

Problems of fertility and their management

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SUMMARY. Subfertility is common. Its management is almost invariably stressful. With the aid of an Upjohn Travelling Fellowship, it was hoped that a more structured role for the general practitioner could be developed, which would be adaptable for use in different areas and which would improve the management of subfertile couples. By personal visits to many hospitals and reviewing recent literature on subfertility, constructive criticism has been made of the service that is provided.

The treatment of subfertility in many cases is still largely empirical. Comparative trials of the management of the subfertile are rarely available.

Recommendations have been made which, it is hoped, will be studied by all those involved in the management of the subfertile. Poor communication is often the root problem, and attention has been paid to devising a remedy for this.

Introduction

IT is thought that between 10 and 15 per cent of marriages in the United Kingdom are involuntarily childless (General Register Office, 1953; Jensen, 1966). In one third of these marriages it is the man who is infertile, in one third the woman and in one third both partners. Changes in the law on abortion having reduced the number of children available for adoption has made childlessness much more likely for the infertile couple.

Statistical analysis of treatment given in different clinics is hard to evaluate. The likelihood of a successful outcome for a subfertile couple will vary according to the nature of their problem. The outcome of referral to different clinics may depend on the advice given previously by the family doctor and other clinics and the investigations undertaken. In some clinics with particular skills, the type of referral is affected also: for example, couples with known endocrine abnormalities are seen more often by clinics with a reputation in this

field. Elusive diagnoses are made less readily where facilities for special investigation do not exist, particularly when male subfertility is a factor.

Physical and psychological factors have primary and secondary implications for the way in which the problem is considered (Menning, 1980). The emotional reactions of the couple highlight the deficiencies of both the family doctor and the specialist, as well as the service they provide. Few couples are spared unnecessary discomfort in the course of their consultations with the profession (Seibel and Taymor, 1982).

Aims

By reviewing the literature on subfertility and by visiting clinics, it was intended to identify common problems of management and, where difficulties were apparent, seek solutions by discussion with patients and staff.

The author set out to visit several different types of clinic and to interview members of the medical and paramedical staff, as well as the patients themselves. Particular attention was to be given to the nature of the general practice referral and the subjective response of patients to their management, both in general practice and at the clinic.

Method

A variety of different types of clinic were approached by the author and arrangements were made for him to visit the clinics. The structure of the visit was intended to provide an opportunity for subjective assessment of every facet of the clinic's work.

Teaching hospitals and regional centres were chosen, as well as district general hospital clinics. The author interviewed the specialists informally and observed them in consultation with patients. Junior hospital staff often took part in the discussions, and paramedical staff—including nurses, social workers, laboratory technicians, clinic clerks and counsellors—were also interviewed when available. Some time was spent at each clinic sitting in the waiting room, and there were further interviews with the patients themselves, either before or after their consultation with the specialist.

The interviews were loosely structured and they varied according to the nature of the clinic. Several clinic meetings

were also attended. Specific attention was given to the nature of the general practitioner referral, its timing and the information given. The attitude of the patients to the family doctor's involvement and to the clinic's management was also discussed.

No attempt was made to standardize the information gathered, and only a broad impression was gained. Nonetheless, placed in the context of previous work this experience proved to be very illuminating.

Results and discussion

The most striking feature of this study was the general level of dissatisfaction, to a greater or lesser degree, of the majority of patients.

When a subfertile couple conceive, the period of investigation and treatment seems to be justified and a generous view of past difficulties is taken. In these circumstances it is hard to evaluate management. The relationship between husband and wife, as well as between the couple and their doctor, will be altered.

Marital disharmony and disaffection with the medical profession were not uncommon in subfertile couples (Owens and Read, 1979; Menning, 1980). Childlessness evokes emotions that can result in unfounded criticism by the couple—criticism of each other and the medical profession (Seibel and Taymor, 1982). Against this emotive background, the validity of critical comment is questioned more easily.

There were several principal themes of dissatisfaction. The most common was delay of one sort or another. Other major concerns were lack of interest and sympathy in the doctor for the patient, and the absence of explanations.

Delays occur at every stage in the management of subfertility. Personal observations confirmed the results of a study which showed that although almost three quarters of a group of patients were referred for specialist care within six months of presenting to their family doctor, the remainder had still not been referred one year after the initial consultation (Owens and Read, 1979). Any delay in referral to hospital is usually compounded by further delays in obtaining the appointment. Then, having seen the specialist, the patient has to wait while tests are carried out and the results collated. For many couples it takes at least three years to establish the cause of subfertility from the time they first try to start a family (Owens and Read, 1979).

Lack of interest and sympathy may be as much a matter of perception than reality. Certainly, the absence of advice to patients from family doctors suggests either lack of interest or lack of knowledge. Furthermore, referral to the specialist, if undertaken without proper explanation, may give the impression that the family doctor sees no role for himself in the management of the subfertile patient. The implications of subfertility for a couple have considerable social content and, since there is evidence that family doctors are reducing their commitment to their patient's social problems (Cartwright

and Anderson, 1981), this may partly explain the attitude of some doctors. The lack of interest perceived in family doctors is also seen in hospital doctors. Not all consultants to whom subfertile patients are referred are interested in the problem and many hospitals make no special provision for the subfertile patient. Treatment is said to be too expensive and in other places the demand is denied.

Poor communication between the hospital and the family doctor, as well as between the various doctors and the couple themselves, is at the root of many of the difficulties encountered in the management of the subfertile. Continuity of care was a major difficulty, with frequent changes of doctor resulting in the patient losing confidence in the hospital, particularly when the patient has had to be asked what stage of investigation or treatment had been reached.

Humiliating and embarrassing tests and investigations were also a problem, the most frequent objection being concerned with the production of semen specimens. Few facilities exist for this, despite its widespread recognition as a problem. Furthermore, when the man is proved to be subfertile, the lack of treatment, advice and explanation can affect self-confidence and potency. Many hospitals neither encourage nor provide facilities for counselling couples together, and yet it is well known that the absence of a spouse at the consultation can frequently result in greater feelings of inadequacy in the partner under treatment.

The management of subfertility seems to be dogged by confusion. Its investigation and treatment varied considerably between clinics. The collection and interpretation of data was difficult, and therefore subject to delay. Poor organization of clinics and the absence of an established proforma made the delays longer. The most efficient management of subfertile patients was undertaken in clinics dealing exclusively with the problem (Philipp and Carruthers, 1981). The establishment of separate clinics was regarded as useful in those hospitals with experience of both separate and mixed clinics. Some hospitals have gone on to subdividing the clinics further, according to whether the problem was principally male or female subfertility.

Problems of communication

Most patients agreed that there were aspects of their management with which they were not familiar. Many of the difficulties encountered in the management of subfertility by both doctor and patient were exacerbated by poor communication. While this was recognized in many places, the absence of effective communication was denied by some clinics and family doctors.

Ineffective communication between the specialist and the family doctor inhibited the active participation of the latter in the management of the patients. In those places where the problem was recognized, poor secretarial support and lack of time were given as reasons for

the failure to communicate regularly. Most hospital doctors were satisfied, however, that they do communicate effectively with the family doctor by writing with any significant details of the patient's management. There was no evidence, however, that simply writing letters was enough to put the patient's management in its proper context; few of the letters written by hospital doctors to family doctors would have achieved this.

Subfertility is unlike any other medical condition. Its management differs substantially, not only between hospitals but even within the same hospital, according to which specialist is responsible for the patient. This situation makes the need for proper communication between doctors imperative if unnecessary confusion and distress for the patient are to be avoided. Most hospital doctors acknowledge that a complete explanation of each stage is important. What many fail to realize is that explanations to the patient are not always understood. This is one area in which the role of the family doctor could be exploited to maximum effect: with close co-operation, it should be possible for the patients to see their own doctor if they require clarification of certain aspects of their management.

Where self-help groups and social workers were present at the clinic, the hospital doctor had to ensure that his traditional role as primary counsellor to the patient was not eroded. Where additional help was available, it was not always easy to avoid a sense of false security. In this situation, the patient tended to be denied an adequate explanation by the doctor because it was believed that such explanation would be provided elsewhere in the clinic. The role of self-help groups and counselling groups in subfertility clinics needs to be more thoroughly evaluated. They have an important part to play in the management of subfertility but this needs to be properly defined. The NAC and CHILD are organizations* formed to help the subfertile and childless.

Fertility co-operation card

The shared care of subfertile patients has much to commend it but requires good communication between those doctors responsible for the couple's management. In antenatal patients, this is usually achieved through a 'co-operation card', and it is suggested that a similar communication system would be appropriate for the subfertile patient as well (Froggatt, 1982).

Most subfertile patients already keep temperature charts and these could be amplified simply and cheaply to provide the required record. The card would reduce the need for frequent exchange of letters between general practitioner and specialist and thereby make the exercise rapidly cost-effective. The record would pro-

vide an *aide memoire* for the general practitioner, who could complete as much of it as appropriate. Preliminary investigations could be recorded, which would be added to after the patient had been referred to the hospital. When explanations by the hospital prove inadequate, the record could act as a point of reference for the general practitioner to develop discussion with the patient.

Conclusions

Family doctor

1. Early referral for specialist advice is indicated unless there are specific reasons for delay. The reasons for a delay should be understood by the patient.
2. Some advice should be given to all subfertile couples, not only to facilitate conception, but also to provide psychological reassurance.
3. After referral to the specialist, the family doctor should retain a defined role in the management of subfertile patients.
4. A fertility co-operation card should be used for communications between the hospital and family doctors.
5. Subfertile patients should not be referred to specialists who have no interest in their management or who manage patients poorly.
6. Counselling of the subfertile couple should continue throughout investigation and treatment. The psychological problems that arise from subfertility should be borne in mind.
7. The psychological difficulties encountered by couples who remain childless should be considered carefully by family doctors. Counselling should be available.

Hospital management

1. Separate clinics should be established for the investigation and treatment of fertility problems.
2. Clinics should be called *fertility clinics*, not infertility or subfertility clinics.
3. A written explanation of the hospital's management of subfertility should be given to each couple before the initial consultation.
4. Couples should be actively encouraged to attend all appointments together. Exceptions should be made only for specific reasons.
5. Where facilities are not available, peripheral clinics should refer patients to major centres with which closer liaison should be established.
6. Investigations should not be repeated without good reason.
7. Delay in the investigation and treatment of patients should be minimized wherever possible. The reasons for delay should be understood by the patient.

*Addresses: National Association for the Childless, c/o The Birmingham Settlement, 318 Summer Lane, Birmingham B19 3RL. CHILD, 'Farthings', Gaunts Road Pawlett, Bridgwater, Somerset.

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8. Decisions on the management of patients should be taken by a strictly limited number of medical staff to whom the patients can relate directly. The number of staff involved should be reviewed regularly.

9. Experience of fertility problems for junior hospital doctors and nursing staff could be gained if they were involved in carrying out investigative procedures, for example post-coital tests.

10. Facilities for the production of semen specimens should be made available. Mildly erotic literature should be supplied.

11. The role of self-help groups and social workers should be evaluated.

12. Comparative trials of different treatments for sub-fertility are needed.

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Homoeopathic treatment of osteoarthritis

A double blind placebo-controlled crossover study compared the homoeopathic remedy Rhus-tox 6X with fenoprofen. The effects of Rhus-tox 6X could not be differentiated from those of placebo, whereas fenoprofen was shown to have beneficial analgesic and anti-inflammatory effects. Patients also preferred fenoprofen.

Source: Shipley, M., Berry, H., Brother, G. *et al.* (1983). Controlled trial of homeopathic treatment of osteoarthritis. *Lancet*, **1**, 97-98.