

Missed conceptions: a call for “positive” family planning

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GPs can play an important role in helping women to realise their plans for a family

You don't think of a first-time, breastfeeding mum experiencing hot flushes, but that's how my story begins.

I was 40 years old when I conceived my daughter — and very easily, I might add. When Abby was about a year and a half old, my husband and I began trying to conceive a second child. Deceived by our luck the first time, we assumed we'd have no problem. Misguided by the prevailing advice, we persevered for 12 months before seeking professional help. When we finally did, my general practitioner advised that I discontinue breastfeeding even once a day, and, a month later, sent me to have my serum follicle-stimulating hormone (FSH) level tested. We might have reversed those steps because the results showed, at 98 IU/L, that I wasn't conceiving, not because I had been breastfeeding, but because I was menopausal.

The penny dropped — the sweatiness I'd been experiencing while still breastfeeding had been hot flushes. My doctor was as surprised as we were that menopause would follow so closely upon the heels of immediate conception and birth, but the results were confirmed. A fertility centre informed us that the only real option for conception was with donated eggs. And, fortunate as we were to have a friend to donate hers (Box 1), after three failed in-vitro fertilisation (IVF) cycles we have resigned ourselves to the reality that Abby will be our one and only child.

That resignation is not without some resentment, however, that my GP, knowing that I was already 41 and trying to conceive, didn't intervene with a fertility assessment well before a crucial year was lost. Given my age and very sporadic cycles (which naively I had attributed to my still once-daily breastfeeding), my chances of becoming pregnant were slim to remote¹ and conception at that point called for a more aggressive strategy. At the age of 40, or even 35, a basic infertility evaluation has been recommended after 6 (rather than the usual 12) months of trying unsuccessfully to conceive,² as has early referral to a fertility specialist.³ In fact, given my age, rather than prescribing birth control pills postpartum, as you might with a younger woman, a candid discussion about whether I intended to try for a second child, while perhaps awkward in those early days, could have been key to conserving my chances.

Why wait?

But isn't it a woman's own responsibility, and not her doctor's, to begin a family while she's still fertile? Perhaps, but what if she lacks accurate information about how long to expect to remain fertile? The current trend to delay childbearing is the result of many factors.⁴ Maybe I did take my mother's admonition not to marry early a bit too far — but not by choice. I was eager to start a family and would have done so well before turning 40 if I had I found a suitable partner.

And I was in very good company. A full 50% of women surveyed at Monash IVF reported that they had delayed childbearing

1 Donor's superovulation ultrasound image



because they lacked a partner.⁵ Another study found that many women delay childbearing in favour of establishing careers, relationships and financial security (often believing fertility treatments will be available as a “backup” if needed).² And if we take into consideration the tendency of women to overestimate their window of fertility,⁶ or to be unaware of the relationship between age and fertility,⁵ we can only expect my experience to be repeated many times over.

I am writing this article to give a wake-up call to GPs and family planning professionals and to urge them to proactively address a suite of problems related to the rapidly ageing population of women seeking to become mothers for the first time. I hope that, in this way, my experience may help to prevent similar “missed conceptions”.

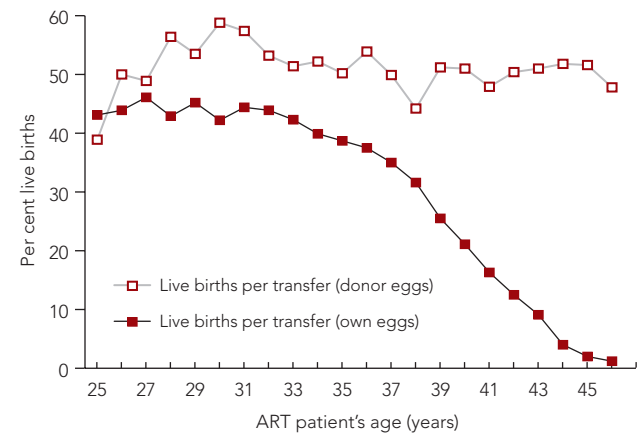
“Positive” family planning

The feminist movement that helped to shape me and my choices was itself shaped by women escaping the confines of the traditional roles of wife and mother. Largely because of this, an emphasis has been placed on “negative” family planning — helping women to prevent unwanted pregnancy or to control the number and timing of children. Contraception and the availability of affordable, legal abortion have meant that women have been free to develop other important dimensions of their lives, such as robust careers and relationships, before having children.

But times have changed — again. Years down the track, major advances in women's ability to break through professional “glass ceilings” and the perception that we can extend indefinitely our ability to become parents have contributed to a growing number of women reaching “biological ceilings” that are even more difficult to break through. It is therefore now time that “positive” family

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2 Live births per transfer for ART cycles using fresh embryos from own and donor eggs, by ART patient's age, 2002*



ART = assisted reproductive technology. *Reproduced with permission from the US Centers for Disease Control and Prevention.⁹

planning be promoted as well. Health practitioners, particularly GPs, now need to provide guidance about the waxing and waning of fertility, preconception care and protective fertility — conception as well as *contraception*.⁷

A partnership between government, GPs and their representative organisations, as well as the family planning community, could help to educate women to have a more realistic understanding of their reproductive lifespan, enabling them to make more informed choices. Because although there may be many women who would not be surprised to find themselves infertile at 42, there are others, some as publicly prominent as ABC Television's Virginia Haussegger, who have been as surprised as I was.⁸ The “misconception” seems to prevail, consciously or unconsciously, that we can expect to be able to naturally conceive throughout our forties, or if we can't, that we can expect IVF treatment to “fix it” for us.⁶ And the truth is, not only does fertility take a nose-dive at about 30 years of age, but the success of IVF, as astounding as its results can be, dives as well (Box 2).^{7,10}

Knowing better

The media are teeming with fertility information. Books with names like *What, no baby?*,¹¹ *Inconceivable*¹² and *Hot flashes, warm bottles*¹³ have been published in recent years describing women's experiences of meeting the challenges of subfertility, of being older first-time mothers, and of dealing with the social problem of infertility. While one news article might bust the “you can have everything” myth and report on the challenges of age-related infertility, another may announce a “miraculous” birth at 60, perpetuating the evergreen fertility myth still further.

In the absence of individualised guidance by GPs, patients (as in many areas of medicine) arm themselves with information obtained on the Internet.¹⁴ Fertility consumers seek advice from sites such as the “Over 40 high FSH” discussion group (www.network54.com/Forum/53068) and “Mothers via egg donation” (www.surrogacy.com/online_support/mved). Such sites are replete with research, anecdotes and coaching about endocrinology, variations in protocols and success rates, and offer moral

support to women wanting to take on the expertise of their reproductive endocrinologists, together with advice on how to discern valid treatments from quackery.

Such sites also bring to the surface a widespread fervour relating to the desire to conceive, with some women willing to try almost anything to have a child. As in other areas, less scrupulous operators prey on this desperation and confusion. In another, parallel universe, new fertility innovations and studies are continually being reported in scientific and medical research. And while we medical consumers may be able to sift through to the best information on our own, how much more likely are we to find what we are looking for if we have the help of a GP who knows us?

What's a doctor to do?

Because of their ongoing interactions with so many women, their knowledge and the resources available to them, GPs are uniquely well suited to convey from the medical world the current and reliable information a woman will need to realise her plans for a family — whether or not to have one, its timing and its size. GPs can play a central and vital role in educating women patients about our fertility's natural expected lifespan while there is still time to act on it.⁵ Perhaps this is more important than ever, given the federal government's recent attempts to restrict Medicare-funded access to assisted reproductive technology — especially for older women.¹⁵

The first step involves a doctor's willingness to broach the subject. And if most Australian doctors are not inviting patients to discuss their family plans, they would not be alone. In one German study, many of the GPs surveyed viewed infertility as a private matter.¹⁶ In a related study of GPs and their infertile patients, most GPs did not ask childless patients about their plans to have children, even though 25% of infertile women and 50% of infertile men said they would prefer their doctor to raise the issue.¹⁷ Beyond that, I offer some suggestions for what GPs and others can do (Box 3).

Conclusion

The growing tendency of women to delay parenthood either by choice or circumstance has implications as we have discussed for the likelihood of successful conception, for the wellbeing of the mother compressing her fertility, and for the children.²¹ It has repercussions not only for the individuals involved, but on the overall fertility rate.²²

Sadly, there is cause for concern that patients may now be bypassing GPs and going directly to fertility specialists.²³ This would be an unfortunate trend likely to lead to more heartbreak, more unnecessary individual and public expense and less holistic and continuous care for the woman or couple involved.

All of these factors provide compelling reasons for GPs to engage in “positive” family planning by helping younger women to grasp the biological imperative to start their families earlier and helping older women to salvage their residual fertility.

Of course, “positive” family planning will not solve all fertility problems. It will not be a treatment for endometriosis, chlamydia or polycystic ovaries. It will not necessarily help women to choose suitable partners during their more fertile years (although it may sharpen their focus). And it will not, in itself, effect the industrial and societal changes required to relieve mothers of the burden of having to compromise their professional lives so much more than

3 "Positive" family planning*

What an individual general practitioner could do

- When a childless woman comes for a health check-up or for contraceptive advice or prescription, take the opportunity to refresh her understanding of her reproductive lifespan, discuss her plans for children and make contraceptive recommendations commensurate with those plans.¹⁸
- Advise women over 35 of the technological advances available for helping to salvage residual fertility. For example:
 - Ovarian reserve screening by transvaginal sonography to establish when a woman's fertility window is likely to close¹⁹ and whether she is a candidate for in-vitro fertilisation (IVF);²⁰
 - Ovulation tracking by blood testing;
 - Cryopreservation of embryos (or eggs, when the technology to achieve that becomes readily available).

What organisations could do

- Family Planning Australia and its local affiliates could draw from relevant courses they currently offer to doctors, nurses and others to address "positive" family planning, the growing problem of the postponement of parenthood and age-related infertility.
- With government support, the divisions of general practice could incorporate fertility into their women's health priorities and assist with informational posters, brochures and other strategies.
- The Royal Australian College of General Practitioners' Women's Health Committee could incorporate fertility into their agenda and urge fertility updates in continuing education programs.
- In light of Australia's declining fertility,⁴ rather than simply cutting off access to IVF at a given age, the government should launch an educational campaign that would help to prevent the need to spend such large sums on IVF.

* Planning for conception rather than contraception. ◆

fathers do. What it will do, however, is give women the information and tools they need to plan and create families responsibly.

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Competing interests

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