

Women and Equalities Committee

Oral evidence: Egg donation and freezing, HC 1503

Wednesday 11 February 2026

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

Questions 57 - 120

Witnesses

[I](#): Helen Gibson, Founder, Surrogacy Concern UK; Dr Zeynep Gurtin, Lecturer in Women's Health, University College London.

[II](#): Dr Ippokratis Sarris, Executive Committee Member and Consultant in Reproductive Medicine, British Fertility Society; Angela Pericleous-Smith, Chair of Accreditation, British Infertility Counselling Association.

Examination of witnesses

Witnesses: Helen Gibson and Dr Zeynep Gurtin.

Chair: Good afternoon, and welcome to the Women and Equalities Committee. Today, we are holding an oral evidence session on egg donation and egg freezing. We have two panels. First, we will hear from Helen Gibson, founder of Surrogacy Concern, and Zeynep Gurtin, lecturer in women's health at the Institute for Women's Health, University College London. Welcome to you both, and thank you so much for coming. We have already had one session, and that has been fascinating in itself. We are really looking forward to hearing from your expertise, and the expertise of panel two so I am going to hand straight over to Dame Nia.

Q57 Dame Nia Griffith: Thank you very much for coming in. We thought we would start off with concerns about egg donation in general. Does UK regulation adequately protect the health and wellbeing of people who donate or freeze their eggs?

Helen Gibson: As you know from our submission, we have significant concerns around egg donation per se because of the culture we think it gives rise to in a society where women's eggs are seen as something people have access to as a resource, and a globally traded commodity. This is very concerning when we are talking about human tissue and the fact that fertilised eggs will hopefully go on to become a donor-conceived person with rights and feelings of their own.

There is a wider issue that sits above all this, but within the framework that surrounds egg donation as it works in the UK today, we have other significant concerns from a safeguarding point of view. As said in our written submission, we have concerns that the minimum age for donors is too low. We have huge concerns about payments and the fact that they may incentivise women to donate their eggs out of financial need, or out of an incentive to get cheaper egg freezing or IVF.

We are very concerned that counselling is not mandatory. You must offer counselling, but it is not mandatory to take it up, and that is a mistake. There is no requirement for a cooling-off period after counselling either. There is inconsistency in the regulations: adverts are not meant to highlight financial gain, but they consistently highlight the so-called compensation of £985 in big letters on a lot of ads—not just the ones that have recently been banned by the ASA, but many others. That marketing provides a real incentive to women to come forward. There is no long-term tracking of egg donors' data after they have donated. They are not followed up over the months and years by clinics. The HFEA is not gathering that data, bar incidents of severe and critical OHSS. There is a huge job of work there.

There are other inconsistencies in the UK system as well. We had previously thought there was a 10-cycle limit for donation in the UK. That was our view and it had been informed by various articles and references



we had seen. Looking again recently, ahead of coming to the Committee, I could not find reference to that 10-cycle limit, which is concerning when you consider how harmful it could be to undergo multiple donation cycles. In America, egg donation is much more of a free-for-all, and interestingly, the American Society for Reproductive Medicine recommends no more than six donation cycles; it says, "Oocyte donors should be limited to six (6) treatment cycles per donor. The basis for this recommendation is rooted in concern over the cumulative risk for the donor after undergoing more than six ovarian stimulation and oocyte retrieval procedures". In the UK, we do not have one.

I know in its evidence the HFEA said very few women ever went through more than five cycles but, if that is the case, perhaps it would be good to have a hard ceiling on the numbers of donation cycles just to better protect women's health. Given that we know a lot about the short-term harms to women's bodies from egg retrieval—whether it is for freezing, your own IVF or donation—the long-term risks are really quite unknown and we are very worried about that indeed. We would like to see that tracking and fertility clinics being mandated to report long-term outcomes to the HFEA, which must report it to DHSC.

We have written to DHSC on more than one occasion about this, but we have concerns that it is not taking its duty to women seriously enough, especially when we consider these are incredibly young women. They are always going to be young women because it has to be young women if you are donating eggs; it cannot be older women. I am too old to be asked for my eggs. We think it is being negligent. It did not undertake an impact assessment before it allowed payments to rise for egg donors in October 2024; it should have done. It has not commissioned research itself to say that egg donation or egg retrieval is safe in the long term.

We are very worried about the long-term impact on women who come forward in future years—beyond the ones that we have picked up on—to say they regret it or that they have been harmed. They may say, "Why didn't the state protect me from private sector fertility clinics and egg banks preying on me through adverts for my eggs when I was just 18 years of age?". The HFEA will be held accountable for that.

Q58 Dame Nia Griffith: I will come to Zeynep in a moment, but if I could just follow up on the issue about reporting. Helen, you mentioned this slightly, but perhaps you could elaborate on whether there are regulatory gaps that lead to under-reporting or inconsistent reporting of problems.

Helen Gibson: Yes, absolutely. As I said, there is no legally required follow-up with donors. It should be part of mandatory reporting. According to the HFEA dashboard, there have been 24,825 donors in the UK since 1991. Those donors' details or last known addresses should be held by the HFEA for the donor register. We would ask whether trying to gather information from those donors might be something that they could do retrospectively in order to start this cohort study that we think needs to happen to look at women who have undergone egg retrieval, at least



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for donation, versus women of similar profiles who have not, to see if there are any emerging patterns in harm.

We think all cases of OHSS, not just severe and critical, should be reported to the HFEA. The RCOG—the Royal College of Obstetricians and Gynaecologists—in its earlier leaflet on OHSS, said that something like a third of all women under 30 will get OHSS. We would like to see how many actually present with that and if clinics are capturing it. That should be reported. There should be a mandatory set of guidelines for clinics in terms of their obligations to women undergoing egg donation or egg sharing, which should form part of the inspection regime of clinics, and that should include some of the things we talked about just now.

There also needs to be capturing of other health complications because there are lots of short-term complications that happen in the immediate aftermath beyond OHSS. We should not just look at this through the prism of OHSS—I can come on to that later—we should also be looking at this. Finally, on capturing information, I would be very interested to see more information about people who are buying eggs in terms of their age, sex, and income brackets. I think the HFEA looks at patient cycles where donor gametes are used which would imply people who have obtained donor gametes, but I think the age limit on that tops out at about 44.

We think lots of people older than 44 are starting to buy donor gametes in ever-increasing numbers. We would quite like to know who is buying donor eggs. As far as we are aware, the fertility sector is set to be worth £1.1 billion to the UK economy by 2030. We would be very interested to know how much of that is coming from the sale of women's eggs.

Q59 Dame Nia Griffith: Zeynep, are we adequately protecting the health and wellbeing of people who donate their eggs in the UK, and are there any gaps in the reporting or any under-reporting that you know of?

Dr Gurtin: Overall in the UK, our fertility sector is very good; it is very well regulated. Generally, the world over, it is considered to be one of the best and a gold standard. Having said that, our regulation, the Human Fertilisation and Embryology Act, which underpins the obligations of the HFEA, was set in 1990, and the sector has changed considerably since then. Is there room for improvement? Absolutely. Have there been changes to the sector that could not have been foreseen in 1990? Absolutely. The HFEA itself has obviously made calls for regulatory change.

I will make my own interests very clear here: I sit on the HFEA committee, so you can filter out my bias as you wish, but the reason I sit on the HFEA committee is that I have always really admired the HFEA. There is a slight danger that the HFEA works so well that the need for regulatory change and updating might not appear to be as necessary as we in the HFEA believe it is, and I can outline some places and reasons why.



Broadly speaking, we can talk about the fertility sector changing hugely since 1990, both in terms of who is receiving treatment and how treatment is provided to patients. Increasingly, we are seeing same-sex couples and single women. We no longer talk about fertility clinics solely as bricks and mortar buildings, which the Act is designed to regulate, but we also talk about online providers and online advertising. We are talking about an industry that is becoming more and more within the private sector. All those things suggest that there is important room for improvement. At the moment, the HFEA has no oversight over the commercial or financial aspects of fertility treatment, and although it has worked very successfully with the CMA and the ASA with regard to issues like advertising, it would obviously be much more seamless if those things were brought under the remit of the HFEA, which is in this sector all the time.

At the moment, the tools available to the HFEA are quite blunt. The HFEA can revoke the licence of a clinic if it believes that clinic has not complied with licence conditions, but the tools available to them are not very flexible. Unlike other regulators—for example Ofcom, which has a system of being able to levy fines—the HFEA has no such powers. You can imagine that powers like that could be used quite effectively in issues of non-compliance that are not serious enough to warrant closing a clinic and risking disrupting the treatment of thousands of patients, but might be important to send the message of penalties in the case of inappropriate advertising, non-reporting of short-term harms, adverse incidents or something like that. That is the broad overall picture.

A huge number of cycles take place in the UK. In 2023, which is the last year we have on record, there were 77,500 cycles of fertility treatment, which is a huge number. Most of those cycles were safe; most of those patients were very satisfied. Again, is there room for improvement? I would argue that yes, there is. The number of cycles involving donor eggs and egg freezing is very small within that overall number. Egg freezing is more my area of expertise and, of the 77,500 cycles of fertility treatment, 6,700 were egg freezing. We see a disproportionate coverage of egg freezing in the media. The number of column inches that egg freezing takes up is disproportionate compared with how much the practice actually occurs, but we could think about that being interesting in terms of where we might go, or the kinds of potential.

Helen and I agree in some respects. There is evidence to suggest that although the risks and harms are generally very well controlled within the fertility sector, there may be some under-reporting. I have been particularly interested with regard to egg freezing, and there is some new research from UCLH that has just been submitted for publication with the *BMJ*—I believe it has been emailed to the Committee—that suggests there are higher numbers of women suffering from short-term adverse impacts than are being reported. In some years, the number of women admitted to UCLH was actually higher than the numbers reported nationally to the regulator, so there seems to be a bit of a mismatch



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there. Certainly, aftercare is an area where we can talk about clinics having more responsibility.

To move on to the more longer-term impacts, that is a really important and interesting question. Is it the HFEA's role? I am not sure. As a sociological researcher, I do not know how appropriate it is to retrospectively contact people and disturb them in the middle of their life X number of years later if they had not given consent to that.

However, that is not to say that follow-up cannot happen. I am currently part of a funding bid that has been submitted to the Wellcome Trust for a longitudinal follow-up of long-term effects that would combine HFEA data with NHS data, so it would be able to track everybody who had been through fertility treatment, egg donation and egg freezing. It would not only look at people who have had fertility treatment, but also at the children of people who have had fertility treatment, and the children of the children, so three generations. What is needed for that is the will and the funding to make that kind of thing available. This kind of research is perhaps more appropriately the role of science and social science researchers—certainly, at the moment, it is not within the HFEA's regulatory remit.

Chair: I just want to point out that we will probably have votes in the next 20 minutes, but we are still on question one and we probably have about 12 questions to get through for this panel alone.

Q60 **Dame Nia Griffith:** You have talked about the general effects. Perhaps we could return very specifically to current research on long-term health effects. Is there anything specific that you are aware of?

Dr Gurtin: The long-term data we currently have does not suggest adverse health effects for IVF patients. In general, it suggests it is a safe treatment. You could look at some work done by Professor Alastair Sutcliffe at UCL. He is the person in the UK who has really looked at that work.

Helen Gibson: Can I answer that briefly?

Q61 **Dame Nia Griffith:** I will come back to you in half a sec. If we can just follow up on the people who donate or freeze their eggs: should the HFEA mandate some sort of follow-up? Are you saying that is not its role?

Dr Gurtin: It depends on what kind of follow-up we are talking about. The HFEA only does what is within its regulatory remit. It cannot decide it wants to do X, Y and Z. If the regulatory framework is changed to require those sorts of things, of course the HFEA can implement that recommendation; it is ultimately up to Parliament. It would certainly be appropriate to require better aftercare from clinics, and that could be in the form of a follow-up appointment one month later or something like that, where it is documented and data provided. I do not think it would be easy or really feasible to contact people years later when they have not necessarily given consent for that.



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Q62 **Dame Nia Griffith:** Are you saying it should specifically be for immediate health impacts?

Dr Gurtin: It should be, yes.

Q63 **Dame Nia Griffith:** Helen, you probably want to come in on that, but can I perhaps pick up on something you said earlier? We understand that the HFEA reports there have been no cases of severe OHSS in egg donors reported in the clinics in 2024-25, but you were talking about a third. Perhaps you could just touch on the two issues there.

Helen Gibson: A third of women under 30 might suffer mild symptoms of OHSS, whereas the severe and critical is expected to be about 1% to 2%. We have not been massively comforted by the fact that, of the 67 severe and critical incidents last year none were apparently to do with donors, but it is still severe and critical for other women who are maybe undergoing IVF, egg freezing, or whatever their reason for egg retrieval is. As we said, all the cases of OHSS need to be captured. One donor reported experiencing horrific pain to us and that would not have come up in the HFEA data, but that does not mean it is not a severe incident to that individual woman.

From the HFEA report last year, I understand there was an increase in incidents reported by clinics. Some 792 incidents were reported to the HFEA; 36% more than the 581 the year before. That covers all manner of things, such as problems in the laboratory or administrative protocols. It is not just about clinical harm to individual women, but it is important to note that these harms and incidents take place in the clinics where egg donation is governed and managed. That is just a context to be aware of.

Q64 **Rachel Taylor:** Helen, does the current compensation limit strike the right balance between compensating women for their time and expenses and at the same time avoiding financial inducement?

Helen Gibson: Not at all. You will be unsurprised to know that we think the word compensation is simply a case of semantics. It is a euphemism; it is payment. You are paid £985 in one or two instalments flat into your bank account after retrieval. I think if you went outside and spoke to somebody in the street and said, "I'm going to give you something in exchange for doing something else. I am going to give you money in your bank account, but it is not a payment," they would be quite surprised that you are saying that. I have never been convinced by the argument that it is compensation.

We think the amount offered seriously incentivises low-income and working-class women to donate when they would not otherwise choose to do so. I have evidence here of women doing it for that reason. We think all payments should be banned. If it is as altruistic as the HFEA and some academics with rather small studies tend to say it is, then let us see how many women come forward and do it altruistically, without the incentive that a payment of nearly £1,000 provides.



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Our view is that payments should be banned and, if that is not forthcoming, we should revert to an expenses-only system of itemised expenses in exchange for train tickets and so on. I do not agree with previous witnesses who said that that was so arduous. Nowadays, we all have train tickets in our emails; they can be easily produced. Filling in a form cannot be seen as arduous when on the other hand you are asking women to go through at least two weeks of clinic visits multiple times, scans, undergoing all those artificial hormone injections, and then injections through your vaginal wall into your ovary. How can expenses be arduous, but this is not? Again, that is a ludicrous, inconsistent argument within the sector.

To a low-income, working-class woman in a precarious part-time job, £985 is a very significant sum of money. We all need to be aware of the financial context in which egg donation sits, which is that we have had austerity, cost of living crisis, pandemic, recession, low wage growth, and stagnant pay for 15 years in this country. I know some witnesses said it, but the idea that £985 is not a lot of money is deeply insulting and untrue.

I am sure in many of your constituencies you have areas of high deprivation where you know full well there are women who would see an ad with shiny, happy, young women on a night out, and £985 in massive letters. On those adverts it does not say a syllable about the health risks, short or long term, of egg retrieval. We know there are women who would do that thinking "Oh, there's no harm. If there was harm the Government would do something about it." I do not buy compensation; it needs to be totally overhauled.

Q65 Rachel Taylor: Why do you think the minimum age should be 25 rather than 18?

Helen Gibson: We said that for very specific reasons not least because—if you look at the numbers—between 1991 to 2022, something like 5,894 young women aged 18 to 25 donated. We are very concerned that at the sharpest end of this it is the youngest women who are at most risk of financial exploitation. If you start at the age of 18, you are targeting women who are maybe still in school or college or going off to university, or, if they are in work, it is probably quite low-paid work or apprenticeships that are not paid that well at the age of 18. They are going to be at the highest risk for financial motivation, inducement and, indeed, exploitation.

Q66 Rachel Taylor: Are there any other comparable countries or areas where the age limit has changed?

Helen Gibson: I do not know about comparable countries on age limit. In Germany, there is no egg donation at all; it is not allowed. In Italy, donors cannot be compensated. There is precedent in this country for some in the private sector to say that to donate eggs you should be 21. I am not a fan of the London Egg Bank, but on its adverts it says 21 to 35.



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There is another clinic in Glasgow that says an age of 19. Within the private sector, there is already this precedent.

There is a real mismatch here in public policy. If a woman goes to the GP in her 20s and says, "I know I definitely don't want children; I want to be sterilised," the GP will tell her to go away and come back when she is older and has thought about it a bit more. I make no judgment on that, and it is quite a paternalistic situation. However, it is one where the doctors are saying, "Wait until you're nearly 30," whereas at the other extreme you can have eggs retrieved to benefit somebody else's fertility treatment—not you, but somebody probably twice your age, who probably has a lot more social and economic capital than you have. They can take those eggs and you are only 18. That is a real mismatch in public policy, and we do not think that is right at all. That is why we settled on the age of 25.

On the egg sharing point, which incentivises some women to donate in order to get cheaper IVF or egg freezing, Lord Winston, who sits in the House of Lords and is a pioneer of fertility treatment, has said that in his own clinic he has seen women who egg shared. He said in a debate in the Lords in 2008 that "women who are not wealthy and are perhaps somewhat dispossessed and have to pay for their in vitro fertilisation treatment opt to donate some eggs from the clutch of eggs taken during an in vitro fertilisation cycle, in return for which they get free treatment. Rightly or wrongly...the HFEA has consistently sanctioned egg sharing of that sort. I am not sure that it is a wise decision". He also said in 2007, "Having met a number of these women after treatment, I can vouchsafe for the serious predicament that they find themselves in after egg-sharing arrangements, when they deeply regret having gone through it".

Younger women are now coming forward to egg freeze, so that is an incentive that they have, as well as the fact that younger women are being targeted with these £985 payments. If you did not have the £985 payment, there would be a stronger argument for not raising the minimum age, but while you have the payments you really need to.

Q67 Rachel Taylor: Zeynep, are there any further safeguards that could protect these women more effectively?

Dr Gurtin: Yes—and may just talk about the £985 figure? I am of a different opinion. I believe it is really important to compensate women who donate. The central question is not whether the figure of £985 in abstract is high, low or a lot; it is what it is in response to what is required to donate eggs, which is usually several weeks and several trips to the clinic. It is appropriate to make sure that women do not end up out of pocket and are not treated in a suspicious manner where they have to provide every single receipt.

The discussions that led to the setting of those figures were appropriate to set a good balance between providing decent compensation and not incentivising. But there is also a slightly larger, more theoretical or



ideological point because if you adopt the attitude that women—because they are women between 18 and 25, or they are talking about reproductive issues—are vulnerable, then it is very difficult, regardless of what piece of social science research evidence you provide to say, “Actually, women overall feel they have consented to this; they are happy with this; they are satisfied with this”, to persuade you otherwise, if you are of an ideological position that women are vulnerable and need protecting.

I agree that 18-year-olds are not really the best people to be donating eggs and the HFEA data shows they are not the predominant people donating eggs; the average age is 30. Overall, we have very good evidence to suggest that people who are going through with egg donation and egg freezing are making those decisions with their own autonomy. Could we make the system even more robust? Could we provide more regulation around advertising? Yes, absolutely. But, in general, thinking about women as vulnerable or desperate is also very patronising.

I would actually be more concerned about the implications of withholding reproductive choices and rights from adult women, who we generally feel are able to make decisions if they receive good information, than otherwise. For me, the onus really has to be on making sure that the clinics provide good information. Again, an area of regulatory reform that the HFEA has called for is that clinics are currently required to offer counselling to people going through egg donation, for example. We would prefer it to be mandated that people have to have counselling, for example. That is another appropriate check to ensure that everybody has enough time to think through these things.

Q68 Rachel Taylor: We were hoping to be joined on this panel by Laura Rose, and these questions were going to be directed towards her. Zeynep, is there sufficient research and data collection on LGBT+ people who donate or freeze their eggs? Is there more that needs to be done? Are they being exploited?

Dr Gurtin: I do not know if they are being exploited. We do not have any robust evidence to show that anyone is necessarily being exploited. Of course, in all these areas there is room for more research, and I am sure everybody would welcome that. I believe in her written evidence, Laura Rose was talking about the case that some same-sex couples might be egg sharing more. Again, if we are concerned about something like egg sharing, our greatest safeguard against something like that would be to increase NHS funding so that people are able to access the fertility treatment they so want to have the children they desire. At the moment, there is almost no funding available through the NHS for same-sex couples or single women, and that is obviously very unfair.

Helen Gibson: It would not be appropriate for us to speak for Laura Rose as she is not here, but I want to say that there are—as I put in the written evidence—significant studies that show that pregnancies with donor eggs are higher-risk pregnancies, and for women undergoing



reciprocal IVF—lesbian women—that is an increasing option to them. We know more lesbian women are undergoing reciprocal IVF. I do not know, and I certainly do not think it is mandatory, whether, if you undergo pregnancy with a donor egg, gestational surrogacy or reciprocal IVF, all of which are the same process, that clinics advise those women that those pregnancies are higher risk, and they should be mandated to do so. Again, this would go some way on the informed consent point to better inform women so they can make a free and informed choice that if you go down that road, you may be at higher risk of some severe pregnancy complications.

Dr Gurtin: I would certainly agree with that as well. Risk management is something we all do all the time in our daily lives, and fertility treatment is no different. If you let women know that they are at a small increased risk of, for example, pre-eclampsia from using donor eggs, it may be that they choose to take that risk anyway, but certainly they should be informed about it.

Helen Gibson: Which I do not think they are at the moment.

Q69 **Chair:** Zeynep, I just want to come back on something you said, that 18-year-olds are not your predominantly preferred candidates for egg donation and they are not the largest number, what is the trend in the numbers and the demographics in terms of the age groups of people donating their eggs? What is the trend?

Dr Gurtin: I do not know those numbers off the top of my head, but I could send them to you. The HFEA certainly keeps track of all those numbers.

Q70 **Chair:** Thank you. I also want to raise the issue about people not doing this because they need the money, which is what we heard in our previous session. Actually we all around this table know that women have found it incredibly difficult over the last 10 years in particular. What data do you have and what kind of evidence and surveys have you done to really dig down into people's motivations for donating eggs?

A few months ago, "Good Morning Britain" surveyed women aged 18 to 25 and found that almost 40% would consider donating their eggs. Of that, half said they would do it because they needed the money. It said, "Nearly 60% of respondents said that the new £985 figure would make them more likely to donate to a UK fertility clinic, suggesting that financial incentives are playing a growing role in donor decision-making."

Do we have a massive gap here in terms of knowledge as to what people are really doing this for and why? There will be people who want to do this altruistically, absolutely, but there will also be people who are doing this because financially it seems like the right thing to do for them. Helen, what hard evidence, apart from surveys such as that, do we have, and do we need to be collecting more data on this?



Helen Gibson: Completely. We are so worried about women coming forward for this because they need the money, and if you took away the money hopefully that would go a long way to getting rid of that. It is not about not rewarding women or compensating them or trying to put up barriers to them coming forward. We have no ideological position against egg donation per se, apart from the fact that it creates these massive harms. But we did not come into it with a concern from the outset; it is only based on what we found. We have found women who reply to us, or who have told their stories in the media, who say they did it for the money. One story said the woman spent the £750, "It went towards travelling. I've dipped into that pot for various things since then." Another, "I was young, free, single and planning on going travelling in America. The £250 fee, as it was back then, would come in pretty handy, I thought. I didn't really think about the bigger picture. I never considered that someone could contact me one day." Another woman: "I've also donated in return for the company freezing my eggs so it is not totally altruistic." That woman also said, "I haven't really considered what it would be like to have the children contact me when they are 18."

In terms of studies, our campaign group has no funding or resource; we do this around our jobs and children in our spare time because we are that worried about these issues of surrogacy and egg donation. What we rely on is women coming to us; we do not even actively seek them out, but every time we mention egg donation, women reply to us and say, "I did it, and I'd never do it again."; "I did it, and I ended up needing a hysterectomy."; "I did it, and I nearly died." These are the reports. I know there was written evidence that criticised—probably us—the use of anecdotes and said we should not change the law because of anecdotes. I would agree, but if the fertility industry had done its job properly and tracked women over the last 30 years, none of us would need to be sitting here today.

Q71 **Chair:** With the greatest respect, Helen, it will be a self-selecting group of people who will be going to an organisation called Surrogacy Concern. You are not going to get a complete blanket overview of everybody's experiences. By the very nature of it, you will get a self-selecting group of people who have had real issues. It is not to say that they are not serious and the anecdotal side of it is not important—it is—but where we have industry saying there is no problem, we need to have hard and quite clear data that can stack up the issues that we feel could be there. We need to be able to have data that is undeniably clear and transparent and take a broad breadth of the people who are involved. Who would be best placed to do that?

Helen Gibson: It is very hard because you rely on what the women who come to the clinics say. I think in the last panel they said vulnerable women are not doing this. Vulnerable women do not go around wearing a sign saying they are vulnerable, so there is no way of necessarily identifying that. Data we can use is the data that the HFEA has provided on the deciles of multiple deprivation. In the bottom three we saw there



were over 4,000 women who had donated their eggs from 2011—when the payments went up to £750—to 2020 who were from the poorest postcodes in the UK, so that is an indicator.

When the HFEA say it is rooted in altruism, I have done as much digging around in the HFEA website as I can about this. It says that egg donors are from comparable areas of the country to other women, and they link to academic studies. Some academic studies were to do with the witnesses who you saw last time. The groups of donors that it has looked at were, I think, 25 in the UK, then 16, another study of 11, and another survey of 124 donors. Those are not what you can rely on. I just do not think the evidence is there to safely say that it is altruistic. You could say, “Well, the evidence isn’t there, Helen, that women are coming forward because they are hard up either,” but I do not think the evidence is there that it is altruistic.

Q72 Chair: That is what I am asking. Who is the best-placed person and organisation to collect this evidence in the most unbiased and open way for all women’s experiences on it?

Helen Gibson: I do not know if there is one.

Dr Gurtin: We are very lucky that the HFEA has had one of the largest databases in the world since 1991, but some of it comes down to how you are interpreting the data that you are seeing. Helen mentioned the figure of 4,000 donors from the lowest three areas. For the same period of time, we had 3,000 coming from the highest three areas. What does that evidence say to you? How do you interpret that evidence?

To me, if we have very similar numbers coming forward from the highest socioeconomic areas as the lowest socioeconomic areas, that would say that the socioeconomic conditions were not the major factor. There is data in the HFEA that we can look at. Certainly, the academics, my colleagues who were on the panel last time, are not people who have a vested interest in proving donation one way or another. Actually, in order to get funding and to go through ethical approval in our universities, we have to prove that our methodology is sound and that our results are rigorous and reliable in various ways.

If you want information around people’s sense of whether they felt they were autonomous, whether they felt they consented, or whether they regretted, that is not the kind of data that you would gain from very large-scale surveys with very large numbers of people. That is the kind of data you would get from detailed qualitative research, where you have the time to individually speak to people and to really understand their experiences and narratives.

There is a bit of a clash there. If you want really huge numbers, it would tend to be survey data; if you want real in-depth data about people’s decision making, it would be qualitative. The reason I would not consider things such as “Good Morning Britain” robust research, as it were, is



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because what people say they might do and what they actually do is very different. In my mind, that does not say anything about who is actually donating.

Q73 Rebecca Paul: I was hoping to talk a bit more about advertising. I would like to hear from both of you about whether you think we have the balance right around regulation. I raised this in the last session that we had, actually. One thing I was surprised to learn was that young 20-somethings are targeted all over social media and I was really confused. I thought, "I'm not getting targeted." Then I realised I am banging on towards 50 now, so that is probably why they are not interested in my eggs. That gave me cause for concern because I started to think about my daughter and her friends as they get older and become targets for that. Could you both maybe talk a little about the state of the adverts that you are seeing, your thoughts on that, and what changes we potentially need to make to improve the regulation? I think you have already alluded to some of it.

Dr Gurtin: I am also concerned about some advertising we are seeing, especially because it is so fast-paced. The Advertising Standards Agency and the CMA put in an enforcement notice to the fertility sector and has said there is actually very high compliance with the adverts that they have analysed. As you say, we also know that there are these adverts appearing in social media. At the moment, we are doing a research study at UCL looking into that. It is an issue. As I have said, the HFEA has no remit over that side of the fertility sector, and it would be really important for there to be some oversight—so yes, I am concerned about the advertising.

We also did a piece of research a few years ago—in 2020—that looked at clinic websites and the ways in which they were talking in particular about egg freezing and found that the information was not balanced. It tended to overestimate the benefits and underestimate the risks. Certainly, the costs were never quite clear. There has since been research by colleagues at Queen Mary that also shows there is still an unclarity of costs of treatment. I find that inexcusable because that is a very simple place to inform people adequately and not add additional stresses to what is already a fairly stressful procedure.

I think there is something to be done. I have provided this in my written evidence, but there are elements that are increasingly difficult to discern and decipher in social media where influencers might have agreements or might be documenting their egg-freezing journeys in ways that are kind of advertising.

Unfortunately, these messages are broader than just the adverts provided by IVF clinics. Young people are part of a whole social culture in terms of how we think about ageing. In fact, the egg-freezing sector is not entirely independent of the beauty sector, which is also telling women that ageing is terrible and bad, and you should remain youthful for as long as possible. There is a lot of work to be done, but regulatory change



to allow the HFEA to be able to action things on advertising would be useful.

Q74 Rebecca Paul: You mentioned that UCL is doing a study on this. How soon will we see findings from that? Is that something we could potentially have a look at? I think we would be very interested.

Dr Gurtin: Actually, my student Nicoletta is doing her PhD on social media advertising on egg freezing. It will not be available in the timescale of this Committee but we can certainly send you some of our preliminary. One thing I will note is that there was an unexpected finding for us. We went into it thinking there might be a lot of advertising and some covert advertising and, actually, one thing we were surprised to find is that on social media there is also a lot of discussion of the problems and risks—for example, individual women talking about having gone back and none of their eggs having thawed, having experienced complications, or having not felt that they were fully prepared. It is quite interesting that there are also discussions on social media which are informative as well. It is not purely a one-sided picture.

Helen Gibson: Again, we have real concerns about advertising around the fact that you can make reference to the £985, although you are not supposed to reference financial gain. This is just a complete contradiction in terms. Either you can reference financial gain or you cannot. If you reference the £985, that is financial gain. The idea that “Oh, but it’s compensation, so it’s not” is just an argument for the birds, to be perfectly honest. Adverts do not have to list health risks in small print or up front.

The number of adverts you see for any product or procedure on the London underground, in magazines, newspapers or on your phone that have to say in the terms and conditions, in the small print, “This may cause X, Y, or Z. You may not get back what you invested,” and so on, they do not have to say that for these adverts. For egg retrieval, which is hugely invasive, it is ludicrous. Whatever you think about the subject of egg donation per se, I do not know why anyone would disagree with saying you must legally have the health risks on the advert.

Our preference is that adverts should be banned. Asking women as young as 18 to donate their eggs for use by others, people who may be wealthier than them, twice their age and so on, should not be proactively allowed. If they continue to be allowed, they absolutely must state the health risks up front, and the reference to any financial gain whatsoever—call it compensation or whatever you want to call it—must be removed from those ads because that is a huge incentive to young women.

I would say something about the marketing of this as well, which is that clinics and certainly egg banks often “love bomb” women. You get this language about, “Do something amazing; do something miraculous; create a family for someone else; change people’s lives; it’s so



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wonderful." You are asking a woman to inject her body with hormones for weeks, not for her own use later in IVF or even for her own egg freezing, but to give to somebody else. This is not in the interests of young women and these adverts are very misleading.

I would like this on the record: in October 2024 we complained to the Advertising Standards Agency about, I think, four adverts, one of which it only banned two weeks ago and we think they only banned it in response to the Committee holding this inquiry in the first place. I have been meaning to write to the Committee about that and I will do so, Chair. You will have that for the public record: you will have our email from October 2024 to the ASA, and you will have its response in which it said it did not think there was a case to answer at the time. We think there are a lot of organisations backpedalling now because they realise they have been slow on egg donation, welfare, and their responsibility to egg donors for years and they are starting to realise they did not do as much as they should have done for these young women and they are trying to cover themselves now.

Q75 Christine Jardine: I just want to clarify something. You were talking about all the adverts for drugs and everything which have small print and list the risks, and there is nothing on the egg donation adverts. If someone sees one of these adverts and thinks, "Oh, I've been looking for a clinic like that; I want to follow it up," when they actually contact the clinic, surely the clinic has a duty of care to make sure they know all the potential risks and side effects. It is not that they are not going to be told; it is just that because it is not a service that is available online, they are being told when they get to the point where they are actually going to come in contact with the service.

Helen Gibson: We would say that the risks should be up front because, at the moment, you have adverts for egg banks on the tube. There is nothing in the small print saying, "Undergoing egg donation or egg retrieval might cause ovarian hyperstimulation syndrome." That is a known risk in the short term. The short-term ones should be printed up front and even the long-term risks that are less well-known.

In terms of the informed consent point that, surely, women are told the risks when they go, actually, we have been told by some donors that their counselling session, if they had one, did not really offer the time to go as deep as it should have done. "When my donations didn't work, I felt like a complete failure. I think feeling like a failure was another side effect I wasn't fully prepared for." Another said, "It's not at all clear enough how damaging and taxing the process can be on the body. This did not go as deep as it should have done."

Some women are reporting to us that they are not told at the clinic that it will be as severe on them as it proves to be. Some women may not have these significant hurts and harms, and we fully accept that, and if women are not being hurt then we are very glad. But for the ones who are, they are coming and telling us, "Oh, actually our meeting and our chat about



risks was perfunctory and brief and didn't really go into much detail." Women should not have to get to the point of walking through the door of a clinic before they are told, "This could harm you." They deserve to have that information straightaway.

Q76 Kim Leadbetter: Thank you both for coming; this is really interesting. I am going to talk a little about psychological health and access to counselling for donors. For the record, you have both clearly said already that you think counselling prior to donating should be mandatory. We are clear on counselling. What are the psychological risks or considerations for donors and those who are freezing their eggs? Are these risks being properly assessed and mitigated throughout counselling?

Dr Gurtin: We know that not everybody takes up the current offer of counselling. As I have already said, that is one change that the HFEA itself has called for as well, certainly in the case of donation. Also, in the case of egg freezing, counselling would be really important, and the offer should be made more robust, but not necessarily mandated.

Just to take a half step back, counselling in the context of fertility treatment is not necessarily what some people might imagine counselling to be. It is not a very long therapeutic conversation. Angela on the next panel is much better placed to speak to this, but it is much more of a detailed information provision in order to enable informed consent, so that should obviously be as robust as possible.

I also want to say that we should be quite careful about being clear that just because there are certain choices we might not make when we are fully informed does not mean that another woman might not make the same choice with full autonomy for herself. That is really important; what we are trying to argue for, I guess, is a structure that enables that for as many people as possible.

Just to go back to Helen's point about some adverts saying like, "Give the gift of life; do something wonderful," in the great majority of cases egg donation is something wonderful and it has led to the birth of so many very loved children who would not have existed otherwise. A lot of women do this altruistically—you heard that in the last panel—and feel that they have done something wonderful. I absolutely agree that the harms should be stated. That should be very clearly done, but we also should not shy away from framing donation in those terms.

The fact that there might be compensation to enable people to do that without losing out or without it being a major inconvenience, that is the same as I might donate blood altruistically, but I might only do it if there is a blood donation happening in my local area that I can walk to. Do you see what I mean? The fact that we make these things possible for people should not necessarily lead us to question their autonomy and ability to make informed choices.

Kim Leadbetter: Like most things, it is not straightforward, is it?



Dr Gurtin: Absolutely.

Q77 **Kim Leadbetter:** It is a complex environment that we are dealing with, and a really serious issue. Helen, do you think the risks are being properly assessed around donors' psychological health and wellbeing, and what more could be done in that regard?

Helen Gibson: I think previous witnesses said there is scope for more studies on the long-term psychological effect, and there is a gap in the research about the long-term psychological impact, and we would agree with that completely. As I have said, some donors have reported to us that they did not feel that they were adequately prepared for how they would feel in the longer term. Views change as we mature across the life course. As women have or do not have their own children, they may come to feel differently about this as they go through menopause and their views evolve.

That is not saying in any sort of paternalistic way, "Lots of women are going to come forward and regret it, therefore they should not be allowed to do it in the first place." Some people are misinterpreting our concerns about this, which is largely based on the for-profit sector preying on young women, and not in their best interests. As the dust settles for some donors over the longer term, given that some women are coming to us now and saying, "I do regret this, and I wish I hadn't done it," we think we may see more of that.

Interestingly, we were contacted by one woman whose friend actually was a sperm donor. He had done it in the 1990s as a student for beer money and, to this day, he bitterly regrets it because he knows he has children out there who he will never know and he will never see. That is one example, but this is a real person with a real crushing sense of, "What have I done? What did I do?" These psychological impacts exist. There was a story in the newspaper—I think I might have linked to it in our written submission—of a woman who had undergone egg freezing, tried for many years to make that work, and it had not; she was crushed.

As the number of women freezing their eggs comes forward, particularly because so many of them are over the age of 35, and for many of them it is not going to work. The fertility clinic will have taken thousands of pounds of their money and then, of course, at the end of it, they will be left in their 40s with no children. Those women are going to be particularly crushed. We need to understand that often with these sorts of cases, if women feel like they are on their own they will not come forward. It takes many years for women to come forward.

If you look at the issue that we saw in the 20th century around forced adoption, it was often women going into mother and baby homes in the 1950s, handing over babies when they did not really want to, but the state, charities and often religious institutions had this framework whereby women had to have their babies taken off them. It was often 40



or 50 years before they came forward and said, "I didn't want to do that, and I shouldn't have been made to do that, and I was."

I am not trying to draw parallels between the two; I am just trying to illustrate the point that women's views and ideas change, and so do men's. Without mandatory counselling, how on earth can we say there is fully-informed consent at the moment, and that we are trying to mitigate psychological harms? We are not doing that at the moment.

Kim Leadbetter: That is really helpful; thank you both.

Dr Gurtin: Can I quickly follow up and say I think Helen raised an important point there? In the case of egg freezing, one of the most important considerations is to just be absolutely clear that this is in no way, shape or form a guarantee of a baby. For me, one of the most concerning things is if a woman freezes her eggs with the idea in the back of her mind that she has got ready children, makes life decisions based on that assumption, and then that is an erroneous assumption. It is really important to be very clear about that.

Kim Leadbetter: Absolutely, and in both situations informed consent is only informed consent if it is informed.

Helen Gibson: If you are not sure about the risks, you are not fully informed and that is what is happening at the moment.

Q78 **Rosie Duffield:** We have obviously touched on this in terms of advertising and things and I know we are short of time, but is there enough informed consent about things like ovarian hyperstimulation syndrome? Could you both briefly say how many women you think are at risk of that? How high is that in people who donate?

Helen Gibson: I think the RCOG—I defer to it—said a third of all young women under 30 might get mild OHSS, and 1% to 2% would get severe or critical. We are guided by its clinical evidence. Our wider view is that donors are not able to give informed consent at the moment because of the reasons we have set out: the risks are not on the adverts; the payments are there, which for many women will always prove to be a financial incentive, inducement or motivation, and that is a risk of exploitation; and there are no long-term studies.

We talked about studies before. I think there is one at the moment at the University of Manchester looking at the cardiovascular health of women who undergo IVF, or mothers and babies. In its Home Office positioning paper—because it involves animal experimentation—titled "Long-term effects of in vitro fertilisation on the maternal foetal cardiovascular system", it states that "women that undergo IVF are 27% more likely to develop hypertension or have a stroke in later life."

I could not see where the study was that they had drawn that from, though I did find the ovarian tumour risk study that you reference. There is a lack of long-term studies, which means that there is a gap in the



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knowledge base, so I do not believe giving informed consent is fully possible, especially when our own Government have said, "Well, we haven't commissioned or seen any research." Then why are they letting these adverts go on without at least the known short-term risks printed on them? How can you give informed consent? I just do not think it is possible at the moment.

Q79 Rosie Duffield: Do you both agree that the process of informed consent needs to be strengthened, and that goes back to data?

Helen Gibson: Yes.

Dr Gurtin: I think the aftercare piece is really important. The medical treatment that you receive, whether you are going through IVF, egg freezing or egg donation, is the same. It is the stimulation of the ovaries; it is egg collection, but obviously the actual mechanisms around them are a bit different. If you are having IVF treatment, you are going to go back and have an embryo put back, so the clinic necessarily has a longer-term overview.

The evidence from UCLH that I mentioned, which has just been submitted to the *BMJ* for publication, suggests that women undergoing egg freezing might have poorer aftercare because, as it were, their eggs have been collected and then they have waved bye-bye to the clinic. I have qualitatively interviewed a number of women who then ended up in hospital and, in some cases, called up their clinic and were told, "Well, just contact your local A&E," which is obviously not appropriate. That is not what we would want to see, and aftercare is really important.

The number of women who have gone through IVF in this country is now very high. We have had over 2 million cycles of IVF in the UK, so huge numbers. Overall, we know it is a safe procedure, but there should be more follow-up and better understanding, and certainly clinics should be required to perform better aftercare. Some clinics might already be doing that in really conscientious ways, but requiring that across the board is no bad thing.

Q80 Rosie Duffield: That is another thing we need to strengthen. You would be astonished: I have done a lot of work on women's health, and no area of women's health—birth trauma included—has aftercare or follow-ups. I have done this for nine years, and it is a recurring theme. Do we know enough about the experiences of women who go on to try to use their frozen eggs? Again, does that come back to more data collection?

Dr Gurtin: The practice of egg freezing is relatively recent, so the numbers have only really been increasing in this country since 2014. The numbers are still low; we are talking about 20,000 cycles overall of egg freezing. There are different reasons: some might be medical or part of a clinical IVF process, but the great majority of those cycles are what we call elective or social egg freezing, so to be used later. By its very nature,



the great majority of people who have frozen their eggs have not come back and may never come back to use them.

I am currently doing some research on the decision making of women who had their eggs frozen some years ago, but it is hard to do that research because it is not a concentrated group that is available somewhere that you can target. We know some of those women go on to have children outside of clinics. Some might still be keeping their options open about whether they are going to have children. Some might have given up on having families altogether. There is a huge variety of experiences after that but so far the numbers that have come back to use their eggs are really low, and so it is very hard to say definitive things about them.

Rosie Duffield: Thank you; that is really interesting. Helen, do you want to come in on that one?

Helen Gibson: On the experience of aftercare, we would agree it seems to be a very mixed picture with some clinics not following up on donors. Of course, they are not mandated to do so in the long term and they are not tracking those health outcomes, which we think they should. One woman reported to us and said, "I later also found out I have a genetic condition. I tried to reach out to the clinic and let them know to pass on the information to the recipients and that I would be open to them contacting me any time if they wanted to. The clinic couldn't care less; no intention of passing anything on. Actually, they passed responsibility to the HFEA." I think there is work to be done.

Dr Gurtin: To me, that would seem like a case of the regulator working well.

Q81 **Chair:** Helen, I just want to clarify a position, because it sounded a bit like you believe that informed consent just cannot exist in this scenario. Is that the case?

Helen Gibson: It can, but it is not there yet. It is not there currently because of the lack of risks on the adverts. Until we have proper long-term cohort data evidence on how this affects women 30 years down the line, there is always going to be a gap in the evidence. You could say to women, "We know there are short-term risks now. You should be aware of OHSS and the other things like perforated bowels and abscesses, and so on". But longer term, clinics should be clear with women. There have not been these huge cohort studies of donors going over the 25 to 30 years that egg donation has been quite widespread, so therefore, there are known unknowns. That is the area.

Chair: I just wanted to be clear.

Helen Gibson: It is about being honest with women. There are known unknowns, and there always will be until you get the long-term data.

Chair: I just wanted to be clear that that is what informed consent looks



like to you. Actually, even if you had that, would you be comfortable with people donating eggs—because, as with any health procedure, there will be unknowns?

Helen Gibson: Of course, and side effects.

Q82 **Chair:** I wanted to get where you were coming from when you said about the problems that you have with informed consent.

Helen Gibson: Certainly, in the immediate term, there is no informed consent now because there is no health risk on the adverts. We have wider issues with egg donation per se because we take a different view in that often you will hear—and have heard I think—a discussion about a shortage of eggs, for example, and this being the only way that people can have families, and nobody fails to have sympathy with that view. There is also a feminist view, which is that these women's eggs belong to these women, and young women should not be preyed on for their eggs to be used as a resource by others. That is a bigger political point outside of the framework of how egg donation works in Britain today.

Q83 **Chair:** That is what I wanted to get to about the feminist ideology that you have just described. Is it your position that, actually, this donation should not exist at all?

Helen Gibson: We would be more comfortable if it did not because we do not think it is an appropriate thing to ask a woman for.

Q84 **Chair:** That is what I was trying to get to with the informed consent as to whether it is ever going to be enough, or whether it is actually an issue with the process itself.

Helen Gibson: If egg donation is legal, it needs to be a decision for the individual woman and there is perhaps a misunderstanding of our view that we somehow think women cannot consent at all, or should not be allowed to, or something. That is not our view. If there are better safeguards there, for example, raise the age, get rid of the payments, ban the adverts, or at least make them very clear on what is involved, if women still want to do it, that is up to them. That is the point about saying raise the minimum age of donation. Then, if you get to 25 or 21, whatever it is, if women still want to go and do it, that is their choice.

In a democracy, as campaigners for the rights of women and children, and it is children who we should always centre in these discussions, we have the right to say there is a bigger widespread societal problem if women's eggs are seen as something that people have a right to access, and it is something you can just go and buy as though you were going shopping. If you go on the London Egg Bank website and look at the categories of how you filter out your donors, it is a bit like online dating and there are real societal harms there with allowing that to continue.

We see a lot of very misogynistic content in videos on social media of people who have gone and bought eggs and are holding up baskets of



chickens' eggs and talking about how they selected their donor, and it is really nasty stuff. We wanted you to be aware of that wider context that we absolutely want the safeguards to be improved for women in Britain in the here and now today, but there are other issues.

Chair: If you could forward those examples to us, that would be really useful to the Committee. I am going to switch over to the next panel now, but I want to say thank you very much to Zeynep and Helen.

Examination of witnesses

Witnesses: Dr Ippokratis Sarris and Angela Pericleous-Smith.

Q85 **Chair:** I know that our next guests were sitting throughout that first panel and no doubt will also have seen snippets of our previous witness sessions. Welcome to the Women and Equalities Committee, Dr Ippokratis Sarris, executive committee member at the British Fertility Society and consultant in reproductive medicine; and Angela Pericleous-Smith, chair of the British Infertility Counselling Association. Welcome to you both and thank you very much.

I have some quick questions based a little more on the health risks and practicalities of this. We have already heard some serious concerns that clinics do not currently communicate health risks to egg donors and egg freezing patients. How valid do you feel those concerns are? Clinics reported 224 grade B incidents in 2024-2025. What type of incidents are considered grade B, and to what extent would they have an impact on egg donors? Angela, I will start with you, if that is okay.

Angela Pericleous-Smith: From a counsellor's perspective and the patients we work with, generally speaking those health risks are portrayed quite well to patients within their consultations, the written information, and the guidance given to clinics to provide that information. Then hopefully with counselling they have more of an opportunity to explore those health risks for themselves.

There is also something very true in there about patients' understanding of those health risks and what their expectations are. From a lived experience, if you like, some patients do not actually truly know what these risks are until they are in it, even though they can read it. We can read on a box of paracetamol what the risks are, but until we have any of those side effects, we cannot truly appreciate them.

Dr Sarris: First, thank you for having me. Giving risks to patients and consent is quite complex. I agree that it can be done very well or very badly. There are multiple levels. First, I will talk about provision of information. The fertility sector is the most regulated area of healthcare in the UK and probably around the world. A lot of information is mandated and given to patients at multiple touch points, which can be a little bit of an issue as well.



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Of course, there is the oral information, which any good clinician should be doing in consultation, and which is obviously under the remit of the GMC. We should also note that the HFEA is not the only regulator of the sector; there are also professional regulators. I would consider that good practice for any doctor doing anything in medicine to give information about what they are doing to their patients. That is documented in the notes, which of course the patients have a right to and most of the time take.

Beyond that, there is written information that clinics must give to patients, patient information leaflets, which the HFEA comes and inspects. Actually, I just had an inspection yesterday with the HFEA, and it asked for hundreds of documents and read through them all. Beyond that, there is consenting when you are actually doing a treatment. If anybody has had an operation there is a whole list of information there and usually—not always but most of the time—there are percentages.

There has actually been criticism that we are giving too much information to patients. When you have too much information, you have information overload. There is a difference between having the information and reading it—I agree with what Angela said—and actually understanding it. That is in all healthcare. I am not trying to say that we should not give information. It is a very, very complex area but there is also a problem with giving too much information.

I agree that anybody who is going through IVF, egg freezing, or egg donation should have all the information. We can have a discussion in one of the other questions about whether the right place to put it is in an advert, but it is definitely given at the time of a consultation and the consenting process. If it is not, that is not a problem with regulation, because regulation says that you should do it; it is with the implementation and potential policing of the regulations. The regulator should step in if there is an issue there. It is the same in medical practice, for example, if a doctor is not doing what they are meant to do. This is not just a fertility question.

That is with regard to consent and information in general. If we go with the short-term complications that people are talking about—infection, bleeding, injury to organs, and OHSS—it is all clearly documented in a consent, and it is mentioned every time someone does a procedure. I just did a procedure in the morning, and I went through it, explained it, and had a signed consent. Healthcare is not zero risk and unfortunately there will always be complications, especially if you treat complex patients. Apart from my hat as the British Fertility Society chair-elect, I am also director of King's Fertility just down the road, one of the biggest clinics in the UK. Of course, if you do thousands of procedures, even one in 1,000 will happen. That is all documented.

The question that I have been hearing is on the long-term effects. I should say that obviously IVF has been around since 1978. There are



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decades of children who have been born; some 3% of all children born in the UK right now are through IVF treatment. Actually, that is low compared with other countries. For example in Denmark, it is 10%. There have been millions of children and women who have been born and treated.

When it comes down to some risks—I put it in our evidence as well—there is a lot of long-term data with regard to cancer risk, for example. It is true to say that there has been some contradicting information. Of course, when you cherry-pick one study versus another, it looks like you can prove whatever you want.

But all the meta-analysis that has been written, actually one from my group as well looking at breast cancer specifically, when you compare the right group—women who are having IVF treatment versus those who have infertility and are not having treatment, because it is a very different demographic, background and medical consideration when you compare wrong treatment groups—has not shown any increased risk in those long-term cancers. This is very important because even a small risk of a common cancer like breast cancer, for example, will translate to a lot of harm to women.

With regard to one of the things that I heard about cardiac, we actually just published a relatively small paper by one of my PhD students. We found that in women who had IVF treatment versus those who did not, when we looked at cardiovascular status with echoes and other parameters, we did not see a lasting effect. Now, that does not mean that there might not be 10, 20 or 30 years down the line, I agree, but the signal is not there, considering that this has been going on for a very long time.

Q86 Chair: I have two questions following on from what you have just said—that was really useful. The first one is—present company excluded obviously—doctors are not always known for having the best communication skills, particularly when it comes to speaking to women and women's health. We already have had a report on medical misogyny and have called for some pretty hard recommendations to improve that. Is there a case to be made that it is not just about the amount of information, but the accessibility and user-friendliness of that information, which needs to be readily available for anybody potentially donating eggs and freezing their own eggs?

Dr Sarris: I 100% agree. I am not going to disagree with that. It is a constant—I would not say a battle, but a balance between how much information you can give and how simply you can give it. Specifically in my own practice and clinic, we have had almost contradicting advice. We looked at some AIS accreditation which said that the average reading level of somebody is fourth or fifth grade, so you have to write information in those simple terms, which is great. But then the regulator rightly says that you have to provide all this very complex information. How do you marry those two things and not end up with something that



is 100 pages long? If I had a simple answer, I would definitely give it to you, but more work has to be done in that area of how we give medical information.

I am digressing, but that is where we have the potential power, but there are also the pitfalls of stuff such as social media. We just published a paper last year with my group—it is obviously publicly available; I am happy to send it—about misinformation, social media and infertility and we found that the majority of information on social media is not from credible sources, not written in language that is appropriate, and is sometimes incorrect. It does not mean there is no good information out there; it just gets flooded away.

Like it or not, my generation—or our generation; I do not want to insult anyone—consumes information very, very differently. In the past, it used to be a more consumer-to-expert approach, but now it is lived experience to lived experience and influencer to another influencer. That is beyond what the HFEA and fertility world can do. Actually, most of the time in my practice I am countering misinformation that patients come with; sometimes it is stuff that even I do not know where they found it. I have to go and ask them where it was, so I can research it myself.

There is a very big balance between accessible, easy information, correct information, and what is regulatorily compliant. You can see all the paperwork I have here to answer your questions. Even I cannot get it right and understand it. It is a complex area, and we should admit to ourselves that we can get it better, but it was never going to be perfect as our knowledge constantly evolves around these things.

Q87 Chair: Angela, we will be coming to you specifically on counselling in a bit. This question is very much the health focus: even though IVF, egg donation and egg freezing have been happening for decades, we know that there has been a massive lack of research done on the impact on women's health, just generally. It does not matter whether it is IVF and fertility, just generally. We have not been considered in these medical advancements and the long-term impacts.

First, would you say that there needs to be more research done and demographic data collected to identify groups that might be at higher risk, to better understand experiences of aftercare? Secondly, do you think clinics in the UK would be open to a framework for long-term follow-up?

Dr Sarris: I have a funny little anecdote: fertility research is the only area of medicine where the research is predominantly on women rather than men, although 50% of infertility is in men. One of my old fellows did a little study, and he found that although the fertility issues we see in the clinics are 50-50, only 1% of all fertility research is on men. Actually, it is interesting that most of what we do is about women, for good enough reasons, obviously.



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Chair: That seems to stop immediately after the pregnancy has been successful.

Dr Sarris: The problem that we have with a lot of medicine is longevity of being able to gather data. You also mentioned birth trauma and so on. There is a great appetite among the more academically minded and doctors in general to have that information. The problem is that it is very fragmented. One solution is to link the databases. We talk about the HFEA, but there are also the NHS databases. Some of the best data we have out there has come from the Nordic countries where they have these big national databases where they have managed to link them. They can look at lifelong courses.

We have regulatory constraints here. It is not specifically about the HFEA, but it has to do with data collection, GDPR and consent. I am not saying they are not valid reasons. We have been trying to link databases in the UK with my research group, but it has been so difficult—it is impossible. That is where the answer is. The answer is not an individual clinic that might or might not exist in 30 or 40 years and might or might not have been sold, with a doctor who might or might not have retired. The data is out there; we just need to link it together. With new technology, we can follow life cycles. Then there are a lot of people who are interested in the academics around who would want to give those answers. We actually want those answers, but it cannot be on an individual clinic level. It is not powerful enough.

Q88 **Chair:** We saw some first-hand experience of that from geneticists in Iceland as well, which has huge amounts of data. Guidance in the US—we do not really want to take any lessons from the US on this—recommends a six-donation cycle limit for a woman in her lifetime. In the UK, there is a limit of 10 families, but not on cycles. Should there be?

Dr Sarris: That is a very, very interesting question. I was just looking at all the different countries and what they have done. In many ways, the UK sounds very liberal in that. It is mainly sperm donation that becomes more of an issue, because of course they can create lots of families, and there are a lot of issues with the international number of families. I am sure you have heard about it. But what is interesting is that even if the limit was changed, the HFEA's own data we are showing here is on average egg donors undergo 1.4 donation cycles. Fewer than 1%—actually 0.7%—of these donors have undergone more than five egg donation cycles. We are talking about a very, very small number.

I do not inherently have a disagreement with having a cap of some sort. Exactly what that should be is open to debate. It is almost impossible that one donor can have not just 10 children, but 10 families with multiple children. Practically, that has clearly not happened. There are a very small number. If that five is high or not, that is fine. But it seems to self-regulate just from the physicality of what goes on. That is what the numbers show. It is a relatively smaller issue for egg donors but it could



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be looked at without greatly changing availability and the pattern of what donors do.

Chair: I am going to hand over to Christine, who is going to talk about demographics.

Q89 **Christine Jardine:** I wonder if I could ask you why you think the proportion of donors between 18 and 25 has doubled in the past 10 years? Does the fact that there is an increase in younger women raise any concerns for you?

Dr Sarris: I was looking again at the data. It is interesting that it has doubled if you compare 2009 with 2013, but actually from 2014 to 2023 there has been a relatively small number. Inherently, from a medical point of view, having people who donate from a younger age is better. We can argue about whether it is 18, 19, or 21. There is some data that suggests—this has to do with egg freezing as well—that if you are younger than 21 you actually have a higher proportion of abnormal eggs in the same way as if you were older. It is almost like a U-shape. We think there are various biological reasons why that is. It is 18 to 24, but medically, 18 to 21 is probably not as optimal. From that medical point of view it makes more sense.

The worry is whether there is vulnerability or exploitation, which is a discussion that cannot just be pulled out of a crude number like this. But the change seems to have been more subtle since 2014 versus before that. On average, the age of donation in the UK the HFEA database has not changed. From looking at it, there seems a slight shift in that you have older women donating less, which medically is probably more appropriate, and some younger women donating more. It seems that the average is the same.

The answer is that one needs to look at it in more detail to understand exactly why there is that pattern. I am just hypothesising here, but one answer could be that younger people in general have better access to information because everybody has a phone now and everybody can look at things. Information is not just adverts or social media; it is also people interacting with each other. That is a possibility, but I cannot prove that because obviously these are just crude numbers. I do not know if Angela knows.

Q90 **Christine Jardine:** The HFEA guidance says that egg donors should be under 35, apart from in exceptional circumstances, but around 15% of egg donors between 2011 and 2020 were 36 and over. Why is this? Does the age of the donor present any specific or significant health risks?

Dr Sarris: Yes. There is an international agreement that donors should be under 35 and probably a little less than that if you are going through the effort of donating to have success for the recipient. But the exception that we are referring to usually refers to people who have a genetic relationship with the donor. For example, we find that we have women



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whose sisters might want to donate, or anybody else. There is then a genetic link. It is never ideal from the point of view of success, but that is also part of the understanding and counselling, which should be, and in my experience is, explaining why that is not ideal.

When it comes to inspections, the HFEA always looks at those cases to understand why that is. It tends to be those sorts of exceptions—I cannot say it is 100%, I am sure there might be other reasons as well—because the genetic link tends to be preferable in that sort of situation versus an altruistic, anonymous donor. It usually tends to be altruistic because no money changes hands, at least not knowingly.

When it comes to the risk to women who donate after age 35, there is no inherent difference in the risk procedurally. The only exception would be that as we become older, most of us are more likely to have medical problems than our younger selves, by and large. But that comes out in the pre-donation screening that you are mandated to do by law to exclude conditions or diseases. Of course, if you had an unhealthy person who wanted to donate, at any age for that matter, it would not be medically appropriate.

There should not be any more risk for older women if selected correctly, but the success rate is different. Usually that is because of an overarching reason, which tends to be genetics.

Q91 Christine Jardine: Briefly, going back to the first bit, do you think this is an area where we need more research and need to find out more? Why are younger women coming forward?

Dr Sarris: Any research to understand why people are coming forward for anything—sperm donors as well—is a good thing. We have good qualitative research, and some has been presented from some groups. I tried to read almost everything that was sent in; I have to admit that there was a lot of information but I did try to read it. Everything seemed to be positive. But of course as we have heard before it captures a very small number. If we can have more data and more information, I agree that that would be useful.

Q92 Chair: Dr Sarris, before we move on, I just wanted to ask what counts as a success rate? When advertising, I would say that there are inconsistencies with what they count and advertise as success when it comes to this process. What do you count as a success rate?

Dr Sarris: I will tell you exactly, but I just want to make sure whether you are asking about egg donation, egg freezing, or own treatment?

Chair: All three.

Dr Sarris: The metric that most fertility people around the world now consider success is a healthy baby with a healthy mother, per treatment started. That is sometimes what people fall foul of when they look at success rates from outside the UK and consider success as a pregnancy



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test, for example. But now it is not just to have a baby, but to have a healthy baby—under the definition of what that is—and a healthy mother. Then, of course, it is per whatever metric; usually it is per treatment started. In my opinion, treatment started is the first day you start any medication because the denominator changes as you go through.

When people come to a clinic, they want “Hello, doctor. I am going to start medication. How likely am I to get a healthy baby? How many goes do I need to do?”. That is really the mark of success, but it is not just the baby; it is also the mother, and the journey if you really want to put it into a more holistic approach.

Q93 Chair: That sounds like a really sensible measure and marker of success. Is that currently standardised across the UK?

Dr Sarris: The HFEA has done some good work, because there were some concerns that previous markers of success throughout were not appropriate. For example, it started with success per embryo transfer procedure, which then meant multiple embryos would be put in to look better. It was then per embryo transferred, which was great, but people were saying, “Well, actually, there are other techniques like genetic testing that might make that look different.” Now it has moved to cumulative births per egg collection procedure over a two-year period. I know it sounds like a mouthful to say, but it is much more appropriate. The downside is it needs a much longer lead time to be able to get the data, so all data will be a minimum of two years old. But it is a good start and is appropriate. That was based on a consultation that the HFEA did with the sector and is a good example of how things can work well.

Q94 David Burton-Sampson: I have some questions for you, Angela, concerning counselling. What does good counselling practice for both egg donation and freezing look like for you, and how widely is that implemented? Going on from that, are counsellors given adequate time and resources to deliver good counselling?

Angela Pericleous-Smith: To me, good counselling practice looks like implications counselling, which we already heard about in the previous panel and the evidence given before. It is not routinely mandated. Good implications counselling is, first, having the implications counselling. It should be routinely offered as part of the natural pathway so that it is not seen as a tick-box exercise, as it sometimes is; sometimes it is just not routinely offered. It is important to be able to have that with a specialised fertility counsellor, independent of the medical clinic side.

We also heard about the cost: sometimes implications counselling is offered, but there is a fee for it. Can we truly say that it is being offered if there is a fee for it? It should be freely available. We need to be able to provide our patients with the opportunity to prepare themselves for being donors from a psychological perspective: the impact for them, the impact now, and how things might evolve in the future. At BICA, we are also adamant and advocate that partners of donors attend implications



counselling. If they are in a committed relationship, partners and spouses should be attending implications counselling as well.

Sorry, was the second part of your question about how widely it is available?

Q95 **David Burton-Sampson:** Is there adequate time given to counsellors?

Angela Pericleous-Smith: Again, BICA advocate for it not being a one-off session. Sadly, there are quite a lot of discrepancies across UK clinics. In some clinics, there is very good provision: it is freely available and is a routine part of the pathway. We have great consultants really explaining what the purpose of implications counselling is and how it can benefit our patients. Elsewhere, people are not explaining what the purpose of counselling is and then some clinics are not providing it, or there is a fee for it. That is inherent, isn't it? The decision to donate comes with permanent, lifelong decisions, and it is really important that people have the opportunity to explore what that means for them, now and in the future.

Q96 **David Burton-Sampson:** You are talking about implications counselling; does the counselling include the possibility of the egg donor discovering that they may have a genetic condition?

Angela Pericleous-Smith: Yes. Obviously, we are not genetic counsellors, but we do that exploration: "How it would be if a genetic condition were discovered? What might that mean for you?". Of course, BICA has recently published a new professional resource for delivering implications counselling in UK clinics. Our new resource is intended not just for counsellors, but for clinic staff, PRs, consultants and anybody involved in the donation pathway. Counselling can explore what would happen if a genetic condition was discovered.

Q97 **David Burton-Sampson:** Following on from that point, would the counsellor within a clinic be a trained counsellor or could it be a clinician who is not necessarily trained in the area of counselling but is giving some guidance?

Angela Pericleous-Smith: That is a very good question. No, there are qualification criteria in the code of practice for a counsellor in a fertility clinic. Again, BICA has advocated hard over the years to have a qualified fertility counsellor delivering implications counselling, so it is not a nurse or a consultant delivering that implications counselling. Don't get me wrong—they are very knowledgeable but they do not do what counsellors do which is really exploring those psychological and psychosocial implications for our patients.

Q98 **David Burton-Sampson:** How widely is follow-up counselling available, and should clinics be required to offer more than one pre-treatment session?



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Angela Pericleous-Smith: Yes. Clinics should be required to offer more than one pre-treatment. Again, many of our patients may require only one session. Looking at audit reports from counsellors across BICA, usually fewer than 10% or 15% of our patients require more than one. But again, this is not like going in and fixing a broken elbow. Our feelings change over time, and we cannot predict them.

I cannot remember but I think it was the previous panel spoke about how complex it is and how much information is involved. It is hard to explore all that in one session. People need time to be able to go away, reflect, think about it, maybe discuss with family members and come back and explore some more. There should definitely be more than one.

Sorry, could you repeat the first part of the question?

Q99 **David Burton-Sampson:** Is follow-up counselling widely available? It links in, really.

Angela Pericleous-Smith: Yes. Again, there are disparities. There are clinics that have very good provision to clinics where there is no provision of follow-up counselling. From a BICA perspective, it is quite concerning that some bigger providers of egg donation do not routinely provide implications counselling or later counselling.

Q100 **David Burton-Sampson:** Do you think counselling should be mandatory?

Angela Pericleous-Smith: Yes. From BICA's perspective, we have advocated for this before. In the law reform a couple of years ago, we advocated for mandated implications counselling because it was a great opportunity to do so. Sometimes people are on their best behaviour. For example, if a clinic is not routinely offering implications counselling and people are on their best behaviour, or the donor seems fine, the clinic does not know if there are any issues there.

Q101 **David Burton-Sampson:** This is the final question from me: how well do you think clinics integrate the implications of commercially available DNA testing into their counselling? Do you think there should be national guidance updated to reflect the technological realities that exist now?

Angela Pericleous-Smith: Yes. In its code of practice, the HFEA has written about DNA testing websites, and clinics' responsibilities to ensure that patients are aware of DNA testing websites and such. But again, there is a big difference between giving patients information and being aware of DNA testing websites, how they are evolving, and being able to have the opportunity to sit down and understand that information and think about how that might impact them and their families in the future.

I know the question was about DNA testing, but 20 years ago we were not talking to our patients about DNA testing because it was not really a thing. Likewise, there are things emerging that we will not be talking to our patients about today. We have a duty of care to our patients to give



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them that opportunity. It is not just about telling them about it but giving them the opportunity to explore what the potential meanings are.

Q102 **Chair:** I had a question about a group of people and individuals post-screening, whom Dr Sarris alluded to and talked about just moments ago. That is the group of people who have an unknown medical issue or ailment that they discover at the screening process. Do all clinics have to give counselling and access to counselling post that information being disclosed to any patients?

Angela Pericleous-Smith: They have to offer that counselling. With genetics, it is a genetic counsellor, isn't it?

Chair: They have to—

Angela Pericleous-Smith: Offer.

Q103 **Chair:** They have to offer it. How is that assessed, in terms of success, suitability and appropriateness? I imagine that it would be a really difficult situation for many people to be in.

Angela Pericleous-Smith: Yes. From a counselling perspective, sometimes when it is a genetic condition, they may not even reach the counselling service within a clinic setting. It is potentially referred to genetic counselling in order to go through the genetic implications for them as individuals.

Q104 **Chair:** Is that followed up by any of the clinics to ensure that that actually happens?

Angela Pericleous-Smith: That was probably not very helpful for you.

Dr Sarris: Just so I can understand the question and answer the correct question, are you talking about when a donor finds out they have a genetic condition and have already donated?

Chair: During the screening process, yes.

Dr Sarris: This falls under the remit of good medical practice, rather than counselling. One of the problems in the Act is that the word counselling has multiple meanings. It is mandated within the code of practice that if something unexpected is found and you therefore cannot treat somebody as a donor because it precludes them, then you have to have a discussion about the meaning and so on. I also want to stress that is good medical practice. If good medical practice is not followed, the issue is not the Act, it is actually medical practice.

I am not going to make any excuses for bad doctors. There are plenty around in many areas, but there are also a lot of good doctors. That is a different level of regulation. In a well-run clinic, you should have all the discussions and offer follow-on care because the follow-on care is not necessarily there and then. This is screening; they do not have a problem. A good example is if you are found to be a carrier of cystic



fibrosis. What does that mean for you and the children? That is where the genetic counsellors come into it. Do you want other members of the family to know? That is a general discussion that is best placed to be had within a geneticist's background because they have the expertise.

It is also inappropriate for clinicians and medical teams without expertise in a given area to take over that expertise. Their responsibility is to inform, make sure that there is a safety net in whatever situation, and refer appropriately. That is good practice rather than just what happens on the level of the counselling. If it does not happen then it is not just a fertility issue, but a doctor issue that should be followed through.

Angela Pericleous-Smith: Sorry, can I just add to that? If a genetic condition is discovered and there is a referral to a genetic counsellor who can go through the genetic implications, clinics would ordinarily also refer to the counsellor for support therapeutic counselling for how that diagnosis is impacting them, rather than the just the medical genetic element of it.

Q105 **Chair:** How quickly would that happen? Is there a long wait list?

Dr Sarris: Unfortunately, the NHS waiting list for genetic counselling can be up to a year. It can be longer in some cases; it depends on where in the country you are. That is a general issue of funding in this particular area. It will increase because genetics is becoming more and more understood, and more and more people are going and having over-the-counter carrier screenings where you can screen for 1,000 things. The era of genetics is here. We have not caught up with it yet regulation-wise, or policy and funding-wise.

Q106 **Chair:** For those who are freezing their eggs, should there be mandatory counselling for them? Either of you?

Dr Sarris: I do not want to hog the microphone.

Angela Pericleous-Smith: Again, yes. It should be a mandated, routine part of the pathway so that people are aware. Counsellors are not medical experts in terms of health risks or medical risks, but there should be an exploration of what those risks are for them. There are also patients' expectations of the number of eggs required: 15 eggs do not mean 15 babies, which a lot of patients might still believe despite having the information.

There are also different reasons people freeze their eggs. Yes, some are social reasons. Sometimes it is medical, such as oncology. We have also seen an increase over the past years in gender dysphoria: people freezing due to gender dysphoria. There are potential implications from that in the future.

Dr Sarris: This is probably the only thing we slightly disagree on. By the way, I totally agree that for donors—and recipients for that matter—implications counselling should be done. It should not just be offered.



That is my personal opinion; I agree with that 100%. I would not personally ever accept somebody becoming a donor, or the other way around, a recipient, if they have not had that. If they have not had it, the reasons need to be explored. That in itself is a red flag.

But talking specifically about egg freezing—I come from experience to explain this—it should not be mandated. It should be offered like any other treatment because it can also come across as very patronising in many ways. In my clinic, we actually used to have it mandated for egg freezing. We had a lot of complaints from women that we mandated. Of course, then we said it should be offered. It is not mandated, but of course, it is available.

There is a difference between women, men, or anyone having fertility treatment requiring counselling for the treatment in general, which of course is available and should be available to everyone, even if they do not pick it up. But specifically for egg freezing, what is more important is not the counselling, but the information that is given by the clinicians, the clinic and anyone else about the success rates. I very much believe that to be the case.

No bad practice should be condoned in any way. It is not a guarantee: 15 babies are not guaranteed with 15 eggs. You need one egg for one baby, or you can have 100 and have zero. Unfortunately, this is the problem for any fertility treatment: statistics work on populations, not individuals. If I give somebody a 10%, 15%, or 50%, for them it is binary. You either have a baby, or you do not: 0% or 100% and everything in between.

Although there are guides to understand whether it will or will not, I have given statistics to people of one in 300 trying to dissuade them, and they had the baby. But there are also the 299 who did not. I have given statistics of 85%, and they did not have the baby. It is binary. The problem with statistics is they do not work on individuals. Proper medical information is needed. The clinician is wrong in not giving the information; it should be done properly, but it should not necessarily be mandatory to see a counsellor to discuss it if they do not want to. That is my opinion of it.

Chair: Yes. You are absolutely right that statistics are about the individual. As somebody who has had fertility issues, you will take any odds at some stages. If you said to anybody, "You have a one in 300 chance of winning the lottery," they would take those odds. If their lottery win is a baby and a child at the end of it, then they would take those odds.

Q107 **Christine Jardine:** Ippokratis, what impact does the current level of compensation have on donor recruitment?

Dr Sarris: I will have to admit that there are a lot more learned people than me who have looked at that, including in this room during the previous panel, so I do not want to assume. I agree with what I heard:



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£985 is a lot of money for some people and saying otherwise would be patronising. But from the data that I have read, the majority do not seem to be doing it for the money, in this country at least. I am sure there are lived experiences, but these are exceptions.

I do not have enough experience and information to be able to give sweeping comments, apart from the fact that everything I have read does not seem to point to an exploitative practice based on just that particular amount. The HFEA has looked at it at various points and has done three reviews with public consultations about the money, so it is not just an opinion of one. The HFEA has put all the information in its report to you—I am not going to go over it—and it seemed to me that was very sensible.

I would agree that the principle of paying for gametes—or blood or organs for that matter—is not acceptable. It is also not acceptable to assume that people should be out of pocket. That level is there. We got it right in this country. Whether it is £985 or £750 is a debate that can be had and you will have arguments on both sides. I do not personally feel that the majority of people would be donating for that money, from my experience, but I am sure there are a few.

As you have heard from the previous panel, it is a very arduous journey to be done. I agree it is a good idea to have all the complications on an advert, but it is not like you go to buy over-the-counter paracetamol and you do not know about it. It takes months from entering a clinic to leaving, with multiple touch points. If a clinic is run properly, and the medicine is run properly, then that should not be an issue. If that is not done properly, there are already regulatory steps and frameworks to make that go away. It is therefore then about policing, not about necessarily needing to change the framework. That obviously is a slightly different sort of discussion.

I think this country has got it right. I do not agree with commercialisation. That is my opinion from the evidence I have seen. As I said, you have heard from a lot more learned people around that who possibly have better opinions than mine.

Angela Pericleous-Smith: Again, this is just my own experience in practice as opposed to an overall experience of BICA counsellors, but it is not the compensation that is motivating donors. Obviously, the compensation sometimes comes up in the counselling sessions. The previous panel showed that the research shows it is not predominantly the compensation that motivates donors to donate. In fact, when I personally see potential donors, a lot of the time they do not even know compensation is available.

Q108 Christine Jardine: How do clinic staff screen—if they screen—for financial pressures, including with egg sharing, and so on? Do you think it is done effectively at the moment?



Angela Pericleous-Smith: From my perspective, implications counselling is that perfect opportunity to explore that because we are exploring donors' motivations, including any financial compensation, incentives, what their status is, work, support, and so on. We are aware of any motivation for the financial aspect. Implications counselling is a good way of having that exploration for our donors.

Q109 **Christine Jardine:** Just on the implications of the donation, the amount of the donation, and whether it actually makes a difference, what is the evidence from Scotland on donor recruitment? There is no compensation offered in Scotland for donating. What do you think the evidence from there suggests?

Dr Sarris: I would need to defer to my Scottish colleagues, of whom there are some very excellent ones, because I do not have the full information. I do not want to mislead the panel on that one.

Q110 **Christine Jardine:** Angela, do you think there is any evidence from Scotland that can be gleaned?

Angela Pericleous-Smith: I do not know. Donors are still coming through, are they not? Donors are not compensated in Scotland. I can get back to you on how that has impacted recruitment and waiting times and such, but not off the top of my head.

Q111 **Christine Jardine:** If you could, that would be very useful. I have just one last thing. You have already touched on the idea of it being very different going through months of preparation and counselling for donation and going in and buying paracetamol. But if you could just lay out for us, how clinics ensure that their marketing practices appropriately portray the physical and emotional implications of donating or freezing eggs.

Dr Sarris: First, I am obviously not here to excuse any bad advertising that is out there. We have to be very clear. The latest Committee of Advertising Practice report in 2025 showed that 96.7% of adverts are good, but that still leaves 3% and a bit that are not good. The fact that we keep on talking about the 2% or 3% that are bad means that they have done the job right, and they should not be there. Interestingly, just to make a point, it is a very small sector. We are all talking about those bad adverts. The fact that it is there means we know what not to do, and of course, we improve.

The specific ad obviously should not be pushing the happy compensation aspect of it. That is correct. That is bad advertising, and it should not be there. Most do not do that. My opinion is that the place of advertising is awareness. That is where social media is, and there is a lot of it. It was interesting to see that post about the eggs being hatched. I would be surprised if that is from a clinic. If it is, it should not be there. But again, you cannot legislate influencers putting out all sorts of stuff. I said the paper that we published last year was about general fertility information.



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It is amazing how much is from non-experts, and how much is lived experiences and everything. It all pretty much floods the good practice.

It should be about awareness, not advertising per se. If you have awareness and are interested and intrigued then the place to have the in-detail discussions is in the clinics. There is a lot of good information out there: the HFEA website has good information, there is some good clinic information, and there is no reason why that cannot be expanded. It is about awareness. Adverts should not necessarily be there to sell egg donation as a product. That is a fairly innocuous belief.

Angela Pericleous-Smith: I was thinking about this, and how do you advertise the psychosocial impacts? How do you get that into an advert? I am not saying that the adverts that are out there are right and I agree with them, but it is very difficult in some ways to get across the psychosocial aspects of being a donor in an advert. There could at least be a line in a lot of these adverts about the psychosocial. I was looking at some adverts, and again there is that, "Do something incredible, give a gift," type of thing. For the psychosocial aspects, there could definitely be a line. They could be improved.

Q112 **Christine Jardine:** Are you thinking just something that would say, "Please be aware that there are psychosocial implications before you consider," that sort of thing?

Angela Pericleous-Smith: Perhaps examples of impact, or things for them to think about. I thought of something very good earlier, but I have forgotten now.

Chair: You can write to us. I should have said at the beginning, but if, when you stand up or at the end of this, you think, "I should have said this," or you think we should have heard something else from you, please follow it up with an email afterwards, because I do not want you to be kicking yourself when you leave this place.

Dr Sarris: If I can just add, it is about advertising standards more generally. Again, it is not just about egg donation, egg freezing or whatever. I see all sorts of adverts out there about sugary drinks and stuff. They do not have a thing saying, "This candy bar can cause diabetes, early death, obesity," and stuff like that. It is through public messaging that we know too much sugar is bad for you. No one reads T&Cs either. I sometimes cannot even hear them on the radio because they are so quick. Is that really effective? I do not know.

Public messaging is better. There are good organisations—of course, I am going to plug the BFS, but also the RCOG and the HFEA—that can possibly do that and actually do some work potentially with the social media giants, which I am sure is very difficult to do, to try to plug good information and not flood everyone with bad information. There is some work hopefully being done there as well. That is really the path, rather than having an extra, "This will lead to long-term whatever it is." That is



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not the place to be. It should come from the clinics. The rest is just awareness of, "This is an option; come and speak to a specialist about this."

Q113 Christine Jardine: Would I be right in taking from what you say that there is a public awareness and an availability aspect to this, which is different from advertising a product? It is about putting women who might want to donate—for whatever reason—together with the facilities, which is a different thing.

Dr Sarris: Yes. I am a very big believer that medicine is not a commodity, and this goes for all medicine. It is about awareness of conditions, and then obviously through that you try to do it properly. If you want to be bold, there could be a national egg bank—like there is a national blood bank or national sperm bank—properly funded, properly done, with not just regulatory oversight but all the ethical frameworks. You take it away from organisations that are private, then people can access it in whatever ways they want to—maybe not just for NHS treatment, but for private treatment—and they will have to contribute to that. There can be bold ideas that can do that.

What I am trying to say is that the need is there, unless we can start creating eggs out of skin cells, which people are trying to. One day, if that is possible and legal egg freezing and the rest may all be gone, but until that day the need is there. When we start closing the net too much, then we push people into countries that have less regulation and have many more issues—I can bore you with those, but this is not the time or the place—or they go into underground routes. For example, we have seen that with sperm donors, where people completely bypass the regulations and just go and do it from the internet and the rest.

If we do not believe this should be banned but believe it is worthwhile and there is an altruistic pathway to do it, then there is a boldness in saying it could be centrally done. It could be part-funded by private equity, or private clinics and stuff like that, which use it for their patients, and it could be almost cost-neutral. This is just an idea, but we can be bold as well when we look at these problems.

Christine Jardine: I like bold.

Chair: Rebecca, you have a follow-up on this, and then you have questions on private equity.

Q114 Rebecca Paul: Yes, just briefly, because it is a really interesting discussion. Going back to what you said on advertising, you made the point that you have to remember that there is a whole process that and you go through all these risks in detail, which makes a lot of sense. I am just thinking through the theoretical arguments there. Take surrogacy, for example: you cannot advertise surrogacy, but you can go ahead with it, and you would go through the process and understand the risks, I would imagine, if you went through a clinic. What is the differentiation for



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you there? Are you comfortable that we have a different approach? Which one do you think is right?

Dr Sarris: That feeds into the previous comment I made about being bold and maybe taking it away from a more commercial setting and having it more centralised. Through that, you can say that it is about awareness and advertising. You cannot advertise surrogacy, but of course, there are charities and agencies that help people to meet in some sort of way.

There was actually a Law Commission recommendation about regulating that space a bit more and having licences and the rest, which unfortunately never came through. But I had a look at it and spoke to the people who were looking at it, and that was very interesting.

That is why I call it an awareness piece. For example, you should never advertise for body products—we do not advertise for bone marrow or anything, but there is an awareness that you can be an organ donor or a blood donor, and there are ways of doing it. Fair enough, in the UK those are currently all through government funding; unless the Government have an appetite to also fund egg donation and sperm donation—I put all that together to some extent—in which case there could be those sorts of frameworks.

What is advertising versus what is awareness can be a little bit of a grey area. That is where the regulators—plural—come in and say, “Actually, this is not good practice. That is good practice.” That is where it can be strengthened, rather than an outright ban because you cannot ban social media as well. You can make sure it has good, proper information and is not misrepresented.

Chair: There are days that I would like to, Dr Sarris.

Q115 **Rebecca Paul:** You make a really good point on blood donation. We are all very aware of how to do that, but no one is advertising to me on Facebook, which shows you there are potential ways to do this.

I want to move on to the financial side. We heard earlier that in 2030 the fertility market in the UK is estimated to be worth £1.1 billion. Do you have any feel for how that breaks down? I appreciate it is quite difficult to break it down between egg donation and IVF because sometimes these things are linked, but do you have a feel for where egg donation and egg freezing comparatively sit within the market, as it were?

Dr Sarris: We can dissect some of those numbers indirectly from the HFEA data that we have already. First, there are very, very few egg donation cycles compared with the number of IVF cycles. In itself, it is relatively small. Actually, what is not captured very well is all this cross-border medicine, because we do not have methods of doing it. A very big proportion of UK people who require donation, especially egg donation, go overseas. Unfortunately, that is something we do not have numbers for because we cannot capture it. It is not captured with the HFEA, by the



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clinics, and it is not captured—it could potentially be, this is where the linkage comes—from hospitals where people give birth.

In the UK it is a relatively small area because there is also a small number of treatments. Egg freezing is a small proportion of the overall treatments, but it is increasing. It will only go up, in my opinion, as young people become more and more aware of fertility and fertility decline because that is something quite new. Not everyone knows and understands fertility decline.

I was of that generation that as a teenager it was all about how you do not get pregnant. Either you do not get pregnant, or you do not get somebody else pregnant. It is all about contraception, which is a fantastic and empowering discussion but there is then no follow-on. It later becomes more difficult. It is not just female fertility; it is also male fertility that drops, but of course it is a very different slope.

As people become more and more aware, they ask, "Okay, what are my options?" You cannot push people into having children when they do not want to or are not ready, so they say, "What other option do I have?" It is an imperfect solution—far from perfect—but it is the only current solution. As people become more aware, they will choose. Whatever regulation there is, whether we ban or not, people talk to people. Most people I see want to come for egg freezing because a friend did it and they told them to do it, or some social influencer or whatever.

Q116 Rebecca Paul: What I am really trying to get at here is just understanding how much money there is to be made in this by the private sector. If we look at the numbers, we know women are being paid £985. Fertility clinics are then selling, say six eggs—that could be one round of eggs—for £5,000 upwards, right? It might even be more than £10,000. That is a massive margin, is it not? Are there costs in there that I am not taking into account? I mean, £5,000 is an 80% gross margin, which is huge.

Dr Sarris: There is a lot of cost in healthcare. Just hands up, in my clinic we do not have an egg bank or anything like that, so I do not do that, but I understand the numbers none the less. Healthcare in general is expensive. The difference with fertility is that it is one of the very few things in this country that we pay for predominantly out of our pockets. There is data showing that about 70% of treatments are from the private sector. There is a huge cost because of technology, people, and overheads.

One can argue about what an ethical margin is in business in general. There will be different models in different clinics, and there is the NHS, which also treats patients privately. It has to be understood that a lot of the private cycles are done within the NHS organisation, and the money goes back to the NHS, so it is not just private clinics that do private treatments.



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There is a lot of cost though, and when you break it down, that is where the cost comes to the treatment. It is true that there is a huge variation in what clinics will charge. That is something that the HFEA and the CMA have looked at, and I do not agree with overcharging for anything. It does not have to be IVF; it can be a bottle of water. Again, that is my stance. People will have a different opinion.

When it comes down to the amount of money that can be made, just to come back to that, inherently there are very few egg donation cycles with UK donors. I will caveat that: we can see from the HFEA that only 1,500 donors in general every year for the past 20 years have cycles of donation. That is not increasing over time. What is increasing and happening is the ability to import donors from overseas clinics. I am sure it is something you are aware of because I have seen it mentioned. That is because there is a need, rather than because UK clinics make money from it. If anything, it is the overseas clinic that makes money. That comes back to the demand that is required and how you can do it more ethically in the country.

The fertility area will only increase in general to move away from egg donation and make it a bit more general, because fewer and fewer people are having children younger. We know that the average age in the UK of women having children is 30; the average age of having treatment is 35; the average number of children per woman has dropped to 1.44. That is a demographic that is not going to change. A lot of people just do not want children early on, so fertility treatment will be required.

Q117 Rebecca Paul: I am really trying to focus on the financial here. I totally understand all that, and I understand why there is a market for it. But the point I am trying to make is, are fertility clinics making a huge amount of money out of this? If that is the case, you can see that we have to be really careful because those eggs are desirable in terms of making money. It is about getting the balance right. Fertility clinics are making a lot of money out of egg donation. Is that fair?

Dr Sarris: Generally, no.

Q118 Rebecca Paul: They are not?

Dr Sarris: I think in general they are not. Some might. I want to caveat it. Some might; the ones that have big donation programmes and might overcharge. Of course, there are 100-something fertility units in the UK, they are not all equally financially viable or successful. There will be exceptions. I am not a clinic owner, by the way, so it is something that I cannot comment on too much as an individual doctor. If you believe as legislators that you can curb, not just for fertility, but for any private medical care, whether that be a cataract operation, a thyroid operation or whatever, what people should charge, and have price caps for example, that is a discussion that you can have on a national level about most things.



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Q119 Rebecca Paul: But is different, is it not? Someone having a cataract operation does not rely on someone else selling part of their body. That is why it is a slightly different argument. But I appreciate the time, so I am going to move on because that was very helpful.

The last question is just around how we focus a huge amount on the impact on donors, which is absolutely right, but someone said earlier about the importance of centring children, which is a very good point. What controls and processes do we have in place? For example, in a fertility clinic, if a man shows up, has a surrogate, and wants to purchase an egg that someone has donated in good faith, how do you make sure that that is going to be a good family and a healthy environment for that future child? Do you do any checks? Is there anything in place?

Angela Pericleous-Smith: Do you want to do the medical side or the initial side?

Dr Sarris: I can say some bits, and I am sure you have more interesting things to say. It is written in the Act of Parliament that a welfare of the child assessment has to be done. That is for any fertility treatment, whether that be surrogacy, donation, same sex or different-sex relationships. It is written in. In a moment I will come to how that is done.

With regard to the specific example that you gave, it is not for me as a clinician or as a doctor to tell you whether that particular example should or should not go ahead. You as a legislator have decided that a single person can do surrogacy as a single man as well. That question has clearly been asked by people who have changed the Act of Parliament. As a doctor, I do only what is lawful.

Q120 Rebecca Paul: Sorry, is there anything in the law around that? For example, a convicted paedophile comes to you and wants to buy an egg. Do we have controls in place around that?

Dr Sarris: Yes, there are, absolutely. It is called the welfare of the child assessment. We can all argue who I am, you, or anyone to assess if somebody can be a good parent or not? That is up to—

Rebecca Paul: I would argue a convicted paedophile would not be appropriate.

Dr Sarris: I totally agree with you; those are probably the very few exceptions where we can all agree that you should not be doing it. Of course I cannot breach confidentiality, but we have had cases in our clinic where—I do not want to get too practical—there is a form that you need to assess, and they need to self-declare stuff. If there are any concerns you go to the GP and get more information or from other areas where you need information, social services or whatever and put it all in. It is a legal requirement. We have declined to treat people based on that, and I am sure people around the country have done the same.



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Personally, the issue is not when you have the two extremes, the obvious one that we do not treat and clinics should not treat. If there is a problem, the law—I am sure, I do not know of a case—can come back and look at why you treated. That definitely happens. Then you have the other extreme, where of course there are no issues whatsoever. The grey area, like most things in life, is when you have that in the middle.

I am not trying to shame anything or anyone, but I will give you a good example. Maybe you can tell me what you would do if you have a patient who has schizophrenia, but it is well-controlled and on medication; they have good support; they have a good psychiatric element around them; they have a good family. Should you or should you not treat? These are real examples. I just picked one because of the stigma that potentially is there.

I will give you another example of other diseases where we do not stigmatise them as much but potentially they have the same implication. You have a couple where one of the two had a heart transplant. We know that if you have had that you have a lower life expectancy, so the likelihood is that that child will end up with one parent. Yet we might have done egg freezing for medical reasons on the NHS, and now we are coming to use them. They are in a same-sex relationship, and you might use a donor sperm, for example. What is your assessment of that and the welfare of the child?

These are everyday complex decisions, and extremes aside, which obviously you would always treat or not treat, there is always the middle. All doctors, and everybody who makes these assessments, have their own opinions where they sit on that. But any time that you refuse somebody a treatment, it is never done as one person refusing treatment; it is always done in a multidisciplinary approach. That is actually where the counselling becomes very important. We actually called the counsellor to say, "We're worried about this. What do you think? Give us your opinion. I'm just a doctor, you have a better understanding of people, what do you think?"

It comes like that, and that is embedded within the law and the welfare of the child. The grey areas will always be grey. We will all disagree, just as in the two examples I gave you, as to what we think and where we stand on that. My opinion is no more valid than your opinion, or anyone else's opinion, and that is why in these cases you have multiple opinions that come together. But no, we would not treat a convicted paedophile for a surrogacy on their own and anybody who would is probably breaking the law with regard to that.

Rebecca Paul: It is good to know that the law is there, and you feel that it is being applied. Thank you so much for your patience.

Chair: Thank you both very much, and all our witnesses for giving their evidence and viewpoints today. It is really helpful in what is quite a complex area, and one that has not been as explored as other areas, so



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thank you very much. That brings this session to a close.