FPs CAN PLAY IMPORTANT ROLE IN TREATMENT OF INFERTILE PATIENTS, COUNSELLORS SAY

Evelyne Michaels

In Brief • En bref

Family physicians can do a great deal more to help patients face infertility assessment and treatment, but they must first recognize how their patients may be emotionally and physically affected by the diagnosis, a therapist told a recent workshop in Toronto. Strategies used by medical counsellors can be adapted by FPs and specialists to help patients address infertility issues.

Les médecins de famille peuvent faire beaucoup plus pour aider les patients à faire face à l'évaluation et au traitement de l'infécondité, mais ils doivent d'abord reconnaître comment le diagnostic peut toucher leurs patients sur les plans psychologique et physique, a déclaré un thérapeute au cours d'un atelier qui s'est tenu récemment à Toronto. Les omnipraticiens et les spécialistes peuvent adapter des stratégies utilisées par les conseillers médicaux pour aider les patients à faire face aux questions d'infécondité.

Family physicians and specialists could do much more to help patients facing infertility assessment and treatment, but they aren't always aware how large an impact the diagnosis can have, says a US medical family therapist. And even if doctors realize there is a problem, they may not feel adequately equipped to deal with it.

Jeri Hepworth, an associate professor of family medicine at the University of Connecticut School of Medicine, and Susan McDaniel, who teaches classes in psychiatry and family medicine at the University of Rochester School of Medicine, recently came to Toronto to speak to physicians, health care professionals and about 50 infertile couples during workshops sponsored by a private infertility clinic.

"Doctors are accustomed to helping their patients cope with physical illness," says Hepworth. "They must understand that their infertile patients, who aren't technically ill, often face a cycle of disappointment and anxiety that places them under tremendous strain."

As medical family therapists, Hepworth and McDaniel represent a new breed of American counsellor who specializes in helping patients and families cope with medical illness or disability, including infertility. They also educate medical students and physicians about ways to recognize and resolve common problems arising from infertility treatment.

According to a report from the American College of Obstetricians and Gynecologists, a medical diagnosis can now be established for about 90% of infertile couples. Reproductive technology can help about half of those who seek treatment to conceive.

But patients often find the experience of assessment and treatment emotionally daunting (see McCall M: Pursuing conception: a physician's experience with in-vitro fertilization. *Can Med Assoc J* 1996; 154: 1075–1079). Besides coping with the initial diagnosis and the possibility of being childless, they endure a chronic hope–loss cycle. In many cases, they must accommodate diagnostic and treatment procedures that can be invasive and embarrassing: men having to masturbate into a bottle to produce semen for a sperm count, or women having to visit their doctor's office for a postcoital exam.

New technologies that help many infertile couples conceive often involve exhaustive cycle monitoring and hormone regimens, the use of donor eggs and sperm, and repeated inseminations. They place such complex psychosocial and physical demands on patients that some American infertility specialists insist that couples undergoing treatment make ongoing visits to therapists.

Hepworth and McDaniel say that the experience of infertility is similar to coping with the death of a loved

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one or being diagnosed with a chronic illness. After the diagnosis is known, patients may go through stages of mourning: denial, shock, anger, bargaining, depression and, finally, acceptance.

"Regardless of who carries the medical diagnosis," says McDaniel, "women tend to assume the emotional responsibility and express the couple's pain." She adds that men are socially conditioned to be more silent in their distress, either denying or avoiding their feelings, or else becoming brooding or withdrawn.

Doctors should also be aware that infertile couples are often on a different wavelength about the entire experience — the women want to talk about feelings and options, while the men want simply to try and forget the problem.

Infertility often causes one or both partners to withdraw from their friends and family to avoid being exposed to small children or pregnant women, reminders of what they see

Physicians treating infertile couples must balance high tech and humanity

As specialists in reproductive medicine, Drs. Ken Cadesky and Carl Laskin spend much time dealing with the technical aspects of their practice, focusing on the complex details of ovulatory and hormonal patterns, sperm motility and tubal patency. However, they agree that it is vital to balance high tech with humanity when treating infertile couples.

Both Cadesky, who specializes in reproductive gynecology and surgery, and Laskin, who is a specialist in reproductive endocrinology, are assistant professors in the Department of Obstetrics and Gynaecology at the University of Toronto. They also work at a private fertility clinic in Toronto.

They admit that when it comes to dealing with the emotional aspects of infertility, most Canadian clinics are not as advanced as their American counterparts.

Some American clinics have medical social workers or other counsellors on staff, or at least available, to help clients who are also experiencing psychosocial problems. However, this aspect of care is not covered by Canada's medicare system, which means that it is usually the doctor's responsibility to make time to deal with these issues. "Unfortunately," says Cadesky, "it doesn't always happen."

Although some patients have physiologic problems that are complex and require referral to specialists, Cadesky says family physicians are quite capable of diagnosing and successfully treating many types of infertility.

"Family doctors are in an ideal position to provide support to infertile patients," he adds. "They are probably more familiar with the patient's health and personal history than the specialist, and [likely] have already established a trusting relationship." Even if a family doctors or gynecologists aren't directly involved in diagnosis and treatment of the problem, they can still provide information and counselling if patients need it.

According to American medical family therapists Jeri Hepworth and Susan McDaniel, the role of the doctor in treating infertility is complex. "You become the object of lifelong gratitude if the treatment is successful, or the object of anger if the treatment fails," Hepworth says.

Researchers who study infertility treatment say that frustration with the physician sometimes serves as a unifying force for a disappointed couple, but this "cycle of idealization and embittered anger" can be very stressful for the physician.

Physicians who treat infertility face problems that other doctors might never encounter. For example, should they schedule appointments for infertile patients alongside those of mothers who are coming for prenatal checkups or well-baby visits? Some specialists make an effort to schedule infertility patients separately, but others believe it is better for patients to realize that they can expect to encounter pregnant women and babies everywhere — in their families, at work, on the street, in the doctor's waiting room.

Besides discussing treatment options, infertility specialists may also find themselves refereeing a couple's discussions about money. Certain treatments, such as in-vitro fertilization, are expensive and may not be covered by health insurance, and couples may disagree about making such a major financial commitment. One partner may be willing to spend thousands of dollars on the possibility of parenthood, but the other may have different priorities.

Infertile patients often hesitate to complain or discuss psychological problems. Laskin says he is often the last one on the team to hear that a patient is upset with some aspect of the infertility diagnosis and/or treatment. Patients are far more likely to make a comment to a nurse, lab technician or receptionist than to a physician.

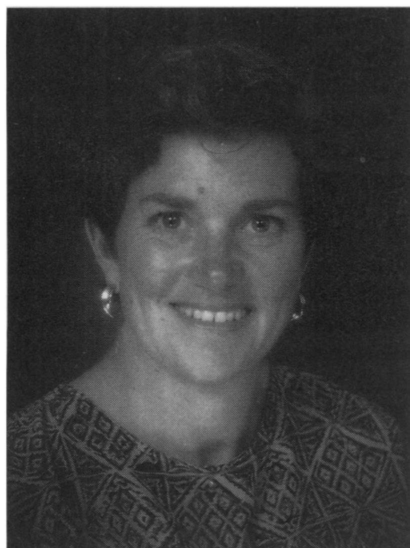
"These patients often worry that they'll be labelled as difficult or hysterical, which will compromise their treatment," he says. "We do our best to reassure them about this and encourage them to bring any problems forward during assessment or treatment."

Some couples are reassured by continuing advances in reproductive technology, feeling that this will bring them closer to a solution. But Hepworth says developments such as egg donation and the use of surrogate wombs also raise new and troubling ethical and emotional dilemmas for patients and physicians. "There's no doubt that as reproductive medicine continues to advance, the emotional and psychological aspects of infertility can only become more complicated," she concludes.

as their own failure. This withdrawal makes the couple feel even more isolated and helpless.

Hepworth and McDaniel say the following strategies, currently employed by medical family therapists and other counsellors, can be adapted for use by family physicians and specialists who treat infertile patients.

- Encourage patients to discuss their infertility rather than keep it a secret. Suggest that they talk to trusted friends and relatives to decrease their isolation and increase the size of their support network. This sharing can help relieve family pressure by eliminating some questions: "When are you two going to give us some grandchildren?"
- Listen to patients to understand what infertility means to them and to their relationship. Once the initial questions about diagnosis and prognosis have been answered, help patients discuss their goals. What things, including children, are most important to making their lives meaningful?
- Help patients put infertility in its place by asking: "Who were you before this took over your life?" Encourage them to continue with hobbies and other activities that they have always enjoyed, rather than adopting infertility as a way of life.



Jeri Hepworth: new breed of counsellor

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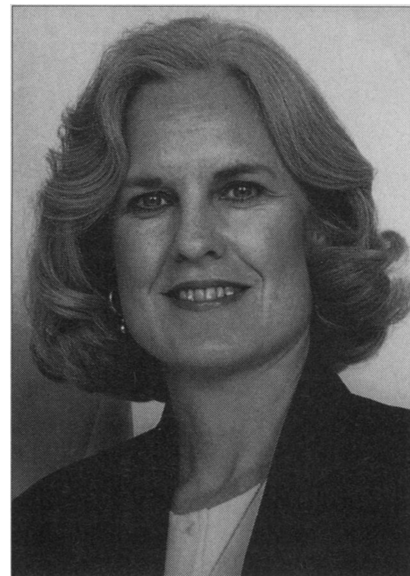

- Encourage patients to grieve losses when they occur, and to take regular breaks from the pressures of treatment. For example, if a particular insemination or conception has failed, suggest that they mark the experience in some way; one couple might console themselves with a quiet evening together, while another may mark the event by planting seeds or bulbs in the garden.
- Do what you can to increase your patients' sense of control. Help them establish agreed-upon goals for treatment, including a reasonable time frame for investigation and treatment; if treatment fails help them discuss other options, such as adoption. There are also times when the doctor must help a couple face the possibility that it's time to stop treatment and "move on."
- Explain that fertility should be seen as separate from potency and sexuality. This is important in helping them protect their sexual relationship during diagnosis and treatment. For example, some patients may opt to refrain from diagnostic testing for a time to help normalize their sexual relationship. If one partner develops a sexual dysfunction, provide reassurance that this is normal under the circumstances, and treat or refer the person appropriately.
- Stay in touch with your own feelings about pregnancy and parenting. Issues in your own life may make you especially sensitive to your patients' experiences, and this can be both a help and a hindrance. Younger physicians who are trying to start a family may feel an underlying sense of anxiety when consulted by an infertile couple. If the physician is a parent, patients may feel some resentment or hint that the doctor "can't possibly understand" what they are feeling.
- Encourage patients to join a support group, such as the Infertility Awareness Association of Canada (based in Toronto, 416 691-3611) or the US group RESOLVE (5 Water Street, Arlington, Massachusetts 12174; **http://www.ihr.com/resolve/index.html**). However, it is important to monitor patients' success in these groups. Support can be valuable, but sometimes patients use them as a way to remain immobilized and focused on their anger. ■