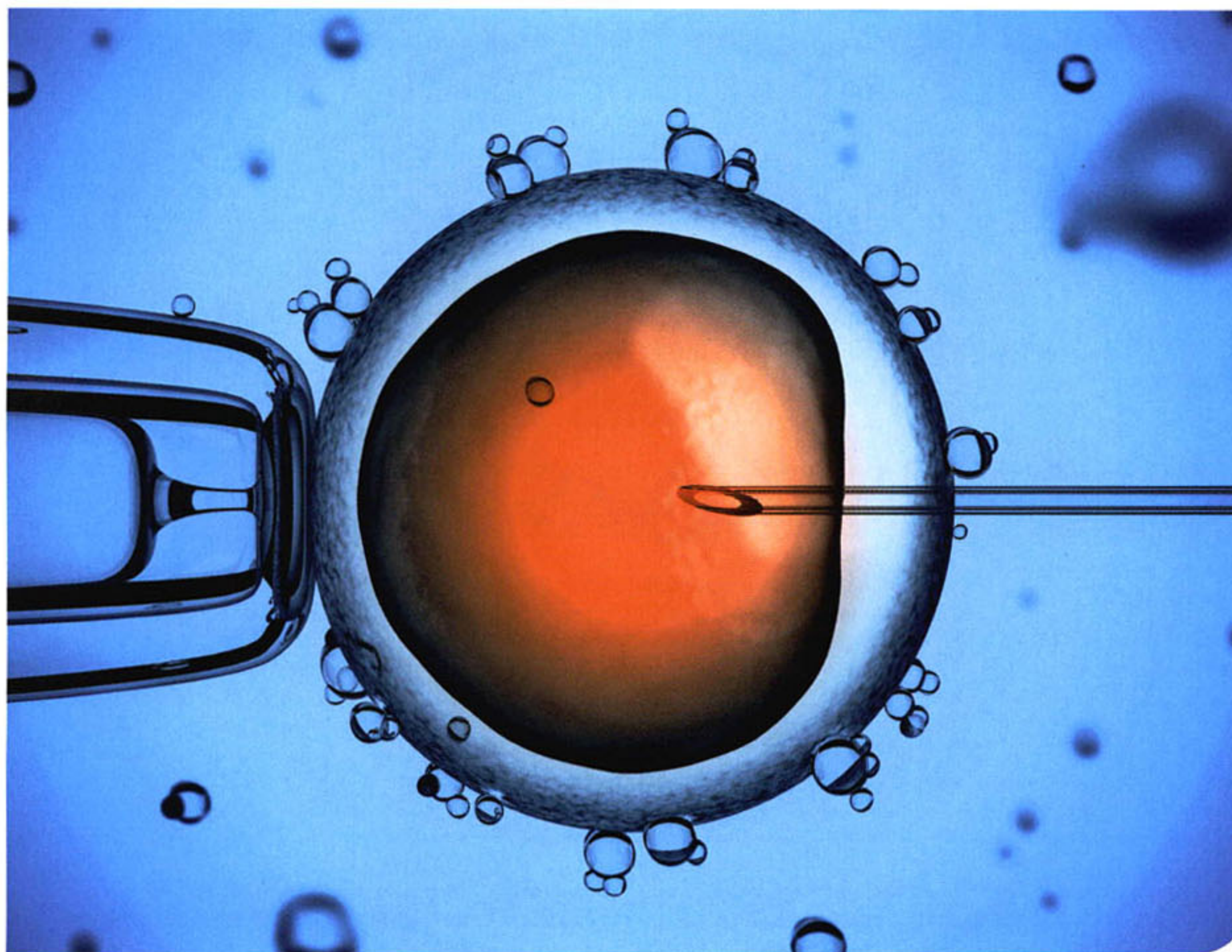




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ASSISTED FERTILITY TREATMENT AND THE QUALITY OF INFORMED CONSENT

Kerry Hampton, Jennifer Newton and Danielle Mazza

Defining informed consent

Informed consent is a well-accepted cornerstone of ethical practice in all fields of healthcare.

The WHO defines informed consent as follows:

Patients have a right to be fully informed about their health status, including the medical facts about their condition; about the proposed medical procedures, together with the potential risks and benefits of each procedure; about alternatives to the procedures, including the effect of non-treatment; and about the diagnosis, prognosis and progress of treatment (The World Health Organization, 1994).

This definition shows that there are several components to gaining informed consent from patients (WHO, 1994). In this article on ethical issues in nursing and midwifery practice, we focus on just one of these components in the health context of infertility: women's knowledge of alternative treatment options to assisted reproductive technology (ART).

Health literacy and informed decision making

We recently completed a four-year fertility-awareness study, which sought to inform a future primary care model as one way of reducing infertility in general practice (Hampton, 2014). We found that only 13% of infertile women who attend ART clinics understand the fertile window of the menstrual cycle for correctly timed intercourse. This is despite, 87% actively tried to improve their understanding of this 'window' to optimise natural conception in the hope of avoiding costly and invasive ART procedures (Hampton et al. 2013).

Evidence and practice

The most reliable test of a couples' ability to conceive naturally, is correctly timed intercourse within the fertile window of the menstrual cycle over six or more cycles (Stanford et al. 2002). For the one in six Australian couples who experience trouble conceiving (Loxton and Lucke, 2009) this test remains true whether the fertility problem is of male, female or

combined (male and female) origin (Eijkemans et al. 2008). In developed countries like Australia, delayed childbearing is the single biggest cause of infertility (Australian Bureau of Statistics, 2008). Seminal studies in Ireland and Canada have shown that educating women regarding fertility awareness in order to correctly time intercourse as part of comprehensive care in general practice can substantially mitigate the impact of reduced fecundity that naturally occurs with increasing age (Stanford et al. 2008; Tham et al. 2012).

Despite the fundamental importance of correctly timed intercourse to women's agency for family planning, Australian studies have consistently shown that women's understanding of 'fertile window' is generally poor across the entire reproductive life course (Hampton et al. 2013; Hampton et al. 2015; Hammarberg et al. 2013).

Bias towards specialist care

In Australia, access to ART treatment is mediated first by



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general practitioners who make referrals to fertility specialists, and second by fertility specialists who then make recommendations for a treatment plan. This systematic approach to accessing ART treatment generally takes around 12 months and is designed to ensure that the treatment plan is both appropriate and appropriately timed (McLachlan, 2005).

Our study of infertile women who attend ART clinics ($n = 204$) showed that half (50%) had attended two or more GP appointments about trouble conceiving, and more than half (62%) had attended two or more fertility specialist appointments (Hampton et al. 2013). Subsequent interviews with GPs and practice nurses (Hampton et al. 2016) showed that referral pathways from general practice to ART clinics are well-understood and well-utilised by these practitioners.

In contrast to these embedded

practices towards ART treatment, few infertile women in our study (<5%) had received counselling from a trained teacher in fertility awareness to optimise spontaneous conception (Hampton et al. 2013). These findings suggest there is a systematic bias towards tertiary level fertility care in Australia's healthcare system (Hampton et al. 2016; Hampton et al. 2013). Similar findings have been reported in the Netherlands (Mourad et al. 2009).

Improving the informed consent process

Preventive healthcare in many aspects of women's sexual and reproductive lives is highly dependent on a correct understanding of their fertile body (Commonwealth of Australia, 2010). The National Women's Health Policy 2010 contends that expanding the role of nurses and midwives in women's health primary care settings is crucial to increasing women's access to such preventive health activities (Commonwealth of Australia, 2010).

Nurses and midwives were first employed in general practices in the United Kingdom in the 1980s to instil continuous improvement in healthcare in general practice (Hoare et al. 2011). This practice has subsequently been adopted in numerous countries (Hoare et al. 2011) including Australia where the role of nurses and midwives are being actively promoted to help reduce unnecessary specialist care through improved health literacy (Australian Government Department of Health

and Ageing, 2010). Embedding a nurse/midwife primary care model in fertility awareness in general practice, would potentially increase women's access to this preventive healthcare activity when first reporting trouble conceiving and before a referral for ART treatment is given (Hampton et al. 2016).

Conclusions

There is no doubt that ART is essential healthcare for infertile couples with proven need. However, consideration needs to be given to informed consent to ART treatment from the perspective of women's knowledge of fertility awareness as an alternative treatment option. This is just one of several aspects of informed consent to ART treatment that requires further deliberation. A nurse/midwife care model in fertility awareness has the potential to not only assist spontaneous conception in couples who report trouble conceiving, but also improve the process of informed consent to ART treatment in couples who actually need tertiary level care to overcome their fertility problem (Hampton, 2014).

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