donate their eggs in a much more commercial system? For example, in America, you can get paid up to \$20,000 for your eggs—I have just seen some adverts on Craigslist for \$40,000. Even with the travel and the two weeks—and possibly longer—of treatment to be able to donate eggs, that is a financially attractive package for many people who are struggling. Has there been any work done on that?

Professor Hudson: There has been research on donors moving around internationally to donate, but nothing from the UK. We do not have any evidence that I am aware of that there are women moving from the UK to donate abroad. There is a little bit of research about people going to South Africa or to the States, but none of those donors are from the UK. It is not something that I have come across, either. I have not heard, in any of the research that I have done, of people going abroad to donate eggs.

- Q27 **Chair:** Okay. Do you think there would be a willingness in the international community to tackle any problems that we see arising from this? Are there counterparts in the US that are raising these concerns around the commercialisation of egg donation, or has it become a part of the culture, which is very different to ours in that respect?

Dr Cavaliere: That is a great question. In Europe, there is quite a lot of collaboration, such as, for example, the Oviedo convention. There are all these conventions that regulate how we treat biomaterials, and there is a very sound framework. The problem with the US is not just about egg donation but about everything: surrogacy and IVF, all of it is extremely inflated and commercialised. I do not have enough geopolitical knowledge to know whether they would be willing to collaborate, but it is a much broader issue than just egg donation, so I am quite pessimistic about that.



HOUSE OF COMMONS

Timothy Bracewell-Milnes: I can answer your question from the other side, because we have a lot of American patients that choose to come to our clinic because of how expensive it is in America. If they have had a cycle in America, I get a lot of feedback from them about how it is just treated like a conveyor belt or how it is just a business, and they do not have any interaction with their doctors. There is a lot of that going on, especially when you have a situation like the one you mentioned, where you thought it was around \$20,000 but then you found an advert for \$40,000. That is just so much money, and it completely sways the motives from an altruistic model and opens the potential for exploitation. It is a totally different system there, and I do not think there would be much appetite, from their side, for a collaboration at all.

Q28 **Chair:** Okay. Thank you very much. I didn't want to make assumptions. I think it is worth noting that, even if you are reporting that you are not finding people coming forward because of financial reasons, that does not necessarily mean that they are not finding other ways for it. We have heard horrific stories—in this Committee but also, as politicians, in our inboxes—of women having to go to extraordinary lengths to make ends meet or to keep a roof above their heads. What you have described for that two weeks, although invasive and probably sometimes quite unpleasant, no matter how comfortable you try to make them, is actually a drop in the ocean compared to what many women are willing to go through to make ends meet.

Q29 **Kim Leadbeater:** Thank you, everybody, for coming this afternoon. It has been really interesting. This is a subject that I, like David, don't know a huge amount about, so it has been really helpful. Just as a heads-up: a bell may ring shortly and, like Pavlov's dogs, us MPs will have to go and vote—it is not personal. If that happens, I apologise. I assume we will come back.

We are going to come on to egg freezing now. Giulia, I am going to ask you first, if I can, why women typically freeze their eggs. What considerations are women making when they are making that decision, in your experience?

Dr Cavaliere: It is another great question. I know in the press there has been a lot of emphasis on people doing it for career advancement reasons, so postponing the time of conception in order to advance their career and therefore freezing eggs as a sort of insurance against future fertility loss because of that. In practice, systematically in all the studies I have looked at, that is almost never a reason. This is quite consistent, both in the studies but also across meta reviews of many studies.

The most common reasons are a lack of suitable partner at a certain point in time, when they would want to have children or they see children in their future; avoiding something called "panic partnering"—getting together with somebody in order just to have children—which is related to the lack of partner; and then, obviously, a desire for biological motherhood, foreseeing running out of time and the related wish to have a

back-up plan. Those are consistently—and I have re-reviewed all the studies in the last few days—the most common reasons to freeze eggs.

Q30 Kim Leadbeater: Timothy, did you want to add anything? This is your area, as well.

Timothy Bracewell-Milnes: I am pleased, although there is a long way to go, with what's been happening over the last few years. I published an article a few years back, when women were really freezing their eggs too late. The majority were doing it—75% at that time, back in 2018—when they were 38 or older, and that is shifting a lot. Somehow, although there is a lot of work still to do on it, we are getting the public message out there more, but it all stems from the very unfair biological clock, frankly.

Kim Leadbeater: Tell me about it.

Timothy Bracewell-Milnes: More women now—looking at HFEA data, 40% are under the age of 35, so 60% are still over the age of 35; the ideal age to do it is 35 and under, from scientific studies out there. But more and more people are doing it as an informed choice to try and, essentially, not have involuntary childlessness or need a donor egg in the future.

Q31 Kim Leadbeater: That is really interesting. Is there a role for workplace cultures or benefits around this? If there is any employer-funded freezing programme or anything like that, does that have an impact?

Dr Cavaliere: In terms of benefits, the first companies that made this a thing were Apple and Facebook—already more than 10 years ago, I think. Now it is becoming more and more common in the package of benefits offered by various companies. One worry is that, when companies are offering this, it might be that people feel pressure to make use of those benefits, but actually there is very little evidence that this is the case. In practice, egg freezing is very costly and so, in a sense, companies offering it—it is true that there could be some pressure, but there is little to no, or basically no, evidence that I could find on that. At the same time, many women could do it because it is part of the benefits package.

Unfortunately, because women maybe are let down in other ways by the public sector, this is a way to address some of those issues. It is not the right way. The right way would be providing better care in the public sector or making this part of a comprehensive package of fertility care. But it is something that happens in-between.

The last thing on company benefits is that lots of benefits in this sphere are offered by companies. Egg freezing gets a lot of press, but some companies are, for example, including IVF for the first time. Some companies—not just in the UK but across the globe—are also including the hormones necessary to transition. So there are various benefits around medical issues; it is not just egg freezing. I think egg freezing falls between the medical-type packages and the benefits related to family. For example, we would not think that a company offering subsidised nursery care was objectionable, but we worry about egg freezing. I do not have a



HOUSE OF COMMONS

settled view on either of them, but I think we should not single out egg freezing as the only thing that companies do in this space.

Timothy Bracewell-Milnes: I am very much in favour of this. When it first came out, as I said, about 10 years ago is when I had just started in fertility and I was a bit sceptical: “Why are companies offering that?” But actually the reason they are is that their employees want that package. They want that and they are the ones driving it. As a doctor who treats a lot of women with egg freezing, you can see that very clearly. The women who are having it paid for by their insurance through work are a lot happier than the ones who are paying for it themselves. And—personal experience—I often give talks in the City, telling companies about fertility treatment, and if the company does not have an egg freezing package, I know what most of the questions are going to be afterwards, which is women saying, “Why can’t we have egg freezing?”, to the point where, when I have gone back, I have been told to remove the slides on egg freezing for the next talk. Companies are being more and more encouraged to do it, and that is coming from their own employees; it is not the other way round.

Q32 **Kim Leadbeater:** How much does it cost? I have no idea.

Timothy Bracewell-Milnes: A cycle of egg freezing is about £5,000.

Dr Cavaliere: Can we talk for a second about the cost, or is there a specific question on the costs of egg freezing and IVF?

Kim Leadbeater: No, I don’t think there is.

Dr Cavaliere: Okay. I think this is quite important for the work that this Committee is doing. First, there is the issue of transparency in prices. Many agencies or companies that offer egg freezing have their prices on their website, but the price often shows only the cost of the cycle, and then there is a separate price for the medication because, depending on the patient, they will need different medications and the price of medication varies so much. For example, a cycle without medication, with just investigation, egg retrieval and everything else, could cost between £2,000 and £4,000. This is just a cycle—without medication. But the medication could cost between—I don’t know—£1,000 and £5,000. The variation in prices is huge.

So first there is the issue of transparency, but maybe this Committee—I don’t know whether I can suggest this—could explore also ideas of price caps. Obviously, the NHS has a system where all the prices are reviewed in a certain way, but in the private sector, although there are baseline regulations, companies can charge very different amounts for the same cycle. It is interesting because with the workplace benefits system, you do not have to worry about that. It also means you can choose the clinic you might want. You do not have to worry about whether a medication is too expensive; you can just trust the doctor. At the same time, the doctor might have an incentive to charge more, because of the benefit, so it is quite complicated.



Q33 Alex Brewer: I want to ask whether you think NHS funding should be more widely available for egg freezing, particularly for women who have medical conditions that might affect their fertility.

Dr Cavaliere: Again, this is something I talk a lot about in my research. Currently, egg freezing is only covered by the NHS if it is called medical egg freezing. If somebody—sorry, if I say something redundant about how it works, you can stop me—has to undergo chemotherapy or any fertility-affecting therapy, patients are offered the option to freeze their eggs and sperm on the NHS. If somebody does it for purely social reasons, which include, for example, lack of a suitable partner, but also the in-between cases like you have described—for example, endometriosis—that is not the same as a therapy that will definitely impair fertility. It is more something that makes it difficult.

There are three sorts of cases, but only the first—those undergoing chemotherapy or anything like that—is covered. The only country that does not have this distinction is France, and that has only been the case for two years. Across the world, when egg freezing is paid for, it is often only medical egg freezing that is paid for, whereas the rest is not.

Going back to the question you asked me, I think there are good reasons to explore egg freezing as a sort of broader fertility care that countries offer, because I do not think there is such a substantive difference between medical and social egg freezing. Both sets of women freeze their eggs to insure against future fertility loss. There might be different reasons, but I do not think they are sufficiently different to warrant the distinction. With PCO—polycystic ovary syndrome—and endometriosis, it is even more compelling, because we already know that these women will struggle in the future. The difference between what is medical and the other categories is even thinner or looser.

Q34 Kim Leadbeater: Does anyone want to add to that?

Professor Hudson: The wider problem here is the lack of NHS funding for any kind of fertility treatment. Even if that were funded, you would still have the problem of people being able to return to have the IVF treatment in order to use the eggs. It is part of a bigger picture of a lack of IVF funding more generally in the NHS.

Timothy Bracewell-Milnes: NHS funding for general fertility treatment is a bit of a mess and a postcode lottery, frankly, at the moment. Some CCGs offer nothing, some offer three cycles, and most—over 80% now—offer just one cycle. You have such a discrepancy, and the NHS has only been reducing that over the last decade; it is only coming down, not going up. In a perfect world, I would absolutely love for every woman who wanted to have egg freezing for social reasons not to have to pay, but it is an unrealistic dream, frankly, that the NHS would be able to afford that.

Q35 Kim Leadbeater: That is really helpful. Petra, do you want to add anything?



Professor Nordqvist: No, I am just fascinated. It is not my area of research, but as a sociologist I cannot help but find it fascinating. Colleagues of mine do research on women who do not have children because they simply cannot afford to have them, full stop. It is a very strange place, where we discuss how women can delay childbirth, but many women cannot even afford to think about it.

Q36 **Kim Leadbeater:** Yes, it is really interesting—new project coming up! What is known about the success rate of egg freezing in terms of live birth outcomes? Is enough data collected on that, and if not, why not?

Dr Cavaliere: It is another great question. There is quite a lot of knowledge that comes from IVF, because egg freezing is just the first step of many IVF cycles. Usually, you do all this and go through all the things that Tim described for donors; it is the same for egg freezing and for IVF with your own eggs. The success rates are IVF success rates.

Basically, what we know is that there is a certain number of eggs that are collected. Not all of them are frozen, because some of them are what are called non-mature. Let us say that 70%, more or less, will be mature and so will be frozen. Of that 70%, only 50% or 60% survive thawing—being defrosted, basically—and then only some of them will reach the six days to be implanted, and only some of the implanted embryos will develop into a foetus and then a live birth.

Basically, it goes down quite a lot. If you have 20 eggs, the chance of success for one viable pregnancy is around 70%. There is quite a lot of data on that, and companies have that on their websites. The problem is that it is very dependent on many other factors. For example, many people freeze their eggs, not their fertilised eggs, so it depends how your partner will be once you decide to fertilise. It might be that they have male factor infertility, or there might be other complications.

The problem with the success rate of egg freezing is that we know that there is a certain number that increases the likelihood of having a live birth, but it is hard to assess whether those specific eggs can develop into embryos and then foetuses, just because of all the steps that are involved in the process. We have estimates and percentages, but it varies a lot from patient to patient. It is quite difficult, because on one hand we want to give this data to the people who want to decide whether to freeze or not, but it is important to emphasise that it can be that you have super-high chances and zero live births. That is also the case for IVF. It is complicated.

Timothy Bracewell-Milnes: It is a really important question, and transparency of data for egg freezing is one thing that the Committee could really help with. A patient can go to a beautiful boutique clinic in London and freeze their eggs, and that clinic might never have had a live birth from someone who has frozen their eggs. When I am giving educational talks, patients are overwhelmed and say, for example, “There are so many clinics in London. How do I choose which one to go to?”



HOUSE OF COMMONS

There are two really important things that clinics should be transparent about in their data. The first is the freeze-thaw survival of the egg. I like to think as a doctor that I am important, but it is your lab—the embryology team—who are freezing and thawing the eggs that are so important. Their technique and experience can improve the outcome significantly, so you will want to know the clinic's numbers there. You also want to know how many patients have come back and used the eggs, and the clinic's data for different age groups: when women froze, and their ultimate success rate when they came back.

I am talking about the clinic's data, not publications—that is what should be more transparent. When patients ask me, "What do I need to know?" I say, "These are the two most important things," and then obviously I present them with our clinic's data. I think that helps patients a lot in choosing.

Q37 Kim Leadbeater: So more transparency on success rates and possibly, again, more transparency on the costs.

Dr Cavaliere: Pricing, yes.

Timothy Bracewell-Milnes: The CMA has really helped here. Since working with clinics, it is one of the big things that it has done. As Giulia said, it is really important not just to say, "This is the cycle cost of egg freezing," but—of course they need medication—"This is the dose I'm going to give you, and this is how much it's going to cost." Then they get a total as opposed to thinking, "Oh, wow, that's really cheap," but then finding at the end of the day that they are paying much more. Patient experience is very important.

Q38 Chair: I can see that a vote is imminent in the Chamber. Professor Hudson, I know that you have to leave at 4 pm for a speaking engagement. That will probably be before we come back from the Chamber, so before we go and vote, I want to thank you very much on behalf of the Committee.

Is there genetic screening before any of the eggs are frozen?

Timothy Bracewell-Milnes: You can't, because the egg is a single cell. If you did a genetic test, you would have taken the nucleus out—

Chair: I mean on the donor themselves, to screen for any illnesses or anything like that.

Timothy Bracewell-Milnes: Oh, for an egg donor, yes, there is extensive screening.

Q39 Chair: Should a donor come forward and find out something that they didn't know about themselves, what kind of support is there for them? Petra?

Professor Nordqvist: I don't know that I am the right person to ask.

Professor Hudson: This is a gap. I am working on another project at the moment on expanded carrier screening for donors and for people who are



not using donation but are having fertility treatment themselves. We are moving into a space where clinics are increasingly screening donors for a range of genetic conditions at the point at which they donate. There is not a huge amount of that going on in the UK. It primarily happens when we import sperm, and the sperm has been tested because it has come from a country where—and so recipients are being screened. But it is another area where we are moving into that space.

Very few clinics do it, although there are a few in the UK that are starting to offer that for donors. There is a bit of a gap, because most fertility clinics do not have trained clinical geneticists that work within the clinic and can counsel donors if something comes up in their genetic history or profile. We are all carriers of something, so it is part of the story that people are given when they are donating their gametes, but it is an area where we do not have a full picture of the implications of donors long term or what it might mean for their own reproductive planning—what it might mean for their partnership decision making about having children down the line—if something comes up in their genetic profile. It is something else that is on the horizon in the UK.

Q40 Chair: What could be done better to support that? Are there any international examples where it is done well?

Professor Hudson: There are countries that are rolling this programme out more generally in the healthcare system. Australia and Belgium are trialling it. There are countries where that is happening more generally, and not just for donors, that we could probably learn from.

Chair: Thank you. I am going to suspend the sitting while we go and vote.

Sitting suspended for a Division in the House.

On resuming—

Chair: Welcome back. I will hand straight over to Kevin to talk about psychological considerations.

Q41 Kevin McKenna: I would love to explore some of the psychological considerations of egg freezing and egg donation. Giulia, what psychological impacts of egg donation and freezing have been identified and how do they reflect your experience?

Dr Cavaliere: If it is okay, I would like you to start with Nicky and Petra on egg donation—especially because you might need to go, Nicky—and then I will talk about egg freezing.

Professor Hudson: Most of the evidence that relates to the psychological impact of egg donation suggests that there is not a huge negative impact on donors and there are not huge numbers who regret donation, for example. But there is some evidence that people would have liked the process of egg donation to happen in a slightly different way. That relates to what we mentioned earlier about how things could be improved from a donor perspective and how the care that people receive could be made



more donor-centric. One thing people say is that they do not realise how long it is going to take and they wish they had known that at the start. Again, that goes back to what people are told and the information that they are given.

Some studies show that people have regrets relating to knowledge about the outcome of a donation, primarily in contexts where donors are anonymous. That does not tend to relate to the context of ID-release donation; in the research we have done with ID-release donors, we have not heard that they have regrets about that. They have thought very carefully about the implications and have received implications counselling. They know that somebody might contact them. The research that shows that people may have regrets about the potential for connection is usually in contexts where they have donated anonymously and then wished they had more information about the potential offspring.

Most of the donors we spoke to in our research described having thought long and hard about the process, often over years—in some cases, they had wanted to fulfil having their own families before making the decision to donate. They were well aware of the implications at the point of donation. You can never capture everything. People look back retrospectively at the things they have done and their decisions and might think differently; this is not a static process. But on the whole, the evidence we have suggests that people are broadly satisfied and do not have lots of concerns or regrets about the process.

Professor Nordqvist: Our studies echo that. It is very rare that people regret having donated. As I said before, it is something that they are proud of. Most of the women in the major study that I was involved in were looking back at having acted as egg donors. The average time when they acted as donors was in 2014 and we interviewed them four or five years later, so they had had time to reflect. Like Nicky said, overarchingly they were positive experiences, and any negative experiences were often associated with a sense of a lack of aftercare from the clinic. Almost the only negative aspect that came up was that they did not feel looked after properly.

Some were critical that if they needed medical care, the clinic did not want to pick up the bill and the NHS had to pick it up. There were some critical notes on that. Along that line of thought, people were critical that they were doing it as an altruistic gesture for another woman or another family to have a baby. They did not particularly want more money for that, but they were critical of how much clinics were charging for their services. Those were the issues.

In terms of a broader psychological or relational impact, there are perhaps long-term consequences related to how you talk about egg donation to your own family and whether you tell your own children. In the law currently, there is no recognition of a donor's own family, so donors' own children do not have access to something like the Donor Sibling Link. They cannot sign up to that; they are not recognised, even though they are as genetically related as donor siblings would be. There is a lack of



HOUSE OF COMMONS

recognition of donors as full humans, with families of their own who may well feel quite impacted by the donation, and the relational impact that might come down the line.

Dr Cavaliere: Sorry, again, to push back on that—

Kevin McKenna: I like assertiveness; it's absolutely fine.

Dr Cavaliere: On egg freezing, there are two things that are often talked about in studies. There has been a lot of bad press and studies countering this, but I am going to make the case that it is important. Two of the positive psychological implications of egg freezing are connected to empowerment and a sense of security—not in terms of thinking, "I'm for sure going to have a baby," because I do not think that women are as naive as they are sometimes portrayed in the media, but more like, "I've done something that can help me in the future, even if it might not work." Empowerment is similar, in terms of women thinking, "I did that for myself. Even if I don't have a partner or whatever, this is my thing."

Those two things get a lot of bad press, both in the media and in academic research and papers. Some people say—and I do not think they are completely wrong, but they are also not right—"Well, it's not very empowering, because you're just going in line with social norms that tell you that you should have babies," or, "It's not correct to have a sense of security, because this might not work." I think that is a simplification of the psychological effects and of the choices that women make. I think these are two positive outcomes of doing it.

On the negative outcomes, from my research—this is not from my experience; I can talk about it, but this is just the picture more generally, which I think is more important and representative—people might go into IVF and egg freezing thinking, "Oh, I'm just going to do this, and it's going to be okay. I will have a sufficient number of eggs," and so on. The problem is that sometimes you do not have the results you expect; for example, your ovarian reserve might be lower than you think, you might get fewer eggs than you were hoping for—all sorts of things. That then generates a cycle whereby someone who was not worried about their fertility before becomes really worried about it. That is sometimes called the fertility treadmill in research.

One way to counter that is by giving very reliable information at the start. Obviously, somebody cannot say the exact number of eggs that will be retrieved or collected, but they could say, "This is the average," and emphasise that it could be that you are one of the unlucky patients. I think that is very important, but the problem is that there is a tension between the commercial interests of companies in providing this service, even with the best intentions, and the need to keep expectations low. That tension does affect the psychology of people who freeze their eggs.

Q42 **Kevin McKenna:** Thank you; that is really helpful. I want to explore the support that is available to women and anyone with them. What variation is there in the provision of counselling services in clinics?



Timothy Bracewell-Milnes: It does vary. I believe some clinics are potentially charging patients—I am not talking about donors, but if a standard fertility patient wanted to have counselling, some clinics charge for that. I do not believe that is right. I do not think they should; that should be swallowed up as part of the fertility treatment cycle overall.

The HFEA code of practice is very clear that all donors should have and see a counsellor, and it strongly encourages them to see one. It also mentions that egg-freezing patients, as they are a potentially vulnerable group as well, should have access to that, and that it should not be limited to one session.

Q43 **Kevin McKenna:** You are saying it should be, but is it mandated and stipulated? Have clinics got a way around that? It sounds like there is variation.

Timothy Bracewell-Milnes: We would strongly recommend all of our egg donors to see a counsellor and would be reluctant to put them through if they did not do that, but it is not 100% compulsory.

Professor Nordqvist: I think clinics have to offer one session, but whether they actually enforce it is a different question. There is also huge variation in what the session might contain, in terms of how the counselling actually pans out. There is also a lack of follow-up care and counselling that people can access over time, and not just egg donors.

For example, an egg donor may have donated anonymously under a contract of anonymity. They might find out through DNA testing, and they suddenly have to think about what to do. "This is not the situation I thought I was in." It can raise a lot of questions, not just about contact with a donor-conceived person but about one's own children. How are they going to feel about the existence of this other child? That is one of the places where there is no support freely available.

Q44 **Kevin McKenna:** Is there enough evidence, from women's experiences, to say what good should look like in terms of counselling? What should the offer be?

Professor Nordqvist: I think it should be freely available. If it costs a huge amount of money, that would prevent people from accessing the kind of support they might want.

Timothy Bracewell-Milnes: I think what Petra is saying is that it is really important that it should not be a case of, "You have completed your treatment, so you are no longer our patient. You no longer have access to the counselling." It doesn't matter if it is years later.

Professor Hudson: It is something we publish from our research on the experience of UK egg donors, specifically of counselling. It is a long-standing issue in the UK fertility sector, in terms of the quality and availability of counselling generally. Again, it is an area where this Committee could have an impact, because we are seeing some clinics roll back from making counselling sessions mandatory for donors because it is



HOUSE OF COMMONS

not in the guidance, which says the sessions should only be offered, not mandated.

For the donors in our study, the kinds of counselling they liked and felt positively about were those where they were offered a new space to explore considerations around counselling that they had not previously considered themselves, and also where it was tailored to their situation. There are so many different scenarios in which somebody can donate an egg. As we have heard, it could be ID-release, it could be known, or it could be in the context of surrogacy. The counselling needs to be tailored to that situation.

Unhelpful counselling was where people felt that the counselling was overly negative, where they were feeling judged or assessed, or where they felt the counselling was unnecessary because it was telling them things they already knew. There is now a bit of evidence on how it can be done in a more positive way.

- Q45 Kevin McKenna:** Is there evidence on the different psychological needs or maybe the different types of counselling required for different demographic groups? It could be a sexual orientation, or particularly neurodivergence.

Professor Hudson: No, but if you had a counsellor sitting here, they would probably say that good counselling should be tailored to the person sitting in front of them. It should be person-centred, and it arises from that encounter. Good counselling should encapsulate that and should meet the person where they are, and so on. I am not a counsellor, but I think the guidelines around counselling would fulfil that.

- Q46 Kevin McKenna:** We have talked about some of the longer-term impacts and the potential for the future, unless anyone has anything to add. This is down the line, beyond the process of donation.

Professor Nordqvist: What we are seeing in the study we have done with people who have either done their own DNA testing, because they are interested, or who have had it happen to them because a relative has done a DNA test—they did not mean to be contacted, but there they are and it is happening—is that navigating the connections that might emerge from that is incredibly complicated, partly because as a culture we don't really know how we are meant to do it.

A lot of the qualitative data in our research is from people saying, "There is no guidebook. I am not sure what I am meant to be doing. How do I relate to these people?" These are very, very tentative encounters, and I think it would be really beneficial to have some guidance on what to expect in terms of closeness or distance from those people, what to expect going forward with the people they are connecting with in that sort of way.

- Q47 Kevin McKenna:** Should there be a long-term duty of care on the clinics offering this service?

Professor Nordqvist: Yes.



HOUSE OF COMMONS

Dr Cavaliere: It is not mandatory for people who are freezing their eggs, and I have not seen a clinic that offers it as part of the package—it is an additional cost. I might be wrong, but I checked.

Timothy Bracewell-Milnes: We don't charge any of our fertility patients, including egg freezing, for any counselling.

Dr Cavaliere: I checked, so you must be a big outlier. Most of the clinics offer it as a separate thing. Are you aware of that?

Timothy Bracewell-Milnes: Yes.

Dr Cavaliere: More than before, it is important to do it afterwards. Again, I might be wrong—apparently I am wrong about this clinic—but after egg retrieval, it would be good to check how the patient feels. There is no mandated session after egg retrieval, but considering there could be a very disappointing result, it is a very important area.

- Q48 **Christine Jardine:** I should probably refer you to my entry in the Register of Members' Financial Interests before I say anything. Giulia, something you said prompted me to think about the health implications of egg donation. You talked about retrieval and a woman not having the same reserve of eggs. I know IVF and egg retrieval are now half a century old. We know an awful lot about them, but what do we know about the short and long-term physical impacts on things like a woman's ability to have children later in life if she has donated earlier on, as well as the implications of the IVF itself and the egg retrieval?

Dr Cavaliere: I will quickly say something, or do you want to start, Tim?

Timothy Bracewell-Milnes: We have a huge amount of data to answer that question. I talked earlier about the short-term risks of the process, which are very well known, but it has been honed over the years, and the patients are monitored so closely in terms of scans and blood tests during that process that we have got it very, very safe. Of course, we are always striving never to have a complication, but that is an unrealistic dream. A significant complication is well below 1% of all cycles started nationally.

Long term, we have a huge number of very large population cohort studies that followed up with women for decades, looking at things like early menopause and all female cancers, and the vast majority of those studies are showing no increase in the incidence of those cancers, so the data is really reassuring.

- Q49 **Christine Jardine:** This is maybe going into it too deep, but what percentage of women who have been through the process, including through egg retrieval and so on, do you keep track of? How many keep in touch, and how many let you know? How big is that database per capita, if you like?

Timothy Bracewell-Milnes: Most of those studies are done by looking at cancers and then tracking back through those patients' histories—I am talking about published medical studies, not, for example, my own follow-



HOUSE OF COMMONS

up. You are right; once the patient has had the baby, and they have completed their family, they often keep in touch and send nice emails and stuff, but you are not tracking their medical history—you are not their GP.

Christine Jardine: Anyone else?

Dr Cavaliere: No.

Q50 **Christine Jardine:** Do you think there is a lack of long-term studies on the impact of egg donation on donors physically? We have talked about the psychological impact, but what about in health terms?

Dr Cavaliere: It is not my area, and someone else may be better placed to answer, but basically there are longitudinal studies on publicly available records. The idea is to compare the psychological outcomes of egg donors with those of the general population. As Petra said, they seem to be positive in the short term, and there is not a lot of data on the long term, but this is quite new, because the law on anonymity did not change that long ago. I think there is scope for more studies on the long-term psychological effect, post changing the law, if that makes sense.

Timothy Bracewell-Milnes: You mentioned the physical impacts, but an egg donor is going through exactly the same treatment, whether it is an egg freeze patient or a standard IVF patient. Therefore, that data is completely transferable to someone who has donated their eggs.

I completely agree that, although there is a lot of research on the impacts in the short term, there is a gap in the research about the long-term psychological impact, especially in a country like the UK, where it has only been 18 years since that change in the legislation. I am not aware of any UK study looking at the outcomes where donor-conceived offspring have made contact with donors, how donors are feeling and how they have been affected. I think that is a big gap at the moment and a real call for research.

Q51 **Christine Jardine:** Petra, do you have anything to add on the physical health aspects?

Professor Nordqvist: Not on the physical health aspects. I absolutely agree that the long-term relational, psychological impact is very understudied, especially because as a field we are moving towards a different situation. Even before DNA testing, egg donors were encouraged by clinics not to post on social media about where they had donated, what time, their donor number and so on in order not to be tracked. But social media makes that very possible, and with DNA testing added into that, people are very, very traceable these days. So the promise of anonymity that we still sort of offer donors isn't really a realistic option. Many of the people we have interviewed in terms of DNA testing feel that that is their only option, whether they would like to do it or not, because they find the legislative framework very restrictive. People go the roundabout route in order to avoid the formal system. So, yes, it is very much opening up as a field, and contact between people connected through donation is very much on the horizon.



Q52 Christine Jardine: Given what you have all said about longitudinal studies, the psychological impact and the health impact, do you think that clinics can be confident that they are obtaining informed consent? With this lack of longitudinal research on impact, and now this anonymity aspect, can you be sure that the consent is completely informed?

Dr Cavaliere: I am just going to take the first part. There are two questions. One is physical health, even if the distinction is a bit wishy-washy. As Tim said, there is a lot of evidence, just because this is the same process as IVF. I read the submitted evidence, and some people were complaining about the lack of studies for egg freezing and egg donation, but there shouldn't need to be a specific study for that, considering that it is the exact same process; with egg freezing, it just gets truncated. So on the long-term health impact, I think we are safe on the consent side of things.

On the psychological issue, I think it is more a question of making people aware, not just of the research that might be done and the results of that research on long-term psychological effects, but by informing people and making them reflect on whether they would be okay with being contacted.

In a sense, it doesn't really matter if there is a lot of research saying some people regret it and some people don't, because when it comes to informed consent, the important thing is the person you have in front of you now, and ensuring that they are properly informed of the consequences, rather than that—I don't know—5% of people might regret their decision. Does this make sense? I am talking about the difference between the person you have in front of you now and the general data on the population that has done it.

Timothy Bracewell-Milnes: Despite the lack of longitudinal data, the consent is definitely informed, because you are telling the patients all these things and they are making that decision—verbally, in extensive medical consultations and counselling, which is, as I said, strongly encouraged, and things like direct-to-consumer genetic testing are absolutely mentioned, as a fundamental part of that. So if they accept that it is a possibility, even before the child has turned 18, that they could get this random contact—if you have explained that to them and they have decided to go ahead with the treatment—whether that affects them negatively in the future is irrelevant to them giving their consent at that point in time.

Professor Nordqvist: What donation means has changed dramatically over the last 20, 30 or 40 years. Whereas in the 1970s and '80s parents used to be encouraged to go home, forget about it and keep it secret from the donor-conceived person, we have shifted as a society towards much more openness. It is difficult to consent to something in the 1990s when in 2026 we are looking at a completely different picture. We have new technologies; we have social media. The world has changed. So it's a sort of moving picture, really.

Q53 Christine Jardine: One last thing—we may have covered this—is the



HOUSE OF COMMONS

aftercare provided to women after egg donation and freezing by clinics. Are you all confident that it is sufficient?

Timothy Bracewell-Milnes: Nationally, in terms of clinics, it is really important. There has been a drive from the HFEA over the last five to 10 years about the aftercare, especially for egg freeze patients. Obviously, if it is a standard IVF couple and they've got pregnant, they've got a baby and they're very happy. If they haven't, they are going to book a follow-up appointment with you, probably, to try for more treatment, or go to another clinic, so their care is continuing. With egg freezing, there was this sudden shut-off where the patients were all out there on their own and didn't have any appointment.

I think clinics should be offering, as part of the cycle package—essentially in the cycle fee; they're not paying anything extra—a medical follow-up appointment with their consultant or doctor. As part of that, I think it is important, in those few days afterwards when the hormones are still raging and they might be in a bit of pain, that the clinic gives them a phone call. More clinics are doing that now, just to check in: "How are you doing? Don't forget to book the follow-up appointment." I think that aftercare is extremely important.

Professor Nordqvist: The evidence we have is that it isn't always there, and I would very much agree with Tim that it needs to be there. When people did feel regretful or negative about egg donation, it was particularly about the relationship with the clinic, the lack of aftercare and the lack of concern.

Dr Cavaliere: With egg freezing, most clinics offer a follow-up appointment or a phone consultation, and they check in after a few days just to check the health—again, I checked. The thing is that the ones who, for sure, get properly looked after are the ones who are doing another cycle, whereas some people are like, "Okay, I'm fine," and they are not having the follow-up appointment. I think it is on a need basis, so it is not great but it is also not bad.

Q54 **Chair:** Thank you. I just want to ask a quick question before we go, because this will be relevant to our future panels. In terms of aftercare, what happens, and what redress do women who have frozen their eggs have, should a clinic go bust or have harmed the embryos in a way that was not agreed upon when they donated or froze their eggs? Are there any protections for people who have frozen their eggs at all?

Timothy Bracewell-Milnes: I am not aware that there has been any situation in the UK when a clinic has gone bust and the patients have all lost their embryos or eggs because—

Q55 **Chair:** So Homerton fertility centre didn't have issues with freezing their eggs and they weren't banned? Because that is what they said in 2024.

Timothy Bracewell-Milnes: What happened, sorry?

Chair: Homerton fertility centre had an issue with not being able to thaw the eggs acceptably, and were therefore—



HOUSE OF COMMONS

Timothy Bracewell-Milnes: Of course, sorry. You were talking about going bust, so I was answering that.

Chair: Yes, there is an element—

Timothy Bracewell-Milnes: Of course, things can go wrong in the lab. That clinic was closed down until what happened was sorted out by the HFEA.

Q56 **Chair:** But also, if they are a commercial clinic, there is a chance that they could go bust, even if they haven't yet.

Dr Cavaliere: Again, it is a very important question. Part of it is in the consent form. You are informed in terms of what can go wrong; this is more like an informed consent issue. Patients—or users; I don't know—can move their eggs from one clinic to the other, so there is this provision, also overseen by the HFEA, in terms of moving eggs from one clinic to the other. This hasn't happened, but this could be one potential solution.

This might change, but often these clinics are part of groups of clinics, rather than one clinic, so there is maybe some provision whereby, if one goes bust, the eggs can be moved across the same company. It might change, but this is the case at the moment.

Timothy Bracewell-Milnes: It is a good question. I am not sure, and I don't want to guess, but I would imagine the HFEA would insist that every clinic has some provision that they have to have a plan in place, if they were going out of business, for what they do with those patients' embryos. Obviously, if that clinic is closing down, which it can do, it would have to have a provision in place, before it completely shuts, for all of the embryos to have been moved to where the patients want. I'm not sure of the exact details, but I am very confident that that is already in place.

Chair: Thank you very much. I know that this is going to be a really interesting inquiry. You have given us plenty to get stuck into, so thank you very much. That brings this session to a close.