A survey of infertility practices in primary care in Scotland

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SUMMARY

An 83% response rate was obtained to a postal questionnaire survey of general practitioners (GPs) carried out as part of a national infertility audit in Scotland. This provided information about how GPs are managing infertility and their opinions on 12 suggested criteria for good practice in a primary care setting.

Keywords: infertility; questionnaire survey; audit.

Introduction

INFERTILITY is a common problem affecting at least one in seven couples at some time in their reproductive lives.[1] Infertility comprises a small part of the workload in primary care: an average GP in Scotland is estimated to see only one or two new couples a year.[2] In recent years, however, rapid advances have been made in the treatment of infertility and there is increasing public awareness of infertility issues and demand for infertility services.

Since 1992, a number of guideline documents covering the investigation and initial management of infertility have been published.[2-4] These guidelines provide a basis against which to measure current practice and opinions in primary care.

Method

In May 1995, a questionnaire was sent to a sample of 500 of the 3491 principals in general practice in Scotland. The sample was stratified using the age and sex of the GP and the geographical location of the practice.

Throughout the questionnaire, practitioners were asked to indicate their current practice with regard to seeing couples together, history-taking, physical examination, temperature charting, confirming ovulation, semen analysis, confirming rubella immunity, advice about folic acid supplements, initiating treatment with clomiphene, and the use of local guidelines. Responders were also asked to indicate their level of agreement with 12 suggested 'criteria for good quality care', which were drawn from published guideline documents,[3-5] the medical literature, and discussion by a panel of gynaecologists and GPs.

Results

The response rate was 83% (414/500). Agreement with the suggested criteria is summarized in Table 1. Responders' reported practices are described below.

Arranging to see couples together

The most strongly supported criterion was that 'the investigation of infertility should include both partners from the outset.' Ninety per cent of responders agreed with this and 66% arrange to see both partners together at the surgery if they are both registered with the practice.

History and examination

Eighty-two per cent agreed that 'a full medical, social, and sexual history of both partners should be obtained,' and 84% reported this as their usual practice. Thirty-eight per cent agreed that 'a pelvic examination of the female partner, a genital examination of the male partner, and a general examination of both partners should be performed by the referring GP.' Forty-one per cent usually perform a full examination of both partners, 14% only perform a pelvic examination of the female, and 27% do not think examination of either partner is necessary in general practice.

Investigation of the male partner

Sixty per cent agreed that 'the initial investigation of the male partner should include two seminal analyses at least one month apart.' Seventy-seven per cent include this in their initial investigations, but 11% said they could not readily organize semen analysis and 8% did not think it an appropriate investigation in general practice.

Investigation of the female partner

Eighty-four per cent agreed that 'a day 21 plasma progesterone level should be the basic investigation of ovulation in a regularly menstruating female', and 78% arrange this test. Only 42% agreed that 'temperature charts are of limited use and couples should be discouraged from keeping them', and 29% usually ask the female partner to keep a chart. Seventy-five per cent agreed that 'the female partner's rubella status should be checked', and 49% reported doing so.

Management

Seventy-four per cent agreed that 'the female partner should be advised to take folic acid supplements while attempting to become pregnant' but only 53% cent actually give this advice. Eighty-eight per cent agreed that 'the presence of amenorrhoea, oligomenorrhoea, oligospermia, a history suggestive of pelvic pathology, or abnormal findings on examination of either partner should result in early referral to a specialist clinic.' Eighteen per cent prescribe clomiphene independently.

Guidelines

Eighty-nine per cent agreed that there should be local guidelines for the investigation, management, and referral of infertile patients; 27% currently follow such guidelines, 66% were unaware of any local infertility guidelines, and 5% had local guidelines but did not follow them. Ninety-three per cent would welcome guidelines.

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Table 1. The 12 suggested criteria for good quality care for the management of infertility in general practice. The criteria are ranked according to the percentage of responders who agreed or strongly agreed with the statement as a criterion for good quality care.

Rank	Criteria for good quality care in general practice	Agree (%)
1	The investigation of infertility should include both partners from the outset.	90
2	There should be agreed local guidelines for the investigation, management, and referral of infertile patients.	89
3	The presence of amenorrhoea, oligomenorrhoea, oligospermia, a history suggestive of pelvic pathology, or abnormal findings on examination of either partner should result in early referral to a specialist clinic.	88
4	A day 21 plasma progesterone level should be the basic investigation of ovulation in a regularly menstruating female.	84
5	A full medical, social, and sexual history of both partners should be obtained.	82
6	The female partner's rubella status should be checked.	75
7	The female partner should be advised to take folic acid supplements while attempting to achieve pregnancy.	74
8	Treatment of anovulation with clomiphene should always be initiated by a specialist hospital clinic rather than in general practice.	65
9	The initial investigation of the male partner should include two semen samples at least one month apart.	60
10	Temperature charts are of limited use and couples should be discouraged from completing them.	41
11	A pelvic examination of the female partner, a genital examination of the male partner, and a general examination of both partners should be performed by the referring GP.	38
12	There are no other biochemical or hormonal investigations of the female partner that are relevant in general practice.	19

Discussion

We have sought to obtain a representative picture of the opinions and current practices of GPs in Scotland by stratifying the sample using factors that may influence the management of infertility. The high response rate suggests that infertility is an area of interest to GPs, and the survey has highlighted simple changes that could improve care in general practice and bring practice into line with the evidence and the expressed opinion of GPs. In some areas, however, opinion, as well as reported practice, was at odds with published scientific evidence.

Infertility guidelines have been shown to improve the process of care,[6] and support for these appear to be strong. The availability of evidence-based, locally available guidelines may stimulate appropriate changes in practice.

References

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