

Social infertility

There is no accepted definition of 'social infertility'. This is a term coined by the Prime Minister, who has his own very narrow definition as espoused through one of his former health ministers whose name I have long since forgotten (funny how you forget politicians so quickly once they are out of office!). That definition was confined to single and lesbian women. If we extend intellectual consideration beyond that usually achieved by politicians, we may include under this rather emotive and arrogant heading those couples in which the husband serves in the armed forces and has protracted periods away from home; those couples, both of whom pursue active careers which keeps them apart for the greater period of time; and those couples who simply delay attempted conception for a variety of reasons and then attempt to conceive at a time when natural fertility has either declined rapidly or virtually ceased.

Single Women

The presentation in the great majority of cases involves a woman over the age of 36 who, although she has had several relationships, has not met anyone that she wishes to marry (or conversely wishes to marry her), who appreciates that her natural fertility is declining and therefore her chance of motherhood is declining substantially with each passing year. She presents with a request for conception utilising donor sperm and often makes the comment that this is a more acceptable and certainly much safer way than simply picking up a man around the time of ovulation. The validity of this argument is inescapable.

'Do we treat these patients, especially those who are getting older and whose natural fertility is declining, or do we make them wait until their husbands come home?'

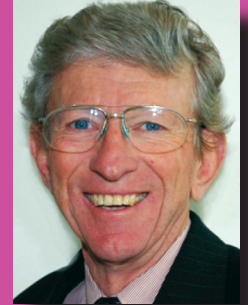
This is not a patient who has deliberately delayed having children for whatever reason but someone for whom circumstances have just not been right. Assuming that we have a sperm donor available who is agreeable for his sperm to be used for the treatment of single women (and, of course, we usually have) the only argument is whether motherhood in a healthy woman is a right (in the same way that labor politicians claim that universal health care is a right) or a luxury. The individual doctor's answer to this question determines whether he will treat the patient or not. There is no convincing evidence that children born to single women grow up any less well adjusted than other children, and some evidence to show that they are better adjusted than children born into an unhappy or violent marriage.

Lesbian Couples

The argument here is that of the couple who wish to have a child, the chosen mother is not prepared to have intercourse and may feel that use of donor sperm (sometimes by a known donor) is safer

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(because of the pre-treatment screening of the donor) and more effective (because of the careful attention to timing of the insemination) than simply attempting to utilise sperm from a casual acquaintance themselves.

A very similar argument applies under these circumstances. The natural prejudices of society suggest that lesbian couples should not have children and that a child brought up in a household with two 'mothers' will grow up less well adjusted than perhaps a child of a married couple or even a single woman would. Although there are a number of small reports in the literature, there is no clear evidence to support or refute this contention. However, since the treatment of single women and lesbian couples is now becoming more common, evidence may ultimately appear one way or the other. Therefore, until such evidence arrives, we have to confess to a personal prejudice if we decline to treat these first two groups of patients. The law doesn't help us in our decisions since it varies between states and even changes within states from time to time.

Women with Husbands in the Armed Forces

Although an uncommon presentation, it is certainly not unknown. The request is for freezing of the husband's sperm before his departure overseas together with a written request from him to the effect that he wishes the sperm to be used for the insemination of his wife, on an IVF program, if necessary. The letter must also state what his wishes are in the event of his death. Do we treat these patients, especially those who are getting older and whose natural fertility is declining, or do we make them wait until their husbands come home? This decision is not difficult in the case of patients whose natural fertility is declining rapidly and who already have a history of unsuccessful attempts of conception. It is more difficult in younger women without that history.

The Career Couple

Certainly in Canberra, and I suspect in other cities, we see a significant number of couples who both spend a great deal of their time not working in Canberra (usually in opposite directions) or overseas (again rarely in the same country). It's easy to feel that in these cases the couples have got their priorities wrong, that they are selfish and that they will find the arrival of a child a major inconvenience to the lifestyle that they have created for themselves, a lifestyle they obviously enjoy. The same requests and the same arguments apply as for the couple with the husband in the armed forces. The sympathy factor may well be considerably less in this case but is this

just personal prejudice? Are we obliged to help these couples even though we feel that they are selfish and have distorted priorities?

Deliberately Delayed Conception

This covers several possibilities.

- The woman who didn't meet the right man until she was in her mid-thirties. She also has a career and one sometimes wonders just how receptive she was to a long-term relationship and marriage in previous years.
- The woman whose husband wishes to delay conception.
- The woman who deliberately delays marriage until she has completed university, had a couple of years working overseas, the purchase of a house, the elimination of a mortgage and the purchase of a luxury car.
- The couple who marry while the woman is still reasonably fertile and deliberately delay conception while they pursue any or all of the above.

While one may seriously question their priorities, this last group of patients forms by far the great majority of the patients under discussion and if they have deliberately delayed conception, they must be included in any group that we or the Prime Minister choose to label 'social infertility'.

It is appropriate to consider the costs of treating these patients.

Patients under the age of 35		
Treatment	Pregnancy rate /cycle	Average cost /cycle
Ovulation Induction	18.4%	\$738.00
Donor insemination	10.0%	\$1434.60
Patients aged 35-39		
Treatment	Pregnancy rate /cycle	Average cost /cycle
Ovulation Induction	6.0%	\$738.00
Donor Insemination	6.0%	\$1434.60

The following chart, taken from data circulated by the IVF Directors Group of Australia and New Zealand, averages the results all units in those countries and demonstrates the decline in success rates on IVF associated with increasing maternal age together with the associated increase in cost.

Age	% Liveborn success	Cost/liveborn \$
<29	28.8%	12,142
30-35	27.8%	12,752
35-37	22.8%	16,382
38-40	15.7%	23,521
41	8.3%	69,538
42	5.0%	114,510
43	2.7%	146,434

RANZCOG Patient Information pamphlets

Updated versions of the following pamphlets are now available:

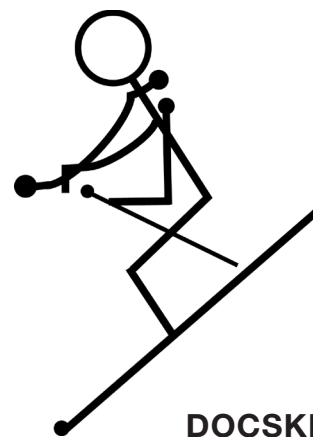
- Prenatal Screening Tests for Down Syndrome and Other Conditions (second edition)
- Amniocentesis and Chorionic Villus Sampling (CVS) – A Guide on Prenatal Diagnostic Procedures (third edition)
- Induction of Labour – A Guide for Women (first edition)

Look out for the following pamphlets, currently in development:

- Postnatal Depression
- Polycystic Ovarian Syndrome (PCOS)
- Chronic Pelvic Pain

To order your copies through MiTec Publishing, please go to: <http://www.ranzcog.edu.au/womenshealth/patientinformation.shtml>.

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